Center for Disease Control and Prevention

Findings and Recommendations Regarding the Commissioned Corps of the United States Public Service at the Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry

January 25, 2008

This Report was prepared by RADM (Ret.) Dixie E. Snider, Jr., MD, MPH with the special assistance of RADM (Ret) Stephen Thacker, CAPT Patricia Simone, CAPT Sven Rodenbeck, members of the Director's Commissioned Corps Policy Advisory Committee, CDC Flag Officers and Chief Professional Officers, and additional CDC staff.

Executive Summary

PURPOSE

The purpose of this white paper is to provide recommendations to the CDC Director, the Office of Workforce and Career Development, and the CDC Director's Commissioned Corps Policy Advisory Committee regarding the Commissioned Corps at CDC/ATSDR in the current environment. The intent of the recommendations is to ensure, to the extent possible, that the transformation of the Commissioned Corps proceeds in a manner that addresses the needs of Corps leadership, CDC, and Corps Officers while at the same time alleviating, to the extent possible, the concerns of CDC Commissioned Corps Officers about the transformation. Some of the recommendations, if accepted, could be implemented by CDC. Others will need to be transmitted to the Office of the Assistant Secretary for Health and/or Office of the Surgeon General for consideration. The context for the recommendations is established by providing background information about 1) the Corps and recent activities aimed to transform the Corps, 2) management's and officer's current perceptions of the advantages and disadvantages of the Corps, and 3) certain factors external to the Corps which are potentially relevant the issue.

METHODS

I read a number of documents related to the transformation, met with members of the Director's Policy Advisory Committee, had numerous "conversations" (in person and by e-mail) with officers and supervisors, had brief conversations with staff of the Office of the Surgeon General and Office of the Assistant Secretary for Health, and circulated drafts of the report to various CDC staff (primarily Commissioned Officers) for review and comment. I deliberately reached out to Officers with diverse opinions and in various categories, but cannot be certain that the perspectives reflected in the document truly represent all opinions. Furthermore, it is not possible to determine the exact "prevalence" of any given perspective. However, the overwhelming majority of the reviewers of the final draft felt that the document accurately captured the current situation at CDC and agreed with the recommendations.

RECOMMENDATIONS

I offer the 11 recommendations below which are expanded upon in the report. If implemented, I believe they would improve the current situation.

1. CDC should request that the ASH and Commissioned Corps leadership articulate the continuing importance of the public health practice and science aspects of the Corps mission and what will be done to strengthen them.

2. CDC should consider designating a high ranking Corps officer as the "leader" of the Corps at CDC. If feasible, this officer would have a position in the OD and would have responsibility for oversight of all Corps issues.

3. CDC should urge the ASH and Office of the Surgeon General to move forward in developing the public health functional group and CDC should play a major role in crafting the requirements for that group (i.e., training, promotion criteria, roles in deployments, etc.). There has been discussion of the proposal for a public health functional group within the Corps, but it is not clear that it meets the expectations of CDC staff as outlined later in this document.

4. CDC should have in-depth discussions with Corps leadership about the appropriate requirements (e.g., for readiness) to place on officers at the agency.

5. Unless a position is designated as being only available for occupancy by a civil servant or a Commissioned Corps Officer, CDC should provide **all** relevant categories of prospective employees with adequate information about the pros and cons of civil service versus the Commissioned Corps so that they can make informed decisions about which to choose.

6. CDC should educate all CDC supervisors and managers about the Commissioned Corps so that they can make informed selection decisions and support the officers they hire in balancing their dual CDC and Corps roles.

7. CDC should consider using special pay authorities for all categories of Corps officers for which special pays are available.

8. CDC should engage the ASH and Corps leadership in Washington in a discussion of how to recruit and retain Corps officers, including those in leadership positions within the agency.

9. CDC leadership should be quick to alert Corps leadership to proposed policies that could impede its public health mission. Similarly, CDC should be quick to point out and highlight aspects of the transformation, e.g. physical fitness, that are in alignment with the agency's mission.

10. If HHS plans to again go to Congress to gain support for strengthening and increasing the size of the Corps, strong emphasis should be placed on obtaining funding for central and distributive support for Officers.

11. CDC and the Commissioned Corps should ensure that there are adequate, formal systems for mentoring CDC Officers so that they get the best possible career advice, including how to succeed as Corps Officers. Advertise, and encourage greater us of, existing mentoring systems by Corps Officers.

PURPOSE

The purpose of this white paper is to provide to provide recommendations to the CDC Director, the Office of Workforce and Career Development, and the CDC Director's Commissioned Corps Policy Advisory Committee regarding the Commissioned Corps at CDC/ATSDR in the current environment. (The leaders of each of these entities requested that I provide this paper. Hereafter, references to CDC should be interpreted as referring to CDC and ATSDR.) The intent of the recommendations is to ensure, to the extent possible, that the transformation of the Corps proceeds in a manner that addresses the needs of Corps leadership, CDC, and Corps Officers while at the same time alleviating, to the extent possible, concerns of CDC Commissioned Corps Officers about the transformation. Some of the recommendations, if accepted, could be implemented by CDC but others will need to be transmitted to the Office of the Assistant Secretary for Health and/or Office of the Surgeon General for consideration. Before listing the recommendations, the context is established by providing background information about 1) the Corps and recent activities aimed to transform the Corps, 2) management's and officer's current perceptions of the advantages and disadvantages of the Corps, and 3) factors external to the Corps which are potentially relevant to the issue.

