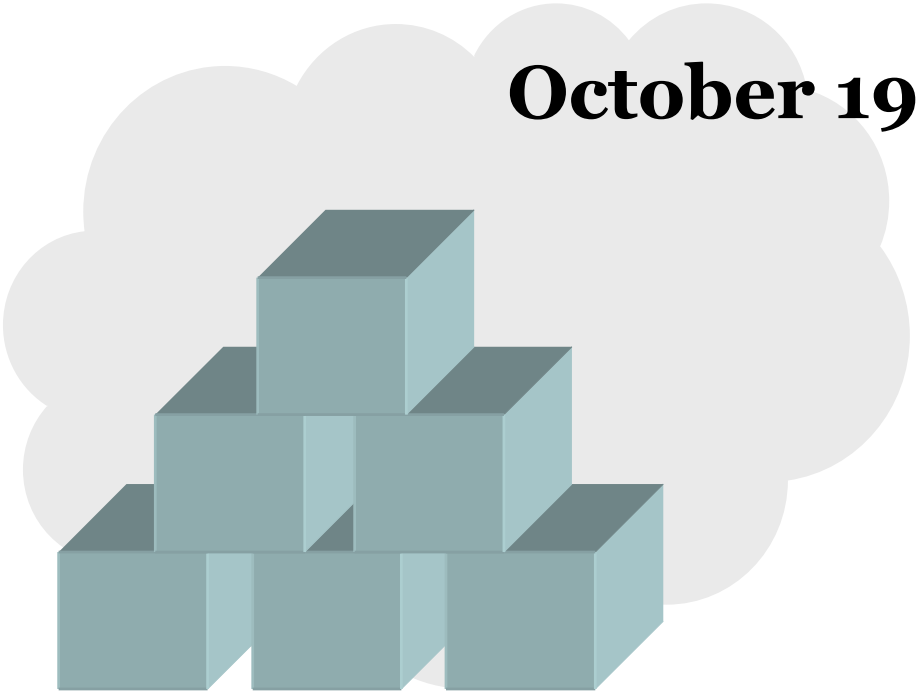
Commissioned Corps Transformation

Implementation Plan

October 19, 2006



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TAB 1

Deputy Secretary's Memo and Transformation Timeline

THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 19 2006

TO: Operating Division Heads
Staff Division Heads

FROM: The Deputy Secretary

SUBJECT: Commissioned Corps Transformation

Following the Secretary's discussion with you about the Commissioned Corps on August 15 and his request for additional feedback on several issues, I sent you a follow-up memorandum identifying the specific information that would be useful in furthering the elaboration of the Department's policy.

I appreciate the amount of thought that you have given to his matter. Many of you focused on the process that you would use to encourage the hiring of Corps officers where possible, particularly in entry-level positions. Most of you did not focus on specific targets to be achieved within the context of your agency missions. At the same time, you reiterated what you consider to be barriers to hiring Corps officers, including the need to strengthen the Corps management and administrative systems for recruitment, selection, assignment, rotation and career development of our officers. We are continuing to move forward in addressing these and other similar issues.

Progress is being made on developing new IT systems and hiring additional Corps management staff. However, many of the systems required will not be on-line until next Spring. Notwithstanding these factors, we can still make significant progress during the coming year. Many of you shared your ideas with RADM Bob Knouss as the Secretary had requested. Now that you have had some additional time to consider your unique needs, I am asking each of you, by November 1, to give me your final plan for emphasizing the hiring of Corps officers through next June 30, across the board, not only for clinical positions.

In June, we will request information from each of you about how successful your plan has been in emphasizing the hiring of Corps officers and fulfilling our commitment to using the Corps according to the Secretary's vision. Based on these reports, we will produce an assessment about how successful we, as a Department, have been. Thereafter, we will be in a position to determine what goals will be needed to be established for FY 2008, including whether we will need to introduce alternative approaches to achieving a specific number or percentage of entry level and mid-career positions.

Furthermore, we are expanding the opportunities for Corps officers, particularly positions dedicated to response; those dedicated to providing clinical care in IHS, HRSA, and other agencies; and those assigned to grantees. Filling these positions will depend on the success of our strengthened recruitment efforts.

In the meantime, based on the comments that have been received, the Secretary has approved the attached milestones for Commissioned Corps systems reform through December 2008. As part of this approval, he has endorsed the recommendations of the Implementation Planning Work Groups except as they apply to the "Corps only" recommendations and the implementation dates where they may differ from the time table approved in the attached milestones.

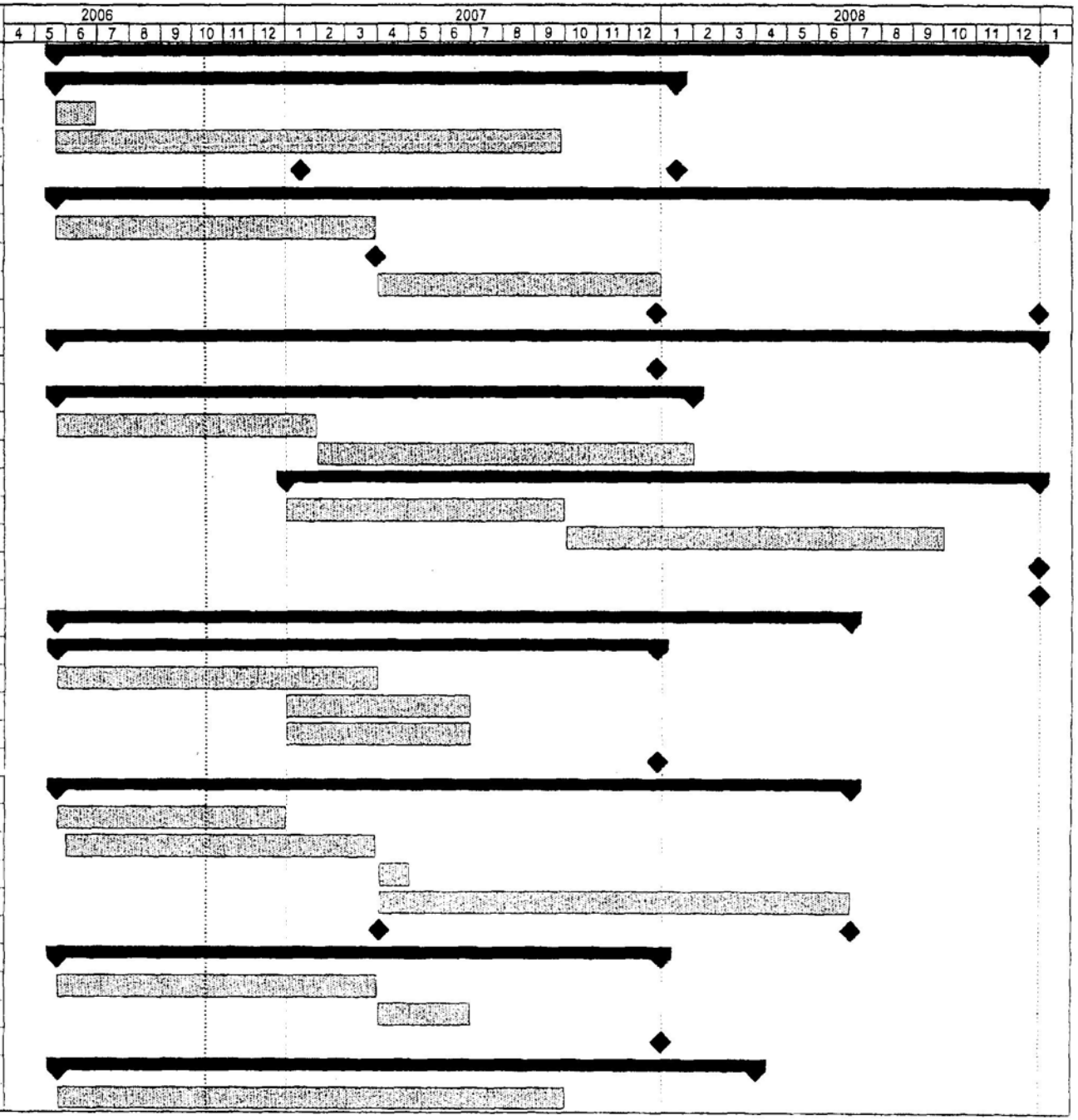
Over the coming months, you will be asked to provide comments about the specific implementation policies derived from these recommendations when they are circulated by the Assistant Secretary for Health. In addition, the Transformation Implementation Planning Coordination Group, chaired by RADM Bob Knouss, will continue to meet regularly to review progress toward the accomplishment of our milestones and to provide advice to the Assistant Secretary for Health and me about the steps we need to take to overcome barriers to our accomplishing our objectives as they may arise.

Alex M. Azar II

Attachment

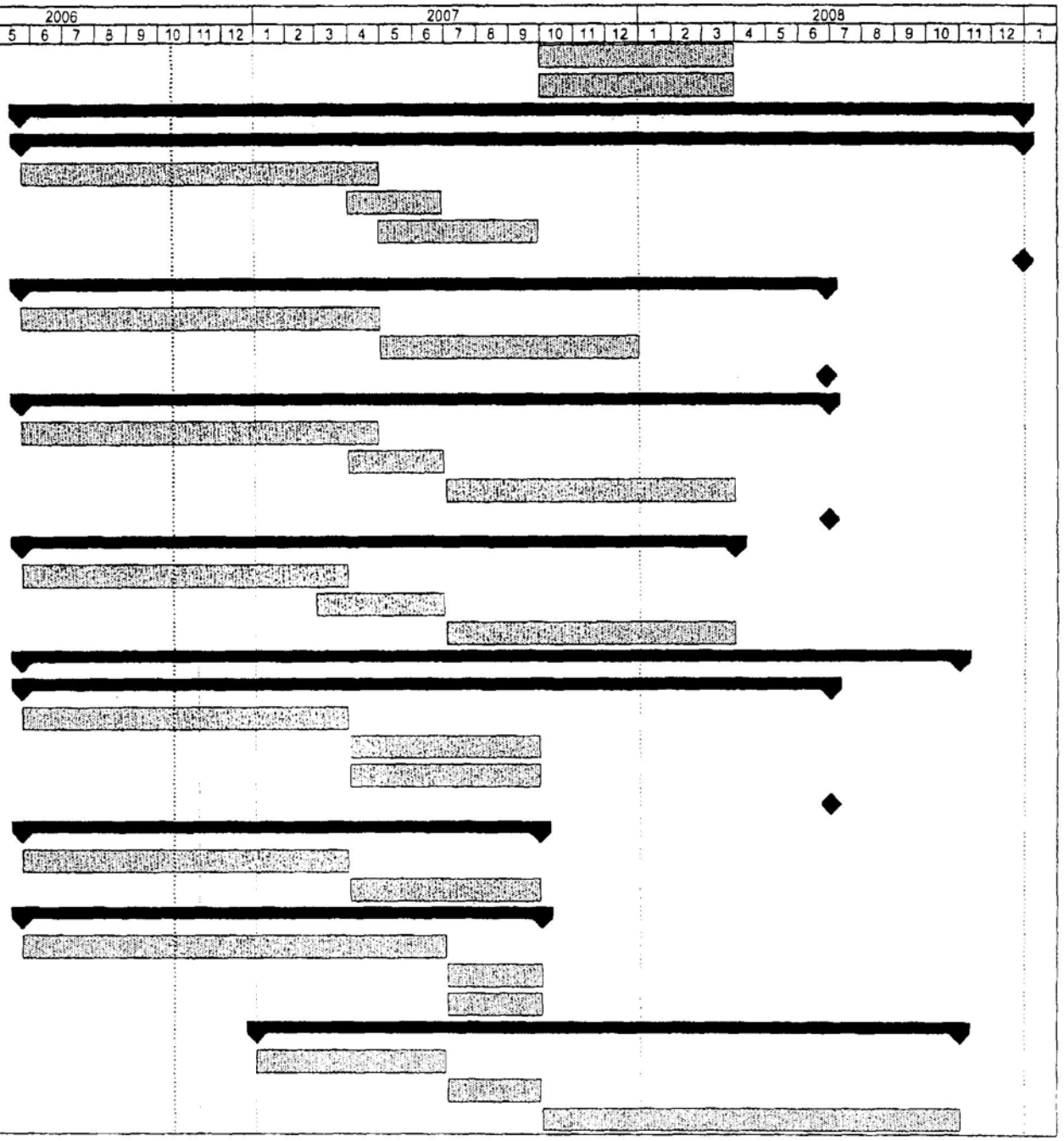
Transformation Implementation Timeline
October 12, 2006

ID	Task Name
1	**Readiness**
2	**Active Duty**
3	Initial Implementation
4	IT and Human Systems Online
5	Assessments Completed
6	**HAMR**
7	Policy/Design
8	Appropriation
9	Initial Implementation
10	Assessments Completed
11	**Sizing**
12	40% of Growth (6,240)
13	**Non-HHS Agency Assignment Increase**
14	Policy/Design
15	Initial Implementation
16	**Ready Reserve**
17	Policy/Design
18	Initial Implementation (pending legislation)
19	Assessment Completed
20	100% of Growth (6,600)
21	**Recruitment/Training**
22	**Recruitment System**
23	Policy/Design
24	Initial Implementation
25	IT and Human Systems Online
26	Assessment Completed
27	**Call to Duty**
28	Policy/Design
29	IT and Human Systems Online
30	Initial Implementation
31	IT and Human Systems Enhancement
32	Assessments Completed
33	**Two-Week BOTC**
34	Policy/Design
35	Initial Implementation
36	Assessment Completed
37	**Training, Education and Career Development**
38	Policy/Design



Transformation Implementation Timeline
October 12, 2006

ID	Task Name
39	Initial Implementation
40	IT Systems/Distributed Learning
41	**Classification**
42	**Functional Groups**
43	Policy/Design
44	Initial Implementation
45	IT and Human Systems Online
46	Assessment Completed
47	**Position Classification (Corps-Only, Mixed, Civilian)**
48	Policy/Design
49	Initial Implementation
50	Assessment Completed
51	**Billet System**
52	Policy/Design
53	Initial Implementation
54	IT and Human Systems Online
55	Assessment Completed
56	**Billet Rewrite**
57	Policy/Design
58	Initial Implementation
59	IT and Human Systems Online
60	**Assignments**
61	**Officer Profiles**
62	Policy/Design
63	Initial Implementation
64	IT and Human Systems Online
65	Assessment Completed
66	**ISOHAR**
67	Policy/Design
68	Initial Implementation
69	**Selection System**
70	Policy/Design
71	IT and Human Systems Online
72	Initial Implementation
73	**Allocations**
74	Policy/Design
75	IT and Human Systems Online
76	Initial Implementation



TAB 2

Summary: Final Transformation Work Group Reports

Summary
Final Transformation Work Group Reports
March 8, 2006

Background

Five Transformation Implementation Planning Work Groups designated by the Deputy Secretary began meeting on January 5 and, after simultaneous weekly meetings, completed their reports on March 8, 2006. Each agency and staff office that employs Commissioned Corps Officers was invited to designate a member of each work group. In addition, the United States Coast Guard and the Federal Bureau of Prisons were invited to designate representatives. The Office of Commissioned Corps Force Management (OCCFM), the Office of the Surgeon General/ Office of Commissioned Corps Operations (OCCO) and a contractor, the Lewin Group, provided staff support. A Coordinating Group of the work group chairs and senior leaders representing the Deputy Secretary, the Assistant Secretary for Health, the Surgeon General and the Executive Secretary also met each week to assure as much as possible that the work groups' recommendations were compatible with each other and with the Secretary's decisions.

The charge to the work groups was to develop the detail that will be needed to implement the Secretary's December 5, 2005, transformation decisions with as much consensus from the Department's agency heads as possible. Following is a summary of the work groups' recommendations. Separate cost projections have not yet been made for each of the recommendations, although the $10 million increase in the transformation budget request for FY 2007 will begin the process to convert to "active management" of the Commissioned Corps instead of the passive system now in place.

Readiness (Chair – RADM John Babb)

The group is recommending that all Corps officers meet readiness standards and that all officers be assigned a deployment status as part of one of the following categories of teams:

- Tier 1 team (response time 12 hours) – a Rapid Deployment Team (5 teams of 105 officers each able to respond in 12 hours), or a Secretary's Emergency Response Team (SERT)(10 teams of 30 officers each);
- Tier 2 team (response time 36 hours)- a Mental Health team (5 teams of 26 each), an Applied Public Health team (5 teams of 47 officers each), or a medical team (10 teams of 105 officers each);
- Tier 3 team – every one else who is on active duty and is not in a mission critical position (this excludes all Coast Guard officers)
- Tier 4 team – the ready reserve

All active duty officers in Tiers 1, 2, and 3 would be placed on monthly rosters, with one-fifth of officers being on-call in a given month. Per the Secretary's request, agencies

would designate a limited number of officers as "mission critical," based on criteria defined in the Readiness Work Group's Policy Document. Such officers would deploy only in the most severe circumstances.

A new type of team, the Public Health Service Health and Medical Response (PHS HAMR) Team, would be organized and trained based on the recently published White House Report on the Katrina response. It would have 315 full time members who would have three missions: 1) deploy on behalf of the Secretary, 2) train or provide training to other officers, and 3) provide clinical and public health services at IHS Service Units or HRSA Migrant or Community Health Centers.

A process is described for determining which Corps officers should be members of which teams, what the training components and commitments should be (Tier 1 teams– 2 weeks annually; tier 2 – one week annually). Furthermore, Corps officers would be activated for emergency responses by the Secretary. For the HAMR team, the Work Group estimates that $36.3 million and 325 FTEs (for the 315 full time team members and 10 support personnel) will be needed annually.

Sizing the Corps (Chair – RADM Sam Shekar)

Based on the mission needs identified by the Secretary, the Sizing Work Group recommended that all initial growth of the Corps should be directed to the clinical needs of the Corps, including those in the mental health functional groups.

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- 48 percent of the Corps' 6,600 officers should be allocated to clinical positions (up from current 43 percent).
- Applied Public Health strength would be preserved at current level (42 percent of Corps).
- Mental Health would make up five percent of the Corps. About two-thirds of the mental health requirement can be met with officers currently on active duty.
- Research will constitute five percent of the Corps; the number of research positions would remain the same as today.

Officers who have clinical skills and credentials should maintain their clinical currency and be available for deployment in a clinical or public health capacity regardless of functional group, including many officers who serve daily in Applied Public Health (APH) roles.

Among officers in clinical billets, 28 percent would be deployable (now 22 percent). As clinical vacancies are filled via growth in the Corps, the availability of clinicians for deployment would be expected to increase. The rate of deployment for clinical officers in underserved areas would be expected to be lower to protect patient care. Officers in the Mental Health functional group would deploy clinically, at a rate of 75 percent. Research officers would not be required to deploy in a Tier 1 or Tier 2 response, but would be expected to deploy in Tier 3, unless in mission critical positions.

Short-term strategies for reaching these goals include filling clinical vacancies, placing officers in non-Federal positions, emphasizing junior officer recruitment, and managing retention (22% of officers have more than 20 years of service and another 22% are within 5 years of retirement eligibility.) Longer-term strategies include creating a warrant officer Corps and a Ready Reserve. (Note that the creation of the HAMR Team will contribute 325 officers to the increased size of the Corps.)

Recruitment, Training and Career Development (Chair – CAPT Kerry Nesseler)

Growing the Corps to reach sizing targets is challenging due to health professional shortages. To succeed, the Corps must recruit and develop officers in a manner that is active, strategic and mission-driven. The Recruitment, Training and Career Development Work Group developed recommendations based on strengthening central force management and developing strong partnerships with HHS agencies and the other customers of the Commissioned Corps

Recommendations for recruitment include:

- Streamline the Call to Active Duty (CAD). Reduce average CAD time from 26-52 weeks to 8-12 weeks by prescreening candidates, adopting a fully capable web-based application system, and out-sourcing credential verification.
- Provide one-on-one assistance for applicants and ongoing counseling throughout an officer's career.
- Employ full-time central recruiters and field recruiters, managed centrally, and charged with carrying out centrally developed goals.
- Establish a Commissioned Corps Centers of Excellence program (C3E) at high-priority centers of healthcare education.
- Employ a Public Information Officer who would be a Corps-dedicated resource integrated with HHS' Office of Public Affairs.
- Establish a USPHS Corps Student Loan Repayment and Scholarship Program and require payback tours in directed assignments in isolated hardship, hazardous duty and hard-to-fill (3H) billets.
- Reorganize existing Corps recruitment programs, such as the Commissioned Officer Student Training and Externship Program (COSTEP), to streamline management and increase their appeal to health professional students.
- Reach more students in agency pipeline programs.[1]

Recommendations for training and development include:

- Develop goals and core competencies, to guide training and career management of officers; these efforts should accord with HHS' human capital management. principles, including strategic workforce analysis, and short and long-term strategies to effectively deploy and develop Corps officers.

[1] Many of the Corps' recruitment goals can be reached by more actively encouraging Epidemic Intelligence Service (EIS), National Health Service Corps (NHSC), and IHS pipeline participants to join the Corps.

- Develop a two-week Call to Active Duty, Basic Officer Training Course (CAD BOTC) as a first priority, using instructional design and adult learning principles.
- Support retention and enhance officers' skills by developing a training and career development continuum throughout their careers using instructional design and adult learning principles. These courses would be offered as a series for officers to receive career-long training specific to their careers as Uniformed Services Officers:
    - Intermediate Officer Training Course: 5-7 years
    - Advanced Officer Course: 10-12 years
    - Executive Officer Course: 17 years and over.

Assignments (Chair – RADM Eric Broderick)

The Assignments Group recommended systems for staffing Corps and mixed positions. It gave special focus to addressing requirements in isolated/hardship, hard-to-fill, and hazardous (3H) clinical positions.

Assignment priorities would be 1) the needs of the Corps; 2) the needs of the agency; 3) the career development needs of the officer; and 4) the preferences of the individual. The Corps would rely heavily on incentives and active career counseling to enforce these priorities. For example, after an officer has occupied a position for a period specified on the billet, Corps detailers will counsel the officer regarding potential new assignments.

Officers rotating out of 3H assignments would have preference in competing for positions for which they are deemed qualified and for which they have applied. However, officers in 3H positions would not be required to rotate out if they prefer to continue.

A new procedure for designating 3H positions will be established. The criteria are designed to be flexible and to allow agencies to provide justification in the most cogent manner. Officers filling 3H positions would receive all benefits and bonuses accompanying such designations, paid by agencies. Congruently, the recipient's obligation to the agency would be recognized. An officer is expected to fulfill the contractual obligation to the agency that funded the incentive pay and, if circumstances warrant a change of assignment, the entity that paid the bonus would be reimbursed a pro-rated amount.

- If designated hard-to-fill, the agency must identify and offer a basic incentive package or designate what incentive goes with the assignment (loan repayment, if allowed, Assignment Incentive Pay (AIP), etc.).
- If designated isolated/hardship or hazardous, the agency would be able to provide AIP up to $3,000/month or up to $36,000/year.
- The Secretary of HHS would authorize the payment of all special and incentive pays officers are entitled to receive under Title 37.

Classification and Positions (C&P) (Chair – CAPT Patricia Simone)

This Work Group developed recommendations in four areas: (1) management of officer functional groups; (2) billet content; and (3) billet review and approval. It also considered the information technology (IT) requirements for achieving transformation in the billet system and related areas of force management.

Each officer would be characterized by three descriptors: (1) professional category, (2) functional group, and (3) deployment role. Officers may have more than one deployment role that might change over time. Functional group advisory committees would be formed with Professional Advisory Committees (PACs), to provide guidance on career development and training. Incentives, special pays, and promotion rates within professional categories would be flexible to meet staffing needs in functional groups.

There would be an individual billet for each of the 6,600 planned Corps positions. The Work Group developed detailed recommendations for standard and position-specific billet components. The standard components would generically describe essential duties and corresponding requirements for schooling, functional expertise, and experience. The position-specific information includes additional duties, geographic location, and additional qualifications. Position-specific information would also indicate a recommended tour length.

Billets would be reviewed on a routine basis (random audits). New billets could be developed by the agency, and approved centrally by OPHS based on needs of the Corps. Functional advisory groups would monitor consistency and uniformity of functional billet content across professions.

To support force management, both position and officer information would be available electronically, and appear seamless to users. This modernized IT system is integral to recruitment, training, assignments, deployment roles, and management of incentive and special compensation payments.

TAB 3

U.S. Public Health Service Commissioned Corps
Readiness and Response Program

U.S. Public Health Service Commissioned Corps Readiness and Response Program

03/07/06

Executive Summary

The U.S. Public Health Service Commissioned Corps is the primary response resource available to the Secretary of Health and Human Services in carrying out his responsibilities to provide public health, humanitarian, and clinical services to an impacted Tribe, state, or local government during a Federally-declared disaster, a National Special Security Event (NSSE), or in response to an urgent public health need. As part of the Transformation of the Commissioned Corps, readiness and response must be addressed as one of the primary missions of the Corps. In the Secretary's transformation decisions, he provided the following guidance related to readiness:

- Implement a four-tiered response capability
- Include both active duty and inactive reserve Corps officers, including those in non-HHS agencies, in this four-tiered response
- Acknowledge those officers meeting critical agency missions in the planning
- Make deployment roles and requirements as specific as possible to ensure optimal use of Corps officers

To prepare an implementation plan to address the Secretary's decisions, a Working Group of 21 officers and 4 civilians was formed, representing HHS Operating Divisions and Staff Divisions, and the Bureau of Prisons. The attached document provides operational guidance.

On February 23, 2006, President Bush announced the findings and recommendations from the White House "Katrina: Lessons Learned" report. Among the major recommendations pertaining to the Commissioned Corps, the following are particularly important in relation to the document:

- HHS should organize, train, equip, and roster medical and public health professionals in pre-configured and deployable teams, and
- Create and maintain a dedicated, full time, and equipped response team of Commissioned Corps officers of the U.S. Public Health Service.

The attached document provides guidance for the four Secretarial decisions and the first bullet of the White House's recommendations, while also fully addressing the second bullet.

Document Recommendations Related to Corps Readiness and Response

- Create five Tier 1 Rapid Deployment Force (RDF) Teams of 105 officers each. Two teams will be located in Washington/Baltimore, one in Atlanta/Raleigh, one in Dallas/Oklahoma City, and one in Phoenix/Albuquerque. This geographic co-location will promote the coming together of team members for training and exercises, as well as ease of travel

via charter air, ground, or rail. Teams will be composed of officers who spend two weeks annually in team training and exercise. The on-call RDF will be ready to deploy in 12 hours.

- Create ten Tier 1 Secretary's Emergency Response Teams of 30 officers each. A SERT will be located in each HHS Region. This geographic co-location will facilitate team training, exercises, and team travel. The on-call SERT will be ready to deploy in 12 hours.
- Create five Tier 2 Applied Public Health Teams (APHTs) composed of 47 officers each that will provide a "public health department in a box" for impacted communities. On call APHTs will be ready to deploy in 36 hours.
- Create five Tier 2 Mental Health Teams (MHTs) composed of 26 officers each that will provide mental and behavioral health support for a community. The on call MHT will be ready to deploy in 36 hours.
- Create ten Tier 2 Mission Teams (TTMTs) that duplicate the capabilities of the RDF Teams. Locations for these teams have not been determined, pending expansion of the Corps. The on-call TTMT will be ready to deploy in 36 hours.
- The remainder of the Corps will be assigned to Tier 3, and will provide augmentation to Tiers 1 and 2, or specialized skill sets of officers (e.g., 20 nurse officers to augment a community hospital) rather than extract that particular skill out of a Tier 1 or Tier 2 team – thus reducing the mission team's ability to provide services as a team. Tier 3 officers who are on-call will be ready to deploy in 72 hours.
- The agencies will designate a limited number of officers as "mission critical". These officers will only be called to deploy in the most severe circumstances.
- All officers in all tiers will be placed on monthly rosters, with one-fifth of officers in all tiers being on-call in a given month.
- The Inactive Reserve Corps will be placed in Tier 4. These officers will augment services in impacted community hospitals or other public health and clinical missions.
- The recommendation of the White House Katrina Lessons Learned Report for the Commissioned Corps to develop a full time, dedicated response team validates the integral role such a team can play in an agile and rapid response capability of the Corps. This team (addressed in the Addendum) should initially be composed of 315 officers. The team will be highly trained and fully self-supporting in the initial stages of a deployment. The team – the Public Health Service Health and Medical Response **(PHS HAMR) Team** – will deploy to both domestic and global events, as directed by the Secretary. As a true "Point-Of-The-Spear" unit, the HAMR Team will be composed of clinicians, applied public health experts, mental health, and a management and leadership staff. The HAMR Team will have 3 missions: 1) Deploy on behalf of the Secretary, 2) Train or provide training to other officers, and 3) Provide clinical and public health services at IHS Service Units or HRSA Migrant or Community Health Centers. The creation of the HAMR Team will give the Secretary an extremely flexible asset that is continuously available to support the health and medical needs of the Nation.

Purpose:
To define the readiness and response program maintained and operated by the U.S. Public Health Service Commissioned Corps through the Office of the Surgeon General.

Applicability:
The U.S. Public Health Service Commissioned Corps is the primary response resource available to the Secretary of Health and Human Services in carrying out his/her responsibilities to provide public health, humanitarian, and clinical services to an impacted Tribe, state, or local government during a Federally-declared disaster, during a National Special Security Event, or for an urgent public health need by an HHS Operating Division**.** The Secretary is responsible for carrying out the requirements of Emergency Support Function #8 under the National Response Plan, and may utilize the Commissioned Corps in carrying out these functions.

Every officer, by virtue of their responsibility as a Commissioned Corps officer, is a deployable asset for the Nation. Even officers with a temporary or permanent medical waiver can be considered as deployable within appropriate, restricted circumstances.

The Secretary may also elect to utilize the Corps for international public health missions. An international response capability will require additional resources, training, and preparation of officers (e.g., immunizations, official passports, security clearances) beyond what is outlined within this document.

Authority:

Proponent:

Summary of Revisions/Updates
This policy document:

- Establishes a team-based tiered approach to disaster preparedness and response by the Commissioned Corps,
- Per the President's Katrina Lessons Learned Report, establishes recommendations for a dedicated Commissioned Corps rapid deployment capability,
- Defines the core response missions for the Commissioned Corps,
- Defines readiness and response training for individuals as well as teams,
- Defines the method by which officer readiness skills, training, and experience are collected and maintained,
- Defines the characteristics of officer positions that should be regarded as mission-critical agency assignments, and
- Describes a plan to deploy officers, provide force protection, provide mental health and medical follow-up, after action reporting, and reimbursement.

Policy

Readiness Responsibilities of a Commissioned Corps Officer
The U.S. Public Health Service Commissioned Corps will become a rapidly deployable, well trained, and appropriately equipped force, such that it can meet the response requirements of the Secretary. All Commissioned Corps officers have an obligation to be public health and medical resources to the Nation as described in the National Response Plan. In order to fulfill that obligation, officers must meet and maintain prescribed readiness and discipline-specific skill standards.

As addressed in the Executive Summary of this document, the "Katrina: Lessons Learned" report's recommendation to create a dedicated response team of Corps officers will be phased in as resource decisions are made.

Readiness Standards for Officers

Active Duty and Inactive Reserve Officers in the Commissioned Corps will be designated to one of three levels of readiness: 1) Basic readiness, 2) Response Team readiness, or 3) Response Team Leadership readiness.

Basic Readiness Standard

All Corps officers will meet the Basic Readiness Standard as described in Commissioned Corps policy.

Response Team Readiness Standard

All Corps officers assigned to Tier 1 (Rapid Deployment Force Teams and Secretary's Emergency Response Teams), and Tier 2, (Tier Two Mission Teams, Mental Health Teams, and Applied Public Health Teams) will meet the Response Team Readiness Standard. In addition to all Basic Readiness Standards, officers assigned to these teams will complete team-focused training outlined later in this document in Section 6.4.2. This training will reinforce and enhance their effectiveness while deployed.

Response Team Leadership Readiness Standard

All Corps officers who are designated to Team Leadership positions will complete Basic Readiness Standards, Response Team Readiness Standards, and Team Leadership training outlined later in this document in Section 6.4.4. In addition, they will have previous experience in leading field response missions.

Core Readiness Missions
Commissioned Corps officers are responsible for responding to a wide variety of public health, humanitarian, and medical needs. During a natural or man-made disaster, a National Special Security Event (NSSE), or a request from Federal, Tribal, state, or local partners to address urgent public health needs, the Corps may be directed to perform the following core missions:

* Provide resources to staff a Secretary's Emergency Response Team (SERT)

Provide resources to staff emergency operations centers in Federal agencies (e.g. FEMA, DHS, FBI, HHS, CDC, FDA, HRSA, EPA, BOP), and in impacted states and local governments.

* Provide a Rapid Deployment Force and/or a Tier 2 Mission Team to staff a Federal Medical Station (FMS), a smaller division of the FMS, multiple Point of Distribution (POD) Sites, Community Outreach Teams, Primary Medical Teams, Immunization Teams, or Casualty Collection Point Teams during a mass casualty event.
* Provide a cadre of officers from the geographically-dispersed Tier 3 to augment clinical services in impacted community hospitals or other public health and clinical missions.
* Provide officers who have specific skill-sets to address a broad variety of applied public health needs such as environmental health; food safety; infrastructure integrity; epidemiology and surveillance (disease investigation, monitoring, and tracking); hazardous substances expertise; and occupational health.
* Provide officers who have specific skill-sets to address mental and behavioral health issues.
* Provide senior officers who have a broad understanding of complex public health systems to provide expertise and advice to impacted communities and states.
* Provide a "point of the spear" Health and Medical Response Team as outlined in the "Katrina: Lessons Learned" report to deliver an agile, highly trained public health and medical capacity to any domestic or international mission as directed by the Secretary.

Tiers of Readiness

Active Duty and Inactive Reserve Officers in the Corps shall be placed into one of four readiness and response "tiers," with the Rapid Deployment Force (RDF) Teams and Secretary's Emergency Response Teams (SERTs) being in Tier One, the Applied Public Health Teams (APHTs), Mental Health Teams (MHTs), and Tier Two Mission Teams (TTMTs) being in Tier Two, the remainder of the Active Duty Corps being in Tier Three, and the Inactive Reserve Corps being in Tier Four.

Placing Commissioned Corps officers into response tiers and teams is being undertaken to bring organization and predictability to the process of preparing and deploying this resource, and to enhance performance and effectiveness.

The Health and Medical Response (HAMR) Teams, addressed in the White House "Katrina: Lessons Learned" report, will function as the "point of the spear", representing the primary HHS asset as a rapidly deployable force to provide public health and primary clinical care in the field, responding to terrorist attacks involving Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) events, augmenting hospitals, complementing the National Disaster Medical System (NDMS) in emergencies, and supporting the urgent needs of medically under-served populations during significant events. The HAMR Team concept is discussed in the Addendum to this document. However, until the HAMR Teams are in place, the RDF Teams will fulfill this role as the first HHS team assets in the field.

Officers on RDF Teams, SERTs, Tier 2 Mission Teams, Applied Public Health Teams, Mental Health Teams, and Tier 3 status will be issued a personnel order that states the responsibilities and expectations of their readiness status within the echelons of response carried out by the U.S. Public Health Service.

USPHS Response Tiers

Response Tier	Response Teams	Readiness Requirement	# Officers on Teams	Development Timeline
"Point of the Spear" Dedicated FTEs (4 hour response time)	HAMRs	Basic Readiness Response Team Readiness ACLS, ATLS, PALS for clinicians Inter-Service exercises Response Team Leadership (for leaders)	315	Phased In
Tier One OpDiv FTEs (12 hour response)	RDFs SERTs	Basic Readiness Response Team Readiness Response Team Leadership (for leaders)	525 300	Immediate: All Teams
Tier Two OpDiv FTEs (36 hour response)	TTMTs APHTs MHTs	Basic Readiness Response Team Readiness Response Team Leadership (for leaders)	1050 235 130	Immediate: APHTs and MHTs Phased In: TTMTs
Tier Three OpDiv FTEs (72 hour response)	Remainder of Active Duty Corps	Basic Readiness	Dependent on critical agency mission #	Immediate: All Officers
Tier Four (72 +_hour response)	Inactive Reserve Corps		2000	Phased In

Tier One

As currently recommended, all officers assigned to Tier One readiness status are pre-identified by the Department and their agency as the first Commissioned Corps assets to be deployed. Their level of readiness and training exceeds that of other officers, and contributes directly to the Department's capacity to respond rapidly and effectively**.**

Rapid Deployment Force (RDF) Teams

As a Tier One resource, the RDF will consist of five separate teams, each composed of approximately 105 active duty officers. Two of the teams will be located in Washington/Baltimore area, one team in the Atlanta area (GA, SC, NC), one team in the Phoenix area (AZ, NM), and one team in the Dallas area (TX, OK). The RDF will deploy as a *team(s),* with a built in command and control structure that will report through the Secretary's Emergency Response

Team (SERT). An RDF will be able to be rapidly contacted (within one hour of activation) via automated electronic notification system and beepers worn by all RDF personnel. Since these individuals have all been pre-identified and pre-approved by their OpDiv for rapid deployment, there will be no delay in responding and reporting to a departure point.

The on-call RDF will report to a point of departure within 12 hours of notification. However, members of the Command Staff will be at the point of departure within 6 hours. All RDF members shall be located within 200 miles of a designated departure point in an effort to facilitate travel. The entire team will be able to depart from one or two points of departure via charter air, ground, or rail – thus improving response time.

Each RDF member will be on orders, which contains the officer's readiness role, outlines the requirement that the officer will be in on-call status every 5 months, and will be expected to function in the HHS response hierarchy.

RDF members assigned to clinical responsibilities as a function of their team selection will be clinically current, as defined in their deployment role. All RDF members will also spend two weeks annually in a team training deployment. This training will include a field exercise, wherein they will use the equipment and supplies designated for RDF use during a true deployment. Optimally, the training/deployment will be conducted at a site where real-time clinical and environmental services may be needed, such as near an IHS Medical Center or HRSA community/migrant health center to provide the team with opportunities to engage in direct patient and public health services in the community.

RDF Personnel

<u>Command Staff</u>	
Team Leader	1
Deputy TL	2
Chief Medical Officer	1
Safety Officer	2
Administration/Personnel	9
Logistics Personnel	4
Communications/Intel	4
Liaisons	2
<u>Clinical Staff</u>	
Physicians	8
Nurse Practitioner/Physician Assistant	8
Dentists	4
Nurses	24
Pharmacists	8
Mental Health Providers	4
Occupational Health/Therapist	4
Medical Records	4

Veterinarians	2
Laboratorians	2
Food Safety/Nutrition	4
Public Health Staff	
Epidemiologists	2
Environmental Health	4
Disaster Response Engineers	2
Total	105

Each RDF will be divided into a "blue" team and a "gold" team, such that one half of the RDF will be primary and the other secondary for their on-call month (as constituted, the RDF can be divided in half) when a smaller response is appropriate, or for two separate mission assignments in the same theater of operations. If the response needs exceed the capacity of the on-call RDF, the team can be augmented by Tier Two Mission Teams, as well as appropriate officers from Tier 3. Five of the RDF administrative personnel will be assigned to "home support" during a mission, such that they will not deploy, but will support the team in all appropriate requirements from the home base.

RDF Capabilities:

- Mass care (primary care, mental health, and public health services for the sheltered population) (May include staffing a Federal Medical Station)
- Point of Distribution (POD) Operation (mass prophylaxis and vaccination)
- Medical surge
- Isolation and quarantine
- Pre-hospital triage and treatment
- Community outreach and assessment
- Humanitarian assistance
- On-site incident management
- Medical supplies management and distribution
- Public health needs assessment and epidemiological investigations
- Worker health and safety
- Animal health emergency support

Other Personnel for RDF Support Functions:

Some of the functionality required in specific RDF assignments, such as supporting a Federal Medical Station, requires a number of support positions that are not found in the Commissioned Corps. Illustrative examples include: nursing aide, housekeeping, transportation, and security. In these specific mission assignments, the RDF must be supplemented by other assets. This supplementation can generally be provided by the Medical Reserve Corps.

