Commissioned Corps BULLETIN

Division of Commissioned Personnel • Program Support Center, DHHS

Vol. XVI, No. 1 **January 2002**

Surgeon General's Column

Survey of Recently Released Surgeon General's Reports

This time of year always prompts two very abrupt responses: While December is typically the time of celebration and reflection of the past year's events, January traditionally demands we shift our focus from the past to the challenges and opportunities of the coming year. I have done both. I have begun reflecting on the events of the past 4 years, and I have also begun to look ahead.

Let me deal first with the events of the past. I am pleased with all that we've accomplished together, not the least of which are a dozen Surgeon General's Reports—three on mental health, three on smoking and health, two on suicide prevention, and one each on oral health, youth violence prevention, sexual health, and overweight and obesity. In conjunction with the Office of Women's Health, we also issued a very important report on breastfeeding.

Reports on Smoking and Health Since 1998

Since 1998, when my tenure as Surgeon General and Assistant Secretary for Health began, we have released three smoking-related Surgeon General's Reports. The first was *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*, which stressed the need to curb rising smoking rates among minority teenagers. Left unabated, increased smoking rates among minority populations threaten to reverse the progress against lung cancer which was made during the early 1990s. Another smoking-related report we released was *Reducing Tobacco Use*, which highlighted the fact that despite the progress we have made in nearly halving the smoking rate in this country, nearly 25 percent of adults continue to smoke and, even more tragically, tobacco use among our youth has increased since the early 1990s. Yet through comprehensive anti-smoking efforts involving a number of intervention modalities—social, economic, educational, and regulatory—smoking rates among teens and adults could be cut in half within a decade. We noted in the Surgeon General's Report on *Women and Smoking*, that the smoking rate among women has nearly doubled since 1965. Today, women account for 39 percent of all smoking-related deaths each year in the United States. In fact, lung cancer has become the leading cause of cancer death among U.S. women, surpassing breast cancer. So there is still much work needed in this area. Our ultimate goal is to bring an end to smoking overall.

Landmark Reports: Mental Health, Suicide, and Oral Health

As important as it is to revisit ever challenging areas of public health, we also recognize the need to focus the Nation's attention on burgeoning issues that heretofore had not been examined in Surgeon General's Reports. Our landmark reports on mental health, suicide prevention, and oral health, brought increased awareness and action to some of the Nation's most pressing health challenges and generated new public health initiatives. For example, we used the 1999 Surgeon General's Report on *Mental Health* as an opportunity to dispel the myths and to erase the stigma surrounding mental illness. Drawing on revolutionary advances in the last 25 years in our understanding of the brain and mental disorders, the report underscored the fact that mental health is fundamental to overall health and well-being, that mental disorders are real, based on physical changes in the brain, and that they are common and treatable. In fact, we conservatively estimated that 1 in 5 people experiences a diagnosable mental disorder each year. We also noted that 80-90 percent of the time, we can treat people with mental illnesses and return them to productive lives and positive relationships. Nevertheless, fewer than half of the people who experience a mental disorder get the treatment they need, because of stigma and discrimination.

Stigma is not just a problem impacting adults; it also impacts children. We noted in the Surgeon General's mental health supplement on *Children's Mental Health* that 1 in 10 children experiences a mental disorder severe enough to cause some level of impairment each year; yet, fewer than 1 in 5 receives treatment. That could be due in part to the fact that people who have children with mental disorders often hesitate to take them for care, because they don't want other people to know their child has a problem. We also

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Published as part of the Commissioned Corps Personnel Manual for Public Health Service Commissioned Corps officers. Forward news of Service-wide or special interest to Division of Commissioned Personnel, Room 4-04, 5600 Fishers Lane, Rockville, MD 20857-0001, Phone: 301-594-3462, E-mail: vkapusnick@psc.gov.

Director, DCP/PSC
RADM R. Michael Davidson
Editor, Mrs. Virginia Kapusnick

Surgeon General's Column

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need a system of care that connects the home, the school, juvenile justice, healthcare, and others. Untreated mental illness in children can result in tragic outcomes such as homelessness, crime, and violence.

Minorities with mental illnesses face their own unique problems. In August 2001, we released another supplement to the broader report on mental health entitled: *Mental Health: Culture, Race, and Ethnicity*. In it, we noted the fact that major disparities exist in recognition, acceptance, and quality of mental health services for racial and ethnic minorities. It noted that minorities are less likely to have access to mental health services, they are less likely to receive needed services, and when they do receive services, the quality of care may not be as good. A critical consequence of these disparities is that minority populations experience a greater disability and limitations in daily activities from mental illnesses than their white counterparts—not because their illnesses are more severe or more prevalent than whites, but because of the barriers they face in terms of access to care and utilization of services.

One of the most, if not *the* most, tragic consequence of untreated mental illness is suicide. We estimate that 80-90 percent of the people who die by suicide are suffering from a diagnosable mental illness. To address that problem, we released the *National Strategy for Suicide Prevention* in May 2001, which followed the *Call to Action to Prevent Suicide* released 2 years earlier. The strategy outlines measures the Nation can take, especially at the community level, to bring about the social change needed to advance attitudes, policies, and services aimed at preventing suicide.