BACKGOUND

The history, mission, and contributions of the Commissioned Corps of the Public Health Service have been well documented in the literature and various reports and will not be recounted here. Commissioned Corps officers have made important contributions to public health for well over one hundred years. However, in order to make those contributions, as well as to retain its status as a uniformed, but not primarily military, service, the Corps has had to adapt and change over time. For example, it began with the primary mission of providing health care to merchant seamen, was militarized during World Wars I and II and the Korean War, and played important roles in bringing entities such as NIH, FDA, and CDC into the Public Health Service and contributing to their success. During CDC's early years and into the early 1990s, most of the leaders of CDC were members of the Commissioned Corps. However, despite some efforts in the 1960s and 1980s to make the Corps more visible as a uniformed service, until recent years most officers (at CDC at least) saw themselves as CDC employees focused on the mission of the agency who happened, by choice or default, to be in a personnel system other than the civil service. Perhaps driven in part by the Nation's experience in Vietnam and the social activism of the 1960s, most officers at CDC were not even comfortable wearing a uniform. Thus, when the charismatic Surgeon General Koop tried to make the Corps more visible, there was resistance to his efforts to impose minimal requirements for wearing the uniform. In more recent times, although there were some OPDIVs where wearing the uniform was standard practice, questions would periodically arise in Congress about the value and purpose of the Commissioned Corps perhaps due to the relative "invisibility" of the Corps and a lack of understanding of its history, evolving mission, past accomplishments, and future potential.

At least some of the initial impetus for the most recent transformation of the Corps was articulated in a February 1998 report from HHS to the Senate Appropriations Committee. The title of the report was, "***The PHS Commissioned Corps: Recent Trends***

and Future Directions: A Report to the Senate Appropriations Committee Responding to a Request in the Committee Report on the FY 1998 HHS Appropriations Bill". This report provided the Senate Committee with a compelling case for retaining the Corps as a uniformed service. The report presented three critical missions of the Commissioned Corps:

1. Providing essential Public Health and Science (specifically mentioning the national health promotion and disease prevention activities of CDC and FDA; biomedical research activities at NIH and other agencies [including CDC]; the direct health care activities of the IHS, NHSC, Coast Guard, BOP, INS, and U.S. Marshals Service; and leadership in many PHS programs)
2. Leading Emergency Responses (including those for terrorist threats and disasters)
3. Military Augmentation (e.g., working with DoD and preparing for militarization during a national security emergency)

In the 1998 report HHS committed to executing several strategies:

1. Recasting Commissioned Corps force management policies and priorities to be consistent with the Department's structure and anticipated new demands
2. Making the Inactive Reserve a responsive resource for accomplishing the missions of the Commissioned Corps
3. Increasing the visibility of, and simplifying access to, the professional health skills of the Commissioned Corps
4. Enhancing the ability of the Commissioned Corps to respond to emerging threats domestically and internationally
5. Developing a mechanism to enhance the capabilities of all officers through formal training programs and a series of assignments and to outline specific plans for officers identified for leadership positions

Efforts to implement these strategies were modest during the remainder of the Clinton administration and the early part of President George W. Bush's administration. However, after 9/11/01 and the subsequent anthrax attacks and the assessment of the Corps role in responses to them, discussions began within HHS and the Office of the Surgeon General about how to execute on the above strategies as well as how to address some "lessons learned" during the responses to the public health emergencies identified above and other emergencies.

On July 3, 2003, HHS Secretary Thompson announced an initiative to revitalize the USPHS Commissioned Corps. In this document all recent and significant changes in the Corps since 2003, either already implemented or proposed, will hereafter be referred to as "the transformation of the Corps". Surgeon General Richard Carmona and his staff were charged with developing and implementing these changes. The late RADM Bob Knous played a major role in crafting the vision for the transformation and beginning its implementation.

Efforts to effect major change in any organization are always difficult, but the initial efforts to transform the Corps were particularly troublesome to most CDC officers. For example, there was a failure of Corps leadership to provide a compelling rationale for change and a vision of the future of the Corps. There was also a lack of transparency in the process of establishing new policies, and CDC officers were not included in the

process of evaluating new policy options and choosing among them. There was also inadequate communication.