Medical Reserve Corps Support

There are Medical Reserve Corps Units located in and near each of the RDF cities. Volunteers from these Units can be recruited to support the RDF Teams in a broad variety of roles. MRC members who volunteer to serve with RDF Teams will be designated as members of the Public Health Service Auxiliary (PHS Auxiliary). Prior to an activation, members of the PHS Auxiliary attached to a particular RDF Team will complete all facets of the HHS requirements for credentialing, background investigation, and employment. After these tasks are completed, the requirement to "federalize" PHS Auxiliary members as un-reimbursed Federal employees can quickly be completed by HHS Human Resources so the PHS Auxiliary members can be sworn in during the event. The PHS Auxiliary in RDF cities will train and exercise with the RDF Team to gain familiarity with the Incident Command System, the Team structure, and the expectations of membership.

Secretary's Emergency Response Teams (SERTs)

As a Tier One resource, the SERT will consist of ten separate teams, each composed of 30 active duty officers. The teams will be associated with each of the HHS Regional Offices, and the SERT Leadership cadre will come from that Region. However, because some regions lack sufficient personnel to support a 30 officer SERT, teams in those regions may be supplemented by officers located outside the immediate area of the regional office. The SERT will deploy as a *team,* with a built in command and control structure that will report through the Secretary's Operations Center. A SERT will be able to be rapidly contacted (within one hour of activation) via an automated electronic calling system and beepers worn by all SERT personnel. Since these individuals have all been pre-identified and pre-approved by their OpDiv for rapid deployment, there will be no delay in responding and reporting to a departure point.

Two SERTs will be on call every 5 months, with one of those two SERTs being the primary on-call team during their assigned month. The on-call SERT will report to a point of departure within 12 hours of notification. However, officers on the Command Staff will be at the point of departure within 6 hours of notification. The SERT Leadership will be located within 200 miles of a designated departure point to facilitate travel. The entire leadership cadre will be able to depart from a single point via charter air, ground, or rail – thus improving response time.

Each SERT member will be on orders, which contains the officer's readiness role, outlines the requirement that the officer will be in on-call status every 5 months, and will be expected to function as the HHS point of the spear.

The SERT may be augmented by personnel from CDC, SAMHSA, and other agencies to direct specialized team operations, such as those provided by the APHTs and MHTs. The agency augmentees may also support other SERT functions.

SERT Personnel

Principal Federal Official Cell Liaison	1
Commander (Regional Emergency Coordinator)	1
Deputy Commander	1
Safety Officer	1
Operations Chief	1
Deputy Ops Chief	1
Liaisons (Env Hlth, Mental Hlth, Med)	6
Logistics Chief	1
Deputy Log Chief	1
Logisticians	4
Planning Chief	1
Deputy Planning	1
Planners	2
Admin/Finance Chief	1
Deputy Admin/Finance	1
Admin Personnel	2
Information Chief	1
Communications Specialists	2
IT Personnel	2
Total	30

Tier 2 Teams

Tier Two Mission Teams (TTMTs)
NOTE: Tier 2 Mission Teams will be phased in over time. First efforts will be directed at building RDF Teams, SERTs, MHTs, APHTs, and Tier 3. Tier 2 Teams beyond the APHTs and MHTs will be developed as the clinical capabilities of the Corps are increased to the target of 6600 officers

The second tier of the Commissioned Corps response will consist of ten separate Tier Two Mission Teams (TTMTs), each composed of 105 active duty officers. The location of each TTMT will be determined after the full implementation of RDF Teams, SERTs, MHTs, APHTs, and Tier 3. TTMTs will deploy as a *team(s)*, with a built in command and control structure that will report through the Secretary's Emergency Response Team (SERT). A TTMT will be able to be rapidly contacted (within four hours of activation) using an automated electronic calling system and the officers' home phone, work phone, cell phone, and email. Since these individuals have all been pre-identified and pre-approved by their OpDiv for Tier 2 deployment, there will be no delay in responding and reporting to a departure point. Two TTMTs will be on call every month (with one being primary and the other secondary), and this on-call status will be rotated among the ten TTMTs. Every attempt will be made to assure that at no time will an RDF and a TTMT from the same region be on call during the same month rotation.

This will avoid too many officers being deployed from duty stations in the same area at the same time, except under the most extreme responses.

TTMTs will rotate being the on-call team every five months. The on-call TTMT will report to a point of departure within 36 hours of notification. Each Team member will be on orders that contain the officer's readiness role, outlines the requirement that the officer will be in on-call status for one month every 5 months, and will be expected to function in the HHS response hierarchy.

TTMT officers assigned to clinical roles will be clinically current, as defined in their deployment position responsibilities. Tier 2 members will also spend one week annually in a team training deployment (as described in 6.4.2.3.2 above). This training will include a field exercise, wherein they will use the equipment and supplies designated for use during a true deployment.

Tier Two Mission Team Personnel

TTMT Personnel will duplicate the roster for the Rapid Deployment Force Team as described in 6.3.1.1.1 above.

Applied Public Health Teams (APHTs) (Tier 2)

The Centers for Disease Control and Prevention (CDC) is widely acknowledged as having the technical expertise in responding to requests for assistance to address applied public health issues. When Mission Assignments are issued to HHS for applied public health requirements, the CDC Director, through the CDC Director's Emergency Operations Center (DEOC), will usually direct those activities on behalf of the Department. A CDC representative may be deployed to augment the SERT for purposes of coordinating and delivering applied public health programs

The U.S. Public Health Service Commissioned Corps can provide officers with a pre-identified skill-set who are stationed throughout HHS and non-HHS agencies. These officers have varied applied public health expertise that, if coordinated, would be valuable resources to the CDC in its response to a community attempting to recover from a natural or man-made disaster or emergency. To draw on this universe of expertise, APHTs will be created to deliver what can be described as a "public health department in a box" to impacted communities. The APHTs may be augmented by Subject Matter Experts, as required by the mission.

An Applied Public Health Team will be integrated into the Commissioned Corps' response at any given point in time, as required by Federal, Tribal, state, or local requests for assistance; or via an international mission request. The APHTs will be composed of experts in public health assessments, environmental health, infrastructure integrity, food safety, vector control, epidemiology, and surveillance. Previous experience in disaster response activities has revealed a significant need for the skill sets listed above when responding to complex disasters.

APHT members will be divided into 5 equivalent Teams of 47 officers. These Teams will rotate being the primary on-call team every five months. The on-call APHT will report to a point of departure within 36 hours of notification. Each APHT member will be on orders that contains the officer's readiness role, and the requirement that the officer will be in on-call status every 5 months, and will be expected to function in the HHS response hierarchy

The APHTs will be "virtual" teams. Since these PHS Commissioned Corps officers are stationed in a variety of locations across the country, the creation of standing teams of applied public health experts based within specific regional geographic areas would be difficult. However, the use of modern electronic communication methods would permit the development of virtual teams with pre-identified team leadership and team members. These standing teams would be able to address the broad and multiple public health issues of a particular disaster/emergency. Recommended training will be on-line, or provided at national professional meetings such as the Commissioned Officers Association.

It is acknowledged that the APHT will report through the SERT hierarchy as part of the HHS response, but will be primarily coordinated by the CDC Director. If the SERT is not deployed, the CDC will manage the applied public health team mission assignments and resourcing on behalf of the Secretary's Operations Center (SOC). For visibility and informational purposes, the APHT leadership will have a "dotted line" relationship with OSG/OFRD.

APHT Personnel

Team Leader	1
Deputy Team Leaders	2
Liaison Officers	2
Safety Officers	2
IT Personnel	2
Industrial Hygienists	4
Hazardous and Solid Waste Experts	4
Epidemiologists	4
Environmental Health	6
Disaster Response Engineers	4
Food Safety Inspectors	4
Veterinarians	2
Physicians (preventive med)/public health nurses	6
Health Educators	4
Total	47

Each APHT will be divided into a "blue" team and a "gold" team, such that one team will be primary and the other secondary for their on-call month. As constituted, the team can easily be divided in half to 23 members for smaller responses, with the Team Leader being the 24th member of both halves of the

team. If the response needs exceed the capacity of the on-call APHT, the team can be augmented by applied public health officers from Tier 3.

APHT Structure

The APHTs will be arranged into the following sub-specialty units:

- Command Staff
- Support
- Water/Waste Water
- Food Safety
- Animal and Vector Control
- Disease Surveillance
- Occupational Safety
- Preventive Medicine
- Community Health Education

Each sub-specialty unit will have a leader. This will permit the deployment of a specific subset of the APHT depending upon the needs of the impacted area and the type of disaster emergency. However, it is preferred that the APHT be deployed as a complete unit so that maximum and comprehensive applied public health interventions can be applied to the situation.

Mental Health Teams (MHTs) (Tier 2)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is widely acknowledged as having the technical expertise in responding to requests for assistance to address mental and behavioral health issues. When Mission Assignments are issued to HHS for mental and behavioral health requirements, the SAMHSA Administrator, through the HHS SOC, may direct those activities on behalf of the Department. A SAMHSA representative may be deployed to augment the SERT for purposes of coordinating and delivering mental health programs.

The U.S. Public Health Service Commissioned Corps can provide officers with a pre-identified skill-set who are stationed throughout HHS and non-HHS agencies, and have varied mental and behavioral health expertise that, if coordinated, would be valuable resources to SAMHSA in its response to a community attempting to recover from a natural or man-made disaster or emergency. To draw on this universe of expertise, Mental Health Teams will be created to deliver a mental and behavioral health capacity to impacted communities and/or federal responders. The MHTs may be augmented by Subject Matter Experts, as required by the mission.

A Mental Health Team will be integrated into the Commissioned Corps' response, at any given point in time, as required by Tribal, state, local, or OpDiv requests for assistance; or via an international mission request. The MHTs will be composed of experts in mental and behavioral health, particularly as these fields relate to disasters, sudden death, and the ensuing dramatic changes in community, family, and personal life. Previous experience in disaster response activities has revealed a significant need for mental health experts when responding to complex disasters.

MHT members will be divided into 5 equivalent Teams. These Teams will rotate being the primary on call team every five months. The on-call MHT will report to a point of departure within 36 hours of notification. Each MHT member will be on orders that contains the officer's readiness role and the requirement that the officer will be in on-call status every 5 months, and will be expected to function in the HHS response hierarchy.

Each MHT will be divided into a "blue" team and a "gold" team, such that one team will be primary and the other secondary for their on-call month. This primary status will be rotated every 5 months. As constituted, the team can easily be divided in half to 13 members for smaller responses. However, if the response requirements exceed the capacity of the entire on-call MHT, the team can be augmented by mental health providers from Tier 3.

The MHTs will be "virtual" teams. Since these PHS CC officers are stationed in a variety of locations across the country, the creation of standing teams of mental health experts based within specific regional geographic areas would be difficult. However, the use of modern electronic communication methods would permit the development of virtual teams with pre-identified team leadership and team members. These standing teams would be able to address the broad and multiple public health issues of a particular disaster/emergency. Recommended training will be on-line, at OFRD headquarters, or provided at national professional meetings such as COA.

It is acknowledged that the MHTs will report through the SERT hierarchy as part of the HHS response, but may be primarily coordinated by the SAMHSA Administrator. If the SERT is not deployed, SAMHSA may manage the mental health team mission assignments and resourcing on behalf of the SOC. For visibility and informational purposes, the MHT leadership will have a "dotted line" relationship with OSG/OFRD.

Mental Health Team (MHT) Structure

Mental Health Teams will be composed of three types of officers: Team leaders, Mental Health Providers, and Incident Stress Team Members. Officers will be assigned these responsibilities consistent with licensure, training, and experience.

- Mental Health Providers are officers who maintain clinical currency and are licensed as independent practitioners of behavioral health care within the following disciplines: social work, psychology, and psychiatry.
- Team Leaders are Mental Health Providers who have experience as deployed mental health responders, and have received a basic level of training as a stress responder, and field leadership training. To accommodate probable missions that will involve small numbers of providers, the MHT will have both a Team Leader and a Deputy.
- Incident Stress Team Members will be those officers who have incident stress management skills, but do not meet the requirements of the Mental Health Providers. Officers who are licensed independent practitioners but have not

maintained currency may fit into this category. Incident Stress Team Members will also include Occupational Therapists, Psychiatric Nurses, and other skilled categories that do not have independent practice licenses for the provision of mental health. These individuals will not be deployed in a mental health role unless accompanied by a Mental Health Provider.

Mental Health Team Personnel

Team Leader	1
Deputy Team Leader	1
Liaison Officers	2
Admin/Logistical Support	2
IT/Communication	2
Social Workers	5
Psychologists	5
Psychiatrists	2
Incident Stress Team Members	6
Total	26

Mental Health Team Capabilities

- Incident assessment including scope and intensity of event and exposure to trauma,
- Collaborating with local officials and professional groups to assess community mental health prevention and treatment needs,
- Providing system-level consultation and support to develop behavioral health training programs for impacted populations (e.g., the Mercy Model)
- Identifying and referring survivors and responders to needed community services
- Screening and assessment of individuals for a variety of conditions including suicide risk, acute and chronic stress reactions, substance abuse, and mental health disorders,
- Utilizing specialized counseling approaches including suicide prevention and intervention with grief counseling,
- Time-limited counseling or psychotherapy to individuals with serious mental illness and/or substance abuse disorders until local resources return to basic functioning,
- Providing consultation to medical staff on the effects of stress on patient behavior,
- Psychological first aid, including crisis intervention to address mental and emotional needs of survivors and responders following a disaster,
- Consulting on-site incident commanders in the prevention and management of stress including site conditions and work hours to ensure continued mission readiness of responders,
- Providing stress management and counseling services including exit interviews to support responders, and
- Providing assessment, diagnosis, and treatment of persons requiring more intensive psychological interventions, including psychopharmacology consultation through a psych-pharmacy specialist referral when required.

Tier 3 Officers

The Third Tier of the Commissioned Corps response acknowledges the geographic dispersal of Commissioned Corps officers across 800 duty stations. Many of them are in isolated, hard to fill, and single officer assignments that are not conducive to providing officers for a rapid response. With this in mind, officers assigned to the third tier will deploy as augmentees for RDFs, SERTs, TTMTs, APHTs, and MHTs, as well as the National Disaster Medical System, or other missions as required. This should not be interpreted to imply that Tier 3 officers will not be asked to deploy. On the contrary, Tier 3 officers will deploy in those missions requiring specific skills rather than an entire team. For example, a mission request for nurses or pharmacists to augment a hospital, or for engineers to augment the Corps of

Engineers will commonly be filled by officers in Tier 3 rather than extracting these individuals from a Tier 1 or Tier 2 team, which would significantly dilute the effectiveness of the team

Officers designated to Tier 3 will be able to be contacted (within 24 hours of activation) using an automated electronic calling system and the officers' home phone, work phone, cell phone, pagers, and email. These individuals will have all been pre-identified and pre-approved by their OpDiv for Tier 3 deployment. Officers assigned to Tier 3 status will be divided equally into 5 equivalent groups of approximately 600-800 officers each. One group of 600-800 will be on-call every 5 months. Every attempt will be made to separate officers at a particular duty station to avoid deploying too many officers from duty stations in the same area at the same time, except under the most extreme responses.

Tier 3 officers will rotate being on call every five months. The on-call cadre will report to a point of departure within 72 hours of notification. Each Tier 3 officer will be on orders that contains the officer's readiness role, outlines the requirement that the officer will be in on-call status for one month every 5 months, and will be expected to function in the HHS response hierarchy. As Commissioned Officers of the U.S. Public Health Service, Tier 3 officers will be expected to meet all the requirements of Basic readiness.

For tribally-managed programs, there is assurance given that no more than 25% of officers assigned to a particular program would be deployed at any one time, regardless of their placement on tiered response teams, except in the most serious National emergencies.

Tier 4 Officers (IRC)

Officers in the Inactive Reserve Corps (IRC) are designated to Tier 4. In this capacity, they can be utilized as assets for direct response assignments or as backfill for officers deployed in other tiers. IRC officers, when activated with personnel orders, possess all of the privileges and responsibilities of their active duty counterparts. Tier 4 members will be contacted by communication systems within the Office of Reserve Affairs

Although Tier 4 officers require a longer period of time between notification and deployment, the use of “intermittent orders” may shorten this time interval. Additionally, sometimes these officers will be able to deploy for longer periods of time as compared to the typical deployment time frame for Active Duty officers.

As the Inactive Reserve Corps transitions to the “Select Reserve”, this cadre of officers will be incorporated into Corps response planning to a much greater extent. Officers in the Select Reserve may be incorporated into Tier 2 teams if required. Because of the annual training requirement for Select Reserve members, they can be expected to function at the same level as their active duty counterparts as it relates to readiness and response activities.

Response Team Leaders

Response Team Leaders will be selected by the Office of the Surgeon General. This selection will be made in full consultation with HHS Operating Division leadership. These Response Team Leaders, in collaboration with OFRD, will then select the remainder of the team leadership utilizing the following criteria:

- Meet the eligibility criteria for the Field Medical Readiness Badge (FMRB),
- Complete 40 hours of "additional" advanced leadership course training within the last 5 years as defined in an SG memorandum and posted at the OFRD Web site.
- Experience in a leadership position/role during a response for a minimum of 21 days (cumulative) within a 3-year period. To document participation in a leadership position/role, officers must submit a written statement to the Director, OFRD, addressing the following leadership factors for each deployment.

  (a) number of persons reporting directly to the officer;

  (b) total number of persons under officer's direction;

  (c) function of the group commanded;

  (d) relationship to the Secretary's Emergency Response Team and HHS headquarters, if any;

  (e) relationship to other Federal partners, or State, tribal, and local governments or entities;

  (f) impact of officer's decisions on team, site, city/county/State or entire deployment; and

  (g) impact of officer's decisions related to personnel assignments, resource allocation, community public health and communications of the strategic vision.

"Mission Critical" Personnel

Several HHS OpDivs and StaffDivs, as well as agencies outside HHS, which employ Commissioned Corps officers, have some personnel that are "mission critical". In addressing this issue, the HHS Secretary acknowledges that some Corps officers occupy these positions, but referred to them as a "limited number".

To provide guidance to agencies as they claim exemption from deployment for an officer due to "mission critical" status, the officer must meet any one of the following criteria:

- The officer is at a duty station where 25% or greater of authorized positions within an officer's area of primary or shared responsibilities and duties are not permanently staffed on a full time basis, or
- The officer is directly and solely responsible for critical program activities that would otherwise jeopardize patient safety or agency-critical responsibilities if the solely responsible officer were absent for two weeks, or
- The officer is actively engaged as a member of an agency emergency response team and routinely deploys with that team during emergency events, or holds a management position with an agency emergency response team, and is actively engaged in response activities at the duty station, or
- The officer is permanently exempt per their status in the Department or Agency Command and Control Structure, or
- The officer holds a position, which is deemed critical to national security, including details to the DoD and the U.S. Coast Guard, which are exempt under all circumstances, or
- The officer holds an international assignment, or
- The officer is in a long-term training assignment.

No later than December 1 of each calendar year, agencies other than those listed in bullet 5 above, will submit to the OSG a list of officers who should be designated as mission critical for response purposes, and therefore exempt from deploying, except to address the most serious national threats. The submitted list should include officer names, PHS number, billet identifier, and cite which criterion above justifies the exemption. The position occupied by the officer will be granted the exemption, rather than the individual officer, and this status will be reflected in the billet.

Agency exemptions from deployment due to mission critical status will be considered separate from Corps officers who are determined to be temporarily unavailable for deployment due to reasons such as pregnancy, family crisis, medical conditions, or temporary agency holds as reported by the respective agency liaison or emergency coordinator.

Officer Selection for Team Membership

After agencies select those officers/billets that are to be designated as "mission critical" positions, all other Corps officers will be contacted by OFRD. Officers who desire to be placed on Tier 1 RDF teams and SERTs, or Tier 2 TTMTs, APHTs, and MHTs, will be asked to submit an application for team membership. With regards to

the geographic considerations for some of the response teams, the Office of the Surgeon General will select the candidate team leadership for each of the teams. Final selection of the team leaders will require concurrence from the OpDiv. The team leadership, in collaboration with OFRD, will select team members based on the submitted applications. Officer's supervisors will sign off on the officer's readiness designation. Once selected, team members will be issued orders that will include the responsibilities and expectations of their membership on the Department's tiered response.

Officer Rotation on Response Teams

Selection for membership on Tier 1 and Tier 2 teams will be for a minimum of three years. With the intent to balance stability and change as these teams are established, 1/3 of team members will rotate off their team assignment at the completion of year 3, year 4, and year 5. This rotation not only preserves team continuity, but also promotes the responsibility of all officers to participate fully in Corps readiness and response actions. A second three year term will be considered for a small number of officers, depending on their role on the team.

Deployed in Place Status

Deployed in Place Status is a scenario where an officer remains at his/her duty station or nearby office and is NOT on travel orders. A majority of the duties performed by the officer must be in support of and directly related to an ongoing OFRD or OpDiv deployment mission in which other officers are being physically deployed.

The Deployed in Place status must last for at least 7 consecutive days. This definition will not include officers who are working extra hours to cover for the officers from their duty station who have been physically deployed. Agencies will be required to supply OFRD with the names and pertinent information of all Deployed in Place officers, thereby verifying their support of the mission(s) as directed by the Secretary. Agency or Corps recognition may be appropriate for Deployed in Place officers.

Interim Readiness Preparedness Steps

- Communicate with OpDivs to ascertain officers designated as mission-critical
- Designate mission critical officers so they will not be recruited for response teams
- OSG selects candidate Team Leaders for RDFs, SERTs, MHTs, and APHTs
- OSG obtains OPDIV concurrence for leadership selections
- Initiate outreach strategy to recruit officers into response teams. This will include Surgeon General messages, OpDiv all-hands meetings, and other strategies
- Ask entire Corps to submit information forms, indicating relevant training, skills and experience as well as their interest in mission team membership
- Response Team Leaders, in collaboration with OFRD, selects possible team members
- Obtain approval by OpDivs for response team membership
- Notify successful candidates
- Purchase/lease beepers for all RDF and SERT officers
- Distribute beepers to RDF and SERT members

- Program Command Caller system to include beeper communication
- Program Command Caller system to group Tier 1 and Tier 2 officers into response teams and to group Tier 3 officers into on-call months
- Hold RDF and SERT informational and training meetings
- Hold RDF and SERT training and exercise activities
- Hold video teleconferencing meetings to inform and train officers on MHTs and APHTs

Longer Term Readiness Preparedness

- Initiate planning for the point of the spear response capability
- Evaluate Tier 3 members for interest and abilities to lead Tier 2 Mission Teams
- Designate geographical areas for Tier 2 Mission Teams
- OSG selects candidate Tier 2 Mission Team Leadership
- OSG obtains OpDiv concurrence on leadership selections
- Initiate outreach strategy to recruit officers into Tier 2 Mission Teams. This will include Surgeon General messages, OpDiv all-hands meetings, and other strategies
- Utilizing previously submitted information forms, indicating relevant training, skills and experience as well as their interest in Mission team membership – Tier 2 Mission Team Leaders, in collaboration with OFRD, selects possible Tier 2 Mission Team members
- Obtain approval by OpDivs for Tier 2 Mission Team membership
- Notify successful candidates
- Program Command Caller system to include Tier 2 communication
- Hold Tier 2 Mission Team informational and training meetings
- Hold Tier 2 Mission Team training and exercise activities

Readiness Training Program

As the primary Federal responders for medical and public health issues related to a natural or man-made disaster, the U.S. Public Health Service Commissioned Corps must be a highly trained resource for the Nation. The Corps' Readiness Training Program has several components:

Basic Readiness that is required of all officers;
Team-Specific Training and Exercises for officers on RDFs, SERTs, APHTs, MHTs, TTMTs, and other pre-designated response teams;
Role-Specific Training; and
Field Leadership Training

Basic Readiness Training

All Commissioned Corps officers must complete Basic Readiness Training in order to acquire knowledge in emergency preparedness and disaster response. The two components of Basic Readiness Training are coursework in preparedness and response, and the American Heart Association's Basic Life Support for the Healthcare Provider course.

AHA BLS for the Healthcare Provider

This requirement will ensure that the officer maintains a basic level of skill and readiness to address cardio-pulmonary resuscitation, airway obstruction, and operation of an automatic external defibrillator for adults, children, and infants. This course must be completed every two years to retain certification.

Emergency Preparedness and Disaster Response Coursework

Officers will obtain this training in one of two ways: either through successfully completing designated web-based readiness training modules on the OFRD training site, or by successfully completing the two week Basic Officer Training Course (BOTC). The BOTC course will include the training modules designated on the OFRD training site as required for basic readiness, plus the following additional courses:

National Response Plan / National Incident Management System
Incident Command System
Cultural Awareness, Empathy, and Sensitivity Training

Physical Fitness

All Commissioned Corps officers, regardless of occupational specialty, assignment, age, or gender should acquire and maintain a base level of general physical fitness. Generalized fitness standards promote physical readiness commensurate with an active and healthy life style, and deployability of the Commissioned Corps. Such a Corps-wide fitness standard will enhance overall health, physical well being, readiness, and appearance as a uniformed service of the United States.

To meet this physical fitness requirement, Corps officers have two options: 1) successfully complete the Annual Physical Fitness Test (APFT) or 2) earn at least the Presidential Champions Silver Award (or equivalent 45,000 points) annually under the President's Challenge program within the President's Council on Physical Fitness and Sports.

The physical fitness requirement may be permanently or temporarily waived by Medical Affairs Branch, based on written justification from an officer's health care provider.

Medical Readiness

All Commissioned Corps officers will have a physical examination on file with Medical Affairs Branch within the previous 5 years. Additionally, all officers must complete immunization requirements per Commissioned Corps policy.

The immunization requirement for individual disease states may be permanently or temporarily waived by Medical Affairs Branch, based on written justification from an officer's health care provider.

Clinical Currency

All Commissioned Corps officers who provide direct patient care will maintain clinical currency. At a minimum, these officers must complete at least 80 hours of appropriate, direct patient care to support their expected responsibilities during a deployment.

Team-Specific Training

Those Commissioned Corps officers who are assigned to response teams such as the Secretary's Emergency Response Teams (SERTs), Rapid Deployment Force (RDF) Teams, Tier Two Mission Teams (TTMTs), and other designated response teams are required to complete training that is focused on a "team" response. The process of coming together as a group for training and exercises helps teams coalesce into a more effective unit. Team leaders are able to assess the strengths and weaknesses of team members to develop a complementary response strategy, and officers are able to better understand their place in the team structure. Familiarity with the incident command system in a practice setting improves its utilization during a true response.

Team training must be structured on a continuum, with the same courses being offered at least every three years to the Team. This repetition will not only reinforce the training for some, but will incorporate the needs of new team members.

Rapid Deployment Force (RDF) Training

The proposed training is for the Rapid Deployment Force Team anticipated to provide primary medical care in an area that has been overwhelmed in the delivery of medical services within a disaster-impacted area. The RDF Team will be comprised of sufficient numbers of individuals with appropriate skills to provide the necessary public health and medical services to staff a Federal Medical Station (FMS), a smaller division of the FMS, a Point of Distribution (POD) Site, Community Outreach Teams, Primary Medical Teams, Immunization Teams, or a Casualty Collection Point Team during a mass casualty event.

The RDF Team will have sufficient capability to cover all necessary operations, including safety, security, environmental health, food safety, mental health, communications, medical services, administrative management, logistics, and transportation to operate as independently and with as much self-sufficiency as possible. The RDF Team will have sufficient administrative personnel to support its own functions. For example, the RDF must have sufficient administrative personnel to arrange for the logistical needs of its members, the safety of its operational location, monitor preventive medicine concerns, re-order supplies, and initiate patient evacuation. The RDF must be appropriately staffed and prepared to provide operations 24x7.

RDF Team Fundamentals

- Interactive training as a team to cover the Federal Medical Station structure, or a sub-set of the FMS and corresponding roles

- Cross-training of team members to achieve better understanding of the role of others and to provide operational flexibility to expand/contract personnel utilization as needs within the response are modified.
- Training for utilization of standardized forms, databases, medical records, reports, etc related to the provision of medical services and integration of information into the overall response documentation.
- Recognition of the role of appropriate preventive medicine or public health approaches during the initial response that will reduce the risk of subsequent disease burden (i.e. water and food safety).
- Team leadership must assure that training incorporates the concept of monitoring one another for signs of problems/stress and appropriate mechanisms for reporting/intervening. The role of trained mental health professionals on the team to assist with stress control and other related issues for deployed personnel must be emphasized.

RDF Team Applied Training

- Annual two week field exercise, scheduled in advance, which promotes experience with the equipment and operations of the FMS (or other utilized system). Knowledge of how supplies and equipment are packaged; how to set up; anticipated time to set up; who has what roles in setting up; and how to break down the site. Knowledge of equipment/supply availability and how to use. The two-week field exercise should mimic delivery of care in a remote environment, mass casualty, pandemic flu or other scenario. This "training/deployment" would be designed to provide hands-on, didactic, mobility, and other scheduled activities.
- Field training could also include opportunities in which real patients would be seen. The most desirable field training session would take place very near an IHS medical center or HRSA community/migrant health center. This proximity would allow team clinicians and public health personnel to provide direct patient or public health services as a part of their annual training. Other options include exercises with various DOD reserve unit training periods, or the provision of augmented medical and public health services in other humanitarian missions). During this period of time there will be a combination of structured training and provision of medical services, each scheduled at specific times.
- Specific training to promote the interactions with the existing infrastructure of the Federal agency, Tribal, state, or local government for whom the response is provided to assure smooth interactions and transitions
- Specific training to promote the interactions required to successfully integrate Federal resources from NDMS, VA and DoD, as well as volunteer members of the Medical Reserve Corps.

SERT Training

This training program is for the Secretary's Emergency Response Team, which is anticipated to provide leadership in ESF #8 operations, administration, logistics, communications, and intelligence; as well as linkages to Federal partners; Tribal, state and local public health authorities; deployed mission teams; and the Incident Management Team located in the Secretary's Operations Center (SOC) in Washington. The SERT will generally be positioned at or near the Joint Field Office (JFO), in an impacted area after a natural or man-made disaster or a public health emergency.

The SERT must be composed of sufficiently trained individuals to provide the necessary leadership, direction, and linkages to a variety of public health and medical mission teams, such as those staffing a Federal Medical Station (FMS), a smaller division of the FMS, a Point of Distribution (POD) Site, Community Outreach Teams, Primary Medical Teams, Immunization Teams, or a Casualty Collection Point Team during a NSSE or other event involving mass casualties.

The SERT must have sufficient capability of covering all necessary operations (safety, security, environmental health, mental health, communications, medical services, administrative management, logistics, personnel, intelligence, and transportation) to operate as independently and with as much self-sufficiency as possible. The SERT must have sufficient administrative personnel to arrange for the needs of not only its members, but the needs of all mission teams in the theater of operations. The SERT must be staffed sufficiently and prepared appropriately to staff operations 24x7.

SERT Fundamentals

- Interactive training as a team to support all designated missions by ESF #8
- Specific training in the Incident Command System, the National Response Plan, and the National Incident Management System.
- Training that is specific to the individual officer's deployment role on the SERT.
- Cross-training of team members to achieve better understanding of the role of others and to provide operational flexibility to expand/contract personnel utilization as needs within the response are modified.
- Training for utilization of standardized forms, databases, medical records, and reports, related to the provision of medical services and integration of information into the overall response documentation.
- SERT leadership will assure that training incorporates concept of monitoring one another for signs of problems/stress and appropriate mechanisms for reporting/intervening. The role of a mental health liaison on the team to assist with stress control and other related issues for deployed personnel must be emphasized.

SERT Applied Training

- Annual two week field exercise, scheduled in advance, which promotes experience with the equipment, databases, and operations of the SERT.

Knowledge of how SERT equipment is packaged; how to set up; anticipated time to set up; who has what roles in setting up; and how to break down the site. Knowledge of equipment/supply availability and how to use. The two-week field exercise should mimic the mission of a SERT in supporting ESF #8 response teams. This training would be designed to provide hands-on, didactic, and other scheduled activities.

- Specific training to promote the interactions with the existing infrastructure of the Federal agency, Tribal, state, or local government for whom the response is provided to assure smooth interactions and transitions
- Specific training to promote the interactions required to successfully integrate Federal resources from NDMS, VA and DoD, as well as "federalizing" members of the Medical Reserve Corps.

Tier Two Mission Team Training

The proposed training for Tier Two Mission Teams is reflective of that described above for Rapid Deployment Force Teams at 6.4.2.1**.** The TTMTs are also expected to provide primary medical care in an area that has been overwhelmed in the delivery of medical services within a disaster-impacted area. TTMTs must be comprised of sufficient individuals to provide the necessary public health and medical services to staff a Federal Medical Station (FMS), a smaller division of the FMS, a Point of Distribution (POD) Site, Community Outreach Teams, Primary Medical Teams, Immunization Teams, or a Casualty Collection Point Team during a mass casualty event.

The TTMTs must have sufficient capability of covering all necessary operations including safety, security, environmental health, food safety, mental health, communications, medical services administrative management, logistics, and transportation to operate as independently and with as much self-sufficiency as possible. A TTMT must have sufficient administrative personnel to support its own functions. For example, the TTMT must have sufficient administrative personnel to arrange for the logistical needs of its members, the safety of its operational location, monitor preventive medicine concerns, re-order supplies and initiate patient evacuation. The TTMT must be staffed sufficiently and prepared appropriately to staff operations 24x7.

Tier Two Mission Team Fundamentals

- Interactive training as a team to cover the Federal Medical Station structure, or a sub-set of the FMS and corresponding roles
- Cross-training of team members to achieve better understanding of the role of others and to provide operational flexibility to expand/contract personnel utilization as needs within the response are modified.
- Training for utilization of standardized forms, databases, medical records, and reports, related to the provision of medical services and integration of information into the overall response documentation.

- Recognition of the role of appropriate preventive medicine or public health approaches during the initial response that will reduce the risk of subsequent disease burden (i.e. water and food safety).
- Team leadership will assure that training incorporates the concept of monitoring one another for signs of problems/stress and appropriate mechanisms for reporting/intervening. The role of trained mental health professionals on the team to assist with stress control and other related issues for deployed personnel must be emphasized.

Tier Two Mission Team Applied Training

- Annual one-week field exercise, scheduled in advance, which promotes experience with the equipment and operations of the FMS (or other utilized system). Knowledge of how supplies and equipment are packaged; how to set up; anticipated time to set up; who has what roles in setting up; and how to break down the site. Knowledge of equipment/supply availability and how to use. The one-week field exercise should mimic delivery of care in a remote environment, mass casualty, pandemic flu or other scenario. This training would be designed to provide hands-on, didactic, mobilization, and other scheduled activities.
- Field training could also include opportunities in which real patients would be seen. The most desirable field training session would take place very near an IHS medical center or HRSA community/migrant health center. This proximity would allow team clinicians and public health personnel to provide direct patient or public health services as a part of their annual training. Other options include exercises with various DOD reserve unit training periods, or the provision of augmented medical and public health services in other humanitarian missions). During this period of time there will be a combination of structured training and provision of medical services, each scheduled at specific times.
- Specific training to promote the interactions with the existing infrastructure of the Federal agency, Tribal, state, or local government for whom the response is provided to assure smooth interactions and transitions
- Specific training to promote the interactions required to successfully integrate Federal resources from NDMS, VA and DoD, as well as volunteer members of the Medical Reserve Corps.

Applied Public Health Team Training

Officers assigned to APHT status are virtual teams composed of officers with skill sets in public health assessments, environmental health, food safety, infrastructure integrity, disease investigation, occupational health and vector control. These officers will be expected to complete and maintain Basic Readiness requirements, as well as role-specific training and experience. Other training related to their APHT status may be required.

Mental Health Team Training

Officers assigned to MHT status are virtual teams composed of officers with skill sets in mental and behavioral health, particularly as it relates to disaster response. These officers will be expected to complete and maintain Basic Readiness requirements, as well as role-specific training and experience.

Mental Health skills training would address:

- Crisis intervention skills;
- Incident assessment including scope and intensity of event and exposure to trauma;
- Community assessment including resources and referrals;
- Assessing suicide risk, acute and chronic stress reactions, substance abuse and mental illness and making appropriate referrals;
- Adapting practices to meet varying age, ethnicity and culturally specific needs;
- Responder stress management including working within command to improve site management, work hours, and exit interviews;
- Advise medical providers on the impact of trauma on patient status;
- Post-deployment care for responders

Advanced Mental Health training may include:

- Cognitive Behavioral Therapy for Post Traumatic Stress Disorder, depression and/or anxiety;
- Suicide prevention and intervention
- Traumatic grief counseling

Tier 3 Officer Training

Officers assigned to Tier 3 are expected to complete and maintain Basic Readiness training requirements. This training includes basic emergency preparedness and response, currency in Basic Life Support certification, and clinical currency if rostered as clinicians.

Role-Specific Training

All officers assigned to Tier 1 and Tier 2 will be evaluated for any training gaps that exist in their education, training, skills, and experience related to their placement on the response team. Any shortcomings will be addressed in a variety of ways: by team-delivered training, HHS-sponsored training, or training available in other venues. The goal is to closely align officer capabilities with those job requirements expected of officers during a deployment. This process can be compared to the traditional "privileging" evaluation that occurs in healthcare organizations.

Field Leadership Training

Officers assigned to leadership positions on the Tier 1 and Tier 2 Teams must complete field leadership training. This prescribed training will be provided at least annually by the Office of Force Readiness and Deployment. Other supplemental

training may be required for leaders. Additionally, officers in secondary leadership roles on these teams will be closely mentored by team leaders during exercises and deployments for their potential advancement within their respective Team, as well as their career development as a Commissioned Corps officer.

Deployment Process

The following procedures address the process of rostering, alerting, activating, and deploying Commissioned officers.

Rostering

All officers on Tier 1 (RDF and SERT), Tier 2, (TTMT, MHT, and APHTs), as well as officers in Tier 3, will be on rotational on-call rosters that recur every 5 months. It is expected that officers will have made arrangements with family, OpDivs and supervisors to ensure swift deployment during their on-call month. Although officers may be on annual leave status during their on-call month, they should not be more than 200 miles from their designated departure airport and have an assured means of being contacted. Only officers designated as having mission critical status will not be on a rotational roster.

Advisory Status

Officers placed on Advisory Status should maintain the ability to be contacted immediately, and remain within one hour of their residence.

Alerting

Officers on a current month's rotational roster will be placed on "Alert" status at the very first sign of an impending response. The numbers of Teams placed on alert will be in relationship to the projected size of a response. For example, in most response scenarios, the on call RDF and SERT will be placed on alert. For larger responses, this may include the on call TTMT, APHT and MHT Teams. For larger scenarios, this may also include all officers in Tier 3 who are on call that month. This Alert status notification will also be communicated with HHS and non-HHS agencies.

Deploying

Activated officers will be directed to report to a departure site by an HHS travel agent or contractor. In the case of RDF or SERT members, the entire team may be placed on a MilAir flight or a contract air, ground, or rail carrier. Alternatively, individual members may be ticketed on public carriers. Tier 2, and Tier 3 officers will be ticketed on public carriers due to their geographic dispersal.

Deployment Order

Deploying officers will be issued a Deployment Order by OFRD. This Order directs the officer to deploy on behalf of the Surgeon General for a prescribed event, to provide public health and medical support to the impacted population. A copy of the Order should also be sent to the deploying officers' supervisors.

Office of Force Readiness and Deployment (OFRD) Support

The increased responsibilities highlighted above related to Commissioned Corps response team creation, maintenance, and training, require additional permanent Full Time Equivalents (FTEs) within the Office of Force Readiness and Deployment, and the resulting budget expansion required to support those positions. The existing staff of 7 officers, structured in 2003, was designed to support a much smaller response portfolio for the Commissioned Corps.