Suicide is the eighth leading cause of death in this country. Older white males have the highest suicide risk, but some minority groups are disproportionately impacted. For example, in some American Indian communities, the suicide rate is three times the national average. Since 1980, the suicide rate had doubled among young African American males.

Another landmark report is the Surgeon General's Report on *Oral Health*, which was released in May 2000. We found that oral health is fundamental to overall health and well-being. That report found a significant disparity between racial and socioeconomic groups in regard to oral health and ensuing overall health issues. Based upon these findings, we called for action to promote access to oral healthcare for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

Several themes have emerged from the reports that offer major challenges and opportunities for the future of the Nation's health. Chief among them is the need to improve access to healthcare and the need for quality healthcare services for all people. The Reports have helped emphasize the fact that minorities, the poor, and children seem to suffer a disproportionate burden when it comes to lack of access. They show the need to eliminate disparities in health, recognizing that when we work to close health gaps, we do the most to protect the health of *all* people. They show the devastating impact stigma has on so many lives and they emphasize the need to erase the stigma that surrounds many sensitive public health issues. They show how environment affects health. With each report, we have tried to show the critical need for more research, especially in the area of health promotion and disease prevention. In fact, the need for a balanced community health system, which balances health promotion, disease prevention, and universal access is clear from all the reports.

It is January. As I shift my focus from the past to what lies ahead, I am guided by those key themes. Our aim in producing these reports is that they make an impact on the Nation's health for years to come. That's why we have continuously emphasized that developing and releasing reports is only the first step. They will not be "complete" until they have been embraced and acted upon by the American people, establishing programs at the community level, and working to bring about the kind of social, economic, legislative, and regulatory change needed to better protect and advance the health of the people. It is important that the Surgeon General communicates directly with the American people based on the best available science. Therein lies the credibility of the U.S. Surgeon General.

VADM David Satcher
Surgeon General

A complete listing of Surgeon General's Reports released since 1998 is provided below:

1998 *Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General*

1999 *The Surgeon General's Call To Action To Prevent Suicide*

Mental Health: A Report of the Surgeon General

2000 *Blueprint for Action on Breastfeeding*

Oral Health in America: A Report of the Surgeon General

Reducing Tobacco Use: A Report of the Surgeon General

2001 *Youth Violence: A Report of the Surgeon General*

Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda

Women and Smoking: A Report of the Surgeon General

National Strategy for Suicide Prevention: Goals and Objectives for Action

Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior

Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General

Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity

For more information, go to http://www.surgeongeneral.gov/library/reports.htm

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5-Day Basic Officer Training Course Launched

Inaugural Class of the PHS Commissioned Corps 5-Day Basic Officer Training Course, Rockville, Maryland, October 15-19, 2001.

The inaugural class of the 5-Day Basic Officer Training Course (BOTC) pilot program was held October 15-19, 2001. It was conducted by the Commissioned Officer Training Academy (COTA), Division of Commissioned Personnel (DCP), in both the Parklawn Building in Rockville, Maryland, and the Humphrey Building in Washington, D.C. The class was composed of 29 newly commissioned Public Health Service (PHS) officers with duty sites in 14 States with the following Agencies/Operating Divisions/Programs:

- Indian Health Service (IHS) (11);
- Food and Drug Administration (FDA) (6);
- Immigration and Naturalization Service (5);
- Federal Bureau of Prisons (3);
- Environmental Protection Agency (1);
- Office of the Secretary (1);
- Health Resources and Services Administration (1); and
- Substance Abuse and Mental Health Services Administration (1).

The officers were at the grades of LCDR (2), LT (15), LTJG (11), and ENS (1); 17 were female and 12 male; representing the professional categories of Nurse (9), Health Services (6), Engineer (5), Dental (3), Pharmacy (3), Veterinary (1), Therapy (1), and Environmental Health (1). Each officer received a binder of materials, the book titled *Plagues and Politics* that contains the history of the PHS from its beginning in 1798, a verbal IOU for their oath coin, class photo, and certificate of completion.

The class experienced classroom presentations, uniform inspections, various exercises and ceremonies, ID card production, the Naval Exchange uniform shop, night trips to the sights of Bethesda, Maryland, and Washington, D.C., and a closing program with family and friends followed by a meet-and-greet session and photo opportunities with Surgeon General Satcher, Mr. Curt Coy, Director, Program Support Center (PSC), RADM Marlene Haffner (FDA), RADM Robert Harry (IHS), RADM R. Michael Davidson (DCP/PSC), and senior category officers.

A card reflecting the mood of the class was received in DCP. The cover of the card read: "What you did was wonderful – I guess we owe you one!" Inside the card, the following was handwritten: "Just to let you know how much we appreciated your informative instruction and support. Makes us proud and honored to belong to such an elite group as the "Surgeon General's Finest!" Thank you, thank you, thank you also for the fine graduation reception you all provided. I only wish my family could have been there. . . We were so in awe of all those who attended our graduation—to think, we had lunch with several Admirals who 'visited' with us as easily as co-workers in an office. Upon returning to our work sites and hectic lives, somehow it seems easier to tackle it now, because we've got your support."