Because of the major concerns of CDC Commissioned Corps officers, the CDC Director asked RADM Stephen Thacker to chair a CDC Emergency Task Force and develop a report on the Proposed Transformation of the USPHS Commissioned Corps. After conducting a large survey of all CDC/ATSDR Officer and a number of focus groups and hiring a contractor to help synthesize and summarize the data, the findings and recommendations of that report were delivered to the CDC Director on September 30, 2003. The Task Force found, among other things, that the transformation and the process by which it was being executed was having an adverse impact on officer morale and was likely to lead to an adverse effect on retention and recruitment, especially among physicians. To minimize the potential impact of the proposed transformation, the Task Force made the following four recommendations:

1. Engage Operating Divisions *fully and actively* in changes to the Commissioned Corps before policies are finalized;
2. Engage Commissioned Officers in the process of changing the Commissioned Corps;
3. Implement a Public Health Force (i.e. functional track) for officers whose career is focused on applied public health practice; and
4. Retain the current or a comparable healthcare plan to avoid disruption in continuity of care. (At the time of that report there were major concerns about healthcare which now appear to have been largely resolved for most officers.)

The purpose of the proposed Public Health Force (or functional track) was, in CDC's view, to create a career path for Corps Officers whose primary focus is applied public health science and practice. The responsibilities of these officers would be to continue the Corps history of providing scientific leadership and technical consultation to local, state, and other federal health agencies in addressing priority health problems; leading the development and implementation of public health surveillance systems; coordinating the investigation of disease outbreaks and the implementation of control measure for specific conditions; and evaluating the effectiveness of public health programs and policies. The officers in this track would have a post-graduate degree, i.e. a doctoral degree or relevant Master's degree and would receive special pays as appropriate for their credentials. CDC indicated that it was open to defining the track more broadly, e.g., to include officers in other OPDIVs such as FDA.

Secretary Thompson and Surgeon General Carmona responded to these findings and CDC concerns in meetings with CDC leadership and staff. They acknowledged shortcomings in execution and modified their approach and agreed that some "content" issues, such as the proposed Public Health Force, should be incorporated into the transformation. There has been greater OPDIV involvement and officer involvement subsequently in transformation efforts, but, as demonstrated below by the recently collected comments of CDC staff, the changes to date have not been sufficient to assuage some of the persistent concerns of officers and managers, regain the trust of all officers, and prevent some of the predicted adverse effects, e.g., resignations, premature retirements, and a lowering of morale.

Despite the controversy about the transformation, the size of the Corps at CDC has remained rather constant (between 800 and 900 officers although there are fewer physicians). Many officers have remained hopeful and upbeat, and some have attempted to help shape the new transformed Corps in a way that could accommodate the needs of Officers, CDC, and the Corps. However, even some Officers who support the transformation have been concerned about continuing poor communication and the failure to implement certain content areas, such as the proposed public health functional group (a.k.a. the Public Health Force). At the other extreme are officers who have left or are planning to leave as soon as they qualify for the retirement benefits they want. CDC Corps Officers' attitudes about the transformation are very diverse and appear to fall along a broad spectrum at and between these two extremes.

The agency itself has taken steps to mitigate some of the adverse consequences of the transformation and related administrative changes at HHS. These include reestablishing a personnel support system for Corps officers, working with Emory U. for medical care for officers, and establishing a Policy Advisory Committee to the Director. CDC, its Director, and its representatives on various Commissioned Corps committees have also continued to advocate approaches to, and policies concerning, the transformation that will create buy-in from CDC officers (to the extent feasible) and outcomes that will have no or minimal adverse impact on the agency's primary mission.

Despite these efforts, the transformation of the Corps remains an issue of concern at CDC. Thus, I was asked to gather information about the status of the transformation and attitudes toward it and provide recommendations which might help ensure that, to the extent possible, the transformation proceeds in a manner that addresses the needs of Corps leadership, CDC, and Corps leadership while at the same alleviates, to the extent possible, the concerns of CDC Officers and their supervisors.

METHODS

In accordance with the charge given to me, I did not do a systematic survey of all CDC staff or Corps Officers. Nor was any random sampling process used to obtain scientifically valid results. The charge carried out was to obtain input from Corps Officers in various categories, at various grades, and with a breadth of perspectives. Input from managers was similarly obtained. As noted in the acknowledgments, there were certain individuals and groups (e.g., the Commissioned Corps Policy Advisory Committee and current and former flag officers) who were consulted more than once about the final content. So, the report should be viewed as a qualitative assessment rather than a systematic quantitative approach.