To adequately deliver the required programs to support 5 RDF teams, 10 SERTs, 10 TTMTs, 5 APHTs, 5 MHTs and the remainder of the Commissioned Corps as augmentees, OFRD will require an additional 10 FTEs. These positions will have the multiple responsibilities of 1) logistics relating to the utilization of deployment caches, 2) training monthly BOTC classes in all facets of basic readiness, 3) team training, 4) field leadership training, and 5) assuring continual effectiveness and efficiency of OFRD operations and outcomes.

During the activation and deployment phases of a response, the Office of Force Readiness and Deployment will also require the use of temporary "details" of officers to support logistics, communications, and team rotations. This detail may consist of between 5 and 25 officers, depending on the size and complexity of the response. These detailed officers should be drawn from a pre-identified cadre of officers.

Readiness Outreach Strategy
The purpose of this Outreach Strategy is to assure optimal awareness and understanding by all PHS officers and their respective supervisors and agencies of the Readiness Transformation strategy and process in order to improve the Department's and the Nation's readiness capabilities.

Assumptions

- Readiness Transformation will not be released until approved by the HHS Secretary
- An array of adult communication/learning methods will be utilized
- It is critical to effectively collect and assess pertinent officer readiness information
- Open, transparent, and timely communication must be the order of the day

Outreach Communication Steps:

- Summary Letter to all officers from the Surgeon General to provide readiness overview and guidance. This summary should be targeted to PHS officers and their agency leadership
- A supplemental document using frequently asked questions and answers should be developed and posted
- Documents should be disseminated via a variety of venues and listservs
- A designated web site should be developed to post transformation-related documents

- Face to face meetings should be held in venues such as agency all-hands meetings and Professional Advisory Committees (PACs.) Particular emphasis should be on geographic locations expected to "host" RDFs and SERTs.
- A video webcast for officers unable to attend face to face meetings should be posted
- Presentations at the Annual COA Meeting, in the Commissioned Corps Bulletin and in the COA Frontline should highlight key transformation issues
- A Readiness Assessment Form must be distributed to and collected from all Commissioned Corps officers (see 6.8 below)

Readiness Assessment

As soon as HHS and non-HHS agencies submit those officers who are "mission critical", all Commissioned Corps officers will be directed to submit a Readiness Assessment Form. The purpose of this form is for officers to self-assess their readiness capabilities, indicate their interest in serving on various Tiers or Teams as described in this assessment, and obtain documentation of agency approval. Agency approval may be delegated by the agency head. The information obtained from this form will be utilized by the Office of the Surgeon General and designated Team Leadership to assist in planning for the formation of response teams, and the associated training shortfalls of team members.

Readiness Assessment/Commitment Form

The form will be utilized by OSG and the response team leadership to identify appropriate team members for the RDFs, SERTs, TTMTs, APHTs, and MHTs, and will be composed of the following segments to support team membership selection:

- general demographics,
- geographic location (within 200 miles of RDF site or PHS Regional Office),
- current and previous Corps assignments,
- clinical experience in the last 5 years (if applicable),
- experience in deployments – including the role(s) filled on those deployments,
- self-assessment of competencies and skills
- readiness training,
- physical fitness,
- temporary or permanent medical waiver,
- officer's desire to be placed on either a Tier 1 or Tier 2 team,
- designation as Mission Critical by the officer's agency, and
- extenuating family or personal circumstances.

Tiered Readiness Structure

Readiness Tier	Readiness Team	Team Membership	Expectation
Point of			**4 hour response time**

the Spear			
	HAMR Teams To be phased in	**3 teams of 105 officers each**	**Point of the Spear Highly trained Agile, rapid response Domestic or global**
One			**12 hour response time highly trained**
	RDFs	**5 teams of 105 officers each**	**Clinical Applied Public Health Train as a Team Geographically co-located**
	SERTs	**10 teams of 30 officers each**	**Manage ESF #8 in theater Train as a Team Centered in each PHS region**
Two			**36 hour response time highly trained**
	TTMTs To be phased in	**10 teams of 105 officers each**	**Clinical Applied Public Health Train as a Team May be geographically centered**
	APHTs	**5 teams of 47 officers each**	**Applied Public Health "health department in a box"**
	MHTs	**5 teams of 26 officers each**	**Mental and behavioral health expertise**
Three			**72 hour response time No team training**
	Tier 3	**5 equivalent groups of 500-800 officers each**	**Clinical Applied Public Health Mental and behavioral health Augmentation for Tier 1 and Tier 2, and specific skill-sets of officers**
Four			**72 + hours response time No team training**
	IRC	**2000 members of IRC**	**Clinical Applied Public Health Mental and behavioral health Augmentation for Tier 1 & Tier 2, and specific skill-sets of officers**
Other	**Critical Mission**	**A "limited number" per HHS Secretary**	**Will only deploy in the most severe events**

Glossary

Applied Public Health Team (APHT) – One of five tier 2 response teams composed of applied public health experts that can provide a variety of public health services to an impacted community.

Deployed in Place – Status wherein some officers remain at their duty station during a deployment, but a majority of their duties are in support of the deployment.

Emergency Support Function #8 (ESF#8) – One of the 15 primary functions of the federal government outlined in the National Response Plan. ESF #8 responsibilities are to provide for the public health and medical needs of the impacted population during a Federally-declared response. The lead for ESF #8 is the Secretary of Health and Human Services.

Health and Medical Response Team (HAMR) – The HAMR team will be composed of 315 Corps officers who are designated full time to readiness and response actions for the Secretary, HHS. The HAMR team will include clinical staff, applied public health experts, and adequate leadership and management personnel that can function as a SERT immediately upon arrival, until the designated SERT is in theater. The HAMR team will be agile, rapid, and capable of responding to any domestic or international requirement.

Mental Health Team (MHT) – One of five tier 2 response teams composed of mental and behavioral health experts that can provide a variety of mental health services to an impacted community.

Mercy Mission – A collaborative program wherein Corps officers provide programmatic support for local, state, and Tribal organizations to assume control and ownership of the delivery of services. Most notably utilized on the USNS Mercy mission to Indonesia, when Corps officers, in collaboration with local authorities, UNICEF, AusAid, and the U.S. Navy, enabled Aceh citizens to carry out a train the trainer program to protect the fragile mental health of Aceh's children after the tsunami.

Mission Critical – An agency-generated designation of those officers who are required for the agency to meet its critical mission. These officers will only be deployed in the most serious of National events.

Rapid Deployment Force (RDF) – One of five tier 1 response teams composed of clinical staff, public health experts, and in-dwelling administrative support for the team.

Secretary's Emergency Response Team (SERT) – One of ten tier 1 teams that will provide oversight, management, and coordination for field assets, as well as liaison activities with federal, state, and local partners, and communication back to the Incident Management Team in the Secretary's Operations Center.

Tier 1 Response – The primary response assets for the Department. Composed of Rapid Deployment Force teams and Secretary's Emergency Response Teams

Tier 2 Response – The second level of response for the Department. Composed of Applied Public Health Teams, Mental Health Teams, and Tier Two Mission Teams.

Tier 3 Response – The third level of response for the Department. Composed of all officers in the Commissioned Corps not designated to a Tier 1 or Tier 2 response team.

Tier 4 Response – The fourth level of response for the Department. Composed of all officers in the Inactive Reserve Corps.

Tier Two Mission Team (TTMT) – One of ten tier 2 response teams composed of clinical staff, public health experts, and in-dwelling administrative support for the team. The TTMT is a mirror image of the RDF described above, but with a delayed response expectation.

(Addendum Follows)

US Public Health Service Commissioned Corps Response Plan
Addendum

As a result of the issuance of the White House Katrina Lessons Learned document on February 23, 2006, two recommendations of particular importance to the

Commissioned Corps must be incorporated into readiness and response planning. The two recommendations are:

- HHS should organize, train, equip, and roster medical and public health professionals in pre-configured and deployable teams, and
- Create and maintain a dedicated, full time, and equipped response team of Commissioned Corps officers of the U.S. Public Health Service.

The first bullet is incorporated into the primary document *The U.S. Public Health Service Commissioned Corps Readiness and Response Program* (above). The second bullet is addressed in this Addendum to the primary document.

Officers in the Commissioned Corps shall be placed into readiness and response categories, with the "point of the spear" being the Public Health Service Health and Medical Response (HAMR) Team. **HAMR Team officers will be full-time employees of the Office of the Surgeon General, dedicated to readiness and response activities.**

Clinicians comprising the HAMR Team will be highly trained in clinical practice (Advanced Cardiac Life Support, Advanced Pediatric Life Support, Advanced Trauma Life Support), as well as in responses to weapons of mass destruction (Medical Management of Chemical and Biological Casualties, Medical Emergencies of Ionizing Radiation). They will be completely familiar with the use of Personal Protective Equipment. Non-clinicians will all be trained as First-Responders to expand Team capabilities. The HAMR Team will be the Secretary's first asset in addressing deployment needs for National Special Security Events, natural disasters, terrorist attacks, international humanitarian missions, and supporting the needs of medically under-served populations. The HAMR Team will deploy as a *team*, with a built-in command structure, configured such that they can serve as a Secretary's Emergency Response Team (SERT) until a full SERT is in theater.

The remainder of the Active Duty Commissioned Corps are expected to complete training in basic emergency preparedness and response, be clinically current if rostered as clinicians, and capable of supporting large events that are immediately staffed by the HAMR Team. The remainder of the Corps can deploy in a second tier configured as response teams, or in a third tier as individuals. They would fall under the command structure of the SERT.

The Inactive Reserve Corps will comprise the fourth level of readiness, and will be available for short or long-term assignments to augment the Active Duty Corps as well as Department of Defense needs.

Alert Level	Staffing	Capabilities
Point of the Spear The Public Health Service Health and Medical Response	Composed of 5 percent of the Commissioned Corps (315 officers)	1) Hospital Augmentation * All clinicians are trained in Advanced Cardiac Life

(HAMR) Team * The "point of the spear" * Can be contacted via beeper in less than one hour * Can be at a departure site within 4 hours of notification * Always on readiness status * Advanced training and capability for entire team * Team has a full array of field equipment, pharmaceuticals, and supplies * Entire team are full time employees of OSG, who engage in 3 activities: 1) deployments, 2) training, and 3) augmenting underserved areas such as in IHS service units, HRSA community or migrant health centers, or in humanitarian operations. This will allow officers to keep clinically current. * Entire team can deploy for extended periods of much greater than 14 days if required. * HAMR deploys as a team.	RDF 10 team leaders/deputies 20 physicians 140 nurses 10 nurse practitioners 10 physician assistants 10 pharmacists 20 mental health 5 dentists 10 environmental health 10 IT/communication 5 disaster engineers 5 medical records 5 medical technologists 5 epidemiologists 5 veterinarians 5 food safety/nutrition 5 therapists 5 logisticians 5 warehouse employees SERT 2 SERT leaders 6 Operations 5 Logisticians 4 Planning 4 Admin/Finance 4 IT/Communications 2 Safety	Support * All physicians trained in Advanced Trauma Life Supp. 2) Support FMSs * Can expand to 10 medical strike teams with medical, nursing, mental health, pharmacy, and sanitarian capacity * All non-medical team personnel trained as First Responders 3) Deployed to a chemical, biological, radiological, or explosive event * Can run 5 mass prophylaxis POD sites * All personnel trained in use of Personal Protective Equip. * All personnel trained in chem/bio/nuclear response. 4) Deploy to National Special Security Events (particularly in National Capitol Region) as medical strike teams. 5) Deploy at full strength or in strike team configurations

<u>Action Plan for HAMR Team</u>

* Obtain funding commitment and FTEs
* Announce position opportunities - recruit from the Corps <u>and</u> in the private sector, with the majority of HAMR Team members coming via recruitment from the private sector

* Prepare HAMR Team caches by incorporating enhanced segments of Federal Medical Stations
* Obtain Warehouse Space
* Select Team leadership
* Select Team members
* Obtain training for team in ATLS, ACLS, MMCBC, MEIRS, First Responder, Respirator wear and use of Personal Protective Equipment
* Exercise with Team Caches and medical go bags
* Support medically under-served needs of the nation (to keep members clinically current)
* Support domestic and international deployment needs of the Secretary

Budget Needs for HAMR Team

* FTE support (annual)	$32,000,000
* Training budget (annual)	2,000,000
* Travel budget for responses (annual)	500,000
* Equipment cache reconfiguration	1,000,000
* Medical Go-Bag caches (10)	150,000
* Warehouse Space (annual)	150,000
* SERT cache	200,000
* Equipment maintenance/replacement	300,000
	$36,300,000

TAB 4

Sizing the USPHS Commissioned Corps Implementation Recommendations

Sizing the USPHS Commissioned Corps: Implementation Recommendations

March 8, 2006

Introduction

To implement the Secretary's decisions about the future size of the Commissioned Corps, the Sizing the Corps work group developed the following major recommendations:

- Direct all initial growth of the Corps to the clinical and mental health functional groups. This recommendation meets Secretary's charge and is reflected in the sizing proposal as well as the discussion of the Mental Health functional group

- Significantly increase the ability of the Corps to deploy in a clinical role. This includes recognizing the clinical resources currently encumbering applied public health billets and includes an enhanced Ready Reserve

- Balance growth in clinical billets with continued strong focus on the public health and research missions of the Corps

Consistent with these recommendations, the group developed a mission-based functional profile of the Corps, as well as an implementation timeline that recognizes recent and potential trends in attrition.

Secretary's Decisions and Charge

Decisions

On December 5, 2005, HHS Secretary Leavitt announced decisions for transforming the Commissioned Corps, to include:

- Achieving a force of 6,600 active duty officers
- Grouping Officers based on a matrix of professional category and function with four functional groups -- Clinical, Applied Public Health, Research and Mental Health
- Growing beyond this force strength as more assignment opportunities in other federal agencies, at the state and local level and in a ready reserve are developed.

For the Corps to expand its capacity to respond to the nation's public health needs, it must grow from its current size of 6,000. A Corps of 6,600 would have a "basic" level of response capability, able to respond to a large-scale natural disaster while preserving the strength of other Departmental missions. The "basic" strength requirement of 6,600

includes a minimum cadre of 2,242 to staff Corps responses.[1] Other goals of Corps Transformation include:

- Provide Corps officers to the Bureau of Prisons, Coast Guard, etc., to meet statutory obligations.
- Increase staffing in hardship, hazardous, and hard-to-fill (3H) positions
- Carry out agency mission-critical roles, including agency-level responses.

The Secretary has also introduced changes in force management to help the Corps operate more effectively. These changes include grouping officers into four functional areas—Clinical, Applied Public Health, Research, and Mental Health—in addition to the professional categories. The decision to create a Mental Health group was based on prior deployment experience, particularly the hurricanes of 2004 and 2005. With officers placed in a matrix of functional group and professional category, force managers can better align skills with the needs of a particular mission.

Charge

The work group[2] was charged with making recommendations in the following areas:

- Creating the roadmap to meet the 'basic' level of response.
- Developing a detailed plan for the future functional group and professional category configuration of the Corps
- Increase the number of officers available to isolated hardship, hazardous duty, and hard-to-fill (3H) positions
- Protect the research mission of the Corps during emergency response

The strength target of 6,600 for the Corps is a floor, not a ceiling. It is the *minimum* required for the Corps to sustain a 'basic' level to meet corps clinical and public health response. Continued growth of the Corps may be necessary to meet the future public health and emergency health needs of the nation.

To address the Secretary's charge, the workgroup developed recommendations based on evaluation of a variety of sizing issues. Numerous independent analyses were conducted to supplement those contained in the "Sizing Paper." A summary of contributing analyses is provided in Appendix 2.

The Mental Health Functional Group

The work group developed the following recommendations for the new Mental Health group.

- The Mental Heath Functional Group will encompass professional activities that relate to direct patient care and provision of mental health services to assess, diagnosis, and treat both victims and responders, and augmenting and supporting local mental health services. These services should foster support, facilitate

[1] Department of Health and Human Services, *Sizing the Corps* (HHS Issue Paper), June/September 2005.
[2] Members are acknowledged in Appendix 1.

resilience, and promote recovery of the communities that are the recipients of a public health and/or emergency response.

- Officers assigned to the Mental Heath Functional Group should have specified training in mental health and have appropriate licensure, certification, and credentials consistent with their training.
- Two-thirds of mental health functional group requirements can be met through officers who are in the Corps now (Appendix 4 provides a detailed breakout of officer trained in mental healthcare).
- Improve the quality of the licensure, certification and credentials information available to force managers responsible for identifying mental health officers in the Corps for response activities.

Functional Profile of the Corps

The recommended mix of functional groups in the Corps supports the need to increase its emergency response capability and enhance its ability to provide clinical care and public health services to underserved populations. It is also consistent with the work group's recommendation to maintain the strength of the Applied Public Health and Research functional groups while at the same time focusing the majority of the growth in the clinical functional group.

The functional profile refers to the type of positions officers hold in their daily duties. An officer's functional assignment may, however, differ from their deployment role. This feature is important to determining the force strength for deployment (discussed later in this report).

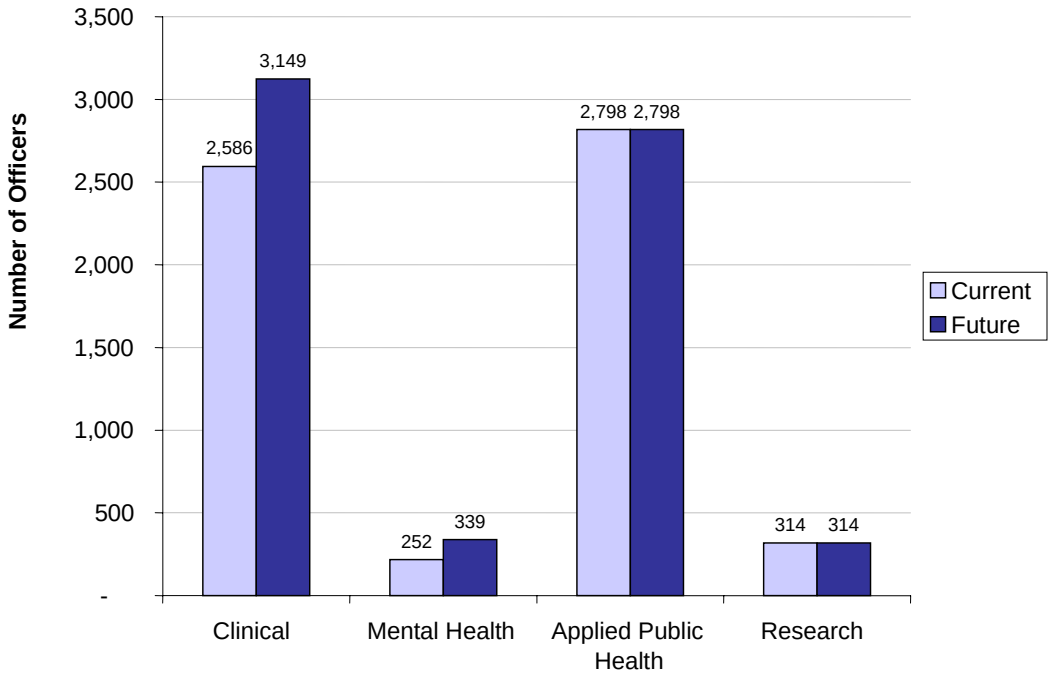
In a Corps of 6,600, officers should be distributed as follows

- The number of officers in clinical billets should be 3,149 (48 percent) of the Corps
- The number of officers in Applied Public Health billets should be preserved at its current level of 2,798 officers (42 percent). Currently, the distribution of clinical and applied public health officers is 43 percent and 47 percent respectively.
- Research strength should be preserved at its current level of 314 officers (5 percent)
- The Mental Health functional group should comprise 339 officers (5 percent of the Corps). This recommendation is based on (a) a 2005 study indicating that the Corps would need 254 officers deployed to fulfill the mental health needs during a hurricane response[3] and (b) an estimated mental health functional group deployability rate of 75 percent.

Figure 1 shows the proposed number of officers in each functional group, in comparison to the current strength[4] by functional group, the method for determining current strength is explained in Appendix 3. Detailed breakouts describing the current inventory of officers with mental healthcare training appears in Appendix 4.

[3] Cornell Weill Medical College, 2005.
[4] As of January 4, 2006.

Figure 1. Current and Recommended Future Functional Distribution of Officers



Fulfilling the Corps' Emergency Response Mission

The recommended functional distribution of billets is designed to support the Corps' multiple missions, including: providing public health services and medical care to the underserved, clinical services to the Bureau of Prisons, Coast Guard, and other statutory agencies, and emergency response. Underlying these recommendations is a set of deployability rates—percentages of personnel who are Tier 1 or Tier 2 deployable—for each functional area. The rates are based on an analysis by Agency and Operating Divisions where officers are currently assigned and their availability to be deployed based on their current assignment.

Based on a review of current force strength and the history of deployments, the following parameters were used to develop a deployability proposal:

- Deployment roles for officers should accord with their qualifications.
- Depending on officer's qualifications and the requirements of the response, some officers who are in the clinical functional group could serve in a public health deployment role during a response, and vice versa.
- Officers who have clinical skills and credentials, regardless of functional group, should maintain their clinical currency and be available for deployment in a clinical or public health capacity.
- Require officers in the clinical functional group to be able to deploy in a clinical role.

- Among officers in clinical billets, 28 percent would be deployable, in contrast to 22 percent today. As clinical vacancies are filled via growth in the Corps, the availability of clinicians for deployment would be expected to increase. The rate of deployment for clinical officers is lower in order to protect their ability to provide patient care in underserved areas.
- Officers assigned to Applied Public Health would deploy at a rate of 40 percent. Their deployability for public health emergencies would be sufficient to meet the need for public health expertise in the response cadre of 2,242. In addition, a significant percentage of Applied Public Health officers (25 percent) would assist with clinical response, and would therefore need to maintain clinical competency.
- Officers in the Mental Health functional group would deploy clinically, at a rate of 75 percent to meet the recommended 254 officers staffing the mental health response.
- Research officers will not be required to deploy in a Tier 1 or Tier 2 response, but would be expected to deploy for Tier 3. Researchers may also deploy in place.[5]

Table 2 summarizes the deployability proposal.[6]

Table 2. Deployability of the Corps

	Future Billets	Total Deployments		Public Health Deployments		Clinical Deployments	
Functional Group		# Deployable	%Deployable	% Deployable	# Deployable	% Deployable	# Deployable
Clinical	3,149	882	28%	0%	0	28%	882
Mental Health	339	254	75%	0%	0	75%	254
Public Health	2,798	1,106	40%	15%	415	25%	691
Research	314	0	0%	0%	0	0%	0
Total	6,600	2,242	38.5%	6.3%	415	28%	1,827

The column labeled Future Billets corresponds to the recommended functional profile of the Corps to meeting the sizing requirement of 6,600 with 2,242 available for Tier 1 and Tier 2 deployment as described previously. The remaining columns allocate officers, who are filling clinical, mental health, applied public health, and research positions, by their deployment role.

[5] Based on previous experience, there will be officers in research billets who want to provide voluntary support during an emergency response. Those officers are not taken into consideration in the deployability proposal and would be considered supplemental to the estimated Corps' response.

[6] Assumptions incorporated into this analysis were (1) The response depicted in this table is through deployment of the active duty force of the Corps. The proposed Select Reserve would be a supplemental resource for deployments. (2) This distribution also assumes 100% of the Corps officers meet readiness standards for deployment. (3) Environmental Health Officers and Engineers are included in the Applied Public Health functional group. Therefore, the Sizing Workgroup considered them as deployment assets in the Applied Public Health deployment role. This results in the 2,242 'Basic' response distributed as 415 in Applied Public Health and 1,827 in the Clinical deployment roles.

A longer-term strategy for ensuring response capability includes a Ready Reserve, which would provide surge capacity in times of emergency.

Future Professional Category Profile of the Corps

The following professional category distribution (Table 3) was developed based on an analysis of the 2004 Hurricane season and was provided to the group in the 2005 Sizing Paper. Alternative distributions could be considered and would yield a different professional category profile for the Corps. These models could focus on the 2005 Hurricane season, 5-year deployment history, agency mission needs, etc.

Table 3. Distribution of Officers By Professional Category and Mission Area: Basic Level

CATEGORY	Tier 1 and 2 RESPONDER	AGENCY MISSION & STATUTORY	FUTURE SIZE
MED	215	928	1,143
DEN	10	395	405
NUR	1,056	928	1,984
ENG	125	284	409
SCI	137	192	329
EHO	160	242	402
VET	55	59	114
PHA	168	628	796
DIE	10	59	69
THE	139	91	230
HSO	167	552	719
All	2,242	4,358	6,600

The distribution of the mental health functional group will consist of five professional categories: Medical, Nursing, Scientist, Therapists, and Health Service Officers.

Achieving Sizing Goals

Attrition

To achieve the sizing goals outlined above, it is important to consider the impact of attrition[7] on the size of the Corps. Current officer information was obtained on January 4, 2006.

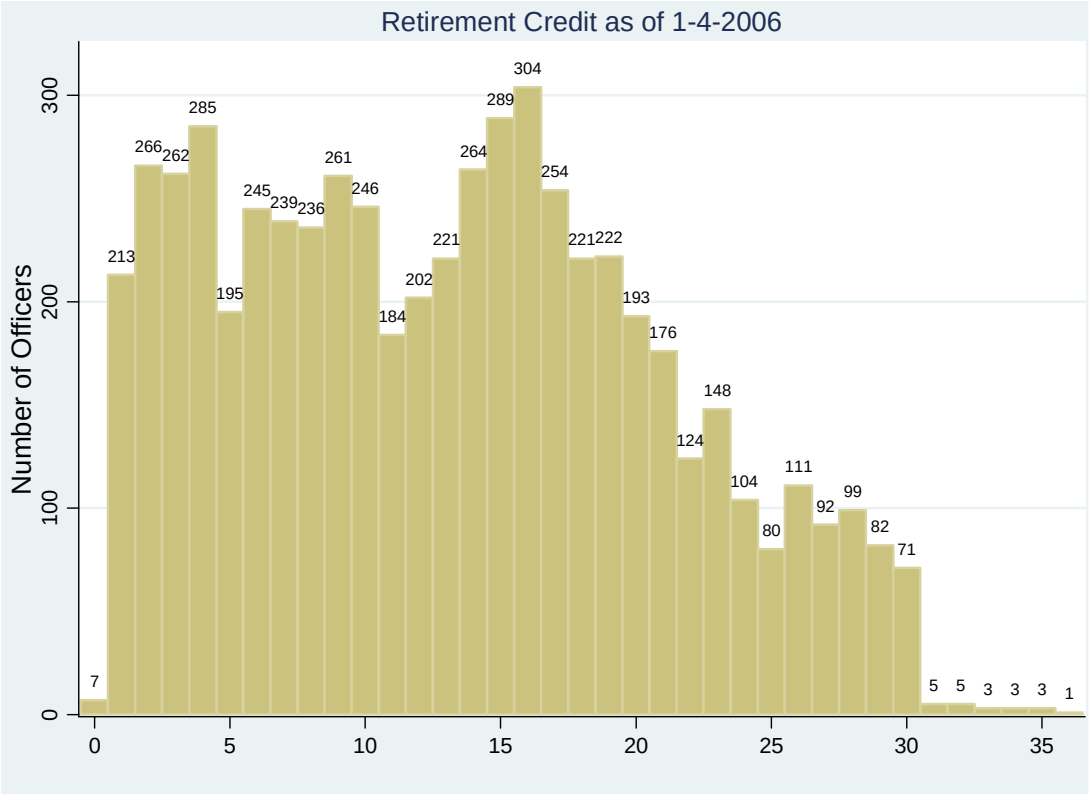
Over the past 10 years, the net attrition of the Corps has remained stable. However, this may change in the near future. Figure 1 below shows the distribution of retirement credit for the Corps. The percentage of officers in the Corps who have 20 or more years of service is at 22 percent. An additional 22 percent will be eligible for retirement within the next 5 years. Based on this information, the workgroup recommends that:

- The Corps should focus efforts and resources on recruitment of junior officers.

[7] Attrition includes separations, terminations, and retirements from the Corps.

- Retention of those approaching retirement is key in retaining the current and future leadership of the Corps.

Figure 1. Retirement Credit as of January 4, 2006

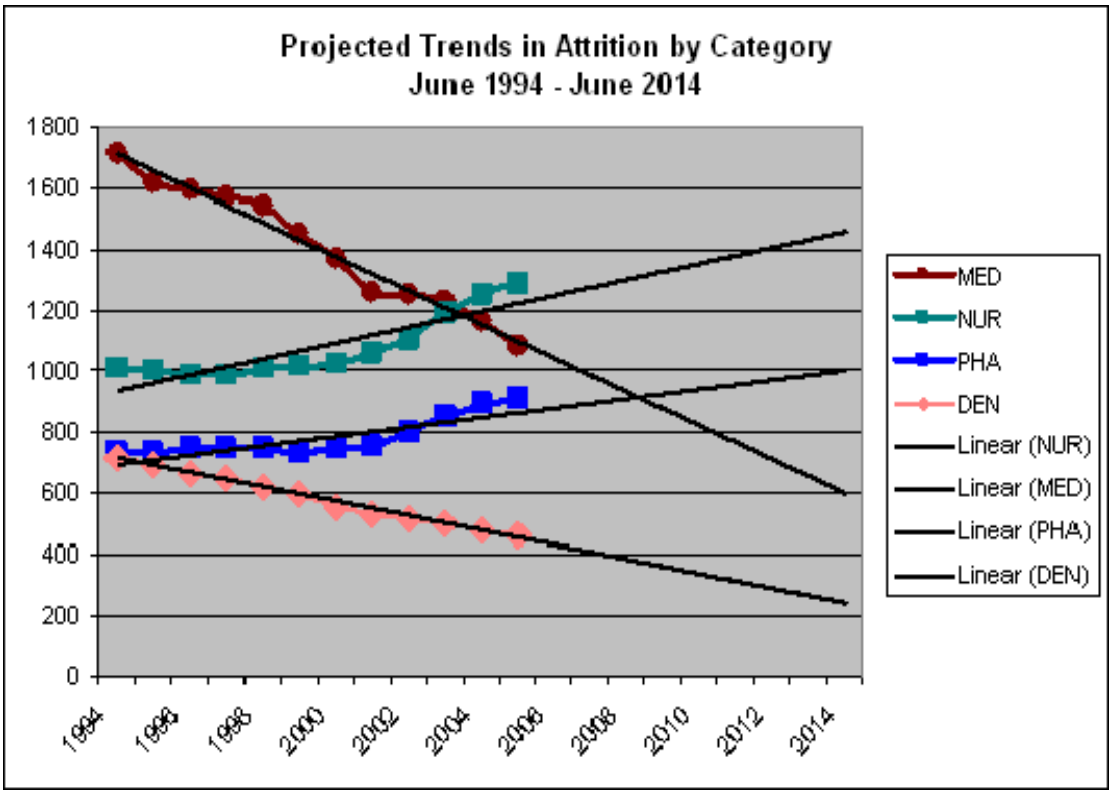


An analysis of potential future trends for the medical, dental, nurse, and pharmacy categories was performed. This model assumed that attrition remained on average the same as in the period from 1994-2005. From this model, it is anticipated that the nurse and pharmacy categories would experience growth while the dental and medical categories would sustain moderate and significant decreases, respectively, in the number of officers on active duty.

Currently, the largest category is nursing at 1,323 followed by medical officers at 1,068. The number of nurse officers exceeded medical officers for the first time in 2005. The next largest number of officers is in the pharmacy category at 922 and the health services category at 828.

Although the Nursing category is currently increasing, it is clear from Figure 2, more officers over the projected goal will need to be recruited to achieve the desired end-strength goal to take into account the rate of attrition. This is even more imperative within the medical officer category which is already showing a negative net attrition.

Figure 2. Projected Trends in Attrition by Category



Implementation Time Table

The sizing work group recommends the growth of the Corps be done in stages. As a result of the attrition information, the goal for 2006 is to first maintain the current strength of the Corps, and to develop the allocation process to distribute officers within the agencies. By December 31, 2007, it is recommended that the Corps achieve 40% of the transformation goal reaching a total size 6250. At the end of calendar year 2008, the end-strength goal of 6,600 Commissioned Corps officers would be achieved as summarized below (Table 4):

Table 4. Timetable of Growth of Corps

	Milestone	Number of Officers
December 31, 2006	Finalize allocations and maintain current levels	5,950
December 31, 2007	40% of Goal	6,250
December 31, 2008	100% of Goal	6,600

Strategies for achieving these goals include:

- Filling existing vacancies[8]
- Emphasizing Junior officer recruitment
- Placing officers in non-Federal positions
- Strengthening the Senior COSTEP program
- Implementing a warrant officers program
- Increasing the number of Corps' officers in the
    - Epidemic Intelligence Service and other CDC training programs
    - HRSA National Health Services Corps
    - NIH clinical research and other training programs
    - FDA research fellows program
- Improving retention

Ready Reserves

A longer term strategy also includes a Ready Reserve, which is discussed in more detail in Appendix 5. Briefly, a ready reserve could constitute a flexible reserve capacity that would constitute a 10% (660 at the outset) increase in strength, to function in clinical (approximately 400), mental health (approximately 100) and other roles.

Conclusion

The Sizing work group determined the functional composition of the Corps (including establishment of the new Mental Health group), established deployment levels of the Corps and its functional groups to meet emergency needs, and evaluated trends in attrition and the professional distribution over time. As a result, the work group envisioned and provided a framework for developing a larger, more clinical Commissioned Corps that will be able to meet agency, clinical and deployment needs for DHHS well into the future.

[8] Currently, IHS has approximately 1,054 funded vacancies: 587 Nurse, 180 Physician, 62 Pharmacist, and 62 Dentist.

Appendix 1: Sizing the Corps Work Group Members

Chair	RADM Sam Shekar
Staff	CDR Kathy Poneleit, OCCFM Christen Kirchner, The Lewin Group
AHRQ	CAPT Ernestine Murray
ASH	CAPT Penny Royall
ASPHEP	CDR Brad Austin
CDC	CAPT Ralph O'Connor
CMS	CAPT Eugene Freund
FDA	CAPT Paul Seligman
IHS	CAPT Richard Rubendall
JOAG/OSG	LT Marna Hoard
NIH	CAPT Charlie McGarvey
OCCFM	CDR Bernard Parker
OGC	Karen Wagner
OSG/ORA	CAPT Jim Sayers
OCCO	CAPT Greg Stevens
OCCO	CDR Steve Blackwell
OSG/OFRD	CDR Renee Joskow
OSOPHS	V. Agnes Davidson
SAMHSA	CDR Wanda Finch

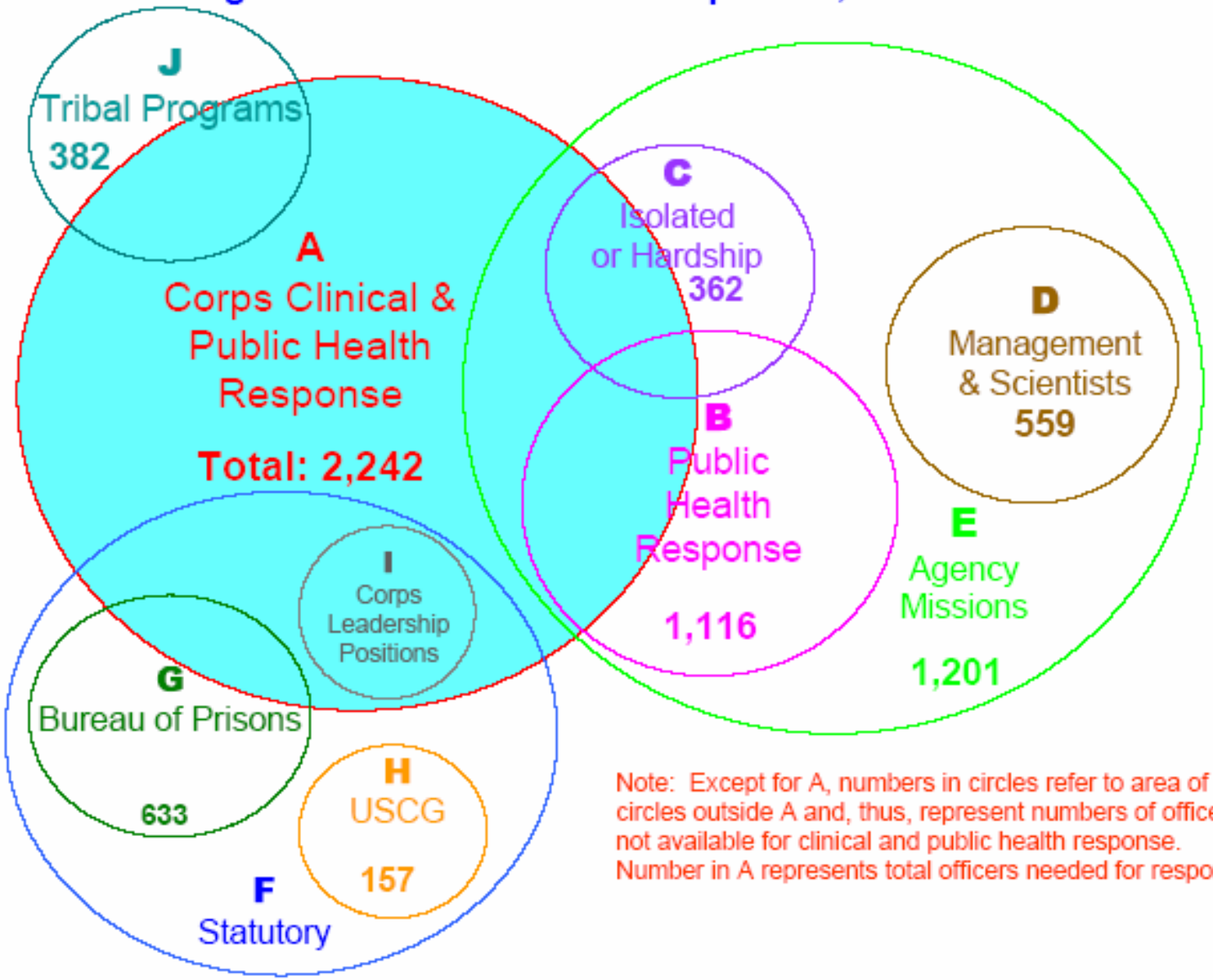
Appendix 2 : Summary of Issues and Data Sources

Assumption or Recommendation	Rationale	Data Source
All numbers in this report are *minimum* required for the Corps to sustain a 'basic' level response	Secretary's decision	
Increase size of Corps from 5950 to 6600 ("Basic" level)	Secretary's decision	
2,242 officers available for Tier 1 and Tier 2 deployment	Prior analyis	Sizing Paper, table 2. Venn diagram.
A mental health functional group should be created	Secretary's decision	Joins clinical, applied public health and research functional groups.
Direct all initial growth of the Corps to the clinical and mental health functional groups	Secretary's decision	
The number of officers in clinical billets should be 3,149	Maximizes number of clinical billets while preserving APH	
Mental Health functional group should comprise 339 officers	Cornell Weill study predicts a need for 254 PHS mental health officers. *Readiness workgroup estimates 160 MH officers needed in Tier 1 & 2.*	Current estimate of mental health professionals in Corps is 252. Primary categories are HSO, nurse, scientist and medical officer.
The number of officers in applied public health should be preserved at its current level	Officers in this group also deploy as clinicians almost as often as officers in clinical billets	Hurricane 2005 OFRD data
Officers in clinical billets should only be deployed in clinical roles	Deployable clinicians are in short supply. Use other officers to fill applied public health deployment roles.	During 2005 hurricane season, OFRD deployed 4 % of officers in clinical billets for non-clinical roles.
Officers who have clinical skills and credentials should maintain their clinical currency	25 % of these APH officers are expected to deploy as clinicians. 15 % to deploy in APH roles.	
Pursue formation of a Ready Reserve	Will help fill gaps in Tier 1 & 2 deployments form active duty officers.	
Identify causes and reverse	Medical officers decreased	OCCFM data

Assumption or Recommendation	Rationale	Data Source
long-term trends in declining strength of medical and dental officers.	to 1700 in 1994 and to 1200 in 2004. Dental officers decreased from 700 in 1994 to 500 in 2004.	
Increase recruitment to: 1) overcome pending retirement of cohort of officers recruited in late 80s and 2) meet growth targets.	22.1 % of officers currently eligible for retirement. Another 21.8 % of officers eligible to retire in next 5 years.	OCCFM data

The Venn Diagram referenced above is shown below.