Before and during the preparation of this report, I read a number of documents related to the transformation beginning with the 1998 report referenced above. In addition, I meet with members of the Policy Advisory Committee for two hours, had numerous "conversations" (in person and by e-mail) with officers and supervisors, circulated drafts of the lists of perceived advantages and disadvantages and drafts of the report (which elicited many individual and collated comments from a broad spectrum of Officers and other staff), and had brief conversations with staff of the Office of the Surgeon General and Office of the Assistant Secretary for Health. In an attempt to engage officers and supervisors (and managers) in a constructive, unbiased dialogue about the Commissioned Corps, I choose to focus participants' thinking and comments

on the advantages and disadvantages of being or employing a Commissioned Corps officer. I further pledged to keep the comments anonymous to encourage participants to speak freely. Because many participants mentioned the same advantage or disadvantage, I eliminated duplicate or essentially similar comments and attempted to articulate an advantage or disadvantage in a way that was clear but not necessarily a direct quote from any particular participant. I can document comments from over 60 CDC staff, but, because a number of comments were collections of comments from several individuals and other comments were received orally, the actual number of persons who made comments is larger than that. As with any voluntary survey without 100% participation, there is no way to be sure that all perspectives were captured. Furthermore, despite efforts to achieve balance, there may have been a tendency for those with negative views to provide more information as compared to those who have more positive views. At the end of the process, however, the overwhelming majority of the reviewers of the final drafts felt that the document accurately captured the current situation at CDC and agreed with the recommendations.

PERCEPTIONS OF OFFICERS AND MANAGERS ON THE ADVANTAGES AND DISADVANTAGES OF BEING OR EMPLOYING A COMMISSIONED CORPS OFFICER

General Comments

The perceptions of officers and the perceptions of supervisors and managers are listed separately in the appendix. I need to emphasize that these are the *perceptions* of participants and not necessarily facts, although, when possible, I attempted to provide the facts that were brought to my attention. In the current environment, perceptions are as important as the facts to identify and consider because these perceptions drive attitudes and behavior. Perceptions become especially important in circumstances where the facts are not well known or well communicated. This appears to be the case today regarding the transformation at least among many officers and supervisors. Perceptions are also surrogates for facts when there is a lack of trust in leaders, which seems to characterize some officers today. Identifying perceptions also offers the opportunity to correct misperceptions through effective communication. This is a major challenge for the Corps and CDC, especially given the geographic distribution of CDC staff around the globe and the concentration of Corps leaders in D.C.

It is also worth noting that the perceptions of CDC officers about the transformation are perhaps slightly more informed but still represent many of the same concerns articulated during the development of the 2003 Task Force report.

Although an attempt was made to ensure that the perceptions lists were are complete as possible, it is not possible to ascertain how many participants have these perceptions or the strength of their beliefs. It is clear that there is a broad spectrum of opinion across the agency about the Corps and the transformation. My general impression is that staff in those components of the agency that are most likely to need to deploy officers to the field have a more positive view than those components that do not. Nevertheless, there appears to be general agreement that, at a minimum, the process of transformation still needs to be improved and that there is a need for better

communication. In addition, I believe it is fair to say that a majority of officers would like to see the Corps move forward in defining the public health functional group and the requirements for that group.

Below I will discuss a few of the advantages and disadvantages that seem most critical in influencing managers' and officers' attitudes and behaviors.

Specific comments - Perceived advantages from the management/agency perspective

From the management perspective, the perceived advantages of employing a Commissioned Corps officer were placed into three categories. These categories are:

A. The lower administrative burden on the agency from several perspectives, e.g., hiring, transferring, leave, etc.,

B. The greater flexibility the manager and the agency have regarding how to utilize Officers, and

C. The additional benefits to the agency of hiring and retaining Corps Officers.

For some supervisors, these advantages (especially the first) are enough for them to want to continue to hire Commissioned Corps officers despite the disadvantages. As stated above, these supervisors appear to be more numerous in agency components that need to deploy officers to the field. One advantage (not explicitly mentioned by participants but which was implicit in some of our conversations) that may also support a positive view is the fact that Commissioned Corps officers are perceived to be generally better qualified than civil service applicants for entry and junior level jobs. This is amplified at CDC by the fact that a significant proportion of Commissioned Corps officers at CDC, especially physicians and scientists, have entered through the Epidemic Intelligence Service. Because of that, they have had to compete rigorously for entry into EIS and complete the two year period of training during which their performance can be assessed. Only those who "measure up" are retained by the agency.

Specific comments – Perceived disadvantages from the management/agency perspective

The perceived disadvantages were placed into four categories. These categories were:

A. The fact that Commissioned Corps Officers work for two organizations,

B. Uncertainty about the transformation

C. Leadership of the Corps at CDC, and

D. Other

The most frequently mentioned disadvantage mentioned by managers (and Officers) is the fact that Commissioned Officers work for two organizations, i.e., their CDC component and the Commissioned Corps. Although this has always been true in theory, the transformation has made it true in fact since the Corps is now placing