Figure 2. Commissioned Corps Size, Basic Level



Note: Except for A, numbers in circles refer to area of the circles outside A and, thus, represent numbers of officers not available for clinical and public health response. Number in A represents total officers needed for response.

Appendix 3: Estimating the Current Functional Distribution of Officers

CC25.2 Instruction 6 on Career Tracks

The number of officers currently working in the clinical, applied public health, and research functions was estimated using OCCFM/OCCO data on the "career track" designations of officer billets. These are the current tracks:

STUDENT	Student (COSTEP or USUHS)
CLINMGMT	Clinical Management
CLINPRAC	Clinical Practice And Consultation
CLINQUAL	Clinical Quality Assurance And Oversight
CLINTRNG	Clinical Training And Teaching
CONSTRUC	EPI/PH Construction, Design, Engineering Consultation
ENVI/SAN	EPI/PH Environmental/Sanitation Consultation/Practice
EPI-PRAC	EPI/PH Epidemiologic Practice, Teaching, Research
HLTHPROM	EPI/PH Health Promotion And Education
OCCUHLTH	EPI/PH Occupational Safety And Health
SCI INFO	EPI/PH Scientific And Technical Information Development
ANALYSIS	EPI/PH Study, Design, Data Collection, Analysis
POLICY D	Prog Mgmt Policy Development, Planning, Evaluation
LEGISLAT	Prog Mgmt Legislation
MANAGEMT	Prog Mgmt Core Management
TRAINING	Prog Mgmt Training
T/A&CONS	Prog Mgmt Technical Assistance And Consultation
ENFORCEM	Reg Aff Enforcement And Compliance
PGM CONS	Reg Aff Program Consultation
STDS DEV	Reg Aff Standards And Specifications Development
TEST&EVL	Reg Aff Testing And Evaluation
RESEARCH	Research Clinical, Field, Or Laboratory Research
RESADMIN	Research Administration
RES SUP	Research Support And Demonstrations Projects
RES TRNG	Research Training

There were further collapsed into the following tracks:

Clinical/Clinical Management
Epidemiology/Public Health Practice
International Health
Program Management
Regulatory Affairs
Research

Clinical and Research career tracks directly translated to the new Clinical and Research functional groups. The remaining career tracks were collapsed to form the new Applied Public Health (APH) Functional Group, and a new Mental Health (MH) Functional Group was added.

Appendix 4: Analysis of Mental Health Officers Now in the Corps

Work group members used existing Corps data to obtain an estimate of the current number of officers (252) who are mental health providers. These officers are in the Health Services, Medical, Nurse, Scientist and Therapist professional categories. Table A4.1 shows the breakout of these officers by mental health training. Note that this list is not meant to be an exhaustive list of officers with mental health competencies in a transformed Corps.

Table A4.1. Current Inventory of Major Mental Health Competencies (January 2006)

Mental Health Training Competency	Officers
Child Psychiatry Residency	2
Clinical and Medical Social Work	7
Clinical Psychology	28
Counseling Psychology	11
Developmental and Child Psychology	3
Family and Marriage Counseling	1
Mental Health Services, Other	7
Nurse - Certified Nurse Psychiatric	1
Nurse - Clinical Specialist Psychiatric	32
Nurse – Straight Psychiatric	8
Nurse – Supervisory Psychiatric	1
Nursing, Public Health (Post RN)	5
Occupational Therapist (Mental Health)	3
Psychiatry Residency	32
Psychology, General	15
Psychology, Other	6
School Psychology	2
Social Work	88
Total	252

Table A4.2 represents the number of officers with the specified training in mental health and the minimum degree levels currently possessed by officers with mental health training. The majority of mental health professionals identified in Table 1 have a Masters or Doctoral degree. All of the Baccalaureate level mental health professionals were in the nursing category. Table A4.3 shows the agency by category breakdown.

Table A4.2. Number of Officers with the Specified Mental Health Training and Minimum Degree Requirements

Training Level and Degrees Criteria of Mental Health Officers	Total
Doctor of Medicine or Doctor of Osteopathic Medicine	5
Doctorate in Nursing	1
Doctorate	54
Masters	127
Bachelors	31
Residency Specialty	34
Total	252

Table A4.3. Distribution of Officers By Agency And Professional Category For The Mental Health Functional Group

Agency	MED	NUR	PHA	SCI	THE	HSO	Total
OS/PSC		4		2	1	9	16
HRSA	2	8	1	6		34	51
BOP		13		14		19	46
CDC/ATSDR	3	1		9		6	19
FDA	3	5		1		4	13
IHS	14	8	1	7		19	49
NIH	9	5		4		5	23
USCG/DHS	2	0		0	0	2	4
OTHER HHS	4	10	1	3	1	10	29
OTHER NON-HHS				2			2
Total	37	54	3	48	2	108	252

Officers who may be currently designated as clinicians, researchers, or public health experts would potentially be shifted into the Mental Health functional group. The current functional breakdown—stratified by professional category—is shown below.

Table A4.4. Current Inventory of Mental Health Officers, By Category and Functional Group

Category	Clinical	Applied Public Health	Research	Total
Medical	21	11	5	37
Nurse	29	22	3	54
Pharmacy	1	2	0	3
Scientist	24	16	8	48
Therapy	1	1	0	2
Health Services	38	69	1	108
Total	114	121	17	252[9]

[9] Officers who did not meet the criteria established above for the Mental Health Functional Group were not counted in the tables; however, these officers would not be precluded from entering into the Mental Health functional group when appropriate.

Appendix 5: Ready Reserves

A longer-term strategy for ensuring response capability includes a Ready Reserve, which would provide surge capacity in times of emergency. Currently, the U.S. Public Health Service Reserve Corps includes the Active reserve Corps (ARC) and the Inactive Reserve Corps (IRC)[10]. Proposals for the future are that the Inactive Reserve Corps will be composed of the Ready Reserve (RR)[11], the Standby Reserve (SR)[12], and the Retired Reserve[13]. The principles delineated in this document relate to the proposed Ready Reserve Corps.

In his announcement of the transformation of the Commissioned Corps on January 18, 2006, Secretary Michael Leavitt emphasized the importance of the Commissioned Corps as an essential resource for the Department of Health and Human Services (DHHS) in meeting its critical mission responsibilities including:

- Responding to national emergencies and urgent public health threats
- Addressing the need for health professionals in isolated, hardship, hazardous, and other difficult-to-fill clinical and public health positions
- Addressing special humanitarian concerns and supporting critical agency missions when other solutions are not available or are ineffective.

To fulfill these needs and to meet a basic level of emergency response, the Sizing of the Corps work group has determined that:

- Additional 660 Commissioned Corps officers are needed on full time active duty
- Ready Reserve is needed to provide surge capacity of trained and uniformed public health officers for emergency response or to backfill critical shortages created when active duty officers are deployed.

Creation of a Ready Reserve would establish a well-trained, managed, and ready surge capacity to help the Commissioned Corps meet its public health and response missions. A Ready Reserve would provide a force that would be:

- Trained to meet specific mission needs of the Corps through regular drills and annual training;
- Available and ready for involuntary calls to active duty (other than for training) during national emergencies and public health crises;
- Ready for emergency response like the active duty corps;
- Available for backfilling critical positions left vacant during deployment of active duty corps members; and,

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[10] See Title II of the U.S. Public Health Service Act (42 U.S.C. 202 et seq.).

[11] The Ready Reserve does not currently exist and would require legislation to be established.

[12] The Standby Reserve is equivalent to today's Inactive Reserve Corps. Members of the Standby Reserve can be *voluntarily* called to active duty.

[13] The Retired Reserve includes individuals retired from the Commissioned Corps. Members of the Retired Reserve can be *voluntarily* called to active duty.

- Available for service assignments in isolated, hardship, and medically underserved communities to improve access to health care for vulnerable communities.

Principles for the proposed Ready Reserve Corps follow.

- Components - The Ready Reserve includes the Select Reserve (SR) and the Individual Ready Reserve (IRR). The Select Reserve will be composed of units of officers which train and drill together and deploy as units. In contrast, the IRR will be composed of individual officers in the Ready Reserve who are not members of units in the Select Reserve5.
- Readiness - Members of the Ready Reserve are expected to maintain readiness for deployment by regular training and drills. RR members are placed on active duty for training for 39 days annually (12 weekend drills and 15 days for annual training).
- Training for Select Reserve - SR units train one weekend each month and two weeks each year as a unit. Activities during drills will depend on the function of the unit. For example, a medical unit may conduct immunization clinics in isolated communities while an environmental health unit may perform a comprehensive consultation for a local community after a flood. All Select Reservists can drill and be activated as individuals or as a team.
- Training for Individual Ready Reserves - individuals who are not members of SR units may perform active duty for training by providing direct service or may be directed to drill with SR units. For example, a pharmacist member of the IRR could serve in an Indian Health Service (IHS) clinic once a month on weekends and for two weeks during the summer in order to relieve staff shortages. Alternatively, the pharmacist might be directed to drill with a regional team of SR members to prepare for a specialized type of emergency response (provision of prophylaxis after an anthrax attack).
- Activations - RR members sign a service obligation and can be involuntarily called to active duty other than for training. During a public health emergency declared by the Secretary or a national emergency declared by the President under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the Secretary may order the Ready Reserve to active duty (other than for training) for up to 24 months plus up to 6 months after the end of the emergency.
- Size of the Ready Reserve - the RR will consist of the number of units in the SR and the number of individuals in the IRR prescribed by the Secretary to ensure that there are adequate units and individuals with required skills to function during mobilizations. An initial target for the size of the RR is 10% of the size of the active duty force of the Commissioned Corps (initial goal of 660 officers). A proposed distribution for the initial RR is as follows:
- Mental health teams: 100 officers - four regionally-based mental health teams of 25 officers who can deploy as individuals or as teams;
- Centers for Disease Control and Prevention (CDC) SR Unit: 50 officers - one unit of 50 officers who are primarily engineers or environmental health officers in the Atlanta, GA area;

- Medical teams: 400 officers - 8 regionally-based medical units of 50 officers each unit who can deploy as individuals or as teams; these teams will meet Public Health Service missions in the region including backfilling staffing shortages in isolated and hardship locations, providing public health expertise to local communities, and responding during local emergencies and disasters;
- Individual Ready Reservists: 50 officers - individuals who are members of the Ready Reserve who would have specific assignments (backfilling for an IHS clinic, specialized emergency response, consultation to a state or county health department, etc.); and,
- To be determined: 60 officers - the remaining 60 officers could be used for a variety of functions, to be determined by the needs of the Corps. Possibilities include: a clinical unit assigned to the Federal Bureau of Prisons (BoP) to backfill significant vacancies; a global health unit to be activated during international public health emergencies or disasters; and, a specialized research unit whose members would be faculty members from universities who would function as advisors to the Secretary on critical issues such as bioterrorism mitigation, novel vaccine production processes, or eradication of infectious diseases.

TAB 5

Recruitment Implementation Plan

RECRUITMENT

Implementation Plan

Secretary's Decisions

- Our first sizing objective will be to achieve a force of 6,600 active duty officers. It may be possible for the Corps to grow beyond this force strength, particularly as we develop more assignment opportunities in other federal agencies, at the state and local level, and in a ready reserve.
- Three recruitment avenues should be used: pipeline programs, agencies, and central recruitment, the last having a particularly important role to play.
- Approaches to recruitment must be consistent, including emphasis on the use of the Corps in assigning scholarship recipients to NHSC and similar programs.

Principles for Transforming Recruitment

- Build a centralized Corps recruitment infrastructure.
- Develop a centralized recruitment plan based on active force management, strategic planning, and the missions of both the Department and the Corps.
- Achieve the optimal strength and skill balance of the Corps by responding to the needs assessment put forth by the Sizing Workgroup.
- Include flexible strategies in the Corps' centralized recruitment plan in order to respond to the changing needs of OPDIV/STAFFDIVs and ensure the availability of qualified, motivated officers.
- Develop recruitment strategies that attract professionals who are (1) committed to achieving HHS core competencies; (2) willing to fulfill missions in isolated hardship, hazardous duty, and hard-to-fill (3H) assignments; and (3) dedicated and prepared to respond to public health emergencies.
- Ensure that recruitment strategies offer competitive career opportunities to young professionals.
- Provide exemplary customer service to potential recruits during call to active duty process (CAD), including an expedient, seamless, transparent electronic application process.
- Reexamine recruitment strategies periodically to adjust effectively to future changes in the desired number and skill distribution of officers.
- Use Corps officers as the leaders and the front line recruitment force.

Achieving the Right Size and Balance of Skills

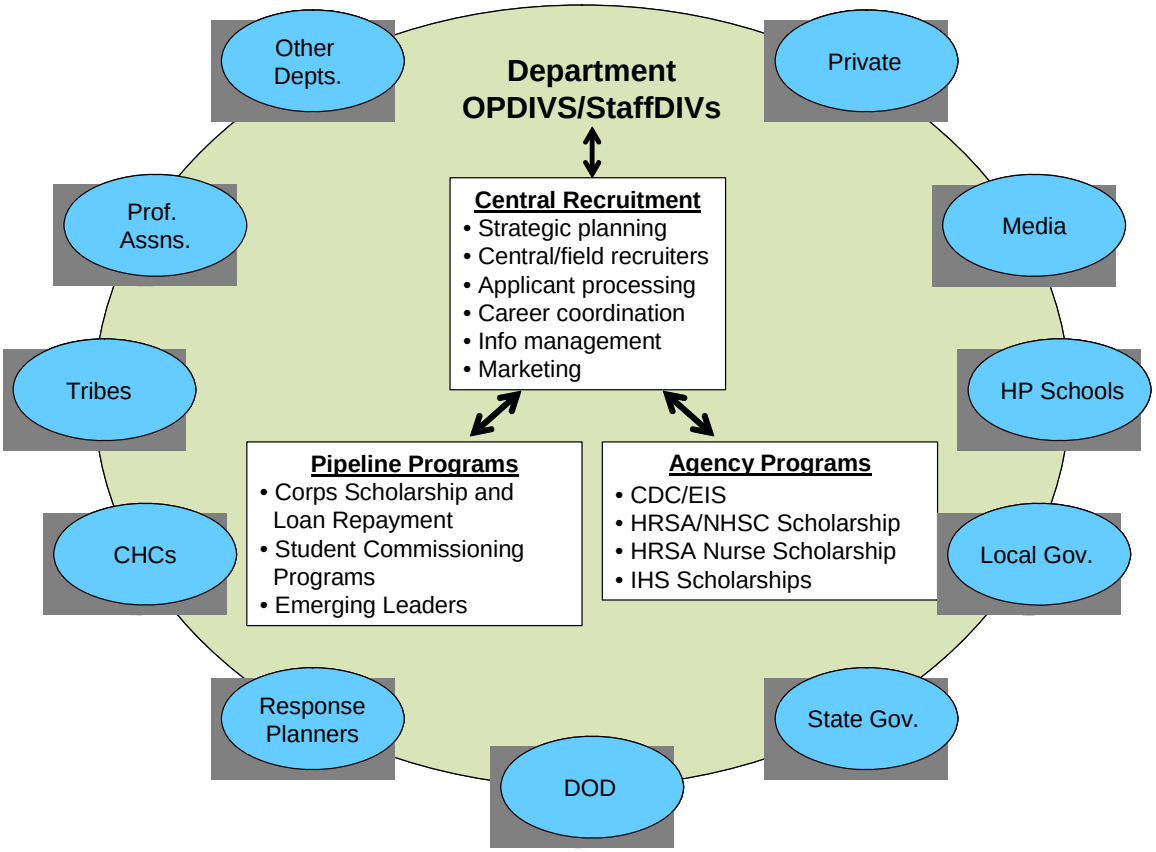
The Corps will expand its capacity to respond to the nation's urgent and emergent public health needs. To ensure a basic level of response, the Corps must grow by 10% to 6,600. Most of the growth is focused on clinical capability including: physicians, nurses, pharmacists, and mental healthcare providers. The Corps may fulfill certain response requirements—for example, two-year registered nurses, emergency medical technicians and paramedics, and respiratory therapists—by creating a Warrant Officer Corps; and it will even further enhance surge capacity for emergency response capacity through creation of a Ready Reserve.

- Some of the Corps' growth can be achieved through retaining officers presently on active duty with proper training and other career development methodologies. However, recruitment of new commissioned officers into active duty will be essential to replace officers who separate or retire to augment the size of the Corps. Once the desired force strength and skill balance of the Corps is achieved, recruitment will continue to be a primary avenue for sustaining the desired profile of the Corps and adjusting to any future increases in the need for Corps officers.
- Recommendations by the Transformation Recruitment, Training and Career Development Committee members (see Appendix 1 for membership listing) describe processes and functions that will be managed by the Corps to meet its responsibilities for recruitment of officers.

Central Corps Recruitment

The Secretary resolved that central coordination will have a "particularly important role to play" in Corps recruitment. In addition to coordinating the Corps' own recruitment efforts, central recruitment will be engaged with OPDIV/STAFFDIV and other stakeholder programs through which Corps officers are placed. The relationships between the three main avenues of recruitment are depicted below.

Figure 1. Avenues of Recruitment



The importance of central, Corps-managed recruitment is confirmed by the experiences of the late 1980s. A surge in calls to active duty followed a cohesive effort to market the Corps and to

more effectively process the applications. Lessons learned from this period, and from a similar effort in the late 1990s, are presented in Appendix 2.
The policies, functions and processes recommended for central recruitment are geared toward creating a cohesive, smooth-functioning infrastructure that is highly responsive to the needs of applicants and OPDIV/STAFFDIVs inside and outside HHS, tribes, emergency response planners, and the Department as a whole.

- Base recruitment on mission driven strategic plans for the Department and the Corps
    - Central Corps managers will meet semi-annually with agency representatives, readiness planners, and other stakeholders to establish personnel needs.
    - On the basis of this input, specific qualitative and quantitative recruitment goals will be developed in each professional category and functional group.
    - Timelines will be established for performance standards and measurements for the evaluation of the operations and management of the Corps.
    - A public information officer will oversee development of a cohesive messaging strategy that portrays the mission and value of the Corps and ensure that recruitment activities are congruent with that strategy. The pubic information officer will be a Corps-dedicated resource integrated with the Department's Office of Public Affairs.

- Form a Recruitment Steering Committee
    - A mechanism to develop goals, strategies, assess the on going needs of OPDIV/STAFFDIVs and monitor progress toward recruitment goals
    - Provide recommendations to the Corps central planning recruitment
    - Membership will consist of
        - OPDIV and STAFFDIV recruitment leads
        - CPO representative
        - Central planning and operational recruitment staff
        - Subject matter experts, and
        - Other stakeholders
    - Members will be selected by the Assistant Secretary for Health
    - Meet quarterly.

- Streamline the Call to Active Duty process (CAD), including the application process; this includes:
    - Gathering information about the candidate via applications and pre-screens to better assure candidate quality and matching to needs
    - Verifying the applicant's credentials
    - Assessing his or her health status
    - Arranging the new officer's first duty assignment.

A streamlined CAD is critical if the Corps is to fulfill OPDIV/STAFFDIV staffing needs efficiently, minimize attrition from the applicant pool, and more efficiently utilize time for the orientation and training of new officers. To accomplish this, the Corps must:

- Reduce the average CAD time from 26-52 weeks to 8-12 weeks
- Adopt a web-based automated application system to include:
  - On-line fully automated application for the Corps and Quick Hire, as necessary
  - On-line prescreen assessment
  - On-line medical self-report that will assess the need for a more in-depth review
  - On-line submission capability for all documents
  - Electronic requesting mechanisms for references, transcripts, licensure, National Practitioner Data Banks inquires, security clearances, etc.
  - Ability to handle applications for active duty, warrant, reserve, and student programs (i.e., the Student Commissioning Program described below)
  - Data from the online prescreening assessment and from the application will better assure the applicant shares Corps values and mission while concurrently generating a skills-based match between OPDIV/STAFFDIV vacancies and qualified applicants.
- Verification of credentials will be contracted out; in-house processing staff will only perform the validation of these verifications.

- Provide one-on-one assistance for applicants and new officers to improve the CAD
  - Corps processing staff will assist with all application-based questions.
  - Career Coordinators will assist with all career based questions along with:
    - Inventory officer's training and competencies in order to match them to vacancies.
    - Coordinate training and first assignment, including attendance at CAD BOTC.
    - Maintain engagement throughout the officer's career (see career coordinator in the Training and Career Development plan).
  - Set up a 1-800-FAQ 24 hour call center to provide one-on-one assistance and human response to inquires regarding the Commissioned Corps, the application process, positions, placement opportunities, etc., when the staff are unavailable.
  - Inventory officer's training and competencies in order to match them to vacancies
  - Coordinate training and first assignment, including attendance at CAD BOTC

- Employ full-time central recruiters and field recruiters, managed centrally, and charged with carrying out centrally developed goals as part of the Corps recruitment operations.
  - Central and field recruiters will be the Corps' full-time, front-line recruitment workforce whose primary charge is meeting the Corps' recruitment goals. Field recruiters would be in district offices to improve outreach in key areas and would be co-located in HHS regional offices when applicable. All central and field recruiters will be Corps officers.
  - Recruitment districts will be formed based on the geographic distribution of duty stations and high-priority schools.
  - Central and field recruiters' duties would include, but not be limited to:
    - Providing one-on-one assistance to prospects by responding to their phone calls and web inquiries, as well as any other methods of direct contact and communication.
    - Initiating and developing contacts through conferences, schools, professional organizations to increase our outreach activities.

        - Coordinating with PAC and OPDIV/STAFFDIVs liaisons to provide updates concerning recruitment via presentations on update of plan, program effectiveness, and roles of their Associate Recruiters.
        - Providing on-site leadership for volunteer Associate Recruiters and OPDIV/STAFFDIVs recruiters at recruitment events. Associate recruiters could be matched to a field or central recruiter based on their location.
        - Providing oversight to a Recruitment Advisory Group that would consist of full-time recruiters and HR officials from the OPDIV/STAFFDIVs and other stakeholder, both uniformed and civilian, who are involved in the recruitment of Corps officers.

- Train central, field, and associate recruiters, processors and career coordinators in:
    - Information on all the agencies (mission, jobs available, etc)
    - Student programs, including federal grants and scholarships
    - Pipeline programs
    - Inter-service transfers
    - Career development information for all the categories
    - Inactive Reserve Corps
    - Readiness requirements
    - Provide and update all information and materials for the 1-800 FAQ contractors

- Develop an information and knowledge management system to support recruitment and facilitate integration of recruitment with other force management functions.
    - Track recruitment information
        - Contacts made through the Associate Recruitment Program, both central and field recruiters
        - Web inquiries
        - Applications and officers awaiting placement
        - Recruitment performance in relation to goals
    - Maintain updated information about applicant skills and preferences, OPDIV/STAFFDIV needs and position vacancies. Have the capability to generate reports for recruiters, agencies, and HHS leadership as needed.
    - Install, update and maintain all web based recruitment information and provide feedback to planners as to its effectiveness.

- Oversee the Associate Recruitment Program (ARP) as part of Corps recruitment operations.
    - Implement guidelines for processing Associate Recruiter applications to ensure that individuals will represent the Corps well and that they have support from their agencies for this activity
    - Ensure that the ARP includes officers familiar with agency programs, such as the Epidemic Intelligence Service (EIS) and the National Health Service Corps (NHSC), and representative of the diverse missions of the Corps.
    - Implement badge and award criteria to recognize the effort of officers in recruiting for the Corps and oversee the process for nominating individuals for the badges and awards as indicated.

- Coordinate and oversee an ARP Work Group consisting of representatives from the professional categories.

- Establish a Commissioned Corps Centers of Excellence program (C_3E) at high-priority centers of healthcare education to:
  - Increase the profile of the Corps among students and faculty via the full time assignment of a Corps officer to a campus.
  - Ensure uniformed officers serve as adjunct professors in all health professional schools at universities.
  - Serve to assure a Corps presence at all on campus student career fairs and other potential recruitment forums.
  - Allow the Corps to more effectively identify candidates for Agency and Corps pipeline programs while providing information and guidance to students on opportunities and financial support available throughout the Department and the Corps, such as COSTEP, loan repayment, and scholarships.
  - Integrate officers into any health focused work groups or initiatives on campus.
  - Facilitate the "PHS branding" of degrees, residencies, internships or other appropriate trainings at the university.

- Sustain a recruitment marketing and messaging effort, overseen by the Public Information Officer under the rubric of Corps central recruitment, including:
  - A clearinghouse for mailings to applicants, schools, Associate Recruiters, and agencies. The clearinghouse may be contracted out.
  - Print media: stories in newspapers, professional journals, university alumni periodicals
  - Radio: Health related station/stories, public service stories.
  - TV: News and special interests shows, documentaries, prime time exposure
  - Paid advertising: print, radio and TV; special health and response related event; conference sponsorships.
  - Public venues: billboards, buses, metro, other health and environmentally conscious locales.
  - Recruitment and Marketing materials
    - Multiple sized displays and associated graphics.
    - Print materials - folders, tri-folds, mailers, posters.
    - Video materials - B-roll footage of Corps officers in action for interviews or stories, category specific for recruitment.
    - "Give-aways"
    - Mailing (postal and email) lists - professional associations, those leaving the military, university health professions schools.
    - Library of photos, video and hard copy print materials.
    - Oversee a clearinghouse contract for mailings and recruitment materials sent to applicants, schools, Associate Recruiters, and OPDIV/STAFFDIVs.

- Align special pays, incentive pays, and career opportunities to meet skill and size requirements of the Commissioned Corps
  - Utilize Assignment Incentive Pay (Title 37 authority).

- Establish clinical competency pays e.g., Clinical Nurse special pay.
- Secure Corps sponsored slots in prestigious HHS training programs, e.g., CDC's Epidemic Intelligence Service (EIS), for qualified officers.
- Support online training for officer stationed in critical needs assignments who are precluded from participating in traditional on campus programs, e.g., tuition, laptops, flexible work schedule.
- Make available Corps sponsored "PHS branded" residencies, internships and trainings at C_3E and other universities and also through established uniformed service programs, e.g., USUHS and Walter Reed Army Medical Center.
- Better reinforce benefits, particularly educational assistance, associated with the Montgomery GI prior to relevant obligation forms being completed.

Pipeline Programs

Pipeline programs are important tools for attracting qualified health professionals before graduation and retaining them via payback tours while increasing the academic population awareness of the Corps. These recommendations include establishing new Commissioned Corps scholarship and loan repayment programs. They also include enhancing existing programs to increase their attractiveness and more effectively channel students into the Commissioned Corps.

- Establish a Corps Scholarship and Loan Repayment Program
  - Create an oversight group (OG) that will:
    - Be responsible for selection of Scholarship recipients, matching the recipients into a payback location, deferral of their payback, along with site designation for all loan repayment assignments and eligible billets.
    - Function under the guidance of the Corps' centralized recruitment, and be guided by the Corps' force management plan and predetermined assignment priorities.
    - Meet quarterly to accommodate changing OPDIV/STAFFDIV and stakeholder needs.
    - Arrange for periodic evaluations of the Scholarship and Loan Repayment Program effectiveness.
  - Scholarship Program
    - Scholarships will be awarded to applicants pursuing a commissionable degree, fulltime in an accredited education program for a duration of no less than one year and no more than six years.
    - Payback will be one-to-one; deferral of payback would be considered for approved residencies, internships, and trainings.
    - Recipients will be assigned a contact within the centralized recruitment entity to assure that all needs are addressed to include, but not limited to, possible externships or trainings, information on placement of all recipients upon entering active duty.
  - Loan Repayment
    - All sites must request designation as a Loan Repayment Site (LRS) on a yearly basis.
    - The eligibility for loan repayment of each billet at a LRS will be determined by the OG.
    - Loan repayment contracts will be for a single year, renewable for up to five consecutive years.

- Loan repayment amounts, tax status, payment schedule, and other contract terms will achieve parity with the DoD Loan Repayment Plan; distributions will be made electronically and apply only to pay an authorized student loan balance.

- Reorganize and expand the scope of the current Junior and Senior Commissioned Officer Student Training and Externship Program (JR and SRCOSTEP) along with reviving an expired policy/ program the Early Commissioning Program (ECP) all under the umbrella of a single entity, the Student Commissioning Program (SCP).

  The SCP will consist of three components, which can be offered to each recruit either independently or in combination: the Student Reserve Commission Program, the Commissioned Officer Student Training and Externship Program (COSTEP), and the Early Commissioning Program (ECP). COSTEP will be a redesigned, more flexible, and attractive version of today's JRCOSTEP. The ECP will be a modified version of today's SRCOSTEP that allows students to defer payback service until completion of a residency or other approved training and be sponsored for a longer period of time. The SCP components will provide a range of options for students interested in service as Commissioned Corps officers. See Table 1, for a comparison of the SCP components.

  - Student Reserve Commission Program (SRCP-formerly the expired ECP)
    - Students would be commissioned into the PHS reserve corps in the beginning stages of a commissionable degree-earning program
    - No service commitment would be required
    - It allows the student to establish a base pay credit date early in their education resulting in a higher entry-level salary if activated.
    - No cost or FTE burden to Corps or OPDIV/Staffed, unless student is called to active duty.

  - Commissioned Officer Student Training and Externship Program (COSTEP—formerly Junior COSTEP)
    - Students enrolled in degree programs may be commissioned for short tours of 15 to 150 days
    - No post-assignment commitment is required
    - It allows the student to establish a base pay credit date as soon as they begin their short tour resulting in a higher entry-level salary in activated.
    - Payment is provided for travel and O-1 salary, Basic Allowance for Housing (BAH)-2, and Subsistence

  - Early Commissioning Program (ECP – formerly SRCOSTEP)
    - Students are commissioned for extended active duty.
    - Students may be sponsored for a period of time determined by the Corps. Sponsorship periods will be consistent with the norms for particular degree program for example, six years for completion of a Pharmacy degree.
    - Payback service can be deferred until completion of approved residency or training.
    - Every day of sponsorship will entail two days of obligated active duty service.
    - Payment for travel and O-1 salary, BAH, and Subsistence.

- Corps student programs will be centrally run.
  - Centralizing funding for pay during rotations during the COSTEP and the sponsorship while in the ECP, along with training requirements for all three components is deemed necessary.
  - All COSTEP and ECP positions should not be considered full time equivalents (FTEs) while the officers are enrolled as full time students; while this change is being constituted all FTEs will be held centrally by the Corps and/ or the Department.
  - Stakeholders may continue to sponsor students (pay salaries and hold FTEs) if their needs extend beyond the SCPs funding or mission scope.
- Corps student programs will be evaluated on a regular basis to determine their effectiveness.
- As part of SCP, the Corps will create options to attend "PHS branded" residencies, internships and trainings at C_3Es, other universities and established uniformed service programs, e.g., USUHS and Walter Reed Army Medical Center.

Table 1. Student Commissioning Program (SCP) Components

	Student Reserve Commission Program	COSTEP	Early Commissioning Program
Eligibility	▪ Students early in a qualifying degree-earning program	▪ Students enrolled in a qualifying degree program	▪ Students enrolled in a qualifying degree program
Commission	▪ Reserve	▪ Short tours of 15-150 days	▪ Extended active duty
Benefit to Student	▪ Establishes an early base pay entry date - increases entry level pay when called to active duty	▪ Establishes an early base pay entry date - increases entry level pay when called to active duty ▪ Paid Externship	▪ Establish entry date for pay purposes ▪ Paid full salary while in school ▪ Paid tuition possible
Service commitment	▪ None	▪ No post-assignment commitment	▪ 2 days for every day of sponsorship ▪ Service can be deferred until completion of approved residency/training
Benefit to the Corps	▪ Service is more attractive duty to higher CAD pay yet no cost until that time ▪ Excellent candidate for Reserve Corps	▪ Provides opportunity to show case Corps opportunities, mentor student and enroll them as an ARP ▪ Same two as SRCP	▪ Locked in force resource ▪ Enroll them as an ARP
Cost	▪ None unless student is called to active duty	▪ O-1 salary, housing allowance (BAH-2), and subsistence allowance during tour	▪ Travel, O-1 salary, housing allowance (BAH), and subsistence allowance

- Establishing opportunities in the Emerging Leaders Program as a way to introduce the Commissioned Corps to emerging healthcare leaders as identified by the Department.

  Emerging Leaders is an HHS program designed to attract promising leaders into the Department. It targets students (mostly Master's level students) nearing completion of a degree in variety of disciplines. Participants learn about the Department through work experiences.

  - Partner with Emerging Leader program management.
  - Attempt to pair Emerging Leaders who are pursuing or who already a Corps qualifying degree with active duty Corps officers; create rotations expose Emerging Leaders to all facets of the Commissioned Corps to include 3H assignments.
  - Offer commissions, preferably extended active duty but also reserve duty, to all Emerging Leaders who meet commissioning standards and show an interest in the Commissioned Corps.
  - Create opportunities for successful Emerging Leaders to participate in the Corps' SCP to assist them in obtaining an additional degree if they agree to serve in a mission critical assignment, e.g. BSN, Medical or Dental degree.

Agency Programs

Agency programs are important vehicles for educating potential recruits about the Corps, encouraging their interest, and bringing them onboard. These programs attract students from clinical disciplines, applied public health, research, and mental health disciplines and then assign them to fulfill the urgent public health and emergency response missions of the Department.

These recommendations are designed to more effectively leverage existing agency programs for officer recruitment by (a) channeling more program participants into the Corps, and (b) retaining more officers after they have fulfilled their initial obligations. At the same time, the recommendations will encourage officers who have already expressed interest in the Corps to take advantage of agency programs. When a Commissioned Corps Ready Reserve is established, reserve duty will be one way for personnel to fulfill a service obligation or to remain available for emergency response once they have completed their obligations. Finally, agency programs can be used to recruit into the Ready Reserve.

CDC Epidemic Intelligence Service (EIS)

The EIS program brought a large proportion of CDC's Corps officers onboard and trained them in acute public health/epidemiologic response. EIS graduates hold positions in applied public health and research throughout the Department and in State governments. In 2004, EIS graduates held 10 of 12 CDC Center Director positions.

EIS officers (EISOs) include holders of DVM, RN and DDS degrees who also have an MPH; MDs; PhDs and DrPHs. Of the approximately 70 American citizens who enter EIS each July, two-thirds elect become Corps officers. Some incoming officers already have experience in the Commissioned Corps (e.g., in the Indian Health Service). Each year's class includes a few officers sponsored by one of the military services. To maximize the recruitment of EIS officers:

- Provide Corps recruiters with information about the EIS program.
- Establish dedicated Corps recruiters who are EISOs or EIS graduates to speak knowledgeably about their experiences and the advantages of commissioning.
- Recruit Associate Recruiters who are EIS graduates and survey current Associate Recruiters to ascertain who are EIS graduates.
- Obtain updated materials from the EIS program to provide to Associate Recruiters in support of this process.
- Attend public health meetings and conferences where the EIS program has success in recruiting in the past.
- Provide an informational booth at the annual EIS Conference to actively recruit while providing examples of officership training materials for incoming EISOs.
- Provide to the EIS Program the names of commissioned officers that meet basic EIS criteria and may have EIS-relevant interests, so that the EIS Program can send these officers an information/application packet.
- Support long-term training to qualified officers, to include salary/benefits/FTE/travel costs, to join the EIS program; this arrangement currently exists between the EIS Program and the United States Navy and the United States Air Force; the billets should be centrally funded and maintained by the Corps.
- Support qualified officers entering CDC's Preventive Medicine Residency for additional training in public health leadership.
- Encourage other OPDIVs/STAFFDIVs to support their qualified Corps officers for participation in the EIS program.
- Provide information about the Corps, extended Active Duty and Reserve Commissions to applicants when they interview for EIS and again when job offers are made to join and graduate from the EIS program; this information will include contact information for Corps recruiters.
- Provide eligible Corps officers, who retain their commission after EIS, the opportunity to compete for loan repayment, scholarships, and other long-term training opportunities.
- Present commissions through the Reserve Corps; these opportunities will be shared with the EIS Program by March each year

HRSA National Health Service Corps – Scholarship Program (NHSC-SP)

The HRSA/NHSC-SP provides tuition, a monthly stipend, and payment of other reasonable costs in return for between two and four years of clinical service at health professional shortage areas (HPSAs). Scholarship recipients include primary care physicians—pediatrics, family practice, and internal medicine—as well as dentists, family nurse practitioners, midwives and physician assistants. In order to be eligible for the NHSC-SP, the law requires that an individual must "be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;" [42 USC 254l(b)(2)]. Approximately 150 NHSC scholars enter service every year. Currently, there are 46 Commissioned Corps officers in Indian Health Service (IHS), Bureau of Prisons (BOP), and Immigration and Customs Enforcement (ICE) facilities.

- Corps central recruitment managers, HRSA, OPDIV/STAFFDIVs, and other stakeholders will be partners in the effort to recruit Corps officers through the NHSC scholarship program.
  - Provide Corps recruiters with information about the NHSC Scholarship Program
  - Invite Corps, OPDIV/STAFFDIVs and other program representatives to NHSC-SP recruitment fairs and scholars conferences
  - Share lists of scholars to be recruited.
  - Provide information about the Corps, extended Active Duty and Reserve Commissions, to applicants when they interview for NHSC Scholarships and again when job offers are made to join and graduated from the NHSC program; this information will include contact information for Corps recruiters.
  - Provide information about the Corps, extended Active Duty and Reserve Commissions to applicants when they interview for NHSC and again when job offers are made to join and graduate from the NHSC program; this information will include contact information for Corps recruiters.
  - Utilize the NHSC Ambassadors, who are NHSC graduates, to assist with recruitment.
  - NHSC SP will provide updated materials to Corps recruiters.
  - Provide Corps information at exhibit booths at the annual NHSC SP Conference to actively recruit while providing examples of officership training materials for NHSC scholars.
- Upon recruitment, scholars will:
  - Complete commissioning process, CAD
  - Be called to extended active duty
  - Attend a two-week CAD BOTC course
  - Begin to fulfill NHSC service commitment in IHS, BOP, ICE or other agency as a Commissioned Corps officer. Salary, benefits, two-week CAD BOTC, readiness training costs will be fully supported by the accepting OPDIV/STAFFDIVs.
- HRSA/NHSC will manage the scholarship commitment.
- Due to the limited number of NHSC Scholars, recruitment must be equitable across all potential placement locations, i.e., Community Health Centers, to avoid criticism for favoring federal programs.

HRSA Nurse Scholarship Program

The HRSA Nurse Scholarship (NS) program provides financial assistance to students who agree to serve as nurses for a period of not less than two years at a health care facility with a critical shortage of nurses. The minimum service requirement is two years for the first year of support as a full time student, and one year of service requirement for each year of support thereafter. The legislation states that Nurse Scholars will be those with the greatest financial need. The FY 2005 appropriation for this program is 9.8 million dollars. Currently, there are over 300 Nurse Scholars in the program with the majority still in training. Approximately 200-300 scholarships are awarded every year.

- Work with IHS, BOP, ICE, other OPDIV/STAFFDIVs and programs to actively recruit scholars to join the Corps.
  - During the final year of their nurse program, nurse recruiters from the Indian Health Service (IHS), Bureau of Prisons (BOP), Immigration and Customs Enforcement (ICE),

and other agencies will contact scholars receiving a Nurse Scholarship through the Nurse Scholarship Program (NSP).
  - Upon recruitment, scholars will complete commissioning process, be called to active duty, attend a two-week CAD BOTC, and begin to fulfill NS service commitment in IHS, BOP, ICE, or other entity, as Corps officers.
  - HRSA/NS Program will manage the scholarship commitment.
  - Salary, benefits, two week CAD BOTC, readiness training costs would be fully supported by the accepting OPDIV/STAFFDIV or program.