requirements upon officers which go well beyond the minimal requirements placed on officers prior to the transformation. Some managers believe that the time Commissioned officers spend on meeting Corps requirements, e.g., training and deployments, does not meaningfully contribute to public health or would at least be better spent on doing their assigned work in their CDC component. To a significant extent, the views of managers seem to be influenced by how closely the mission of their component of the organization is aligned with the **priorities** of the Corps. At present, the perception is that the Corps priorities are the emergency response mission and the direct clinical care component of essential public health and science mission rather than, for example, the health promotion and disease prevention and research components of the essential public health and science mission (see 1998 report to the Senate referenced above) which is a central mission of CDC. So, there is a perceived incomplete alignment between the priorities of the Corps and the priorities of CDC components. Furthermore, there is the perception that officers can be pulled from their daily work in CDC components for deployment by the Office of Force Readiness and Deployments (OFRD) whether that is true or not. From many managers' perspectives, officers' absences from their daily jobs for Corps requirements can have adverse consequences on the program in terms of delays in completing important tasks, increasing the burden on other employees, opportunities lost, etc. At best, managers will be fully informed of the importance of the Corps requirements and agree with them, but this is often not the case. Some managers do not believe that the Corps assignments generally are more important than the officer's usual daily work. Some managers feel that they do not have enough information to make an informed judgment. Anecdotal reports by many officers of their deployment experiences have raised questions among managers about the value of certain deployments. While some experiences have indeed been perceived as benefiting public health, others have been perceived as a "waste of time".

Uncertainty about the future direction of the transformation appears to underlie much of the concern among CDC staff. For example, it is unclear about whether the proposed public health tract will actually be implemented.

In addition, Corps leadership has recently proposed that Health and Medical Response [HAMR] teams be created, "owned" by the Office of the Surgeon General, and be deployed as first responders in disasters. The OFRD had hoped to stand-up the HAMR teams in FY 2008, but lack of funds may not allow that to happen. So it is not clear if the HAMR teams will be stood-up, and, if so, it is not clear how that would impact the deployment of CDC officers.

Another development has been the formation of Commissioned Corps Applied Public Health Teams (response teams). The relationship between these teams and the HAMR teams is not yet clear, although it appears that a HAMR team may determine that an Applied Public Health Team, or team member, is required to complete a response begun by a HAMR. Exactly how and when these teams will be deployed by the Corps versus CDC deploying a response team, perhaps comprised of Corps and non-Corps members, is also unclear.

Another element recently introduced is a CDC effort to educate all CDC staff (Corps and non-Corps) about emergency deployments and prepare them for appropriate roles. Corps training requirements regarding deployments fit well with this new

initiative, but the initiative also signals that CDC does not plan to depend entirely upon Corps officers for emergency deployments.

The other disadvantage I will highlight in this section is concern about Corps leadership at the highest levels at CDC. Compared to the situation in the 1940s to the 1990s, there are fewer Commissioned Corps officers at the highest levels of leadership at CDC. Some officers have left primarily for reasons unrelated to the Corps and its transformation (see external factors below), but others have left the Corps because of the transformation or because other personnel/pay systems offer greater financial benefits without the requirement of working for the Corps as well as CDC. Whatever the reasons for this change, it is in the best interest of the Corps (and the Officers) to have a significant number of agency leaders in the Corps regardless of their professional category. Without this, achieving some of the aims of the Corps, e.g., greater visibility of the Corps; the increase in size of the Corps; the perceived leadership position of the Corps; agency understanding of, support of, and input into the transformation effort; improvement in morale; better communication; etc., will be a greater challenge. At the agency level, the impact of the premature loss of Officers from the Corps has been attenuated because some of the Officers became civil service employees (e.g., Title 42). In any event, the departure of many highly-regarded, widely-known experts has, at a minimum, required substantial resources to recruit placements and has reduced CDC's depth of expertise in some areas. On the positive side, the departure of experienced high level leaders has resulted in opportunities for younger leaders to emerge or be recruited. The main point is that the number of Center Directors (or above) who are civil servants has increased while the number who are Corps officers has decreased.

Specific Comments – Perceived advantages from the officers' perspectives

From the officers' perspectives, the advantages of being in the Corps were placed into two categories:

A. Expectations and aspirations, i.e., an ability to realize their dream of service to people throughout the world by improving their health and well-being and to be a part of an elite group **and an agency** that has a long and proud history of doing that despite (or perhaps because of) the fact that it calls them to be available to serve 24/7 whenever and wherever they are needed.

B. The benefits (e.g., salary, special pays, medical care, VA approved home loans, medical, retirement, RIF protection, moving, leave, etc.) they and their families receive.

It is interesting and informative to note that officers' have a wide spectrum of perceptions about whether some of the features of the transformation are advantages or disadvantages. Thus, for example, some officers have a positive view about issues such as mobility, deployments, physical fitness requirements, and maintaining clinical skills while others have a more negative view of these. Based on my interactions, it would appear that these perceptions vary depending upon the interaction of a variety of factors. These factors may include age, position in the organization, service entry date, mission of their "home" organization and their role there (e.g., whether it is oriented toward science

and program related to a chronic non-infectious disease at one extreme or toward emergency response at another extreme), the demands of their "home" organization (e.g., how well funded and staffed their organizational component is and the scope and number of projects they have responsibility for), their previous work experiences and career goals (e.g., whether they have already changed jobs several times or have been on a track to become an in-depth subject matter expert), family situation, baseline health and fitness and current habits in this regard, etc. Officers weigh all these factors (and others) in considering whether to assess the transformation requirements as advantages or disadvantages.