Indian Health Service Scholarship Program

The Indian Health Service (IHS) manages four interrelated scholarship programs to train professional health personnel. The following recommendations are designed to introduce young health professionals to the Corps and proactively recruit active duty officers that have an affinity for clinical service in isolated-hardship, hazardous, and hard-to-fill assignments.

Health Professions Scholarship Program

The Health Professional Scholarship Program targets health professional students in a variety of clinical and public health disciplines (Appendix 3 for a listing). In 2005, 422 Health Professions Scholarships were awarded (176 new and 246 continuing). The contract requires that the recipient serve one year for each year of scholarship support received with a minimum service period of two years.

- Corps central recruitment will coordinate with the IHS scholarship programs
- IHS will share with the Corps the list of graduating scholarship students in March and October of every year that are eligible to be commissioned in the Corps.
- Advertise the Corps in the application phase could assist IHS to aggressively recruit scholars to fill vacancies, which meet the IHS requirements and meet the force management goals of the Corps.
- Upon successful recruitment, scholars will:
  - Complete commissioning process, CAD
  - Be called to active duty, and
  - Attend a two-week CAD BOTC course.
- IHS will manage scholarship commitment.

Other IHS Scholarships

The Health Professions Preparatory Scholarship, the Health Professions Pre-graduate Scholarship, and the Health Professions Extern Program are available to students in pre-medical, pre-sanitarian, and other undergraduate degree programs. To leverage these programs for Corps recruitment,

- Commissioned Corps central recruitment will coordinate with the IHS scholarship programs
- Each fall, the IHS will share with the Commissioned Corps the list of preparatory and pre-graduate scholarship students that are eligible to be commissioned in the COSTEP program.
- Upon successful recruitment, scholars will:
  - Complete the commissioning process by the COSTEP deadline
  - Serve in an IHS assignment
  - Notify the IHS Area scholarship coordinator about the desire to become an extern by the first Friday in February.

- The IHS will fund the COSTEP scholarship student with funds from the Health Professions Extern Program.
- (Appendix 3 – IHS Scholarship Program Disciplines)

Using Pipeline and Agency Programs to Build a Ready Reserve Component

- Commission all or some of the HRSA/NHSC Scholars Recipients in the USPHS Ready Reserve component to grow a pool of clinicians who can be activated for national emergency response.
  - If there were Statutory Authorization and Appropriation for a USPHS Ready Reserve, the HRSA/NHSC would make available the opportunity to recruit NHSC scholars into the Ready Reserve as they begin their service obligation.
  - Scholars should be introduced to the Corps Student Commissioning Program during their training.
  - Upon graduation, the NHSC Scholar would:
    - Commissioned in the Ready Reserve component
    - Attend a two week BOTC course, and
    - Train as Ready Responders, two times a year
  - In the event of a national emergency the USPHS Ready Reserve would be activated and deployed in accordance with HRSA and OFRD guidelines.
  - Applicants accepting a commission in the Ready Reserve could be given a preference in the scholarship award process

- Commission all or some HRSA/NS Scholarship Recipients in the USPHS Ready Reserve component to increase the number of nurses who could be available in a national emergency.
  - If there were Statutory Authorization and Appropriation for a USPHS Ready Reserve, the HRSA/NS would make available the opportunity to recruit NS scholars into a USPHS Ready Reserve component as they begin their service obligation.

- Encourage all DHHS Health Professional Educational Programs to provide the Corps' Officer of Reserve Affairs an opportunity to interface with their program participants in the early stages of the program.
  - Includes HRSA, SAMHSA, NIH, and other federal training programs
  - Upon graduation, they would be commissioned, attend a two week BOTC course and train as Ready Responders, two times a year.
  - In the event of a national emergency the USPHS Ready Reserve would be activated and deployed in accordance with OPDIV/STAFFDIVand OFRD guidelines.

List of Committee Members
Recruitment, Training, and Career Development

CAPT Kerry Nesseler-Chair, HRSA

Carol Arbogast-PSC
CAPT Steve Blackwell-OSG/OCCO
CAPT Laura Chisholm-NIH(alt.)
CAPT Dean Coppola-OCCFM
Beverly Dart-OGC
CDR Lisa Dolan-Branton-AHRQ
CAPT Stephanie Donahoe-FDA
CDR John Eckert-ASH
CAPT Sandra Farley-CMS
LT Jason Jurkowski-ASPHEP
Holly Kilness-ASL
CAPT Denise Koo-CDC
Theresa Lawrence-ASPE
CAPT Nick Makrides-BOP
CAPT Florentino Merced-Galindez-SAMHSA
LCDR Kimberly McIntosh-Little-OCCFM
LCDR Cheryl Peterson-IHS
LCDR Laura Pincock-JOAG/FDA
CDR Carol Rogers-IHS
CAPT Lee Shackleford-OSG/OCCO
CDR Dana Taylor-OSG/OCCO
LT Betsy Valenti-OSG/OFRD
CAPT Diane Walsh-NIH
Carol Moore-Lewin
Jeff Chandler-Lewin

Appendix 1

Recruitment Lessons Learned from the 1980s and 1990s

A major centralized recruitment effort was made in the mid-80 during Revitalization. There was a marked rise in commissions in that period of time. This effort was spearheaded by then ASH, ADM James O. Mason. It was funded by equal contributions from all PHS Agencies into a central funding source. Denoting that at that time the ASH had supervisor authority over the PHS Agencies. The primary components of that program were:

- Eight full-time recruiters whose primary responsibilities were:
  - Developed and implemented a strategic targeted recruitment plan
  - Recruited for all the PHS agencies, yet each were assigned specific categories
  - Developed and coordinated the Associate Recruiter Program (ARP)
  - Interacted with the PACs/CPOs and Agency recruiters to get the most recent vacancies
  - Developed relationships with universities
  - Attended the majority of the recruitment site visits

- The other major component was a large contract (at that time it averaged $5.5 million). The contractor's responsibilities were:
  - Developing, updating and distributing all recruitment materials (print and video)
  - Manning the "1-800 call center," 24/day, every day
  - Developing and placing advertisements in professional periodicals
  - Coordinating and paying for all exhibit spaces
  - Designing, fabricating and distributing all displays used at exhibits
  - Collecting and collating all interested contacts

This recruitment effort increased calls to active duty primarily by having a centralized recruitment structure with a strategic targeted plan that involved all stakeholders coupled with a large sum of dedicated dollars available to an organization whose primary responsibility was recruitment for the Corps. This organization also chose to purchase contractual assistance verses creating a large permanent office. Lastly, there was no historical recollection of any issues with the Corps' ability to process applicants efficiently.

A similar effort was made in the late 1990s, when the Recruitment and Assignments Branch was formed by then-Director of the Division of Commissioned Personnel (DCP), RADM Davidson. The primary components of that Branch's recruitment efforts were:

- Strategic recruitment plan driven by OPDIV/STAFFDIV needs but incorporated into already functioning category/discipline specific recruitment efforts
- Focused recruitment targets developed from an OPDIV/STAFFDIV needs analysis
- Reconstitution of the Associate Recruiter Program
- Development of high quality Corps specific recruitment materials, including professionally contracted recruitment CD, print materials, and multiple size displays along with graphics
- Marketing program
  - Radio and print media ads
  - Video that marketed the Corps to the Agencies

- Coordinated Corps presence at professional conferences, universities and training sites; the majority of efforts in this area continued to be done on a voluntary basis since there was no independent funding sources

While successful in many respects, the return on investment was not as great as it had been a decade earlier. In 1999, the there was a three-fold increase in the number of applications to the Commissioned Corps over the next three years, yet the inability of DCP's processing system to meet this surge of applications resulted in a only a 20% increase in the number of calls to active duty. The primary factor in the Branch's inability to resolve the processing and placement issues were inadequate support for application processing and lack of direct placement authority.

Appendix 2

Indian Health Service Scholarship Program Disciplines

IHS Health Professions Preparatory Scholarship

- Pre-Clinical Psychology (Jr. & Sr. undergraduate years)
- Pre-Dietetics
- Pre-Engineering
- Pre-Medical Technology
- Pre-Nursing
- Pre-Occupational Therapy
- Pre-Pharmacy
- Pre-Physical Therapy (Jr. & Sr. undergraduate years)
- Pre-Sanitarian
- Pre-Social Work (Jr. & Sr. undergraduate years)

IHS Health Professions Pre-graduate Scholarship

- Pre-Medicine
- Pre-Dentistry
- Pre-Podiatry

IHS Health Professional Scholarships/Extern Program

- Nurse: Associate & Bachelor Degrees in Psychiatry, Geriatric, Women's Health, Pediatric Nursing, Nurse Anesthetist & Nurse Practitioner.
- Chemical Dependency Counseling
- Clinical Psychology
- Coding Specialist
- Counseling Psychology
- Dental Hygiene
- Dentistry
- Diagnostic Radiology Technology
- Dietitian
- Environmental Health & Engineering
- Health Care Administration
- Health Education
- Health Records
- Injury Prevention Specialist: Certificate
- Medical Technology
- Medicine: Allopathic and Osteopathic
- Occupational Therapy
- Optician
- Optometry
- Pharmacy

Appendix 3

- Physical Therapy Assistant
- Physical Therapy
- Physician Assistant
- Podiatry
- Public Health: M.P.H only (Applicants must be enrolled or accepted in a school of public health with concentration in Epidemiology
- Public Health Nutritionist
- Respiratory Therapist
- Social Worker
- Ultrasonography (Prerequisite: Diagnostic Radiology Technology)

Appendix 3

TAB 6

Training and Career Development: Implementation Plan

TAB 6

Training and Career Development: Implementation Plan

TRAINING AND CAREER DEVELOPMENT

Implementation Plan

Secretary's Decisions

1. A two week Basic Officer Training Course (BOTC) should be required of all new officers at the start of their careers (or within 6 months if a delay is necessary);
2. Training throughout officers' careers must be a shared responsibility of the Agencies (for their mission) and for the Corps (for "officership" matters).

Principles for Transforming Training and Career Development

- Build a centralized USPHS Commissioned Corps (Corps) training and career development infrastructure
- Train and develop Corps officers in accordance with Health and Human Service (HHS) human capital management principles, including strategic workforce analysis, and short and long-term strategies to effectively deploy and develop Corps Officers
- Develop goals, to include core competencies, to guide training and career management of officers
- Engage OPDIV/STAFFDIVs in the development of these core competencies, with oversight from a Corps Steering Committee for training and career development
- Develop a two-week Call to Active Duty, Basic Officer Training Course (CAD BOTC) as a first priority, using instructional design and adult learning principles
- Support retention and enhance officers' skills by developing a training and career development continuum throughout their careers using instructional design and adult learning principles. These courses will be offered as a series for officers to receive career-long training specific to their careers as Uniformed Services Officers:
  - Intermediate Officer Training Course: 5-7 years
  - Advanced Officer Course: 10-12 years
  - Executive Officer Course: 17 years and over
- Integrate information systems fully in the training and career development process
- Use Corps officers as the leaders and career management force for Corps officers.

Central Corps Training and Career Development

The Secretary decided that "'Training throughout officers' careers must be a shared responsibility of the Agencies (for their mission) and for the Corps (for "officership" matters)." Recommendations by the Transformation Recruitment, Training and Career Development Committee members (see Appendix 1 for membership listing) describe processes and functions that will be managed by the Corps to meet its responsibilities for officer training and career management.

Development of Goals, Core Competencies, and Evaluation Strategies for All Training and Career Development Courses

- Determine program goals, competencies, learning objectives, and evaluation methods for all Corps training and career development components that should be common for all HHS employees
- Collaborate with the Corps Steering Committee for training and career development in the development of these goals
- Utilize optimal instructional design techniques and principles of adult learning to assure that objectives are attained, including use of distance learning, and web-based methods where appropriate
- Develop CAD BOTC curriculum to support acquirement of competencies identified as necessary for Corps officers to begin their careers
- Identify competencies that are unique to Corps officers and should be acquired through Centralized Corps training or Corps assignments
- Define core competencies and develop a career development guidebook (see Appendix 2 for an example) and a career development matrix that provides options to achieve these competencies and assists in active force career management of officers throughout their careers. Competency subject areas include:
  - ***Officership***: upon completion of CAD BOTC and throughout all stages of an officer's career
  - ***Leadership***: utilizing the existing HHS (Appendix 3) and OPDIV/STAFFDIVs competencies, identifying the most relevant for Corps officers at various stages of their careers
  - ***Readiness***: upon completion of CAD BOTC and to guide officers as uniformed services officers deploying in a readiness environment, in concert with other response organizations
  - ***Functional groups*** (clinical, applied public health, research, and mental health): utilizing OPDIV/STAFFDIVs expertise, for example, IHS for clinical, CDC and HRSA for applied public health, NIH, AHRQ, and FDA for research, and SAMHSA for mental health
  - ***Professional categories*** (for development of career paths): involving the CPOs and PACs, building on existing competency sets in these disciplines (e.g., from American Medical Association or Accreditation Committee on Graduate Medical Education, or various provider organizations), and coordinating with professional categories as they track potential changes in Corps mission affecting category competencies
- Develop evaluations for core competencies from the continuum of courses to assure that officers develop the necessary knowledge and skill level required at specific points in their career.

Career counseling and management

- Assign all officers to a career counselor/detailer, who is also a Corps officer; all officers will have a counselor at all stages of their career, starting at the Corps application process until retirement

- Train career counselors/detailers provide one-on-one guidance to applicants on matters such as required and recommended training, potential assignments, promotion requirements, and career pathways and milestones
- Publish a career matrix, indicating milestones, potential assignments, readiness training, and other training that will aid career decisions for officers by grade, functional group, and professional category (see Appendix 4 for a recommended career matrix format).
- Create a Corps Steering Committee for training and career development
  - Members will be selected by the Assistant Secretary for Health to include:
    - OPDIV/STAFFDIV representatives
    - Chief Professional Officers
    - Appropriate training entity staff members
    - Subject-matter expertise in program and curriculum development and evaluation.
  - Members will be responsible for
    - Development of core competencies, course goals and content guidelines, across functional grouping and professional categories.
    - Development of evaluation methodology of the training components in order to assess the topic content and distribution, material accuracy, presentation clarity, and any other factors
- Maintain a central repository of training opportunities that can be accessed by officers, which will identify long-term-training, intra-departmental training (e.g., HHS-U, FDA-U, etc.), intra-disciplinary training, intra-agency training opportunities; IT and audio-visual resources require updating
- Augment central staff to coordinate OPDIV/STAFFDIV needs, assignments and career counseling, manage training materials and on-line resources, and provide clerical and administrative support***. Full staffing is essential to undertake a two-week CAD BOTC and to develop and implement career-focused training and readiness training programs***.

Career Development Matrix

There will be active force management and assistance for officers throughout their careers. A Career Development Matrix was developed in concept to illustrate and offer a guide for officer career pathways in areas of officership, leadership, response readiness, and professional development. The matrices seek to assist career counselors to provide active career guidance to officers. The matrices are intended to group officers by functional groupings as well as professional categories and grade. The matrices focus on a sample of competencies and experiences that are considered desirable throughout a career. The recommended career development matrix format is based on systems and models from the Coast Guard Environmental Health officers, Air Force Dental officers, Navy Dental officers and the Medical Service Corps officers.

The strengths of existing systems were adapted to form a preliminary model for each of the Corps' professional categories. Additional input was received from the Joint Career Development ad Hoc Committee that consists of representatives from the Junior Officer Advisory Group (JOAG), Minority Officer Liaison Council (MOLC), and the Office of Commissioned Corps Force Management (OCCFM). One of the preliminary matrices for the

Dental category is shown in Table 1. Preliminary matrices for the other categories are found in Appendix 5.

The Chief Professional Officers commented on the matrices. Some recommended next steps include:

1. Determine relationship of the matrices to the assignments and billet systems
2. Clarify relationship to promotion precepts
3. Clarify relationship between matrix elements and core competencies/goals
4. Collaborate with categorical and functional representatives and other stakeholders to refine the content appropriate for each stage of the career
5. Define which elements are required and which are suggested.

Table 1. Career matrix illustration

Dental Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:**BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs.	**Courses** Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses** Executive Leadership, CPO Training, Flag Officer Training, Retirement Training. Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness	All officers must meet BASIC standards including COMPLETE Immunizations.		
Readiness Checklist	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course, Homeland Security Executive Course
Education Long-Term Training (Degree/Residency)	DMD or DDS and state license Clinical proficiency in Pros.,Endo., Oral Surg., and Restorative Dentistry Informed about Adv. Training/Career Tracks	pursue Adv. Training: AEGD/AGPR or Specialty Residency	complete Adv. Training: AEGD/AGPR or Specialty Residency
Short Courses Agency Training	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Dental Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	CPR/BLS, Cont. Ed. (annually recurring) Joint Medical Planners Course
Billets	Staff Dental Officer/Basic (O-3)	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Dentist, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Dental Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist
Applied Public Health	Basic Project Officer Course	begin MPH, MHA, MSD or equivalent	complete MPH, MHA, MSD or equivalent
Research	publications in journals or grants submitted	begin PHD, MSD, or DrPH 2 publications per yr./ grant funding	complete PHD, MSD, or DrPH continued grant renewal and publication
Mental Health			
Resources	Agency/Corps funding for courses. (Res) lab/field facilities for data collection	Funding for courses, funding for intra/extramural adv. training slots at USUHS or distance learning	Agency funded courses, distance learning, USUHS, hospital based training, training in clinical/program management
Staffing	Specialists to provide PHS wide training (Res)Lab & technical staff support	Clinical Specialty Instructors: 2 per specialty for I.H.S 1 per specialty for all the others	Clinical Specialty Instructors: 2 per specialty for I.H.S 1 per specialty for all the others

Two-Week Basic Officer Training Course

The Secretary resolved that "a two week Basic Officer Training Course (BOTC) should be required of all new officers at the start of their careers (or within 6 months if a delay is

necessary)." We refer to this initial BOTC as Call to Active Duty (CAD) BOTC to distinguish it from other basic officer training courses currently being offered.

The purpose of the CAD BOTC is to establish a standardized, highly reliable core of basic information, to inspire Corps officers and to establish an emotional bond to the service. It supports acquirement of competencies that officers need to begin their careers, with emphasis on officership and readiness. When officers complete the CAD BOTC, they will meet basic readiness requirements and be familiar with both readiness standards and the necessity of emergency response and deployment. Finally, the CAD BOTC fosters officers' emotional bonds to the Corps and to other officers before they begin their OPDIV/STAFFDIV tours. Thus, CAD BOTC is an essential step in developing esprit d' corps and relating as members of a uniformed service.

- There will be some flexibility (e.g., in timing, location, and content) for officers being called to active duty directly to participate in training programs such as CDC's Epidemic Intelligence Service (EIS) and NIH Residency/Fellowships officers. These officers are participating in full-time training programs designed to support the critical USPHS mission of scientific readiness, applied public health, and/or research; thus flexibility in implementation for these programs is crucial to the future of the Corps.

Corps development of CAD BOTC

- Develop a mission statement, goals, core competencies, learning objectives and evaluation strategies for the CAD BOTC
  - Review current content of CAD BOTC, with oversight by the Steering Committee
  - Integrate readiness training, coordinated by staff from OFRD
  - Compare CAD BOTC core competencies and course content to the CDC EIS training, NIH residency and fellowship training, and any other Agency-sponsored, required training to avoid duplication of course material
- Ensure that new Corps officers participate in the two-week resident-based CAD BOTC prior to their first duty assignment, with few exceptions
  - Provide orders for temporary duty (TDY) to attend CAD BOTC prior to arriving at the duty station when the call to active duty is initiated by the employing OPDIV/STAFFDIVs; there will be a six-month grace period allowed for the newly commissioned EIS and NIH Residency/Fellowship officers to attend the CAD BOTC
  - Evaluate the resident-based concept for efficiency, instructional value, and cost effectiveness. (*Note*: CDC, NIH, FDA, and HRSA believe that an evaluation study is necessary prior to a resident-based course requirement)
  - Evaluate innovative use of online/distance learning and other remote training techniques
- Explore starting the first day of CAD BOTC on Saturday through the next Sunday to shorten delay to duty station
- Rename current three day BOTC to eliminate confusion with the new CAD BOTC
- Provide the CAD BOTC in a central location in the Washington D.C. area, preferably on a military/ federal facility, with additional locations in Atlanta and Phoenix.

  - Location should be within a reasonable distance to Headquarters and easily accessible for the Corps leadership, special guests, speakers, and dignitaries; specific site requirements are listed in Appendix 6
  - Military facilities are preferred to allow new officers interacting with military personnel, which supports instruction in the practice of being an officer, e.g., exhibiting military courtesies
  - Central location site will become the Central Training Academy for the CAD BOTC
  - Two other CAD BOTCs will be held in regional locations once each per year, in Atlanta for EIS officers (mid-fall), and in Phoenix for west coast based officers (early spring)
- Convene classes on an approximate monthly basis, with additional courses scheduled for historically large influxes of new officers; historical accession patterns will be studied to ascertain the most effective mix of course offerings
- Use web-based distance learning in a supportive role to reinforce instruction after the officer has completed the CAD BOTC; use of web-based distance learning will be a major component of training courses following the CAD BOTC
- Allocate costs as follows:
  - Instructional costs - paid through a centrally funded and coordinated effort
  - Salaries, benefits, travel costs - paid by the employing OPDIV/STAFFDIVs
  - Initial estimates to the OPDIV/STAFFDIVs of a two week resident course are:
    - $3000 per student, if located on a military base/ federal facility, using base lodging and messing facilities
    - $5000 per student, if housed off-base using available commercial lodging, and payment of M, I & E.

Readiness and Preparedness Training

The structure of readiness and deployment training will be expanded and realigned to meet the Corps' emergency response requirements. Basic readiness training will be offered through the CAD BOTC. Readiness training beyond the basic level will be coordinated through OFRD, with support from the Office of Public Health and Emergency Preparedness (OPHEP) and other OPDIV/STAFFDIVs, as appropriate. The readiness training as outlined by the Readiness Transformation Implementation workgroup should be implemented. Educational content/subject matter experts will develop content, provide updates and research educational topic needs. Logistics staff will provide logistical arrangements. IT and administrative staff will assure program support.

To complement recommendations of the Readiness implementation plan, the following training will be available:

- CAD BOTC
- Rapid Deployment Force Team (RDF)/Tier/Field Courses – includes logistics, content
  - Just in time/pre-deployment training
  - Live field training and exercises
  - Live team classroom training
- Online Training Course Program (requiring maintenance of the system/platform, curriculum updates, and new curriculum development)
- Basic Life Support Courses – for current and new staff
- Higher Level Competency-based Live Classroom Training Courses

- Response Leadership
- Skill Competencies
- Role specific training
- Subject matter training.

The Continuum of Training and Career Development

These recommendations include a continuum of training to help officers develop throughout their careers, in alignment with the needs of the Department, OPDIV/STAFFDIV, and the Corps, funded and provided centrally. Beyond CAD BOTC, the Corps will provide a series of officership courses to officers at key points in their careers:

- Intermediate Officer Training Course
- Advanced Officer Training Course
- Executive Officer Training Course.

Officers will take additional courses to support continued learning. These courses will focus on Departmental and OPDIV/STAFFDIV matters, general management, and administration. The Corps would help officers make decisions about training opportunities available through the Department and their OPDIV/STAFFDIV, through private training institutes and foundations, and through colleges and universities. In contrast to the officer training courses, additional courses will not be funded and managed by the Corps. A variety of training techniques, including distance learning, Click to Meet, and short courses could be used to meet recommended training needs and to supplement the officership courses.

Table 2 illustrates the continuum of training concept. The centralized courses will begin with the CAD BOTC and continues with a range of courses for intermediate, advanced, and executive training. The years in service are approximate. The recommended courses are, for convenience, labeled Pre-Intermediate, Pre-Advanced, and Pre-Executive, but a variety of options are possible depending on the officer's career focus and interests. Officers will be required to pursue a recommended training option to be eligible for the Intermediate, Advanced, and Executive training.

Table 2. Continuum of Training

Course Title	Timing (Years of Service)	Centralized Officership	Recommended
Basic Officer Training Course (BOTC)	CAD	X	
Pre-Intermediate	1 – 5		X
Intermediate Officer Training	5 – 7	X	
Pre-Advanced	7 – 10		X
Advanced Officer Training	10 – 12	X	
Pre-Executive	12 – 17		X
Executive Officer Course	17+	X	

Centralized Officership Courses

Developing leadership attributes and officership skills are essential for career progression. This training is progressive and will be offered at different stages of an officer's career. The centralized training program will:

- Identify competencies and objectives essential to the mission of the Corps
- Ensure that competencies and objectives are met
- Provide officers career guidance
- Provide training that will commence with a CAD BOTC and progress with periodic resident courses (intermediate, advanced, and executive levels).

Intermediate Officer Training Course (5 to 7 years of service)

The Intermediate Officer training course will incorporate the inter-Agency concept into an officer's Corps development. It will also help the officer to prepare for assignments in mid-level management and supervision positions. Potential topics include:

- Officership updates
- Differences of OPDIV/STAFFDIV and Non-HHS Agencies
- Agency liaison presentations – Agency Introductions
- Professional Advisory Committee (PAC) chair introductions; breakout sessions by category
- HHS leadership updates
- Develop presentation skills
- Additional Career Opportunities and Corps structure
- Corps managerial skills/supervisor training – Formal Mentoring/Coaching Programs
- Awareness of resources for supervisory courses
- Benefits and retirement updates
- Writing of Reviewing Official Statements (ROS)

Advanced Officer Training Course (10 to 12 years of service)

All officers will be eligible for the Advanced Officer Training Course, which is designed to build future Corps leaders. The Training and Career Development Steering Committee will coordinate with Corps leadership to establish criteria for priority placement in this course, which will train Corps officers in advanced leadership matters.

- Building relationships with agencies outside of DHHS
- Organizational update
- Public Information Officer (PIO)
- Character development/ethics
- Advanced topics in team-building and working with others
- Proactive Leadership Roundtable
- Retirement on the horizon
- Help officers obtain leadership positions within OPDIV/STAFFDIV
- Introduce "meta-leadership" foundation skills

Executive Officer Training Course (17 or more years of service)
Executive training will be offered to selected officers. The Training and Career Development Steering Committee will work with Corps leadership to identify specific qualification guidelines to identify potential officers.

- Inter-agency Institute for Federal Healthcare Executives (IAIFHCE)
- HHS Internship in the legislative process
- Political/Strategic Leadership – Governmental Interactions
- Temporary Detail (e.g. Executive Assistants to Chief of Staff)
- Interactive Roundtable with the Assistant Secretary of Health and Human Services (ASH)

Recommended Additional Training

Pre-Intermediate Training (1 to 5 years of service)
Officers will complete between three and five areas after CAD BOTC as a prerequisite to the intermediate course. The areas for development may include:

- Team development/leadership
- Corps organization orientation
- Commissioned Officer Association participation
- Senior officers mentoring
- Public Health Service (OCCO, OCCFM) module completion
- Commissioned Corps Heritage/Legacy/History Module (BOTC refresher) completion
- Writing Skills development
- SERT/Response training

Pre-Advanced Training (7 to 10 years of service)
Post-Intermediate training will allow officers to maintain a connection to the Corps mission and values in the years between intermediate and advanced training courses. This menu of training opportunities would educate officers in Departmental management matters and skills needed to lead groups of officers.

- Foundations of leadership techniques, such as negotiation skills, and conflict management
- Understanding the qualities of a "Senior" officer
- Fundamentals of management such as fiscal decision-making and budgeting

Pre-Executive Training (10 to 17 years of service)
Post-Advanced training will prepare the officer to lead in a division, OPDIV/STAFFDIV, or departmental upper management/ leadership position, and introduce cross-departmental leadership.

- Foundations of executive leadership techniques, such as negotiation skills, and conflict management
- Define the qualities of an "Executive-level" officer
- Fundamentals of strategic-planning, visioning, fiscal planning and budget projection

List of Committee Members
Recruitment, Training, and Career Development

CAPT Kerry Nesseler-Chair, HRSA

Carol Arbogast-PSC
CAPT Steve Blackwell-OSG/OCCO
CAPT Laura Chisholm-NIH(alt.)
CAPT Dean Coppola-OCCFM
CAPT Beverly Dart-OGC
CDR Lisa Dolan-Branton-AHRQ
CAPT Stephanie Donahoe-FDA
CDR John Eckert-ASH
CAPT Sandra Farley-CMS
LT Jason Jurkowski-ASPHEP
Holly Kilness-ASL
CAPT Denise Koo-CDC
Theresa Lawrence-ASPE
CAPT Nick Makrides-BOP
CAPT Florentino Merced-Galindez-SAMHSA
LCDR Kimberly McIntosh-Little-OCCFM
LCDR Cheryl Peterson-IHS
LCDR Laura Pincock-JOAG/FDA
CDR Carol Rogers-IHS
CAPT Lee Shackleford-OSG/OCCO
CDR Dana Taylor-OSG/OCCO
LT Betsy Valenti-OSG/OFRD
CAPT Diane Walsh-NIH
Carol Moore-Lewin
Jeff Chandler-Lewin

Appendix 1

THE COAST GUARD OFFICER
CAREER DEVELOPMENT GUIDE BOOK (Second Edition)
U. S. Department of Transportation United States Coast Guard

INTRODUCTION

PURPOSE This guidebook was prepared by the Office of Leadership and Professional Development to assist officers in making informed career choices and for supervisors to use as a counseling tool for junior officers. It also provides information on the officer personnel system and career planning in general, including the value of various assignments.

COMMAND INSTRUCTIONS Commands should use this book as a cornerstone for professional development. Whether you have an enlisted member striving for a commission; a reservist desiring information on the Mentoring Program; or a Guard can benefit from some portion of this book. Every Coast Guard unit will receive at least one copy of this book and one personal copy is being given to all new officers at accession points. Commands are to make this guidebook available for all personnel. It has been redesigned to allow for easier administrative maintenance. It is recommended that the master copy be kept in a unit library so individuals can reproduce sections as needed. Bulk reproduction of this book at the unit level is authorized.

HOW TO USE THIS GUIDEBOOK

CAREER PLANNING A successful career doesn't just happen: officers must plan for future success and satisfaction. Although there is no magic formula for success, understanding the promotion system, postgraduate education, assignments, and other topics in this guidebook gives an officer a strong start. Officers are encouraged to incorporate this information in planning for a Coast Guard career. DISCLAIMER This guidebook's information is taken from various sources, including official Coast Guard publications; however, its material should not be viewed as authority for official action. UPDATES This is a tool. As with any tool, the more it is used, the better it works. We live in times when change is the only constant. Corrections, clarifications and requests for additional information are strongly encouraged and welcome.

Appendix 2

TABLE OF CONTENTS

Appendix 2

Chapter 4 – OFFICER CAREER PATHS

Chapter 5 – ASSIGNMENTS

Chapter 6 – PROFESSIONAL DEVELOPMENT

Appendix 2

Appendix 2

HHS Leadership Competencies and Observable Behaviors by Level

Leadership Levels→ Competency Areas↓	I. Basic (Foundational) – All Leaders Must Possess	II. Supervisor/Team Leader	III. 2nd Level Supervisor/Manager	IV. Senior Executive
Leading Change	**Continual Learning** Grasps the essence of new information. Masters new technical and business knowledge. Recognizes own strengths and weaknesses. Pursues self-development. Seeks feedback from others and opportunities to master new knowledge. **Flexibility** Is open to change and new information. Adapts behavior and work methods in response to new information, changing conditions, or unexpected obstacles. Adjusts rapidly to new situations warranting attention and resolution.	**Resilience** Deals effectively with pressure. Maintains focus and intensity and remains optimistic and persistent, even under adversity. Recovers quickly from setbacks. Effectively balances personal life and work. **Service Motivation** Creates and sustains an organizational culture which encourages others to provide the quality of service essential to high performance. Enables others to acquire the tools and support they need to perform well. Shows a commitment to public service. Influences others toward a spirit of service and meaningful contributions to mission accomplishment.	**Creativity and Innovation** Develops new insights into situations and applies innovative solutions to make organizational improvements. Creates a work environment that encourages creative thinking and innovation. Designs and implements new or cutting-edge programs/processes	**External Awareness** Identifies and keeps up to date on key national and international policies and economic, political, and social trends that affect the organization. Understands near-term and long-range plans and determines how best to be positioned to achieve a competitive business advantage in a global economy. **Strategic Thinking** Formulates effective strategies consistent with the business and strategy of the organization. Examines policy issues and strategic planning with a long-term perspective. Determines objectives and sets priorities. Anticipates potential threats or opportunities. **Vision** Takes a long-term view and acts as a catalyst for organizational change. Builds a shared vision with others. Influences others to translate vision into action.

Leading People	**Integrity/Honesty** Instills mutual trust and confidence. Creates a culture that fosters high standards of ethics. Behaves in a fair and ethical manner toward others. Demonstrates a sense of corporate responsibility and commitment to public service.	**Conflict Management** Identifies and takes steps to prevent potential situations that could result in unpleasant confrontations. Manages and resolves conflicts and disagreements in a positive and constructive manner to minimize negative impact. **Leveraging Diversity** Recruits, develops, and retains a diverse high quality workforce in an equitable manner. Leads and manages an inclusive workplace that maximizes the talents of each person to achieve sound business results. Respects, understands, values, and seeks out individual differences to achieve the vision and mission of the organization. Develops and uses measures and rewards to hold self and others accountable for achieving results that embody the principles of diversity. **Team Building** Inspires, motivates, and guides others toward goal accomplishments. Consistently develops and sustains cooperative working relationships. Encourages and facilitates cooperation within the organization and with customer groups. Fosters commitment, team spirit, pride, and trust. Develops leadership in others through coaching mentoring, rewarding, and guiding employees.		

Appendix 3

Results Driven	Customer Service	Accountability	Entrepreneurship	
	Balancing interests of a variety of clients. Readily readjusts priorities to respond to pressing and changing client demands. Anticipates and meets the need of clients. Achieves quality end-products. Is committed to continuous improvement of services. **Decisiveness** Exercises good judgment by making sound and well-informed decisions. Perceives the impact and implications of decisions. Makes effective and timely decisions, even when data are limited or solutions produce unpleasant consequences. Is proactive and achievement oriented. **Problem Solving** Identifies and analyzes problems. Distinguishes between relevant and irrelevant information to make logical decisions. Provides solutions to individual and organizational problems. **Technical Credibility** Understands and appropriately applies procedures, requirements, regulations, and policies related to specialized expertise. Is able to make sound hiring and capital resource decisions and to address training and development needs. Understands linkages between administrative competencies and mission needs.	Assures that effective controls are developed and maintained to ensure the integrity of the organization. Holds self and others accountable for rules and responsibilities. Can be relied upon to ensure that projects within areas of specific responsibility are completed in a timely manner and within budget. Monitors and evaluates plans. Focuses on results and measuring attainment of outcomes.	Identifies opportunities to develop and market new products and services within or outside of the organization. Is willing to take risks. Initiates actions that involve a deliberate risk to achieve a recognized benefit or advantage.	

Appendix 3

Building Coalitions/Communications	Interpersonal Skills Considers and responds appropriately to the needs, feelings, and capabilities of different people in different situations. Is tactful, compassionate, and sensitive, and treats others with respect. **Oral Communication** Makes clear and convincing oral presentations to individuals or groups. Listens effectively and clarifies information as needed. Facilitates an open exchange of ideas and fosters an atmosphere of open communication. **Partnering** Develops networks and builds alliances, engages in cross-functional activities. Collaborates across boundaries, and finds common ground with a widening range of stake holders. Utilizes contacts to build and strengthen internal support bases. **Written Communications** Expresses facts and ideas in writing in a clear, convincing, and organized manner.	Influencing/Negotiating Persuades others. Builds consensus through give and take. Gains cooperation from others to obtain information and accomplish goals. Facilitates “win-win” situations.	Technology Management Uses efficient and cost-effective approaches to integrate technology into the workplace and improve program effectiveness. Develops strategies using new technology to enhance decision making. Understands the impact of technological changes on the organization.	Political Savvy Identifies the internal and external politics that impact the work of the organization. Approaches each problem situation with a clear perception of organizational and political reality. Recognizes the impact of alternative courses of action.

Appendix 3

Business Acumen		**Human Resources Management** Assesses current and future staffing needs based on organizational goals and budget realities. Using merit principles ensures staff are appropriately selected, developed, utilized, appraised, and rewarded. Takes corrective action.	**Financial Management** Demonstrates broad understanding of principles of financial management and marketing expertise necessary to ensure appropriate funding levels. Prepares, justifies, and/or administers the budget for the program area. Uses cost-benefit thinking to set priorities. Monitors expenditures in support of programs and policies. Identifies cost-effective approaches. Manages procurement and contracting.	

Appendix 3

Underlying Competencies	Self-Direction	All Level I Competencies in All Areas	All Level I & II Competencies in All Areas	All Level I, II, and III Competencies in All Areas
Technical Competencies	As appropriate for the specific Position	As appropriate for the specific position	As appropriate for the specific position	As appropriate for the specific position
Competencies Required/Valued by Organizational Culture	As appropriate for the organization	As appropriate for the organization	As appropriate for the organization	As appropriate for the organization

KEY to Rows and Color Coding for the following Career Paths and Training Matrices:

	Career Stage/Rank		Basic/O-1 to O-3	Intermed-iate/O-4 to O-5	Senior/O-5 to O-6
Career Elements		Officership Development			
		Response Readiness			
	Functional Group - clinical	Education (Degree/residency focused)			
		Training (C.E., Short Courses, Agency)			
		Experience (Billets)			
	Functional Groups - others	Applied Public Health			
		Research			
		Mental Health			
		Resources			
		Staffing			

(01) Medical Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency**	Preventive Medicine Training Maintenance of state license Advanced courses in specialty Additional Residency Informed about Adv. Training/Career Tracks	Graduate Medical Education Humanitarian coursework Maintenance of state license	Humanitarian coursework Advanced courses in specialty Maintenance of state license
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring)		
	Resume & KSA writing	ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Joint Medical Planners Course
Billets	Staff Officer/Basic (O-3)	Chief Basic Unit, satellite or solo (O-4)	Chief of a complex unit (O-6)
	Assistant Division Officer	Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

Appendix 5

(01) Medical Career Path and Training Matrix (continued)

Applied Public Health	Basic Project Officer Course EIS, MPH or equivalent CDC Field Epidemiology	Begin MPH, MHA or equivalent EIS CDC Field Epidemiology	Complete MPH, MHA or equivalent
Research	Publications in journals or grants submitted	Begin PHD or DrPH 2 publications per yr./ grant funding	Complete PHD or DrPH Continued grant renewal and publication
Mental Health			
Resources	Agency/Corps funding for courses Training from sister services DHHS	Agency/Corps funding for courses Training from sister services DHHS	Agency/Corps funding for courses Training from sister services DHHS
Staffing	Specialists to provide PHS wide training Training staff at OCCO Agency Staff	Specialists to provide PHS wide training Training staff at OCCO Agency Staff	Specialists to provide PHS wide training Training staff at OCCO Agency Staff

(02) Dental Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	DMD or DDS and state license Clinical proficiency in Pros.,Endo., Oral Surg., and Restorative Dentistry Informed about Adv. Training/Career Tracks	Pursue Adv. Training: AEGD/AGPR or Specialty Residency	Complete Adv. Training: AEGD/AGPR or Specialty Residency
Short Courses	CPR/BLS, Cont. Ed. (annually recurring)	CPR/BLS, Cont. Ed. (annually recurring)	CPR/BLS, Cont. Ed. (annually recurring)
Agency Training	Resume & KSA writing	ACLS, Dental Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Joint Medical Planners Course
Billets	Staff Dental Officer/Basic (O-3)	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Dentist, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Dental Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

(02) Dental Career Path and Training Matrix (continued)

Applied Public Health	Basic Project Officer Course	Begin MPH, MHA, MSD or equivalent	Complete MPH, MHA, MSD or equivalent
Research	Publications in journals or grants submitted	Begin PHD, MSD, or DrPH 2 Publications / yr / grant funding	Complete PHD, MSD, or DrPH Continued grant renewal and publication
Mental Health			
Resources	Agency/Corps funding for courses	Agency/Corps funding for courses Funding for intra/extramural adv. training, slots at USUS or distance learning	Agency/Corps funding for courses Distance learning, USUHS, hospital based training, training in clinical/program management
Staffing	Specialists to provide PHS wide training (Res) Lab & technical staff support	Clinical specialty instructors: 2 per specialty for I.H.S. 1 per specialty for all the others	Clinical Specialty Instructors : 2 per specialty for I.H.S. 1 per specialty for all the others

(03) Nurse Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	Specialty training programs Continuing Education Informed about Adv. Training/Career Tracks	Specialty training programs Continuing Education Long Term Health Education & Training Program	Specialty training programs Continuing Education Interagency Institute for Federal Healthcare Executive Course
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	CPR/BLS, Cont. Ed. (annually recurring) Joint Medical Planners Course
Billets	Assistant Division Officer Staff Officer	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Nurse, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

Appendix 5

(03) Nurse Career Path and Training Matrix (continued)

Applied Public Health	Begin MS, MSN, MPH, PHD	Begin MS, MSN, MPH, PHD	Complete MS, MSN, MPH, PHD
Research	Publications in journals or grants submitted	2 publications per yr./ grant funding	Continued grant renewal and publication
Mental Health	Psychiatric/Mental Health Nursing Course		
Resources	Agency/Corps funding for courses Corps Central training budget, work with sister services to get slots in their programs	Agency/Corps funding for courses Corps Central training budget, work with sister services to get slots in their programs	Agency/Corps funding for courses Corps Central training budget, work with sister services to get slots in their programs
Staffing	PHS Training Center, which includes administrators, instructors, support staff & IT staff.	PHS Training Center, which includes administrators, instructors, support staff & IT staff.	PHS Training Center, which includes administrators, instructors, support staff & IT staff.