Specific Comments – Perceived disadvantages from the Officers' perspectives

The perceived disadvantages were classified into three groups:
A. The issues which arise as a result of working for two organizations,
B. Lack of trust in leadership, and
C. "Non-benefits" to all or some Officers in the Corps

As with managers, one of the most important and frequently discussed disadvantages of being in the Corps is the requirement to work for two organizations. This is especially true if there is a perception that those two organizations do not share the same priorities. It is useful to understand that many officers came to CDC because they identified with its mission and values, not because they identified with, or even understood, the mission of the Corps. Until recently, many officers were never told that they had a choice of being a civil servant or, if they were told, they were not educated about the pros and cons for them of each system. Furthermore, after being at CDC for a few years, many officers were drawn to, and encouraged by management to, become in-depth subject matter experts in some area of public health. Thus, until recently, a generation of officers populated CDC who were unaware (or thought it unlikely) that the Corps could place requirements upon them that were not in alignment with their daily jobs and/or did not originate at the initiation of, or with the involvement of, CDC leadership. So some officers see the Corps requirements as adversely impacting their lives. Officers in positions which address the non-clinical care aspects of the essential public health and science mission of the Corps tend to view the priority placed on "officership", deployments, and clinical care, for example, as devaluing their daily work. They also feel, as do some of their managers, that meeting these requirements has an adverse effect on their component's mission as well as placing a burden on them, their co-workers, and sometimes their families.

Early efforts by Corps leadership to effect the transformation were admittedly not handled well. Although there have been laudable efforts to change the approach, there are still problems that instill a lack of trust and confidence among some officers. The complete turnover in Corps leadership recently may eventually lead to positive outcomes, but the fact that the initial leaders and advocates for the transformation are gone now has rekindled cynicism. For example, the previous ASH signed a memorandum eliminating the "salt and pepper" uniform, which took away a uniqueness of the Corps and placed

financial burden on officers to buy new uniforms. In one officer's words, "he did this as he was walking out the door to take a lucrative position in the private sector". This and other actions have reignited a host of other speculations about the "real reasons" for the transformation.

Commissioned officers are concerned that high level CDC leadership does not have many Corps officers and, therefore, do not feel that there is a strong, effective, and credible "voice" for Corps issues at the agency. One reason for this is that a number of high level physician leaders who were in the Corps have retired or left. Another reason is that newly recruited individuals have chosen Title 42 (or Title 38) because of its greater financial benefits and because they do not incur the burden of meeting Commissioned Corps requirements. Title 42 and Title 38 are also attractive options for Corps officers who have reached retirement and for new recruits. Although there are three active duty Corps officers on the CDC Executive Leadership Board, they are believed by many Officers to be more focused on the broader needs of the agency and their Coordinating Centers rather than issues related to the Corps.

In the appendix, there is a relatively long list of "non-benefits", generally benefits that civil servants have which Commissioned Corps Officers do not. In some cases, there are alternatives which could provide the benefit to Officers, but the Officers may either not be aware of them or choose not to utilize them. Furthermore, although these "non-benefits" were indeed noted by the respondents, for most of them, the number of people who raised these concerns was small and the level of concern about them was not as strong as it was for most of the other issues discussed above.

In summary, despite the many things that CDC leadership and Corps leadership have done to support Commissioned officers at CDC through the transformation, it has not been sufficient to avert some of the concerns and negative perceptions of the transformation by many agency staff, especially its Commissioned Corps Officers.

EXTERNAL FACTORS

It is very important to understand that the transformation of the Corps has been occurring concurrently with a number of other important events, namely:

1. Changes in leadership at CDC and within HHS
2. A major reorganization at CDC
3. Following and during some of the most important public health challenges and disasters, e.g., the attacks on the twin towers, the anthrax attacks, SARS, avian flu, hurricanes Katrina and Rita, etc.
4. In an environment where public health science, and all science, seemed to be less well accepted or valued for policy purposes (based on former SG Carmona's testimony, personal experience as Chief Science Officer at CDC, and numerous media reports) and
5. During a period of war

Some of these factors might have had a direct bearing on the transformation of the Corps and others had at least some indirect effect. If nothing else, many of these factors placed additional burdens on CDC officers to adapt to change. The most directly challenging has been the transformation and reorganization of CDC – a work still in progress. Changes in leadership at CDC and within HHS (as with changes at Corps headquarters)

also require resilience and adaptation which further stresses the workforce, including officers. CDC's high profile responses to large outbreaks and disasters were highly scrutinized and placed further stress on the agency. There has been frustration among agency staff when other considerations "trump" public health science in the policy arena. Finally, because the Corps can be militarized by the President and wars are continuing in Afghanistan and Iraq, some officers believe there is a plan to utilize them in these areas of conflict. Thus, any policy that appears to "militarize" the Corps is seen as antithetical to the mission of public health.