Appendix 5

(04) Engineer Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies Developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	Technical training specialty programs Continuing Education Engineer in Training Certification Professional Certifications Informed about Adv. Training/Career Tracks	Technical training specialty programs Continuing Education Professional Certifications	Technical training specialty programs Continuing Education Professional Certifications
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing HAZWOPER, Certified Project Manager, Registered Land Surveyor	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	CPR/BLS, Cont. Ed. (annually recurring) Joint Medical Planners Course
Billets	Assistant Division Officer Staff Officer Junior Engineer	Chief Basic Unit, satellite or solo (O-4) Staff Engineer Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Engineer, complex unit (O-6) Deputy Chief, complex unit (O-5) District Engineer (O-6) Research Project Officer-Primary Investigator Research Scientist

(04) Engineer Career Path and Training Matrix (continued)

Applied Public Health	Begin MS, MPH, PHD Occupational and Health training	Begin MS, MPH, PHD	Complete MS, MPH, PHD
Research	Publications in journals or grants submitted	2 publications per yr./ grant funding	Continued grant renewal and publication
Mental Health			
Resources	Agency funding for courses. Corps Centralized source for budget, training, funding for courses, certification	Agency funding for courses. Corps Centralized source for budget, training funding for courses, certification	Agency funding for courses. Corps Centralized source for budget, training funding for courses, certification
Staffing	Staff to gather information, and maintain databases and search systems for the centralized sources of information.	Staff to gather information, and maintain databases and search systems for the centralized sources of information	Staff to gather information

(05) Scientist Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	Training specialty programs Continuing Education Professional Certifications Informed about Adv. Training/Career Tracks	Training specialty programs Continuing Education Professional Certifications	Training specialty programs Continuing Education Professional Certifications
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring)		
	Resume & KSA writing	ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Joint Medical Planners Course
Billets	Research Scientist Staff Officer Assistant Health Education Scientist	Environmental Health Scientist Officer Staff Clinical Scientist Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Support Scientist Officer Research Scientist	Chief Scientist, complex unit O-6) Deputy Chief, complex unit (O-5) Director, Research Scientist (O-6) Senior Research Support Scientist Officer (O-5) Director, Clinical Scientist Officer (O-6)

Appendix 5

(05) Scientist Career Path and Training Matrix (continued)

Applied Public Health	Begin MS, MPH, PHD Occupational and Health training	Begin MS, MPH, PHD	Complete MS, MPH, PHD
Research	Publications in journals or grants submitted	2 publications per yr./ grant funding	Continued grant renewal and publication
Mental Health			
Resources	Agency /Corps funding for courses IT Support, Training, Budget Support, Research support, category support	Agency /Corps funding for courses IT Support, Training, Budget Support, Research support, category support	Agency /Corps funding for courses IT Support, Training, Budget Support, Research support, category support
Staffing	Staff to gather information; IT, admin, travel Maintain databases and search systems for the centralized sources of information.	Staff to gather information; IT, admin, travel Maintain databases and search systems for the centralized sources of information	Staff to gather information; IT, admin, travel Maintain databases and search systems for the centralized sources of information

(07) Veterinarian Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education Long-Term Training (Degree/Residency)	Vet. Board specialty training program Continuing Education Informed about Adv. Training/Career Tracks	Vet. Board specialty training program Continuing Education	Vet. Board specialty training program Continuing Education
Short Courses **Agency Training**	Resume & KSA writing CPR/BLS, Cont. Ed. (annually recurring) Assistant Division Officer Staff Officer	Resume & KSA writing CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Resume & KSA writing CPR/BLS, Cont. Ed. (annually recurring) Joint Medical Planners Course
Billets		Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Veterinarian, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

Appendix 5

(07) Veterinarian Career Path and Training Matrix (continued)

Applied Public Health	Food Inspection Training Begin MPH, PHD Vet preventive medicine training/fieldwork	Begin MPH, PHD EIS	Complete MPH, PHD
Research	Publications in journals or grants submitted Post-doc in a research lab/fieldwork	2 publications per yr./ grant funding Post-doc in a research lab/fieldwork	Continued grant renewal and publication Post-doc in a research lab/fieldwork
Mental Health			
Resources	Agency/Corps funding for courses Lab funding	Agency/Corps funding for courses Lab funding	Agency/Corps funding for courses Lab funding
Staffing	Specialists to provide PHS wide training Category-specific staff at OCCO Agency/Corps/IT/University staff	Specialists to provide PHS wide training Category-specific staff at OCCO Agency/Corps/IT/University staff	Specialists to provide PHS wide training Category-specific staff at OCCO Agency/Corps/IT/University staff

Appendix 5

(08) Pharmacists Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs.	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	Board Certification or clinical specialty certification or post-grad PharmD Pharmacy Continuing Education Informed about Adv. Training/Career Tracks	Board Certification or clinical Specialty, certification or post-grad PharmD Pharmacy Continuing Education	CPR/BLS, Cont. Ed. (annually recurring Board Certification or clinical specialty certification or post-grad PharmD Pharmacy Continuing Education
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Joint Medical Planners Course
Billets	Assistant Division Officer Staff Officer	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Pharmacist, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

Appendix 5

(08) Pharmacists Career Path and Training Matrix (continued)

Applied Public Health	Basic Project Officer Course	Begin MPH, MHA, or equivalent	Complete MPH, MHA, or equivalent
Research **Mental Health**	Publications in journals or grants submitted	2 publications per yr./ grant funding	Continued grant renewal and publication
Resources	Agency/Corps funding for courses DHHS, IT database for mgmt & tracking	Agency/Corps funding for courses DHHS, IT database for mgmt & tracking	Agency/Corps funding for courses DHHS, IT database for mgmt & tracking
Staffing	Specialists to provide PHS wide training Category-specific staff at OCCO Agency Reps	Specialists to provide PHS wide training Category-specific staff at OCCO Agency Reps	Specialists to provide PHS wide training Category-specific staff at OCCO Agency Reps

Appendix 5

(09) Dietitian Category Career and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies Developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs.	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	RD or LD Informed about Adv. Training/Career Tracks	Advanced RD or equivalent Continuing Education in pediatric & renal nutrition, nutrition support, diabetes education ADA Leadership Institute	PHD Continuing Education in Community & Public Health Nutrition
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	CPR/BLS, Cont. Ed. (annually recurring) Joint Medical Planners Course
Billets	Assistant Division Officer Staff Officer	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Dietitian, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

(09) Dietitian Category Career and Training Matrix (continued)

Applied Public Health	Basic Project Officer Course Maintain CEUs in RD, LD	Begin MPH, MHA, or equivalent MOUs with State & Local health depts to offer community nutritional outreach.	Complete MPH, MHA, or equivalent MOUs with State & Local health depts to offer community nutritional outreach.
Research	Publications in journals or grants submitted Maintain CEUs in RD, LD	2 publications per yr./ grant funding for projects in the nutritional field	Continued grant renewal and publication for projects in the nutritional field
Mental Health			
Resources	Agency/Corps funding for courses.	Agency/Corps, state & local health dept. funding for intra/extramural adv. training, slots at USUHS or distance learning	Agency/Corps, state & local health dept. funding for intra/extramural adv. training, slots at USUHS or distance learning
Staffing	Specialists to provide PHS wide training Training Staff at OCCO Agency Reps	Agency Reps OCCO developing partnerships with universities	Agency Reps OCCO developing partnerships with universities

(10) Therapists Career Path and Training Matrix

	RANKS (Career Stage)		
	O1-O3 Basic	**O3-O4 Intermediate**	**O5-O6 Senior**
Officership Development (competencies developed)	**Courses:** BOTC/IOTC Competencies: History and Structure of USPHS and Agencies, Officership and Core Values, Uniformed Services Customs and Courtesies, Uniform wear, Administrative responsibilities, Introduction to Career Tracks, Career planning and mentoring programs	**Courses**: Intermediate Leadership & Management Development Leadership Competencies: Teambuilding, Planning, Prioritization Management skills: Communication, Written Correspondence, Admin. Management	**Courses**: Executive Leadership, CPO Training, Flag Officer Training, Retirement Training. Optional training: Exec. Medicine Competencies, Strategic Planning
Response Readiness Readiness Checklist	All officers must meet BASIC standards including COMPLETE Immunizations.		
	SERT Training, Medical Management of Chemical & Biological Casualties		Joint Operations Medical Management Course Homeland Security Executive Course
Education **Long-Term Training (Degree/Residency)**	Continuing Education for clinical specialty Advanced Therapy coursework Informed about Adv. Training/Career Tracks	US Army-Baylor PT Doctoral Program & their short courses Doug Kersey Neuromuscular Skeletal evaluation course	Continuing Education Fellowship in Therapy Specialization National Defense University CPR/BLS, Cont. Ed. (annually recurring)
Short Courses **Agency Training**	CPR/BLS, Cont. Ed. (annually recurring) Resume & KSA writing	CPR/BLS, Cont. Ed. (annually recurring) ACLS, Casualty Care (DOD) Grant Management (HRSA) Technical and Research Writing	Joint Medical Planners Course
Billets	Assistant Division Officer Staff Officer	Chief Basic Unit, satellite or solo (O-4) Staff Officer/Advanced (O-4) (Consider IsoHar/Haz/Hard-to-Fill billet) Research Project Officer Research Scientist	Chief Therapist, complex unit (O-6) Deputy Chief, complex unit (O-5) Area/Regional Consultant (O-6) Research Project Officer-Primary Investigator Research Scientist

Appendix 5

(10) Therapists Career Path and Training Matrix (continued)

Applied Public Health	Basic Project Officer Course Fieldwork, outreach activities, basic data collection	Begin MPH, MS, OTD, DPT Fieldwork, outreach activities, basic data collection	Complete MPH, MBA, PHD
Research	Publications in journals or grants submitted Research Training; NIH Therapy program	2 publications per yr./ grant funding	Fieldwork, outreach activities, basic data collection, continued grant renewal and publication
Mental Health			
Resources	Agency/Corps funding for courses. Professional time/station leave to maintain clinical competences	Agency/Corps funding for courses. Professional time/station leave to maintain clinical competences	Agency/Corps funding for courses. Professional time/station leave to maintain clinical competencies
Staffing	Specialists to provide PHS wide training Agency Reps, Training Staff OCCO, IT Support Staff	Specialists to provide PHS wide training Agency Reps, Training Staff OCCO, IT Support Staff	Specialists to provide PHS wide training Agency Reps, Training Staff OCCO, IT Support Staff

Site Requirements for CAD BOTC

- Two classrooms that seat a minimum of 50
- Field area for emergency response exercises
- Storage (binders, BLS equip, IT equip (i.e. projectors, testing laptops)
- Accessible to rest
- Lodging/berthing available within walking distance/public transport to class
- Shuttle bus available at all times, metro access, and/or parking available at all times.
- Appropriate resources to administer vaccinations
- Adequate IT support (internet for minimum of 50 PC's or laptops, ability to leave cables, equipment set up)
- 50 computers/laptops
- Ability to enter officers in DEERS/produce ID cards
- Capability to "register" students
- Access to compensation, MAB, OCCO, etc
- Mass copying/production capabilities
- Photographer
- Uniform shop/tailors
- AV equipment
- Set of flags
- PT facility/APFT track
- Adequate student access to facilities (i.e. key cards)
- "Communications Center" for students to make phone calls, check email, etc
- First aid/BLS equipment

Appendix 6

Glossary

APFT – Annual Physical Fitness Training

BLS – Basic Life Support
BOTC – Basic Officer Training Course

CAD BOTC – Call to Active Duty Basic Officer Training Course
CC – Commissioned Corps
CDC – Centers of Disease Control & Prevention
COS – Chief of Staff
CPO – Chief Professional Officer

DCCTCD – Division Commissioned Corps Training and Career Development
DEERS – Defense Enrollment Eligibility Reporting System
DoD- Department of Defense

EIS – Epidemic Intelligence Service

FDA – Food and Drug Administration

HHS- U – Health and Human Services University
IHS – Indian Health Service
HRSA – Health Resources Agency

MAB – Medical Affairs Branch
M, I, & E – Meals, Incidentals and Expenses

NIH – National Institutes of Health

PAC – Professional Advisory Committee
PIO – Public Information Officer

OCCO – Office Commissioned Corps Operations
OCCFM – Office Commissioned Corps Force Management
OFRD – Office of Force Readiness and Deployment
OSG – Office of the Surgeon General

PT – Physical Training

RDF – Rapid Deployment Forces
ROS – Reviewing Official Statement

SERT – Secretary's Emergency Response Team

Appendix 7

TAB 7

Assignment Work Group Commissioned Corps Transformation Implementation Final Report

COMMISSIONED CORPS TRANSFORMATION IMPLEMENTION ASSIGNMENTS WORKGROUP FINAL REPORT

I. Guiding Principles

A. Four overall priorities are essential considerations when assigning Commissioned Corps officers. The following needs, in priority order must be assessed when considering the assignment of officers: (1) the needs of Corps; (2) the needs of the Agency;[1] (3) the career development needs of the officer; and (4) the officer's preference.

B. These staffing-related needs should be met by filling a valid billet requirement with the best qualified officer available.

C. Successful implementation of the Commissioned Corps transformation will require:

- a new and robust information technology (IT) system;
- an effective program to recruit and develop junior officers and to support succession planning; and
- an expanded centralized system of officer support in the Commissioned Corps personnel system.[2] The Commissioned Corps personnel system should include designated human resource staff – located in central office and within the Agencies – that focus on recruitment, management of officer assignments, balancing officer and Commissioned Corps needs, identification of agency needs, and management of administrative processes.

D. The Assignment Group believes that the following recommendations will enhance the efficacy of the Corps assignment process for meeting public health needs and assuring force readiness. The Group recognizes that existing federal policy provides for directed assignment if enhanced voluntary incentives and processes that are recommended throughout his report do not meet Corps staffing requirements.3

II. Filling Isolated/Hardship, Hazardous Duty, and Hard-To-Fill Positions[4]

A. Definition and process for designation of positions

1. The procedures for designation of hard-to-fill assignments should include the following elements:

a. Designation of positions as hard-to-fill are made by the assigning Agency and approved by the Director the Office of the Commissioned Corps Force

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1 For the purpose of this report, "Agency" is defined as those Public Health Service (PHS) components, as well as non-PHS federal entities to which Corps officers are assigned, such as Bureau of Prisons and Coast Guard.

2 Corps personnel functions are currently decentralized into many offices, such as Assistant Secretary for Health (ASH), Office of the Surgeon General (OSG), Office of the Commissioned Corps Force Management (OCCFM), Office of Commissioned Corps Operations (OCCO), and others. In an expanded system, it is envisioned that current functions and responsibilities of offices may be redesigned.

Management (OCCFM), within the Office of Public Health and Science (OPHS). Agency justification may include the length of time the position has been vacant, position vacancy rate over time, measures taken to fill the position, use of contract providers, national hard-to-fill designation for the profession, pay discrepancy with the private sector, and historical hard-to-fill status.

b. Agency staff submits the vacancy announcement or billet to OCCFM;[5] with a transmittal describing the Agency's justification for designating the position as a hard-to-fill assignment.

c. Hard-to-fill status is designated on a by-facility and by-position basis.

d. OCCFM staff reviews the Agency's justification for designating the position as a hard-to-fill assignment.

   1. If OCCFM staff concurs with the designation(s), the vacancy announcement may be published, and the billet assigned, with those designations.

   2. If OCCFM staff does not concur with a designation, the Agency staff is informed of this non-concurrence and given an opportunity to appeal. If said Agency declines to appeal, the vacancy announcement may be published, and the billet assigned, with those designations with which OCCFM concurred.

e. The Agency head may appeal any non-concurrence by OCCFM staff by submitting a written request to the Assistant Secretary for Health (ASH).

   1. The request should provide specific facts that rebut the OCCFM's determination.

   2. The ASH's determination about the designation of a position or billet as a hard-to-fill assignment is final. The vacancy announcement is published, and the billet is assigned, only with those designations determined by the ASH after an Agency's appeal.

f. Officers filling positions designated as hard-to-fill are entitled to receive all benefits and bonuses accompanying assignment to that position.

2. The criteria for designation of *domestic* isolated/hardship positions should include the elements described below. A total of 6 six points is required for isolated/hardship designation.

This designation can be fulfilled by either the most extreme situation in any one of the three categories of physical isolation, area designation, or availability of medical facilities, or by a combination of points from the list below for a total of six points. The criteria for designation of *domestic* isolated/hardship positions should include:

a. Physical Isolation, for a maximum of 6 points

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[3] DHHS Personnel Manual, Part 2, Chapter CC23.5, Transfer and Reassignment of Commissioned Officers.

[4] These designations are not for purposes of special or incentive pays authorized by Chapter 5 of Title 37 of the US Code.

[5] This section addresses designation of positions. It is not intended to be used for purposes of special or incentive pays authorized by Chapter 5 of Title 37 of the US Code.

- Frontier area (= 6)[6]
- Less than 2,500 population (=3)
- 2,500 up to 20,000 (=2)
- 20,000 up to 50,000 (=1)

b. Area Designation, for a maximum of 6 points [7]

- Over 100 (=6)
- 81-100 miles from PHS site to urban designation (=3)
- 61-80 miles (=2)
- 41-60 miles (=1)

c. Medical Availability, for a maximum of 6 points [8]

- Greater than 100 miles (=6)
- Between 71-100 miles (=4)
- 51 to 70 miles (=2)
- 26 to 50 miles (=1)

d. Criteria such as availability of adequate housing, substandard living conditions, and a designated health professional shortage area (HPSA) can be used in an appeal for up to two points should OCCFM not agree with Agency designation of isolated/hardship position.

e. It is the Group's intent to assure consistency with Bureau of Census classifications or other established guidelines in defining isolated/hardship locations.

3. Hazardous duty assignments are those where the officer is engaged in professional activities requiring frequent and/or significant risk to the officer's safety. Positions are designated as *domestic* hazardous assignments if they involve any of the following for a period of 180 days or more of a continuous duty or exposure.

a. Law enforcement accompanying duty

b. Hostile territory, violent imminent danger

c. Bureau of Prisons (BOP) working directly with inmates

d. Immigration and Customs Enforcement (ICE) detention

e. St. Elizabeth Hospital or other forensic unit

f. U.S. Marshall Service

g. Routine exposure to atomic, biological, chemical, hazardous, infectious agents

h. Routinely scheduled small aircraft travel over isolated and hazardous terrain

i. Exposure to hazardous weather and terrain/climate (including water)

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[6] Frontier" is defined as an area having a population density of six or fewer people per square mile. Other factors, such as travel distance, may also isolate an area.

[7] As measured by ground transportation.

[8] Defined as access to a hospital providing secondary level of care (stabilize patients, ER, major surgical facilities, OB care, ICU, etc.), with access available to both officers and their dependents.

j. Other attributes considered, if meet criteria

4. Procedure for designation of *domestic* isolated/hardship or hazardous positions.

a. When preparing a vacancy announcement or billet for a Commissioned Corps officer, the Agency staff makes the preliminary decision about whether the position being announced or the billet is to be designated as an isolated/hardship or hazardous assignment. A position or billet can receive one or both of these designations (isolated/hardship and hazardous).

b. If the assignment is not listed on the currently identified isolated/hardship or hazardous assignment list, the Agency may request the assignment receive such designation by submitting justification to the OCCFM for review and action.

c. OCCFM staff review the Agency's justification for designating the position or billet as an isolated/hardship or hazardous position.

1. If OCCFM staff concurs with the designation(s), a vacancy announcement may be published, and the billet assigned, with those designations.

2. If OCCFM staff does not concur with a designation, the Agency staff is informed of this non-concurrence and given an opportunity to appeal. If the Agency declines to appeal, the vacancy announcement may be published, and the billet assigned, with those designations with which OCCFM concurred.

d. The Agency head may appeal any non-concurrence by OCCFM staff by submitting a written request to the ASH.

1. The request should provide specific facts that rebut the OCCFM staff's determination.

2. The ASH determination regarding the designation of a position or billet as an isolated/hardship and or hazardous assignment is final. The vacancy announcement is published with, and the billet is assigned, only those designations determined by the ASH in the case of an appeal.

e. Officers filling positions designated isolated-hardship are entitled to receive all benefits and bonuses accompanying assignment to the position.

f. If an Agency designated a position as isolated/hardship, another Agency can use such designation for the purpose of assigning Corps personnel.

5. Commissioned Officers Assigned to *Foreign Areas* Designated as Hardship or Dangerous Posts

The Assignment Group recommends that officers assigned to foreign areas receive special and incentive pays in accordance with Chapter 5 of Title 37 of the U.S. Code. Officers of the uniformed services may receive certain special and incentive pays authorized under Chapter 5. The law at 37 U.S.C. § 101(3) says "uniformed services" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and Public Health Service. The Secretary of HHS may authorize the payment of certain special and incentive pays for officers serving in foreign duty stations. [See 37 U.S.C. § 101(5)(F)].

B. Identification of vacancies and processes for recruitment, selection, and assignment of officers

The Assignments Group is envisioning a future Recruitment and Support Network that is encompassed within a centralized personnel office, for facilitating and managing communications for the purpose of enhancing Corps assignments and assuring force readiness requirement.

1. A mechanism shall be in place (e.g., billet or vacancy announcement) to identify the skill sets needed for each particular assignment.
2. A web-based system shall be in place which includes the candidate pool database. The database will include both individuals being called to active duty and officers to be considered for reassignment. Candidates may self identify their desire for reassignment or they may be identified as an officer whose current rotation is ending.
3. Applicants should complete, and all officers should annually update, the data sets that identify their skills, experience, preferences, career paths and rotation dates. These data should be updated in coordination with the annual COER submission process. (The data elements are being developed by Billet Work Group.)
4. A web-based application process should be developed for those applying to the Corps, as well as for those seeking reassignment. The objective is to automate and integrate the Corps commissioning and assignment process.

    a. The web tool should include a candidate tracking system that provides and updates applicant status.

    b. It should capture new available assignment vacancies.

    c. The web-based tool should integrate information for specific assignments, including data on officer assignment preferences.

5. Effective force management needs to consider varying lengths of assignments to meet agency staffing needs and officer career progressions. A system should be developed that notifies a staffing officer one year prior to the date assigned officers are scheduled to complete their current rotations. The system should also provide notification of an individual officer's desire for reassignment.
6. For first time applicants referred by the Office of Commissioned Corps Operations (OCCO) to a requesting Agency, the centralized applicant system should track and identify duty assignments offered to applicants, as well as those refused. Three assignments may be offered before an applicant referred by OCVCO is removed from the central active applicant pool.
7. The system should include the opportunity for Agency human resources staff to upload job assignment directly to VATS.
8. The three systems (VATS, USA jobs and Quick Hire) should be integrated completely with centralized database where officer availability, vacancies and placements are available.
9. The system should provide a portal that allows the option to enter notations about recent contact with officers and new applicants. This will allow others with access to the database information on communications with the officer and new applicants.

10. The job announcement should state the rank of the officer preferred, status of the assignment (isolated/hardship, hazardous or hard-to-fill), and available incentives (loan repayment, type of special pay).
11. To meet force readiness requirements, the Corps should assure the completion and accuracy of up-to-date medical history, fitness, licensing and certification, and other information (such as college accreditation and transcripts, timely and outsourced background investigations, etc.) for applicants.
12. The system should include making the applicant's file available via web-based portal to Appointment Board members.
13. Electronic messaging and notification should be used whenever possible to increase the efficiency of correspondence and communication.

C. Incentive systems and family support

1. If positions are designated isolated/hardship or hazardous, the Agency may provide Assignment Incentive Pay (AIP) up to $3,000/month or up to $36,000/year.
2. If a position is designated hard-to-fill by an Agency, the Agency must identify and offer a basic incentive package or designate what incentive goes with the assignment (possibly loan repayment, if allowed, and AIP).
3. The payment of AIP will be based on a written contract and be independent of any other pay to which the officer is entitled.
4. Flexibility in the use of AIP allows officers to address their professional, personal and family needs in the manner they deem most appropriate. This flexible AIP approach would be offered in lieu of more directed types of benefits.
5. Agencies with the authority to offer loan repayment to commissioned officers should identify methods for offering loan repayment to the officer at the time an assignment is accepted, rather than after the assignment is underway. If current authorities do not permit this, new authorities should be sought to offer loan repayment.
6. HHS should support a federal budget request that includes funding sufficient to fully meet the need for Commissioned Corps loan repayment incentives.
7. HHS should seek authority to extend loan repayment to Corps officers in all HHS Agencies, as HHS authority for general loan repayment (authorized by 5 U.S.C. sec. 5379) does not extend to the uniformed services.
8. When an officer accepts a loan repayment incentive, s/he should serve the full length of time to which s/he is committed at the location assigned.
9. We recommend that the Secretary of HHS authorize the payment of all special and incentive pays that officers are entitled to receive as authorized by Chapter 5 of Title 37 of the U.S. Code. The group acknowledges there are examples of exceptionally hazardous assignments specific to the Public Health Service commissioned Corps. We recommend that the Secretary seek the authority to define these hazardous and hardship assignments specific to the PHS (such as St. Elizabeth Hospital's forensic unit, law enforcement accompaniment) so that officers in those positions can receive special or incentive pay.

D. Application to promotion system

1. Officers who accept assignment in isolated/hardship and hazardous should have equal opportunity for promotion. To accomplish this objective, a comprehensive approach is required and should include: priority for career counseling; priority placement in rotational assignments; a current billet which is appropriately graded and accurately reflecting the officer's level of responsibility; and awards recognition commensurate with annual performance review and location.
2. The Group understands that an interim measure is being considered to award promotion points for officers serving in isolated/hardship and hazardous locations. Without detailed analyses, it is not possible to determine whether the proposed policy would afford all officers equal opportunity for promotion.

E. Assignment rotation system and officer placement in context of career development and service population preferences

1. A pre-screening mechanism should be developed to eliminate unqualified individuals and those who may not be appropriate for the PHS. We recommend that those candidates be electronically referred to federal civil service opportunities.
2. We recommend that Agencies accept some number of officers rotating out of isolated/hardship, hazardous, or hard-to-fill assignments each year who are qualified for positions and who have responded to a vacancy notice. (See III. C. 3.)
3. If a commissioned officer is rotating out of an isolated/hardship, hazardous or hard-to-fill assignment, and the officer's performance has been acceptable, that officer should be given preference over other similarly qualified candidates. If the selecting official chooses not to select such a candidate, the reason for non-selection should be provided in writing to the Corps' human resources office.
4. Placement assistance for officers rotating out of isolated/hardship, hazardous or hard-to fill assignments should be provided on a priority basis.
5. The Commissioned Corps personnel system will actively refer officers rotating out of isolated/hardship, hazardous or hard-to-fill assignments to agencies for consideration. Referred officers must be qualified for the position being considered and have expressed the desire for placement in like positions.

F. Functional requirements and responsibilities for management of the rotation system

A central premise of career development within the Commissioned Corps is that individual officers are responsible for their own careers and career development. That premise continues in the model described in this report. It is envisioned, however, that officers will receive active support in all aspects of career development from the Commissioned Corps personnel network. The functions of that network are described below.

1. The Central Commission Corps Office
    a. Administrative personnel processes
    b. Career development (and coordination)
        - officer training

- counseling
- officer-ship issues

c. Track all current and potential vacancies available to Corps and match candidates

d. Review & approve agency hard-to-fill & isolated/hardship and hazardous designations

e. Match qualified candidates with appropriate vacancies for selection by agencies

f. Submit candidates to agencies

g. Recruit candidates

h. Maintain APPLE data base[9] and eOPF[10]

i. Approve the billet: verify that function is equivalent to the job

j. Monitor and facilitate officer rotation

2 Agency responsibilities

a. Administrative personnel processes

b. Assists in career counseling, either agency-specific for Corps officers or training particular to agency

c. Identify vacancies

d. Designate which are isolated/hardship, hazardous, or hard-to-fill

e. Identify incentives

f. Evaluate and select officer for vacancies from pool provided by (what is now) OCCO

g. Recruit candidates

h. Develop and draft the billet

3. Human Resource Centers/Offices

a. Announce and track vacancies for HHS Agencies and automate system to interface with the Central Commission Corps Office; this would not supplant Agencies' ability to re-assign or directly hire officers

b. Certify candidates and produce panel

G. Assignments to isolated/hardship, hazardous and -to-fill

1. Assignment to isolated/hardship, hazardous or hard-to-fill locations may occur at any time in an officer's career, depending on the needs of the Corps, Agency and officer.

2. The role of the network of individuals responsible for matching officers in need of reassignment with vacancies is to assure that the career stage and career track of the officer is appropriate to the assignment.

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[9] APPLES = Assignment, Preference, Proficiency in Languages, Education and Skills

[10] eOPF = electronic Official Personnel Folder

III. Officer Assignment System

A. Process for being informed about Corps or potentially "mixed" positions becoming vacant and being advertised

1. A central candidate contact management tracking system should be developed for all recruiters and hiring managers, as this would increase the Corps' ability to view files on prospective candidates, respond to applicants, and manage their progress through the application process.

B. Administrative processes required for referring candidates for positions – knowledge, skills, and experience inventory matched to job requirements

1. The primary reassignment consideration should be the officer's current qualifications to fill a valid requirement and the officer's ability to be productive in that position.
2. Assignments are classified by duty types (isolated/hardship, hazardous, hard-to-fill), functional group (clinical, public health, mental health and research), officer category, tour length and rotations, and administrative retention.
3. Important factors to consider in assigning and reassigning officers include the Corps' needs, the agency's mission needs, force management and personnel inventory, assignments available, future requirements, and fiscal constraints.
4. For positions identified as suitable only for Corps officers, the following guidelines are provided for the duration of the assignments:
    a. For assignments that are designated as isolated/hardship, hazardous or hard-to-fill, the estimated length of the assignment is 2-3 years.
    b. For assignments other than isolated/hardship, hazardous or hard-to-fill, the estimated length of the assignment is 4-6 years.
    c. Job announcement and billets should identify an estimated length of tour.
    d. If the billet stipulates an estimated tour length that is longer or shorter than the general estimate provided above, the billet takes precedent.
    e. As the officer reaches the end of the assignment, electronic notification will be provided to the centralized commissioned corps personnel system. The officers will also be contacted to discuss potential appropriate rotational assignments.
    f. A career development review board should be established in OPHS to provide guidance to officers approximately one year prior to the end of his/her assignment. The board will identify vacant positions for potential placement of officers that are consistent with the needs of the Corps, Agency, and the officer's career development.
        - At a minimum, the board should include agency representatives to provide programmatic information and may include Agency representatives of PACs (professional advisory committees).
        - The boards may be organized along functional groups or categories.
        - It is expected the board will meet at least annually and may meet more often, based upon the needs of the Corps.

- The career development review board should have as a priority consideration of officers rotating out of isolated/hardship, hazardous or hard-to-fill assignments.

5. Isolated/hardship, hazardous and hard-to-fill assignments will be identified and flagged and assignment commitments will be confirmed in writing.

C. How to handle rotational requirements within a system that respects agency selection processes

1. It is expected that an officer will fulfill his/her contractual obligation in the Agency that funded the incentive pay, accession bonus or other special pay in advance. However, if circumstances warrant a change of assignment prior to completion of the contractual obligation for which the incentive pay, accession bonus or other special pay was provided, the site or Agency that paid the bonus must be reimbursed a pro-rated amount by the site or Agency receiving the officer.

2. Agency human resources policies should require that all qualified Commissioned Corps applicants for a position be provided to the selecting official for consideration.

3. Officers rotating out of isolated/hardship, hazardous, or hard-to-fill assignments shall have preference in competing for positions for which they are deemed qualified and for which they have applied. The Secretary and Agency heads will negotiate the portion of these officers that will be placed each year within the respective agency. This negotiation will be conducted as a part of the negotiation described at IV.B.9.

D. How to use system for filling otherwise difficult-to-fill positions

1. Filling hard-to-fill assignments systematically is predicated on an enhanced IT system and an improved system of officer support at the Agency level, as well as in the central Commissioned Corps personnel system. Filling these assignments is also dependent on a system of incentives that provides for maximum Agency flexibility in designation of assignments to receive incentives and the nature of the incentive offered.

IV. Allocation of Positions

A. Development of options and opportunities for Corps officer assignments

1. Potential sites and opportunities include:

   - Tribally-operated health care organizations and epidemiology centers
   - HHS grantees (e.g., Centers for Disease Control and Prevention, Agency for Children and Families, Substance Abuse and Mental Health Service Administration, Health Resources and Services Administration [community health centers and other grant programs])
   - State and local health departments
   - Career Epidemiology Field Officer Program
   - CDC EIS program

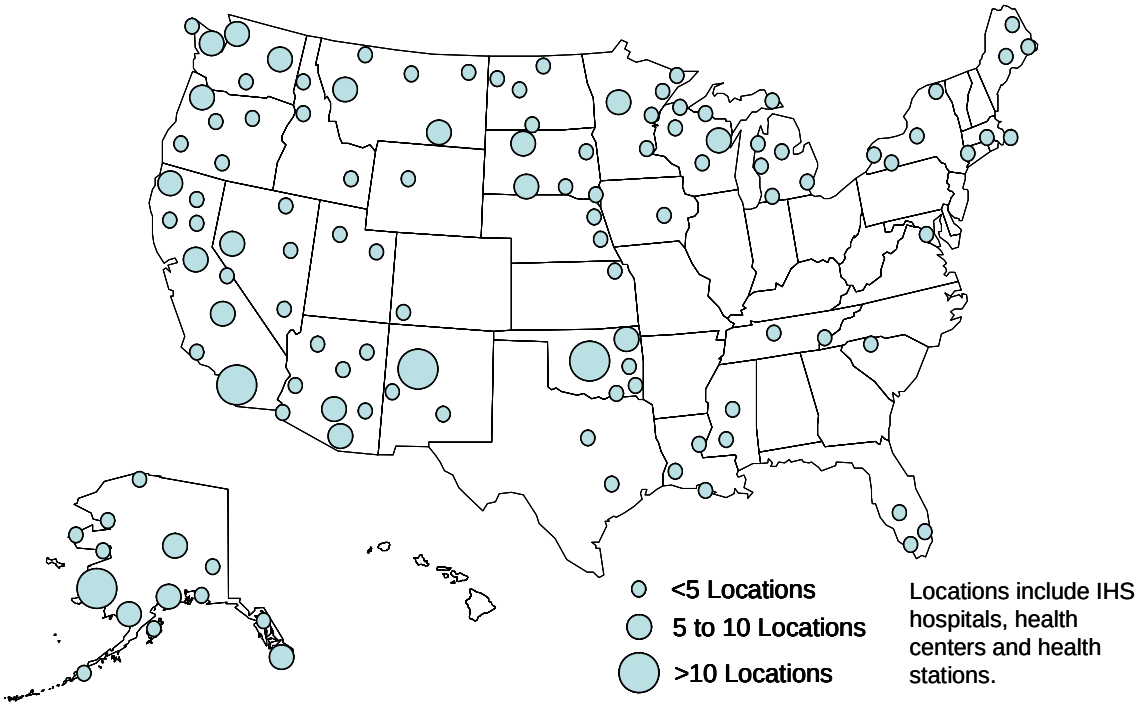
- The Department of Veterans Affairs (agreement is in place)
- The Global Fund (international)
- Peace Corps
- Department of Defense, NSA, security agencies, FBI, CIA, other federal agencies
- World Health Organization
- Congress
- National Health Service Corps
- Academic institutions

2. The group believes the following entities should receive priority focus for placement of Corps officers.
    - Tribally-operated health care organizations and epidemiology centers
    - HHS grantees including HRSA's community health centers and other HHS agency grantees
    - State and local Health Departments
    - Career Epidemiology Field Officer Program
    - CDC EIS Program
    - The Department of Veterans Affairs
3. The Group recommends that these non-HHS assignments be FTE ceiling-exempt and reimbursable by the receiving Agency.
4. The Group recognized the importance of marketing the value of the Commissioned Corps to these potential placement entities.

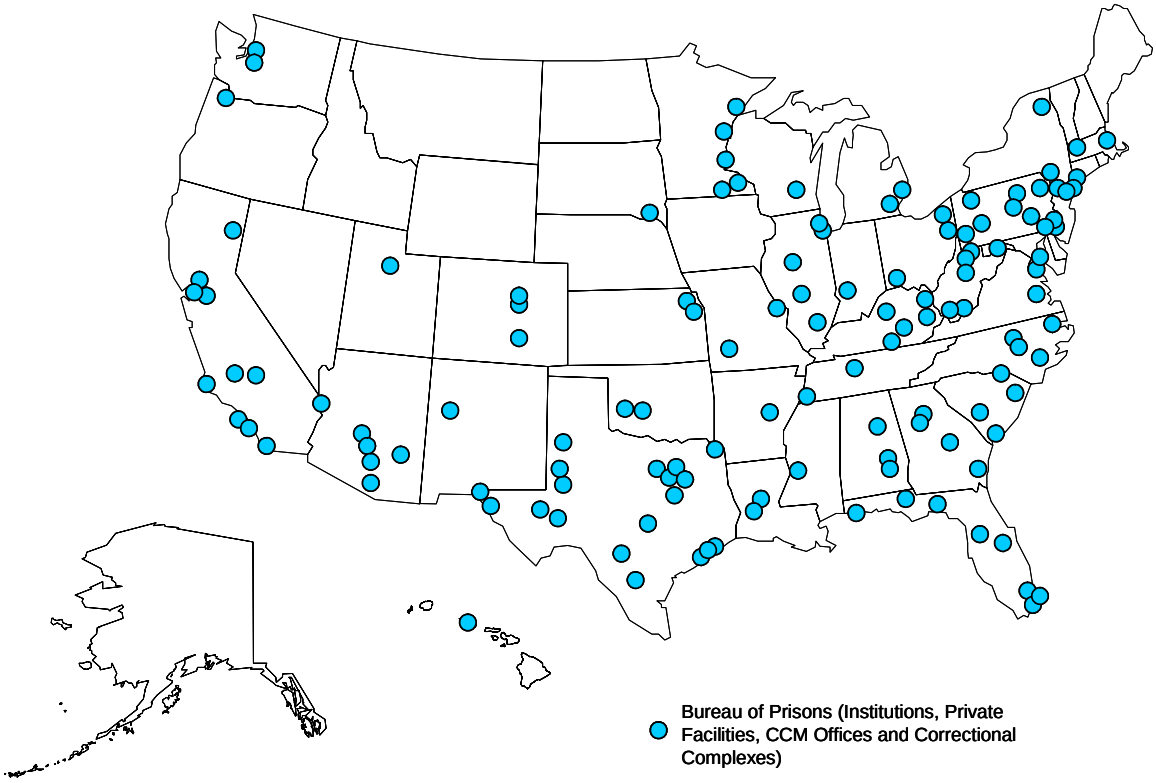
B. Role of the Ready Reserve for meeting staffing requirements. The Assignment Group supports the establishment of the Ready Reserve.