Since the last inquiry about the Corps from Congress was apparently nearly ten years ago, it is unclear how much interest there is in Congress on funding changes in the Corps. The administration has supported additional appropriations for the Corps during the past two years and, although there has been support in Congress, no such appropriations have as yet been passed. Within Congress, there has been a higher priority placed on changing certain OPDIVs (e.g., The FDA Amendments Act passed in 2007) than on changing the Corps. The assumption is that the transformation was stimulated, in part, by the perception that the Corps was at risk of being harmed or disappearing if its value to the nation was not made clearer, especially to Congress and the Executive Branch. With the departure of SG Carmona, the ASH (RADM Agwunobi) and RADM Moritsugu and the "sun setting" of the current administration, the prospects for sustained support of change in the Corps in the next administration is uncertain and unknowable at this time. The new, perhaps interim, leaders of the Corps have experience at various OPDIVs within HHS and have pledged to move forward in a collegial and transparent manner. They are making considerable progress, but their efforts are hampered by inadequate funding. In addition, the time available to them could be short. Thus, there will be a tension between moving forward rapidly enough to "complete" the transformation by 2009 while at the same time doing it in a way that is transparent and trusted and does not have major unintended consequences.

In addition to transforming the Corps, the ASH and Office of the SG are seeking to increase the size of the Corps to 6,600 by 2009. Agencies are being asked to set their own ambitious goals. There is, however, no final plan yet as to how these targets will be achieved (e.g., what disciplines, what ranks, etc.), although there is an interagency group working on this. Furthermore, all the systems needed to increase the numbers of Corps officers are not in place yet. Unfortunately, health care experts say that there is a severe shortage of nurses now and a shortage of physicians is predicted in the near future (although medical school applications hit an all time high this year). This could mean that any significant growth in the near term may depend upon the recruitment of significant numbers of officers in other categories. Although CDC has recruited non-physicians into the Corps, it is yet clear that CDC will be able to recruit more. The number of Commissioned Corps officers at CDC has remained rather stable for the last ten years and the number of physicians and dentists has decreased. Recruitment might be adversely affected (and anecdotally already seems to be) by the counsel being given to some prospective EIS officers by older officers who are unhappy about the content and process of the transformation.

On the other hand, CDC has embraced its role in emergency preparedness and response. If a new administration confirms its support of this aspect of CDC's role, new opportunities could open up with organizational components and positions in alignment

with the emergency response mission and priority of the Corps. Based on officer input, however, the infrastructure at HHS appears to be currently inadequate to support recruitment and adequate servicing of the existing officers let alone an influx of new officers. So, in the end, Congress will need to take action to move this plan forward.

RECOMMENDATIONS

Based on the above analysis, I offer 11 recommendations below which I believe would improve the current situation. Many of these suggestions were included in an earlier "white paper" developed within the agency which had 22 recommendations. However, some important recommendations in that paper have not been acted upon and are reiterated here. Other recommendations are new or at least articulated in a different way.

1. While a focus on clinical skills and emergency response is perhaps necessary in the post 9/11 environment, CDC should request that the ASH and Commissioned Corps leadership articulate the continuing importance of the public health practice and science aspects of the mission and what will be done to strengthen them.

Since 1998, the mission of the Commissioned Corps of the USPHS has been rearticulated as "Protecting, promoting and advancing the health and safety of the nation. As America's uniformed service of public health professionals, the Commissioned Corps achieves its mission through:

a. rapid and effective response to public health needs,
b. leadership and excellence in public health practices, and
c. the advancement of public health science."

Despite this restatement of the mission, Section 216 of the Public Health Service Act is still in effect and permits the President, at his discretion, to militarize the Corps. Thus, although there appear to be no plans in the current administration to militarize the Corps, an officer considering a career, esp. a 20-30 year, in the Corps should be aware of Section 216 as well as of the fact that the Section has not been used since the Korean War.

Although the non-clinical elements of the essential public health mission (e.g., public health practice and advancement of science) of the Corps are now given prominence in writing, actions to date have given many officers the impression that these elements are relatively undervalued and may be further damaged by continued overemphasis on emergency response and clinical work. If the Corps leadership and HHS believe that the future needs of the Corps and HHS require placing a priority on recruitment, training, and retention in these two areas, then that should be made very clear to officers. However, I personally believe that an overall balance in the Corps' three missions is critical to maintaining and growing the Corps in all OPDIVs and to the Nation's health. If Corps leadership agrees, then this message must be clearly and repeatedly sent to officers who are engaged in pubic health science and public health practice activities as well as persons considering a career in these areas.