1. The Ready Reserve should be FTE ceiling-exempt.
2. Direct accessions to the Ready Reserve should be actively pursued.
3. The Ready Reserve should be used to support (e.g., backfill in) isolated/hardship positions (such as do 30 days in summer or on weekends).
4. The Ready Reserve should be deployed to backfill active duty officers during deployments and for needed surge capacity during deployment events.
5. Recruiting for the Ready Reserve should be actively pursued with HHS partner organizations identified as potential Corps placement locations (see Section IV. D above).

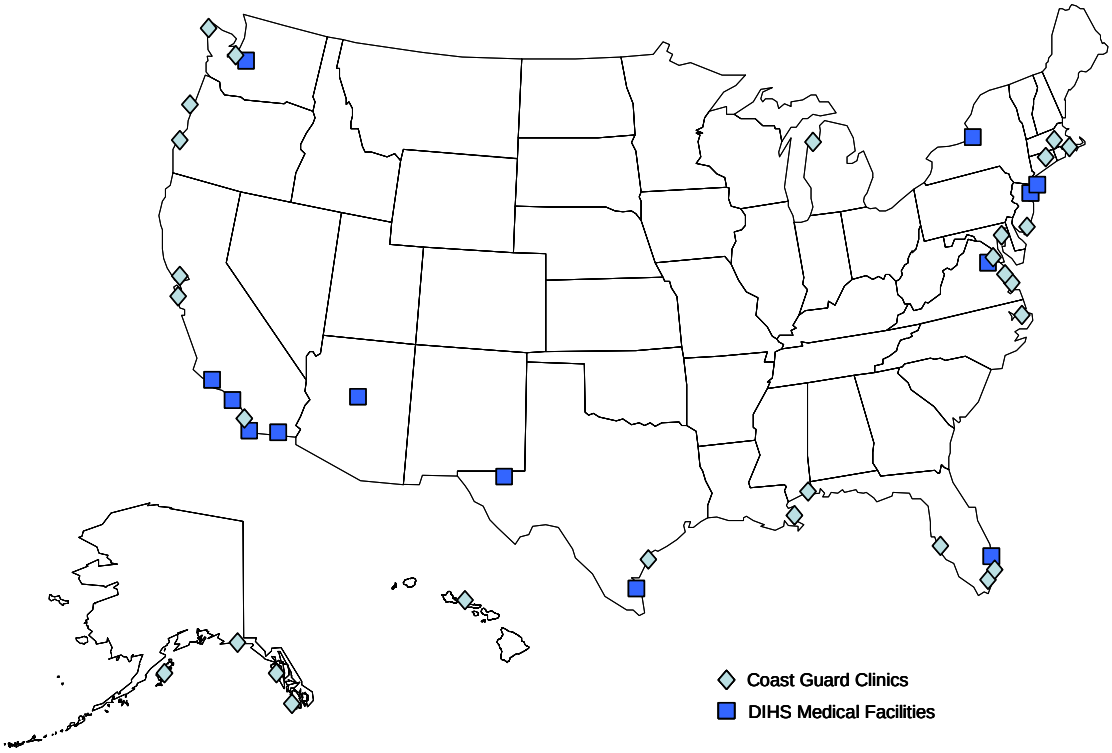
Indian Health Service Approximate Assignment Locations



BOP Assignment Locations



Department of Immigrant Health Services and Coast Guard Assignment Locations



TAB 8

Classification and Positions Work Group Report

Classifications and Positions Work Group Report
March 3, 2006
Version 6

Executive Summary and Key Findings

The Classifications and Positions Work Group developed the following report based on the decisions that the Secretary has made for grouping of officers, position identification, billet content, and billet approval. The successful implementation of this report is heavily dependent on (1) identifying adequate resources to develop a robust information technology (IT) system; (2) ensuring resources and commitment to fully staff the Commissioned Corps personnel offices for implementing the contents of this report and ensuring that the separate offices work together effectively; and (3) securing buy-in from officers, supervisors, and agencies by providing support during the changes, providing regular and transparent communication, and demonstrating the added value (not just the added burden) of the transformation to each group of stakeholders early in the process. The transformation process will be ongoing and dynamic and will require regular assessments to adjust as the process evolves.

Several key findings from the report are listed below. More details can be found in the body of the report and the accompanying tables.

- Grouping of Officers
  - The four functional groups (clinical, applied public health, research, and mental health) will form a matrix with the professional categories. The functional groups will identify the overall focus of an officer's work activities and career path, supplementing an officer's identification with his/her profession and associated Professional Advisory Committee (PAC). An officer will belong to a functional group based on their billet and the career track to which their billet belongs.
  - Functional advisory groups will be formed from PAC membership (or PAC designee) for each of the four functional groups. The advisory groups will work with the PACs to develop career tracks, ensuring consistency and uniformity across professional categories, and to develop the educational and training requirements for deployment roles.
  - Mental health has been identified as a fourth functional group, mainly because of difficulty in meeting the deployment needs for mental health workers during the hurricane response. The mental health group will promote the professional identity and career growth of mental health professionals, establish the professional and training standards for deployment as a disaster mental health specialist for Commissioned Officers, and create the incentives and training to maintain a cadre of trained mental health specialists that can be deployed.
  - Recruitment and retention needs will be assessed regularly both by category and the functional groups. Incentives and special pays, and even promotion rates, will be flexible in order to be responsive to recruitment and retention needs in each of the categories and functional groups, as well as specific groups within categories (e.g., clinical nurses).

    - Each officer will have three designations: professional category, deployment role(s), and functional group/career track.
- Position Identification
    - Filling mixed positions with Corps officers will be encouraged as much as possible. Solutions to perceived barriers of hiring of more Corps officers will be addressed.
    - The number and types of positions to be maintained or added in each agency to meet force management needs will be identified and incorporated into the agency heads' performance contracts, including an allocation to each agency for placing a certain number of officers rotating out of Isolated Hardship, Hazardous Duty, and Hard-to-Fill (3-H) positions.
- Billet Content
    - There will be an individual billet for each of the 6,600 planned Corps positions. Every billet will consist of two parts: standard components and position-specific components. The standard components will generically describe essential duties and corresponding requirements for education, training, and experience, designated functional group, and career track (e.g., staff dental officer). The position-specific information will provide more precise information about the duties, geographic location, and additional required or desired qualifications (e.g., for the staff dental officer at a particular clinic at a particular agency).
    - For force management needs, there will be two types of data available electronically: position information (describes the position and its requirements, including standard components and position-specific information of the billet) and officer information (describes the characteristics, experience, and preferences of an individual officer, enabling qualified officers to be identified and matched to vacant positions; also includes collateral duties).
    - A critical factor in the success of transformation is the ability to generate a list of qualified officers for vacant positions. This must be able to done quickly and accurately. Providing a list of highly-qualified officers to supervisors in a timely way, coupled with the ability to select and move officers into a position quickly, will be one of the strongest incentives for hiring Corps officers.
- Billet Approval Process
    - All current billets and will be reviewed and revised. The PACs will develop standard billet components, drawing from existing billets. Commissioned Corps personnel office staff will work closely with the PACs and functional advisory groups during this process. The standard components will be reviewed for agency input and approved by Commissioned Corps personnel offices.
    - After the initial phase-in of the new billets, any additional billets needed will be developed by the agency and approved centrally.
    - A standardized and structured process will be implemented for negotiations between the agencies and the Office of Commissioned Corps Operations (OCCO) in the billet grading process.
    - The current process for flag-grade billets will remain unchanged.
- The new IT system will have functionalities based on the needs of the officer, the agencies, and the Commissioned Corps personnel offices.
    - Drop-down menus will be used whenever possible to ensure consistency.

- A wide variety of standard and ad hoc reports needed for force management will be easily generated.
- The interface (between various databases within a data warehouse) will appear seamless to the user, with no dual entry required.
- The system will include additional needs specified by other transformation working groups for force management.

First steps for implementation

- Corps leadership
  - Immediately address current staff, fiscal and equipment resource needs in OCCO, Office of Force Readiness and Deployment (OFRD), Office of Commissioned Corps Support Services (OCCSS), and Commissioned Corps Systems Branch (CCSB) to meet current workload responsibilities and identify additional resources for the transformation activities.
  - Develop a roll-out plan for communicating with and supporting officers, supervisors, agencies, and Commissioned Corps personnel staff, and a plan for managing the various stages of the transformation.
- PACs and functional advisory groups
  - Develop standard billet components for the billets, drawing from existing billets.
  - Organize the billets into career tracks by functional group, starting with existing career tracks.
  - Develop the requisite training, experience, competencies, certifications and licensures for each deployment role as the basis for the deployment role assessment tool.
- Commissioned Corps personnel offices (OCCO/OCCSS/Office of Commissioned Corps Force Management(OCCFM))
  - Develop drop-down menus for grading billets.
  - Hire officers to fully staff the personnel offices, and hire officers for new full-time equivalents (FTEs) as they become available.
  - Develop business requirements for IT contractor.
  - Provide staff support to PACs, Chief Professional Officers (CPOs), and functional advisory group chairs for billet rewriting process.
- Agencies
  - Every agency will have a at least one dedicated Corps liaison who is an O-5/O-6 level officer (or retired officer) whose dedicated job is to conduct liaison activities, with adequate staff support as appropriate for the size of the agency.
  - The agency will set up a network of officers to support officers and their supervisors for career counseling and guidance on transformation issues.

Background

The Classifications and Positions Work Group was charged with developing implementation recommendations for transformation of the Commissioned Corps in the following areas: grouping of officers, position identification, billet content, and billet approval.

The guidance developed is based on the following decisions by the Secretary by providing answers to a designated set of questions for each area.

- Grouping of officers
    - Officers will be grouped based on a matrix of professional category (retaining the current description of CPOs) and four functional groups: clinical, applied public health, research, and mental health.
    - Questions
        - Adding a new mental health category (functional group)
        - Criteria for inclusion in functional groups
        - Application of categorical and functional groups according to accession, promotion, and assimilation decisions
        - Changes required for new CPO and PACs
- Position identification
    - Department of Health and Human Services (HHS) positions will be categorized as either Corps, civilian, or open to either system.
    - Criteria to determine which ones will more likely be Corps (or mixed) positions
        - Provision of clinical services
        - Required for readiness and response
        - Needed for filling 3-H positions
        - Needed for rotation of officers
        - Needed for training
    - Questions
        - Criteria for determining which positions are Corps only, which are civilian only, and which are mixed
        - Process for classification and decision
- Billet content
    - Billet content will be changed to facilitate force management
    - Descriptions will be unique for each position
    - Each billet will contain both general and position-specific information
    - Questions
        - What information will be required in the "general" and "specific" portions of the billet
        - Process for rewriting every billet
- Billet approval process
    - Billet development and approval process will be managed centrally (agency development, central approval with an appeal process to resolve disagreements). Such a system will require a complete understanding of agency requirements and timely action of central Corps management.
    - Questions
        - Process for approval of billet with PAC-developed standard components, agency-developed billet content and central review and approval of billet content and rank
        - Adjudication of agency/central management disagreements
        - Incorporation of non-HHS assignments into process

In addition, during the course of the process the group was tasked with identifying the information technology functional requirements for these recommendations and addressing how special pays relate to the new functional group and professional category matrix.

Recommendations

Grouping of Officers

- There will be four functional groups: clinical, applied public health, research, and mental health. The functional groups identify the overall focus of an officer's work activities and career path, supplementing an officer's identification with his/her profession and associated PAC.
- The four functional groups will form a matrix with the current 11 professional categories.
- There will be four functional advisory groups composed of representatives from each of the PACs from which representation is relevant. The PACs will choose the representatives from within the members of the committee members or from the members of the category at large who will serve as the functional group lead for the PAC and the PAC representative to the functional advisory group. The representative will be responsible to the PAC, as illustrated in Exhibit A.
    - The category-based PACs and CPOs will continue as they currently exist.
    - Communication and consistency across categories is vital, hence the functional advisory groups will convene on an ad-hoc basis to conduct specifically identified and special tasks:
        - review the career tracks developed by the PACs for consistency and uniformity (functional career track workgroup),
        - provide periodic review of career tracks to maintain consistency and uniformity as professional and functional roles evolve over time (functional career track workgroup),
        - develop the content for the deployment role tools (functional deployment role workgroup), and
        - complete special tasks as assigned by the Office of the Surgeon General (OSG).
    - Each of the functional advisory groups will designate a group chair.
- Each officer will have three designations: professional category, deployment role, and functional group/career track. For example, an officer may be in the dietitian professional category, occupy a public health billet (in a public health career track), and have a clinical deployment role.
    - Each officer will continue to have a designated professional category, which is unlikely to change during an officer's career.
    - Many officers will have more than one deployment role, and the roles may change over time.
    - An officer will belong to a functional group based on their billet and the career track to which their billet belongs. There will be several career tracks in any functional group. An officer can change career tracks by changing positions and occupying a billet in a different career track.
- As part of the PACs' role in creating and maintaining the standard components of billets (see **Billet Content** below), they will identify the career tracks and therefore the functional group to which the billet belongs.
- Career tracks
    - Functional groups will serve as a means to organize career tracks that span the categories for the purposes of recruitment and planning career development.

- The PACs will be responsible for developing detailed career track models (see Exhibit B, Navy Dental Corps Career Development Matrix).
- Each of the four functional career track workgroups will review the career tracks that fall within that function and provide recommendations to the PACs to ensure consistency and uniformity across the professions. Efforts should be made in advance to ensure that the PACs use the same terminology and a uniform model of career track development.
- The uniform model will act as both structure for career tracks and a tool for officer recruitment, retention, guidance, and position development. The model (see Table 1) will display career tracks both by professional category and by functional group.
  - The career tracks consist of billets/positions that define the multiple levels of professional responsibility and achievement for an officer within a track (see Table 1).
  - The career tracks will comprise positions throughout the agencies (including non-HHS agencies) Corps-wide, representing for officers the opportunities both within and outside of their own agencies.
  - Corresponding competencies will be developed for each position in the career tracks. (Refer to the report authored by the Recruitment and Training group.)
- Currently, Research Officers Group (ROG) is treated as a 12th professional category for promotional purposes. When the career tracks are revised, ROG will become a discrete career track within the research functional group, i.e., the Research Academic Track.
- The current career track taxonomy used by OCCO (see Table 2) will be modified to reflect the revisions made by the PACs and functional group leads.

- Deployment roles
  - The deployment roles for most officers will parallel their career track functional group since officers are more likely to be prepared for deployment roles that match their day-to-day duties.
  - In response to deployment needs, it may be necessary to encourage officers (through provision of additional training or incentives) to maintain adequate clinical skills for use in a clinical deployment, particularly if their regular duties are not clinical. This may also be true for mental health deployment needs.
  - An officer's education, training, and experience will be matched to the requirement for every deployment role to determine all the roles for which the officer is qualified (see Table 3).
  - For each deployment role, the requisite training, experience, competencies, certifications and licensures will be specified, and the deployment duties will be defined (see Exhibit C).
- Role of functional groups for promotion
  - In general, promotion will remain primarily within the professional categories.
  - Career progression within the functional group career tracks will remain one factor considered by promotion boards.
  - Grouping officers by functional group within certain categories will facilitate review by the promotion boards. In addition to the category benchmarks that exist currently,

sub-benchmarks specific to certain career tracks will be added by the PACs to aid the promotion boards in comparing qualified candidates. This step will likely be particularly useful in the largest categories (medical, nursing, pharmacy).
    - ROG will become the Research Academic Track within the research functional group and will continue to use independent criteria for promotion.
    - The Health Services Officer (HS) PAC will delineate a limited number of professional groupings of officers by functional group for promotion purposes.
  - The promotion success rates could be used as a tool in force management, especially with respect to officer retention. The matrix of categories and groups could be used for more tailored promotion rates to facilitate retention of particular groups of officers (e.g., clinical nurses) based on regular assessments of attrition rates, force needs, and agency needs.
    - Although promotion obviously supports retention, promotion will continue to be based primarily on performance and can not be the only tool used for retention. Special pays and other incentives are required for retention of officers needed by the Corps who are not ready or eligible for promotion.
  - Consideration will be given to allowing agencies to indicate priority for promotion for officers in a manner that preserves equity and transparency.
  - Routine and ongoing career counseling will be offered to officers, including retention reviews.
  - The three and freeze policy should be replaced with a more flexible approach to retain the best officers based on detailed force management assessments. Officers who are not promoted will receive career counseling, and those who consistently rank in the lower percentiles of promotion candidates will have a retention review and be frozen in grade.
  - Variable promotion rates will not be a useful tool for satisfying deployment needs. Rather, incentives and special pays in recruitment and retention efforts should be strengthened to achieve deployment force goals.
  - Annually, officers ranked O-6 and above will receive a reminder and a briefing on the benchmarks by the PACs to prepare for their potential participation on promotion boards.
  - All officers will continue to have access to the benchmarks and sub-benchmarks on the internet.
- <u>Role of functional group in special pays</u>
  - For the present time, special pays will continue to be used as they are currently, regardless of which functional group or deployment role officers are affiliated with.
  - Special pays will be expanded to permit flexibility for recruitment, retention, and deployment needs.
  - The PACs will review the current system and recommend changes to permit this flexibility. The current system of determining medical special pay rates based on Department of Defense requirements for particular medical specialties will be included in that review.
    - It should be noted that special pays are important not just for recruitment and retention of clinicians in clinical billets or deployment roles but also

serve an important role for recruitment and retention of officers with clinical training to serve in public health positions with clinical aspects (e.g., responsible for developing treatment guidelines).
        - The current system of special pays for ROG is another example of a useful recruitment and retention tool for officers conducting academic research.
    - The statute which does not permit special pays for flag officers will be revisited to align flag officer positions pay with Title 42 and Senior Executive Service (SES) pay so that the Corps is more attractive for persons in high-level agency positions.
- Accession
    - Accession rates for persons recruited through central recruitment (i.e., those not recruited specifically for a particular agency position) will vary by category and functional group and will be determined by a regular assessment of the force management needs of the Corps and the agencies.
- Assimilation
    - The number of officers authorized for the Regular Corps will need to be increased as the number of officers increases in the Corps.
    - The size and distribution of the Regular Corps will be analyzed regularly with respect to distribution of officers by rank, category, and functional group so that assimilation rates can be adjusted to the long-term force management needs of the Corps.
- Mental health group
    - Mental health has been identified as a fourth functional group, mainly because of difficulty in meeting the deployment needs for mental health workers during the hurricane response. The mental health group will promote the professional identity and career growth of mental health professionals, establish the professional and training standards for deployment as a disaster mental health specialist for Commissioned Officers, and create the incentives and training to maintain a cadre of trained mental health specialists that can be deployed.
    - In order to meet the deployment needs for mental health, officers with mental health training and experience who are not in mental health billets will be encouraged (through provision of additional training or incentives) to maintain the skills needed for deployment.
    - Consideration will be given to providing training to other health professionals in the Corps as appropriate to provide basic disaster mental health services.
    - Mental health career tracks and mental health billets will be developed during the career track review and revision process by the PACs and functional advisory groups.

Identification of positions

- Filling mixed positions with Corps officers will be encouraged as much as possible.
    - For certain types of positions it is advantageous to fill them with a Commissioned officer, for a variety of reasons.
        - Benefits of incumbent having specific Corps knowledge or experience (e.g., OCCFM, OSG (includes OSG primary staff, OCCO, Inactive Reserve Corps (IRC), Medical Reserve Corps (MRC), and OFRD) or Agency/Corps liaison positions)

        - Need for tours of duty more easily met by incumbent being subject to duty 24/7
        - Need for frequent or rapid deployment
        - Need for directed assignments (e.g., hard-to-fill positions)
        - Combination of reasons (e.g., quarantine officers who work with uniformed immigration and customs officers and may be required to work long or varied tours of duty).
        - Corps officers add value to agencies in filling positions (see Table 4).
- It will be important for each agency to have key leadership positions filled by Corps officers to serve as role models, demonstrate agency commitment to the Corps, assist the agency in implementing Corps policies, and provide tangible evidence of career advancement within the Corps.
- Every agency will have a at least one dedicated Corps liaison who is an O-5/O-6 level officer (or retired officer) whose dedicated job is to conduct liaison activities, with adequate staff support as appropriate for the size of the agency.
- Each agency will set up a network of officers to ensure officers and their supervisors have access to someone from whom they may receive career counseling, information about awards, etc. This is how the agencies will demonstrate their commitment to the Secretary's transformation initiative. The IHS has implemented such a structure, and it will be used as a model.
- A critical factor in the success of transformation is the ability to generate a list of qualified officers for vacant positions. This must be able to done quickly and accurately. Providing a list of highly-qualified officers to supervisors in a timely way, coupled with the ability to select and move officers into a position quickly, will be one of the strongest incentives for hiring Corps officers.
- <u>Solutions to perceived barriers of hiring Corps officers</u>
    - It must be noted that there are perceived barriers to the hiring of more Corps officers at this time that must be addressed in order for transformation to be successful. Examples of perceived barriers and potential solutions are listed below.
        - The annual cost of an officer is often perceived as more than the annual cost of a civilian. Statistical data will illustrate that this is a misguided perception, and the information will explicitly describe the costs that the agency is not responsible for assuming (e.g., retirement, health insurance, and overtime).
        - Civilian supervisors are often unfamiliar with the Commissioned Corps and their value to HHS and non-HHS agencies. Civilian supervisor education and communication is necessary to mitigate this issue. The new IT system will allow supervisors of Corps officers to be identified more readily to facilitate ongoing communication.
        - Support systems for Corps personnel are variably effective within many non-HHS organizations. Appropriate support systems will be ensured for all non-HHS agencies with Corps officers.
        - Varying payroll systems used by agencies may not capture adequate information for Corps needs. For example, at EPA in the Superfund program, all hours are tracked and charged against various work sites. This is accomplished through the EPA Employee Pay and Time Tracking System. Since Commissioned Corps officers are not in the EPA payroll system, the

agency can't take credit for work done by officers at a particular site. The Agency for Toxic Substances and Disease Registry (ATSDR) has developed a solution to this problem, and applying this to EPA will be explored.

- Although an agency may desire Corps personnel, the relocation cost to move officers can be a barrier. Funds used to pay salaries are not the same as funds used for relocation expenses, and those funds may be unavailable. Some agencies have established a central agency fund for relocation costs so that the financial effect on individual departments is diluted.
- Some supervisors are reluctant to fill key positions with officers because of time away from the duty station for readiness, deployment, and other Corps activities. The supervisors' reluctance will be addressed in the supervisor training, which will include descriptions of added value of officers and clarifications of the levels of commitment for deployment and other Corps duties. The training will be offered in different formats such as local, distance-based, and centralized learning.

- To further mitigate perceived barriers, other options for providing incentives to hire Corps officers will be explored, such as providing ceiling-exempt FTEs for field positions or organizing a centrally-funded group of officers who would serve in the first tier of deployment but could be detailed to agencies part-time supplementary staff with their own FTEs and salary support.

- Other force management needs
  - For force management to be effective, it is necessary to have a sufficient number, type, and rank of Corps positions throughout HHS for career tracks (including some key leadership positions) and for meeting rotational, education, and deployment requirements.
  - An analysis of the short- and long-term force management needs will be conducted annually, including an assessment of trends.
  - Gaps compared with the current force strength will be identified, and the number and types of positions to be maintained or added in each agency will be identified and incorporated into the agency heads' performance contracts. This will include an allocation to each agency for placing a certain number of officers rotating out of 3-H positions. The agencies will identify positions and work with detailers to place officers appropriately. (Refer to the report authored by the Assignments group.)

Billet content

- There will be an individual billet for each of the 6,600 planned Corps positions.
- Every billet will consist of two parts: standard components and position-specific components.
- The standard components will generically describe essential duties and corresponding requirements for education, training, and experience, designated functional group, and career track (e.g., staff dental officer).
- The position-specific information will provide more precise information about the duties, geographic location, and specify additional required or desired qualifications (e.g., a staff dental officer at a particular clinic at a particular agency).
- Apart from a unique identifying number, some billets might be identical (e.g., two entry-level medical-surgical nursing positions at the same hospital) or might differ only in terms of

information about the duty station (e.g., two entry-level medical-surgical nursing positions at two different hospitals).

- For force management needs, two types of data will be available electronically (see Table 5).
    - Position information (includes standard components and position-specific information), and
    - Officer information (includes collateral duties).
- The position information describes the position and its requirements. The components relate to the position and are not dependent on the officer filling the position.
    - The billet will describe both the requirements for the position, as well as additional desired qualifications. Although there was a desire by the group to allow growth within a position, it was decided that changes in the level of duties will be managed by revising the billet rather than maintaining two-level billets (e.g., O-4/O-5) as is sometimes done in civilian positions, because it would make force management more difficult.
    - When an officer is ready for a higher level of duties, he/she should seek a position at the next level in his/her career track. In exceptional circumstances, if the requirements (level of duties) change over time, the billet will be changed as needed to properly reflect the increased duties and responsibilities inherent in the position. Billets will not be changed to a higher level solely on the basis of time served in a position or to facilitate the promotion of an officer who remains in the same FTE and same location.
    - When a group of officers perform as a unit (i.e., officers cover one another's duties when necessary), the billet duties will be described in a way to encompass those cross-coverage duties.
    - The billet will include the elements listed under "position information" listed in Table 5.
        - Each billet will have a designated expected length of tour, in years, (e.g., 2 or 3 years for 3-H positions) to facilitate the assignment system as outlined by the Assignments group.
    - The billets will be created electronically. For most of the components of the billet, there will be a standard format and defined fields, with the use of drop-down menus whenever possible to facilitate standardization and comparability. The supervisor or designees will select the appropriate entry for each component, with the assistance of "help" options such as definitions. The "position-specific duties" component will be developed as narrative text by the supervisor or designee with information unique to that position.
    - In order to standardize determination of the appropriate level (rank) of a billet, there will be a series of drop-down menus in the IT system that allow the supervisor or designee to choose the appropriate factors, with the IT system then automatically assigning a preliminary level.
    - The Commissioned Corps personnel offices will develop the drop-down menus to be used for grade classification of billets. Human Resources classification specialists will be involved to ensure appropriate consistency with equivalent civil service positions. CPOs, PAC chairs, functional advisory group chairs, and agency representatives will review and provide input before the classification system is finalized.

        - These factors for the drop-down menus will be based on a reviewed and updated set of factors derived from the Commissioned Corps Personnel Manual (CCPM) Pamphlet 57 point system:
            - Education and experience required
            - Accountability
            - Supervisory responsibility
            - Personal responsibility
            - Personal work contacts
        - Because of the importance of consistency with equivalent civilian positions (especially in designated "mixed" positions), the process for reviewing and updating the factors will ensure that all of the key areas from the civil service factors currently in use (listed below) are accounted for.
            - Knowledge required for the position
            - Supervisory controls
            - Guidelines
            - Complexity
            - Scope and effect
            - Personal contacts
            - Physical demands
            - Work environment
- The officer information describes the characteristics, experience, and preferences of an individual officer (e.g., Assignment Preferences, Proficiency in Languages, Education and Skills (APPLES)-type information), enabling qualified officers to be identified and matched to vacant positions (by matching to the position information). A small subset of this information comprises officer information that has been included in the billet form currently used (see PHS-4392, Exhibit D) to describe the incumbent (i.e., the officer's name, category, permanent and temporary rank, PHS serial number, and Regular or Reserve Corps). The additional information is used to match qualified officers to vacancies and other force management needs. This information is needed for new applicants as well as for officers already commissioned.
- The collateral duties are additional duties that are linked to an individual officer rather than a particular position but are relevant to the position because of the impact on the officer's ability to perform the position duties. Examples are clinical work performed to maintain clinical competence, Corps activities (e.g., PAC chair), and deployment team assignment.

Billet approval

- Process for rewriting every billet
    - The PACs will develop the standard billet components (see highlighted fields of Exhibit D) for positions within the career tracks. Much of the information needed will be drawn from existing billets. Commissioned Corps personnel office staff will work closely with the functional advisory groups and PACs during this process. Standard components for multidisciplinary billets will be developed by a cross-PAC workgroup.

- The standard components will be reviewed for agency input and approved by the Commissioned Corps personnel offices. These will be reviewed in groups to ensure consistency in grade across agencies.
- The phase-in process for assigning officers to the new billet structure will be developed by the Commissioned Corps personnel offices, depending on the readiness of the new IT systems.
- The process for classification of flag billets will continue under the existing policy.

- Process for developing additional new billets after the initial phase-in
  - Billets will be developed by the agency and approved centrally as outlined below.
    - The supervisor or designee will develop the billet by using the IT system to select the appropriate entry for each component, with the assistance of "help" options, such as definitions. Agency liaisons will work with the supervisor or designee as needed.
    - The "position-specific duties" component will be developed as narrative text by the supervisor or designee with information unique to that position.
    - The appropriate grade will be assigned based on the updated CCPM Pamphlet 57 point system. By using the drop-down menu, a preliminary grade will be assigned.
    - Next, the billet will be sent to a civil service human resources classification specialist. The Human Resources classification specialist will work with supervisor and agency liaison to ensure both parties agree on equivalency between the civilian classification and assigned grade (General Schedule) and the Corps level for consistency.
    - The Corps agency liaison will review the HR classification and, if there is concurrence, submit the billet to Commissioned Corps personnel offices for final approval.
    - The Commissioned Corps personnel offices will review the material and will send it back to the liaison if there are any clarifications, corrections, etc., to be made prior to approval. The agency liaison will work with the supervisor to resolve the issues.
    - This will be an electronic process, and metrics for this will be captured to identify bottlenecks in the system that can be addressed to ensure maximum efficiency and ensure timeliness (approximately two weeks).
  - The current process for establishing new flag billets will continue to be used.
- Periodic review process
  - Every 3 years the PACs will review the standard components of the billets, develop new standard components where necessary, and review the distribution of billet grades and trends to help ensure consistency across agencies and prevent billet creep.
  - OCCO will develop measures to check for congruence between duties and billet. Periodic random audits may be a cost effective and transparent way to achieve this task. These additional controls (internal audits of billets and positions) will increase the perception of the Corps as a self-regulating organization.
  - A periodic review process to ensure that current and newly proposed positions are consistent with the mission of the Commissioned Corps will be established. This review will also meet force management needs to support flexible and effective force

management processes, especially, but not limited to, assignment and rotation policies.
    - The established review process for flag billets will continue to be used.
- Adjudication of disagreements between the agency and central management
    - A standardized and structured process will be implemented for negotiations between the agencies and OCCO in the non-flag-grade billet process. The current process for flag-grade billets will remain unchanged.
        - OCCO staff will review the supervisor's justification for the billet grade.
            - If OCCO staff concurs with the grade, the designated grade remains.
            - If OCCO staff does not concur with the grade, the Corps liaison is informed of this non-concurrence and given an opportunity to appeal. If the Corps liaison declines to appeal, the billet will be assigned the grade level with which OCCO concurred.
            - The agency head may appeal any non-concurrence by OCCO staff by submitting a written request to the Director of OCCO.
                - The request will provide specific facts that rebut the OCCO staff's determination. Any need for further adjudication will be forwarded to the OSG.
                - The determination by the OSG regarding the designation of a grade level will be final.
    - If an officer disagrees with the grade of his/her billet, the officer may submit a request for a review to his/her supervisor. The request should include the reason for the disagreement and documentation to support the request.
        - If the supervisor agrees with the request, the billet will be reviewed according to the process outlined above.
        - If the supervisor disagrees, the officer may appeal to OCCO through the agency liaison, according to the process outlined above.
- Incorporation of non-HHS assignments into process
    - The PACs must take into account non-HHS positions when developing career tracks and standard components for the billets with representation from the non-HHS agencies.
    - Supervisors or designees writing billets at non-HHS agencies will rely upon the agency liaison for expertise in developing billets and will have access to the IT system.
    - Adjudication will be handled according to the process outlined above.
- Flag-grade billets
    - The authority to designate and approve flag-grade billets resides with the Assistant Secretary of Health, pursuant to Subchapter CC23.4, INSTRUCTION 7, "Flag Grade Officer Selection and Assignment." The policies and procedures for the designation of flag-grade billets and the selection of flag officers will continue as stated in this INSTRUCTION.

IT functionality requirements

The IT system will have the following functionalities.

- Drop-down menus will be used whenever possible to ensure consistency

- A wide variety of standard and ad hoc reports needed for force management will be easily generated.
- The interface (between various databases within a data warehouse) will appear seamless to the user. No dual entry will be required.
- The system will include additional needs specified by other transformation work groups for force management.

- The functionality is described below based on the needs of the officer, the agencies, and the Commissioned Corps personnel offices (OCCO, OCCFM, OCCSS).
- <u>For the officer</u>
  - Officers will be able to access all data from one place (Commissioned Corps Management Information System (CCMIS), OFRD, etc.).
  - Officers will have an officer summary page including items such as training and education (T&E), readiness status, the expected tour length of their current billet, etc. Some information elements could be entered, modified, and updated by the officer (e.g., officer preferences for next assignment and contact information). Other elements, such as the billet components, will not be modifiable by the officer.
  - Officers will be able to use a link to access systems such as payroll to update dependents, etc. The link will appear seamless to the user.
  - A standard curriculum vitae (CV) cover sheet will be generated by the officer using a standard electronic fillable form.
  - Officers will be able to search for available (or potentially available) positions and use a filtering mechanism to narrow the search. (e.g., What positions similar to the officer's are available in the Florida/Georgia area? What positions at the next billet level are available in the agency?)
  - To relieve the burden on the Commissioned Corps personnel offices and facilitate maintaining the most accurate and up-to-date information about the officer in the system, a tickler system will be created to remind officers to update their contact information, CV, when certifications are expiring, when immunizations are expiring, eligibility for promotion and assimilation, etc. Some elements are critical (e.g., contact information) and therefore will be mandatory for the officer to update on a regular basis.
  - Officers may indicate a desire to receive emails about potential vacancies (includes vacancies in the civilian system posted in USAJOBS) and set criteria for the types and location of positions in which they are interested. In addition, consideration will be given to allowing officer to indicate their level of interest in seeking a new position (see below).
  - Officers will have access to Frequently Asked Questions (FAQs) and an index to define the drop-down menus and other fields.
  - Officer preferences about their next assignment will not jeopardize the officer in any way in their current assignment. Officer preferences will be a restricted field, visible only to authorized users.
  - Officers will be able to learn quickly and confidentially about vacancies or impending vacancies for which they are qualified.
  - Officers' electronic Official Personnel Folders (eOPFs) will be user-friendly and easier to manipulate. (Currently, an eOPF can be viewed only one page at a time—never as a whole document.)

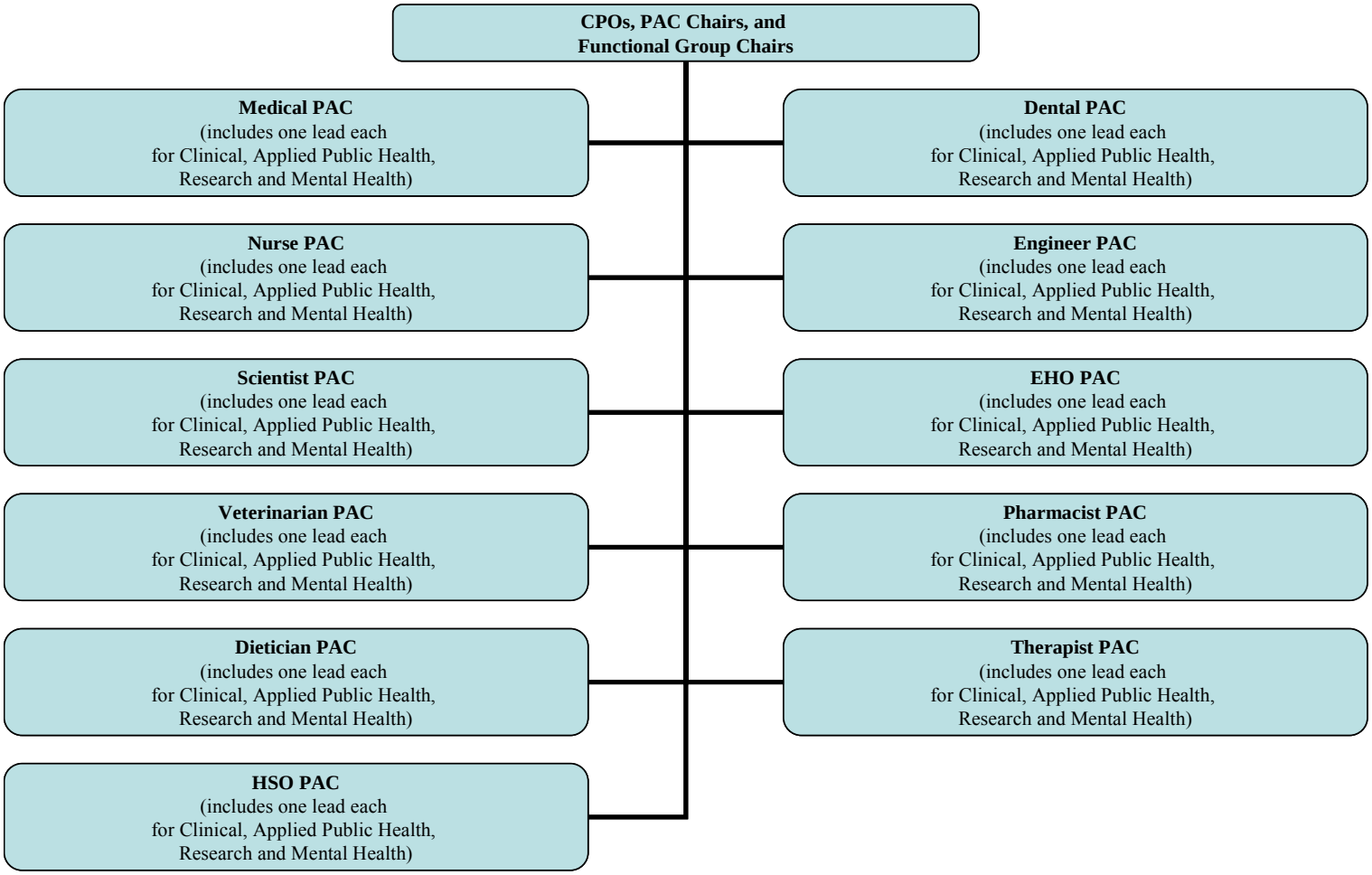
- Officers will be able to upload and update documents in certain sections of their eOPF.
- Officers will receive automatic notification when new documents are added to their eOPF.

- For the agency
  - Agencies will be able to use the system to generate reports easily for summary statistics (e.g., number of officers by grade or functional category; number of officers receiving special pays; number of officers in 3-H positions, or billet by expected tour length) to use for planning and budgetary purposes, etc.
  - The Corps IT system will be compatible with relevant civilian systems (i.e., maintain comparable data and generate comparable reports) to facilitate agency force management overall.
  - Agencies will be able use the system for forecasting and workforce projections (e.g., how many officers will be eligible for 20-year retirement, how many can do voluntary retirement, how many are known to be retiring at 30 years, and number of calls to active duty).
  - Supervisor will be able to review officer information, such as type of positions and experience the officer has had or other information currently in the Promotion Information Report (PIR), to assist the officer during career counseling.
  - Agencies will be able to (formally) request a list of Corps officers qualified to fill particular vacancies within the agency. The Corps' ability to provide a list of highly qualified officers when requested, as well as being able to bring them on board quickly if selected, will serve as a strong incentive for agencies to fill positions with Corps officers.
  - Consideration will be given to allow officers to indicate their level of interest in seeking certain types of positions, e.g., "very interested" to "might consider," so agencies can gauge the level of interest.
  - Agencies will be able to search officer criteria (not necessarily with officer names included) to evaluate the number of officers with certain types of experience that exist throughout HHS (and non-HHS agencies) to assess the potential for filling positions. The agency may request the Corps to furnish a list of qualified officers who have indicated their potential interest in the new position.
  - Prospective employers receiving a list of qualified officers will have a measure of assurance that lists of potential candidates are unlikely to include unqualified officers or officers who would not contemplate transferring from their current position. It will be useful to allow officers to indicate when they are interested in being considered for a particular vacancy for which they are qualified before the list is forwarded to the agency.
  - Agencies will receive notification from the automated tickler system when an officer is (or soon to be) out of compliance with particular requirements (e.g., readiness requirements, licensure).
  - Agencies will also be able to use the system to determine:
    - Retention rates for each position,
    - How to set up career tracks within an agency, and suggest how to balance this with overall career tracks,
    - Timeframes in which to fill positions,

        - Officers who will soon be eligible for promotion but whose current billets do not support a higher rank,
        - Deployment activities, tiers, and rotations for their officers,
        - Up-to-date contact information for rating and reviewing officials for their officers, including whether they are Corps or civilian, and the average Commissioned Officer Effectiveness Report (COER) given by those officials, and
        - When selected information (personnel orders or awards) has been added to their officers' eOPFs.
- For Commissioned Corps personnel offices
    - Staff will be able to:
        - Administer simple, fast queries that are needed regularly (current systems [e.g., Wang] are too cumbersome and slow),
        - Access real-time data,
        - Easily post documents on the website,
        - Track and analyze website use to ensure maximum usability for officers
        - Provide additional links to pertinent sites,
        - Extend access to people outside of Rockville, Maryland to allow remote applicant boards,
        - Employ a method to compel officers to update their contact information at least annually,
        - Employ an automated tickler system, and
        - Verify advanced degrees and capture data more easily.
    - The PIR will be updated to include more complete information on billets, time in each billet, and time elapsed since last programmatic or geographic change.
    - Consideration will be given to issuing department-specific, rather than agency-specific email addresses so that an officer's transfer between agencies does not result in lapse of a reliable communication method used to reach an officer if contact information has not been updated (particularly in the case of officers who are assigned to non-HHS agencies).
- Liaisons and CPOs will continue to have access to information on individual officers for career counseling. Functional advisory group chairs, CPOs, SG-PAC representatives, PAC chairs, and Junior Officer Advisory Group (JOAG) chairs will be granted appropriate levels of access required to run reports needed to fulfill their duties.

Exhibit A

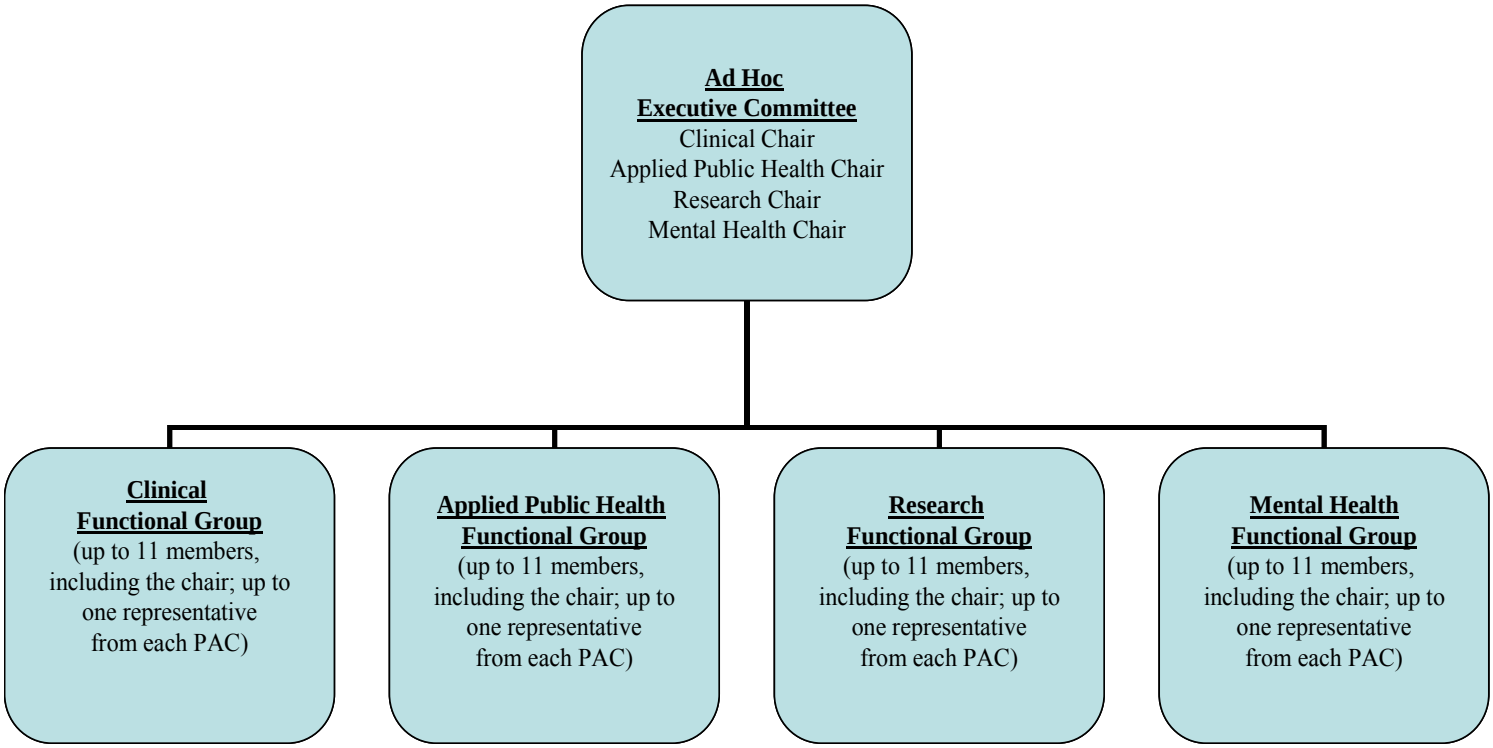
Functional Group Membership in PACs



There are 11 PACs. Each PAC has a corresponding PAC chair and CPO. In addition, one member of each PAC will be designated as the lead for each functional group.

Exhibit A

Functional Advisory Groups



- Each functional group will be composed of the leads from each PAC. For example, the Clinical Functional Group will be composed of the clinical lead from the Medical PAC, the clinical lead from the Dental PAC, etc.
- Some PACs may not have a lead for each functional group. For example, the Dental PAC may not have a Mental Health lead.
- One of the representatives will serve as a chair for the group. The four chairs will work closely with the CPOs and PAC chairs.

Exhibit B

NAVY Dental Corps Career Development Matrix

		Clinical Executive	Administration Executive	Operational Executive	Academic Executive	Research Executive
CAPT	EXECUTIVE	Service Line Leader Director Program Manager Dental Clinic Director, Lg M T F Associate Director Specialty Leader Dental Dept Head, Lg Clinic Advanced Practitioner Training: (10) (11) (12) (13) (14) Qual: (A) (B) (F) (G)	CO/XO Naval Medical Center CO/XO FP Teaching Hospital, CO/XO MTF Director, Lg MTF Dept Head, Lg MTF Chief of Staff BUMED OIC HSO OIC TRICARE Mgmt Activity Joint Task Force Navy IG Director TRICARE Reg. Office BUMED Deputy/Senior Start HSO Senior Staff Joint Task Force Headquarters/ SECNAV Staff Training: (10) (11) (12) (13) (14) (15) (17) Qual: (A) (B) (F) (G)	CO/XO FSSG Med/Dent BN CO/X0 Fleet Hosp (FH) CO/XO Hospital Ship (TAH) MEF Surgeon CC of Marine Corps MARFORPAC/LANT DO COMLANT/COMPAC Feet GO TYCOM Dental 0fficer CFFC Surgeon CC Field Med Service School Training: (7) (10) (11) (12) (13) (14) (15) (16) (17) Qual: (A) (B) (F) (G)	Commander NME T C Deputy CDR NMETC CO/XO NSHS CO/XO Navy Hosp Corps School CO/X0 NOMI Director NPDS* Director, GDE, NMETC Dept Chair NPDS* Senior Staff NPDS* Director. ACP Director, Large AEGD/GPR Training: (10) (11) (12) (13) (14) Qual: (A) (B) (F) (G) *Board Certification Required	CO/XO Research Command Dir, Clinical Invest NMETC Head, Clinical Invest MTF Dept Hd, NPDS Research Dept Hd, NIDBR Research Specialty Leader Research Scientist, NIDBR CO/XO NOMI Training: (10) (11) (12) (13) (14) Qual: (A) (B) (C) (D) (E)
CDR	SENIOR	Dental Clinic Director, Med MTF Dental Dept Head, Med Clinic Associate Director Advanced Practitioner Training: (4) (9)	BUMED Staff TRICARE Regional Office Staff TRICARE Mgmt Activity Staff HSO Staff Joint Task Force Staff OIC/Director: Lg Branch Health Clinic OIC/Director: Lg Naval Health Clinic Director, Sm MTF Training: (9) (10) (14) (15)	MED Dept OIC – CV/CVN/LHA/LHD SDO – CV/CVN, TAH, FH OIC FMF Lg. Healthcare Det. OIC Dental Platoon Training: (4) (5) (6) (7) (8) (9) (16)	Director ACP Academic Director NSHS Staff, NPDS* Director, AEGD/GPR Program Training: (4) (9) (10) Qual: (C) (B) (F) (G) *Board Certification Required	Head, Clinical Invest MTF Clinical Researcher, NSHS Clinical Researcher, NOMI Staff Researcher, NPDS Research Scientist, NIDBR Training: (4) (9) Qual: (C) (D)

LCDR	INTERMED	Dental Clinic Director, Sm Clinic Dental Division Officer Advanced Practitioner Staff DO HTF/ Dental Clinic DUINS Residency/ACP T raining: (3) (4) (9)	OIC/Director: Sm Branch Health Clinic OIC/Director: Sm Naval Health Clinic Division Officer, MTF Clerk-Dental Corps Chef Office Training: (3) (9)	SDO - LHA/LHD OIC - FMF Sm Dental Det. SDO – MEU Staff DO – FSSG, CV/CVN Training: (3) (4) (5 (6) (9)	Junior Staff, NPDS* Director AEGD/GPR Program DUINS Residency Training: (3) (9) Qual: (C) *Board Certification Required	Research Project DUINS Research Scientist, NIDBR Training: (3) (9) Qual: (C)
LT	BASIC	Dental Division Officer Staff DO- HTF/Dental Clinic DUINS Residency Resident in AEGDIGPR Training: (1) (2) (4) Qual: Dental Licensure in 1st Yr	Clerk - Dental Corps Chief Office Dental Division Officer Training: (1) (2) Qual: Dental Licensure in 1st Yr	SDC -MEU DivO -CV/CVN, TAH, FH Staff DC - FSSG, MEU, CV/CVN Training: (1) (2) (5) (6) Qual: Dental Licensure in 1st Yr	DUINS Residency Resident in AEGD/GPR Training: (1) (2) Qual: Dental Licensure in 1st Yr	Research Project DUINS Training: (1) (2) Qual: Dental Licensure in 1st Yr

Training					
(1)	Basic Officer Leadership Training Course at OIS	(7)	Joint Operational Medical Management Course	(13)	Interagency Institute For Federal Healthcare Exec
(2)	Basic Medical Department Officer Course	(8)	Navy Trauma Training Course	(14)	Naval War College
(3)	Advanced Medical Department Officer Course	(9)	Clinic Management Course	(15)	Marine Corps Command and Staff College
(4)	Dental Specialty Training	(10)	TRICARE Financial Mgmt Executive Program	(16)	Operational Medicine Courses (NOMI, NMETC)
(5)	Combat Casualty Care Course (C4)	(11)	PXO & Command Leadership Training	(17)	Joint Task Force Medical Leader Seminar
(6)	Mobilization Platform Training	(12)	MHS CAPSTONE Course	(18)	CATF/ESG Course

Qualifications	
(A)	JMESDP AQD 67A Executive Medicine
(B)	JMESDP AQD 67G Managed Care Coordinator
(C)	Specialty Board Certification
(D)	PhD
(E)	Masters in Health Sciences, GWU
(F)	Masters in Health Care Administration, Army/Baylor
(G)	Masters in Business Administration

Table 1

Commissioned Corps Officer Career Tracks

(For Illustrative Purposes Only)

By Professional Category	**Dental**	**Scientist**	**Pharmacist**	**HSO…etc.**
	Dental Researcher	Scientist Researcher	Pharmacist Researcher	
	Clinical Dentist	Clinical Scientist	Clinical Pharmacist	
	N/A	Behavioral Health Scientist	N/A	
	Operations Dentist	Operations Scientist	Operations Pharmacist	
	Administrator Dentist	Administrator Scientist	Administrator Pharmacist	
	Etc….			
By Functional Group	**Clinical**	**Applied Public Health**	**Research**	**Behavioral Health**
	Clinical Scientist	Operations Scientist	Scientist Researcher	Behavioral Health Scientist
	Clinical Nurse**	Nurse Epidemiologist	Nurse Researcher	Behavioral Health Nurse
	Clinical Dentist	Dental Epidemiologist	Dental Researcher	N/A
	Etc….	Environmental Health Officer	Research Academic Track (old ROG)	

Each career track will be developed to include specific types of positions at various ranks for that track. For example, see Navy Dental Corps Career Development Matrix (Exhibit B) or current Clinical Nurse and Environmental Health Officer tracks.

(Examples for illustrative purposes only)

Clinical Nurse Career Track

- O-6 Chief Nurse (Deputy Hospital Administrator)
- O-5 Head Nurse (Ward Administrator)
- O-4 Staff Nurse II (Nurse Supervisor)
- O-3 Staff Nurse I (Staff Nurse)

Environmental Health Officer Track

- O-7 Environmental Health Officer VI (Chief, Environmental Health Program, National in Scope)
- O-6 Environmental Health Officer VI (Deputy Chief/Program, National in Scope)
- O-6 Environmental Health Officer V (Supervisory Chief, Area/Region)
- O-6 Environmental Health Officer V (Deputy Chief, Area/Region)
- O-5 Environmental Health Officer IV (Supervisory)
- O-5 Environmental Health Officer III (Supervisory)
- O-4 Environmental Health Officer III (Non-supervisory)
- O-4 Environmental Health Officer III (Staff Sanitarian)
- O-3 Environmental Health Officer II (Field)
- O-2 Environmental Health Officer I (Junior Field)

For certain career tracks, the categories may merge at the higher levels, such as for operations or administrative tracks.

Table 2

Current Commissioned Corps Career Track Taxonomy, Reorganized into New Functional Groups

New Functional Groups	**Clinical Functional Group**	**Applied Public Health Functional Group**				**Research Functional Group**	**Mental Health Functional Group**
Current Commissioned Corps Career Track Taxonomy	**Clinical**	**International Health**	**Epidemiology/ Public Health Practice**	**Program Management**	**Regulatory Affairs**	**Research**	**N/A**
	Clinical Management		Construction, design and engineering consultation	Policy development/ planning / evaluation	Enforcement and compliance	Clinical, field, or laboratory research	
	Clinical Practice and Consultation		Environmental/ sanitation consultation / practice	Legislation	Program consultation	Administration	
	Clinical Quality Assurance and Oversight		Epidemiologic practice / teaching / research	Corps management	Standards and specifications for development	Support and demonstrations projects	
	Clinical Support		Health promotion and education	Training	Testing and evaluation		
			Safety and health	Technical assistance and consultation			
			Occupational safety and health				
			Scientific, technical and information development				
			Study design, data collection, analysis				

Table 3

Mental Health Deployment Roles Assessment Tool

(For Illustrative Purposes Only)

The following tool will assist you to identify the mental health deployment roles for which you are qualified by virtue of your education, training and experience. Please mark all the items that pertain to you and the tool will automatically offer deployment roles for which you are qualified. You will then have the chance to accept those roles or to decline them and to provide an explanation of the circumstances that lead you to decline those roles.

If you have already used the similar tool for one of the other deployment groups (Clinical, Applied Public Health, Management, etc.) you will find that some of the items here are already marked. The information from the other tools was automatically imported into this one when you signed in. Similarly, any information that you enter here will be exported to the other tools as is appropriate.

Education / Professional Licenses		**Additional Training and Experience**	
☐	Ph.D., Doctor of Philosophy.	☐	Clinical currency (clinical encounters involving assessment, ongoing treatment and/or treatment planning accounting for 50 or more hours over the past year).
☐	Psy.D. , Doctor of Psychology.		
☐	M.A. (or M.S.) A Master of Arts or Master of Science may be earned in counseling, psychology or related fields.	☐	Disaster counseling experience.
☐	M.D. / D.O. Doctor of Medicine / Doctor of Osteopathic Medicine.	☐	XX Credit hours of disaster mental health training from accredited source.
☐	M.S.W. , Master of Social Work.	☐	Completed approved disaster mental health outreach worker/crisis counselor training from accepted source.
☐	Ed.D. , Doctor of Education. Professionals with Ed.Ds practice therapy just as those with Ph.Ds.	☐	SERT Liaison Training.
☐	L.C.S.W. (Also the A.C.S.W., L.C.S., L.I.C.S.W., C.S.W.) Licensed Clinical Social Worker.	☐	Previous disaster outreach worker experience (40 hours over the past two years).
☐	L.M.F.T. (Also the M.F.C.C.) Licensed Marriage and Family Therapist.	☐	Experience as clinical team leader.
☐	L.P.C. (or L.M.H.C., D.A.C., M.F.C.C.) Licensed Professional Counselor / Mental Health Counselor.	☐	Deep working knowledge of State mental health systems functions, local mental health services organization
☐	A.P.R.N., A.P.N., A.R.N.P.P., or M.H.N. Advanced practice registered nurses have a master's degree in psychiatric-mental health nursing. These nurses are eligible to be licensed as therapists (e.g., O.T.R./L., Registered Occupational Therapist/Licensed).	☐	Experience in mental health planning on regional or national basis.
☐	D.Min., Doctor of Ministry.		
☐	B.C.D., Board Certified Diplomate. Board certification granted to a number of practitioners. These individuals have demonstrated a high level of competency and experience in their field.		

Mental Health Deployment Roles*:

Clinical Roles

Mental Health Prescriber

• Trained in diagnosis and treatment of mental health/substance abuse (MH/SA) disorders.
• Ability to prescribe psychotropic medicines.
• Screens for organic brain syndromes presenting as psychological reactions.

Disaster Mental Health Clinician

• Aids persons demonstrating acute severe disturbances of arousal, behavior or cognition.
• Screens for acute stress reactions.
• Provides psychological first aid to those survivors with physical injuries.
• Provides individual and group debriefing services.

Mental Health Crisis Counselor

• Aides persons at the direction of emergency workers, where the psychological state of the person may be inhibiting the rescue attempt (e.g. trapped persons).
• Offers support to those bereaved by the disaster (this may be at the holding site or the morgue and conducted in collaboration with the team that operates this program routinely).
• Provides psychological first aid to those survivors affected but not physically injured.

Mental Health Outreach Worker

• Provides general support and comfort to those affected by the disaster.
• Provides information about normal responses to disasters and about how to access mental health.

Clinical Mental Health Team Leader

• Provides clinical oversight and supervision to clinical team.
• Coordinates the responses with sources of personal support (e.g. Red Cross) as needed, and ensures that anyone in need of specialist mental health services is seen by the mental health response team.

Management and Consultation Roles

SERT Mental Health Lead

• Consults to State on assessing mental health needs after disaster.
• Serves as primary contact for State MH/SA authorities on federal activities and plans for disaster mental health response.
• Serves as primary liaison between State MH/SA authorities and federal mental health resources.
• Analyzes needs as identified by federal, State and local authorities and proposes activities/initiatives to address those needs.

MH Liaison

• Provides consultation to other Emergency Support Functions as well as ESF-8 health functions on strategies and tactics to minimize further distress.
• Provides consultative and administrative support to SERT Mental Health Lead.
• Proposes and leads activities/initiatives in support of identifies mental health needs.

Liaison Officer for MH

• Provides general logistic, program and administrative support to SERT Mental Health initiatives.
• Serves as liaison to Emergency Support Functions for information sharing and joint activities.

Clinical Team Administrator

• Collects details of disposition of physically injured victims (for later mental health follow-up services).
• Keeps records of all persons seen and interventions offered (for both follow-up and research purposes).
• Provides point-of-contact for reports required by and generated for team(s).
• Serves as liaison for logistics needs of team(s).

***Each deployment role will list the required training, experience, competencies, certifications and licensures associated with that role.**

Exhibit C

Sample Description of Mental Health Deployment Role

Mental Health Outreach Worker

(For Illustrative Purposes Only)

REQUISITE TRAINING AND EDUCATION:

1. Role is open to any Commissioned Officer.
2. Officers with specific mental health services education and training qualify for this role.
3. Officers with NO specific mental health services education and training qualify for this role after having completed an approved comprehensive training course (see sample curriculum below) in disaster mental health designed for non-mental health professionals.

Overview of Comprehensive Disaster Mental Health Training Course for Non-Mental Health Professionals

(For illustrative purposes only)

	Content Area	Suggested Time Required
Activity 1:	INTRODUCTION	0.5 hour
Activity 2:	DISASTER INFORMATION	1.5 hours
Activity 3:	ORGANIZATIONAL DISASTER RESPONSE NETWORK	1.5 hours
Activity 4:	PHASES OF REACTIONS TO DISASTER	0.5 hour
Activity 5:	ADULT AND CHILD REACTIONS TO DISASTER	2.0 hours
Activity 6:	STRESS PREVENTION AND MANAGEMENT	1.5 hours

ROLE FUNCTIONS:

Outreach human services functions

Outreach is a method for delivering services to disaster survivors and victims. It consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster- related services. Officers in this role will generally work in Disaster Recovery Centers, at shelters, mass care sites, water and relief distribution sites, or any location where survivors and/or emergency workers are gathering. They may also canvas urban, suburban or rural areas to assess the relative impact of the disaster and assertively seek out survivors.

1) Provide outreach services at the community level, with emphasis on:
   a) providing general support and comfort to those affected by the disaster
   b) casefinding - locate survivors, assess their needs and provide information regarding available mental health services in the community
   c) mental health education
   d) public education
   e) community organization.

Mental health team administrator functions

2) Serves as administrator for mental health team or several teams
   a) liaison for logistics needs of team(s)
   b) gathers necessary data to crack clinical encounters
   c) provides point of contact for reports required by and generated for team(s).

OPERATIONAL ISSUES:

1) Officers with NO specific mental health services education and training must remain under direct team supervision of a *Mental Health Crisis Counselor*, *Disaster Mental Health Clinician,* or *Mental Health Prescriber*.

Sample Description of Mental Health Deployment Role

Mental Health Crisis Counselor
(For Illustrative Purposes Only)

REQUISITE TRAINING AND EDUCATION:

1. Role is open to any Commissioned Officer.
2. Officers with specific mental health services education and training qualify for this role.
3. Officers with NO specific mental health services education and training qualify for this role after having completed an approved comprehensive training course (see sample curriculum below) in disaster mental health designed for non-mental health professionals.

Overview of Comprehensive Disaster Mental Health Training Course for Non-Mental Health Professionals
(For illustrative purposes only)

	Content Area	Suggested Time Required
Activity 1:	INTRODUCTION	1.0 hour
Activity 2:	DISASTER INFORMATION	1.5 hours
Activity 3:	ORGANIZATIONAL DISASTER RESPONSE NETWORK	1.5 hours
Activity 4:	PHASES OF REACTIONS TO DISASTER	0.5 hour
Activity 5:	ADULT REACTIONS TO DISASTER	2.0 hours
Activity 6:	DISASTER MENTAL HEALTH INTERVENTIONS	4.0 hours
Activity 7:	CHILDREN IN DISASTER	2.5 hours
Activity 8:	SPECIAL POPULATIONS IN DISASTER	2.0 hours
Activity 9:	STRESS PREVENTION AND MANAGEMENT	2.5 hours

ROLE FUNCTIONS:

Counseling functions

Officers in this role will generally work in Disaster Recovery Centers, at shelters, mass care sites, water and relief distribution sites, or any location where survivors and/or emergency workers are gathering. They may also canvas urban, suburban, or rural areas to assess the relative impact of the disaster and assertively seek out survivors.

1) Provide mental health services at the community level, with emphasis on:
   a) aiding persons at the direction of emergency workers, where the psychological state of the person may be inhibiting the rescue attempt (e.g. trapped persons)
   b) offering support to those bereaved by the disaster (this may be at the holding site or the morgue and conducted in collaboration with the team that operates this program routinely)
   c) providing psychological first aid to those survivors affected but not physically injured
   d) mental health services outreach - delivering counseling services to disaster survivors and victims primarily through face-to-face contact with survivors in their natural environments
   e) casefinding and referral - locate survivors, assess psychosocial needs refer them for traditional mental health services in the community when appropriate
   f) mental health education
   g) public education
   h) consultation
   i) community organization.

OPERATIONAL ISSUES:

1) Officers with specific mental health services education and training qualify for this role. If the officer has not deployed in this role previously the officer must be under supervision of a *Disaster Mental Health Clinician* or *Mental Health Prescriber* for a minimum of seven (7) days in the field before the officer may independently fulfill a therapeutic role while deployed.

2) Officers with NO specific mental health services education and training must remain under direct team supervision of a *Mental Health Counselor*, *Disaster Mental Health Clinician,* or *Mental Health Prescriber* when engaged in one-on-one counseling activities.

Table 4

Benefits of Hiring Commissioned Officers

Characteristics	Benefit
Duty Hours	• Increased availability of officers • No overtime pay or compensation • More focus on the job than on "hours worked"
Ease of Reassignment	• Increased flexibility for personnel management
Skill Diversity/ Depth of Knowledge	• Culture of "encouraged moves" broadens overall depth of knowledge and skill sets of Commissioned Officer, which benefits Agency
Deployability and Readiness	• Mandatory responsibility to be ready for deployment 24/7 if needed
Physical Fitness	• Commitment to healthy lifestyle • Commitment to **"**practicing what is preached"
Visibility	• Immediately recognizable to public • Uniform automatically instills ideals of duty, competence, and authority • Unique and underutilized route of communication for Agency to deliver messages to public and medical community • Officers serve as a natural bridge between the uniformed services and the civilian workforce
Licensure	• Licensed personnel (when applicable) available for Agency missions and needs
Clinical Skills	• Bridges gap between clinical medicine and public health • Maintenance of skills, facilitates credibility among clinical practitioners • Enables optimization of public health practice by practical experience and application • Commissioned Officer practicing clinical medicine must maintain their continuing medical education, which maintains knowledge base of clinical advances and current clinical issues of importance
Operation	• Enables efficient management of capable personnel • Increased flexibility with filling positions • Promotion still dependent on job performance
Retention	• Ensures highly skilled public health professionals will be available to achieve agency missions

Table 5

Position Information and Officer Information Needed for Billets, Including Collateral Duties

	Position information	Officer information (including collateral duties)	Comments
Definition	Description and requirements of the position	Characteristics, experience, and preferences of an individual officer (and additional duties linked to an individual officer rather than a particular position)	
Identifying information	Position ID number (P) Position title (D, S) Organization (D) Geographic location (D, P) Civil service series (D, S)	Basic demographic data: (includes name, etc.) Contact information PHS number Retirement Credit Date Length of time since last billet change Length of time since last geographic change Electronic CV cover sheet (includes identifying information, education, experience, and other information)	All data currently in PIR needs to be captured here or below. Position ID will have a category (01-12), agency (HN, HF, HC), functional groups (1-4), sequential unique billet number (3 digits). Officers will be 'compelled' to update their contact information on a regular basis.
Rank and equivalent grade	Series of drop down menus to standardize classification of rank of position (D) Civil service series equivalent (S)	T-grade and P-grade Regular or Reserve Corps	
Clearances	Sensitive/non-sensitive (D,S) Security clearance requirements (D)	Security clearance Other clearances	
Category/group/track	Professional category (or multidisciplinary) (D, S) Functional group (D, S) Career track (new list) (D, S)	Professional category (D) Previous positions held in various career tracks	
Type of position	Supervisory/Not supervisory (D, S) Direction Received (P) Does the position meet the criteria for (D): -rotational -isolated -hardship	N/A	Definitions for terms are being developed by the Assignments group (D).

	-hazardous -hard-to-fill Regular Corps required? (yes/no)		
Expected length of tour	In years (D)		
Education	Minimum degree (S) Minimum education (S) Recommended or additional education	All degrees, year received, and granting institution Corps training (includes deployment training) taken and dates (pre-populated from another database) Other training received	
Certifications and licensure	Required certifications and licensures (S) Recommended certifications and licensures	Clinical specialty/area of expertise Board certification Certification type, date obtained, date certification expires, certifying body Professional licenses, registrations, issuing date, issuing state, expiration date Additional certifications/licenses (e.g., SCUBA, pilot)	
Experience	Minimum experience (S) Recommended or additional experience or skills	Years in Corps T&E Prior Corps service Prior military service Prior civil service Prior COSTEP Years of professional experience Years of functional experience Years of supervisory experience	Displayed as ranges of time with drop-down menus. Some of the elements are self-declared. All data currently in PIR needs to be captured here or above.
Duties	Standard duties (S) Position-specific duties (P)	Other official duties*	Other official duties* may include clinical duties or other duties needed to maintain required proficiency, certification or licensure.
Readiness/Deployment	Position meets criteria for (D): -deployable -mission critical -exempt in training status -other (e.g., deployable with backfill) If deployable, position is eligible for (D): -tier 1 -tier 2 -other	Readiness status (medical waiver, etc.) Primary and secondary (or all) deployment roles Other expertise (to be selected from a list of skills and key words provided) Tier or team assignment and where officer is in the rotation*	(See Readiness group report for definitions.)
Additional expertise		Language proficiency (D) Officer will choose types of	Expertise fields will link seamlessly with

		expertise with key words, (e.g., tuberculosis, toxic waste, field work, cultural competency) that may be of interest to selecting officials or even for deployment needs	corresponding fields for deployment roles.
Preferences		APPLES-like information (D) Next assignment preferences: -time frame (reassignment year) -functional group/career track -geographic location -agency/Operating Division/program/non-HHS	Preferences will link to related fields in billet (position information).
Corps activities		Approved Corps duties (e.g., professional PACs, JOAG, SG PAC, CPO, recruiter)*	
Restrictions		Training obligation Medical limitation (field is visible only to authorized users, to observe HIPAA regulations) Limited tour (pending receipt of qualifying degree)	

S = Standard billet components
P = Position-specific billet components
D = Drop-down menu needed in IT system
* = Collateral duties

Access rights for each field will be defined. For example, officers may edit some fields and not others, and officer preference information will have restricted access.

Exhibit D

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
COMMISSIONED OFFICER'S

BILLET DESCRIPTION

02CC060

1. ORGANIZATION (Bureau, Division, Branch, Section, etc.) and location of duty station

Items 28.2C.3 and 4 to be completed by the Division of Commissioned Personnel ONLY

2. EQUIVALENCY STATEMENT	2A. BILLET SENSITIVITY	2B. GRADE 0-3 2C. TOTAL	3. CAREER TRACK	4. CIVIL SERVICE SERIES
GS-9/11	Non Sensitive		81 - 11	0680

5. FUNCTIONAL TITLE: STAFF DENTAL OFFICER/BASIC CLINIC - Non-Supervisory

6. Pertinent program information (e.g., size of hospital; geographic limits of water pollution control project; type of hospital; primary function and size of Branch, Section, Unit; etc.)

7. *Brief* statement of *most important duties* supervisory responsibilities and work relationships.
A) Serves as a dental officer (full journeyman) for the Dental Unit with responsibilities for performing a variety of professional tasks of overage technical and administrative difficulty in conformance with established criteria and guidelines. B) Proper judgment is required to prevent delays in service provision, avoid adverse impact on the health status of individuals and the population served, reduce wasted efforts and resources, and assure a successful final outcome for the dental care system. C) Provides dental services of a scope, quality, and quantity consistent with PHS policies. b) Primary contact is with persons outside the immediate work environment, but within the Department (DHHS) or assigned agency, and with the general public or patients and patient's families in a clinical situation in order to obtain and provide information, present reports, and further the goals and objectives of the dental program.

8. Direction received (title of supervisor and type of direction upon assignment of work, during course of work, and at its completion).
A) Planning and organizing work and sequence of assignments are prescribed. B) Recurring assignments are not accompanied by instructions; however, objectives, priorities, and deadlines are given on new assignments. C) Incumbent selects own methods and solves most normal problems arising during the course of work. D) Work is reviewed for professional judgment and the attainment of objectives. E) Incumbent plans and carries out the successive steps and handles problems and deviations in work assignment in accordance with guidance and PHS instructions and policies; or by the use of accepted professional practices. F) Completed work is usually evaluated for technical soundness, appropriateness, and conformity to professional standards and PHS requirements. G) Work is reviewed for professional judgment and attainment of objectives. H) A moderate to extensive number of well defined guides, methods, theories, and precedents are available. I) Although these guides may be highly complex and require sound judgment in selecting among them, only a limited amount of modification and innovation is required. J) Situations in which existing guidelines cannot be applied or which require significant alteration of guidance are referred to higher authority. K) Administrative supervision is provided by the facility Director in non-professional matters. L) Professional guidance is provided by the Chief, General Dental Unit, or Chief, Complex Dental Unit (or in his/her absence, the Area/Regional dental officer or the Chief, Dental Program).

9. *Minimum* qualifications (education and experience) required to perform this job satisfactorily.
ODS or DMD from a dental school accredited by the Commission on Dental Accreditation.

10. INCUMBENT'S NAME	**11. INCUMBENT'S CATEGORY**	**12. INCUMBENT'S RANK** Permanent Temporary
13. SERIAL NUMBER	**14. INCUMBENT'S PROFESSION**	15. ***(Check* One)** □ Regular Corps □ Reserve Corps

16. Certification concurrence of the officer's supervisor	Signature	Title (Position)	Date

PHS-4392
Rev. 2/01

Billet Color Coding for Current Billet Structure

Position Information

Yellow = standard components
Blue = position-specific information
Green = includes standard and position-specific information
Pink = officer-specific information

Officer Information

- **Name**
- **Category**
- **P and T Grade**
- **Serial number**
- **Regular or Reserve Corps**

Position Information

- **Standard Components**
  - **Equivalency status**
  - **Billet sensitivity**
  - **Grade**
  - **Career track**
  - **Civil service series**
  - **Functional title**
    - **Supervisory or Non-supervisory**
  - **(standard duties)**
- **Position-specific components**
  - **Organization**
  - **Pertinent program information**
  - **(position specific duties)**

Classifications and Positions Work Group Report
Appendix

Definitions of data elements essential to billet and position generation, description, and maintenance.

Content Area	Definition	Notes
APPLES	Assignment Preferences, Proficiency in Languages, Education and Skills (APPLES).	This system is no longer in use, but a variation on this system will be included in the new IT system.
Benchmarks	Benchmarks are the guidelines used by promotion boards as they review the service records of each officer under consideration for promotion. Benchmarks are intended to describe a range of officer accomplishments and no officer is expected to have achieved all of them.	In addition to the category benchmarks that exist currently, sub-benchmarks specific to career tracks may be added.
Billet	An official document that describes the requirements and specifications of a position. In its current format, a billet also contains information about the officer currently assigned to that position.	
Billets - Position-specific information	Precise details and information about the duties and site. This portion of the billet identifies any additional required or desired qualifications (e.g., Staff Nurse at a particular hospital for a specific agency).	All billets contain some amount of detail specific to the unique position, such as position ID number, geographic location, direction received, and positions-specific duties. Each billet and job announcement will include a live website link that will provide additional information about the geographic area in which the position is located, i.e. schools, climate, population, health care, etc.
Billets – Standard components	Generic description of essential duties and corresponding requirements for education, training, and experience required for the position (e.g., Staff Nurse).	All billets contain certain standard components (position title; civil service series and equivalency status; billet sensitivity; grade; career track and functional group; professional category; supervisory or not; minimum education, degree, and experience; required certifications and licensures, standard duties).
Career track	A career track is a series of positions in ascending order of responsibility that exemplify a path an officer may take as he/she progresses through his/her career. A career track is both a tool for officers to use in helping guide their careers and choose positions commensurate with their goals and a means for the Corps to ensure that billets/positions provide adequate opportunities for officers while simultaneously serving the professional and skills needs of the Public Health Service.	Each billet will be associated with one or more career track. Career tracks will benefit the officer with career development and CC force management with recruiting efforts.
Collateral duties	Additional duties linked to an individual	Examples: CPO, PAC chair, deployment role

	officer rather than a particular position, but are relevant to the position because of the impact on the officer's ability to perform the position duties.	duties, clinical work required to maintain an officer's clinical competency, etc.
Functional Advisory Groups	The functional advisory groups will be formed from PAC membership for each of the four functional groups.	The advisory groups will work with the PACs to develop career tracks, ensuring consistency and uniformity across professional categories, and to develop the educational and training requirements for deployment roles.
Functional groups	A means of identifying the overall focus of an officer's work activities and career path that is meant to supplement an officer's identification with his/her profession and associated PAC. Under the proposed system, functional group will be determined by the designation of an officer's billet.	The four proposed functional groups are: clinical, applied public health, research, and mental health.
Incentives	Additional pay or other benefits designated to encourage officers to accept hard-to-fill positions (e.g., 3-H). Incentives may also be used to encourage officer to maintain skills needed for deployment roles.	
Officer information	Includes characteristics, experience, and preferences of an individual officer. This information enables qualified officers to be identified and matched to vacant positions. Other officer information will be captured, including information currently in the PIR, a standard CV cover sheet, etc.	Example: Officer information can be used to match an officer with experience working in the Hmong population to a community health clinic in Fresno, CA.
Periodic billet review process	Managed by the PACs, a billet review process will take place every three years.	In the review the PACs will examine the standard components of the billets, the distribution of billet grades, and trends to help ensure consistency across agencies.
Position	A job within an agency that has specified duties and is located in a designated part of the organizational structure.	
Random audits	A process used by OCCO to assess the congruence between the officer's billet (including grade) and his/her work responsibilities	OCCO will perform random audits assessing the congruence between an officer's billet and his/her work responsibilities every two years.
Rotational positions	A detail on which an officer serves for 2 - 3 or 4 - 6 years, before being given the opportunity to move to a different assignment (e.g., rotational positions often include 3-H assignments which are usually filled by officers on a 2 - 3 year rotation).	Rotational positions may also include positions for the next assignment for officers rotating out of 3-H positions.
Special pays	A set of additional pays that officers of certain categories may be eligible for. Currently, the medical special pays are based on DoD rates.	Special pays should be expanded to be more flexible for recruitment and retention needs for all categories.
Sub-benchmarks	Additional guidelines within the category benchmarks that have more specificity applicable to functional groups and career tracks in that category. They are used for promotion purposes, as noted above.	

Wang	Antiquated computer data system currently used by Corps management.	