2. CDC should consider designating a high ranking Corps officer as the "leader" of the Corps at CDC.

There are several options for accomplishing this. If feasible, it might be ideal for this officer to have a position in the OD (either permanently or on detail) and have responsibility for oversight of all major Corps issues. This would accomplish a number of things, including:

a. Giving CDC a more authoritative voice in shaping Corps policies

b. Send a signal to CDC officers that top management is seriously concerned about Corps issues

c. Improve communications by providing a formal channel for official communication about Corps issues in all directions, i.e., both up and down the chain of command among officers and across the agency among leaders, managers, supervisors, and others. If these communications are executed well (perhaps in cooperation with the Office of Enterprise Communication), it would help clarify the Corps vision, mission, values (as emphasized in RADM (Ret.) Richard Wyatt's draft white paper), priorities, policies and their rationale to CDC officers as well as inform the Corps leadership of official CDC positions on Corps activities and proposals. The fact that many of the perceptions of Corps officers are misperceptions is strong evidence of the need for an official, trusted source of information at the agency. (At the present time, there is a reticence on the part of CDC officers to speak openly with Corps leadership. The person in this position should feel comfortable speaking openly but constructively with leadership.)

If recommendation #2. is not followed or cannot be acted upon quickly, then an alternative approach to getting accurate and current information disseminated to CDC officers and other CDC staff needs to be put in place. Similarly, an alternative approach to designating the "CDC Corps leader" is needed. Because of a number of factors, e.g., the persistence of misunderstandings and inaccurate information; the fluidity of the transformation process and Corps leadership; the rapidity with which new policies are being developed; the opportunities for an authoritative CDC Corps leader to influence those policies; the persistence of concerns about issues that have apparently been, or are being, resolved; and the great geographic dispersion of CDC officers around the globe; there is a critical need for the functions outlined above to be carried out as soon as possible.

3. CDC should urge the ASH and Office of the Surgeon General to move forward in developing the public health functional group that Secretary Thompson approved in concept early in the transformation process.

Corps leadership has indicated its intention to do this. CDC should play a major role in crafting the requirements for that group (i.e., training, promotion criteria, roles in deployments, etc.). (Note: Although there has been discussion of the proposal for a public health functional group within the Corps, it is not clear that it meets the expectations of CDC as outlined earlier in this document and, thus, CDC needs to have substantial input.)

4. CDC should have in-depth discussions with Corps leadership about the appropriate requirements to place on officers at the agency.

RADM [Ret.] Richard Wyatt has referred to this in another white paper as "balance". Corps leadership has indicated that it is looking at this issue. It is clear that "one size does not fit all" (although some basic information about and requirements for the Corps are relevant to all officers). For example, the needs and roles of officers who are high-level leaders are very different from the needs and roles of officers entering the Epidemic Intelligence Service. These discussions should take place in the context of considering the impact of the requirements, not only on the officers themselves, but also on the programs in which they work, their co-workers, their families, and on the overall non-clinical aspect of the Corps essential public health and science mission. If, as plans evolve, HHS and the Corps decide to use the Corps primarily for clinical work and emergency responses, then those officers whose daily duties do **not** relate to such work should be offered the opportunity to transfer to the civil service with provisions for appropriate benefits.

5. CDC should provide **all** relevant categories of prospective employees with adequate information about the pros and cons of civil service versus the Commissioned Corps as soon as practical so that they can make truly informed decisions.

This could achieve two aims: (1) identify persons who are candidates for the Corps who otherwise might not be considered, and 2) identify those pursuing the Commissioned Corps option whose career goals might be better realized outside the Corps (thus avoiding Corps expenditures on such persons and the potential problems associated with their subsequent dissatisfaction). Ideally, this information could be given, when practical, to groups but individual consultations would be available to those who have questions and concerns about their particular circumstances.

6. Educate all CDC supervisors and managers about the Commissioned Corps so that they can make informed selection decisions and support the officers they hire in balancing their dual CDC and Corps roles.

7. CDC should consider using special pay authorities for all categories of Corps officers for whom special pay is available.

It was reported, for example, that there are potential special pays for the health scientist category. The possibility of such special pays being available and used at CDC should at least be explored.

8. CDC should engage the ASH and Corps leadership in a discussion of how to recruit and retain Corps officers, especially in leadership positions within the agency.

OWCD has recently hired a strategic recruiter and this person could play a role in Corps recruitment. With regard to retention, the Physicians Professional Advisory Committee

is currently making recommendations for physician special pay, but those recommendations, if implemented, are not likely resolve the problem with high-level leadership positions at CDC, especially as it relates to non-physician Corps Officers. For recruitment, the use of the COSTEP program should be considered.

9. CDC leadership should be quick to alert Corps leadership to proposed policies that could impede its public health mission. Similarly, CDC should be quick to point out and highlight aspects of the transformation, e.g. physical fitness, that are in alignment with the agency's mission.

10. If HHS plans to go to Congress to gain support for strengthening and increasing the size of the Corps, strong emphasis should be placed on obtaining funding for central and distributive support for officers. In addition, HHS should consider the possibility of having a fund for reimbursing CDC programs that deploy officers for HHS, but non-CDC, missions.

11. CDC and the Commissioned Corps should ensure that there are adequate, formal systems for mentoring CDC Officers so that they get the best possible career advice, including how to succeed as Corps Officers. Advertise, and encourage greater use of, existing mentoring systems by Corps Officers.