The 5-Day BOTC programs are conducted approximately every other month in Rockville, Maryland, and in the Washington, D.C. Metro Area. Officers traveling from afar to the program are funded by their local duty sites which are subsequently reimbursed by DCP. This is a pilot program initiated by the COTA staff of DCP, greatly supported and helped personally by the Director of the PSC with funding from five PHS Agencies/Operating Divisions.

Information and future programs can be found at—http://dcp.psc.gov, 'Training', 'COTA', make your selection from the menu on the left.

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To Get All the Latest: Sign up for the PHS Nursing Listserv

Sign up for the Public Health Service Nursing Listserv and keep current on the latest happenings with nurses in the Department of Health and Human Services—for example, current job opportunities for nurses, nursing education and training opportunities, nursing news, Nursing Professional Advisory Committee meeting agenda and minutes, current events, etc.

Join the group by accessing—http://list.nih.gov/archives/phsnursing-l.html— and following the directions.

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Independent Officer Training Course Now Available on DCP Web Site

The Commissioned Officer Training Academy is pleased to announce that the Independent Officer Training Course (IOTC) is now available on the Division of Commissioned Personnel's (DCP) Web site at http://dcp.psc.gov, 'Training', 'COTA', select 'IOTC' from the menu on the left.

There are two parts to the IOTC. The first part (resources) is available to all officers. The second part (examination series) is a continuation of the Basic Officer Training Course (BOTC) and contains the instructions to secure a password to begin the examination series.

Officers enrolled in the IOTC will work at their own pace. Those undertaking intense study can conceivably complete the IOTC in 2 to 3 weeks. Officers working at a slower pace may complete the course work within an estimated 3 to 4 months.

Upon the successful completion of both the BOTC and IOTC, officers will be awarded the Public Health Service Commissioned Corps Training Ribbon.

The following is a listing of the BOTCs completed as of mid January 2002. All those officers who completed one of these BOTCs are eligible to receive a password. Please visit the DCP Web site—http://dcp.psc.gov—for additional information and instructions.

February 15-16, 2000 ..... Billings, MT
March 13-14, 2000 ..... Rockville, MD
April 3-4, 2000 ..... Rockville, MD
June 5-6, 2000 .. *(Commissioned Officers Association's Annual Meeting)* Scottsdale, AZ
July 26-27, 2000 ..... Oklahoma City, OK
August 2-4, 2000 ..... Rockville, MD
August 22-23, 2000 ..... Farmington, NM
September 12-13, 2000 ..... Albuquerque, NM
September 26-27, 2000 ..... *(Bremerton Naval Shipyard)* Bremerton, WA
November 1-2, 2000 ..... Aberdeen, SD
November 16-17, 2000 ..... *(Walter Reed Army Medical Center)* Washington, DC
December 5-7, 2000 ..... *(Bolger Center)* Potomac, MD
February 12-14, 2001 ..... Phoenix, AZ
February 21-March 9, 2001 ..... Rockville, MD
March 27-28, 2001 ..... Keams Canyon, AZ
May 1-2, 2001 ..... Cincinnati, OH
June 20-21, 2001 ..... *(Elmendorf AFB)* Anchorage, AK
July 18-20, 2001 ..... Rockville, MD
July 31-August 2, 2001 ..... Tucson, AZ
August 21-23, 2001 ..... Atlanta, GA
September 11-12, 2001 ..... Whiteriver, AZ
October 15-19, 2001 ..... Rockville, MD and Washington, DC
October 22-24, 2001 ..... Rockville, MD and Bethesda, MD
November 27-29, 2001 ..... Rockville, MD
December 11-13, 2001 ..... Rockville, MD
January 8-10, 2002 ..... Baton Rouge, LA

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Call for Nominations for PHS Pharmacist Awards

The Public Health Service (PHS) Pharmacist Professional Advisory Committee (PharmPAC) recognizes outstanding PHS pharmacists each year. This is a reminder that nominations for full-time PHS commissioned corps or civilian pharmacists for these prestigious awards are due **February 1, 2002**.

Pharmacists should pay *strict* attention to the instructions and criteria posted on the PharmPAC Web site— http://www.hhs.gov/progorg/pharmacy/main.html. It is the position of the PharmPAC that these deadlines will *not* be extended. Self-nominations are acceptable for all awards except the "George F. Archambault PHS Career Achievement Award in Pharmacy."

The PharmPAC strongly encourages supervisors to discuss these awards with pharmacists who meet the eligibility criteria and work with them to develop a suitable nomination packet in a timely manner. Questions may be referred to:

CAPT Kathleen Downs
PharmPAC Awards Chair
Phone: 301-443-1167 x954
E-mail: kdowns@osophs.dhhs.gov

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Deadline for Submission of Applications for Assimilation into the Regular Corps

Applications for assimilation into the Regular Corps must be received in the Division of Commissioned Personnel (DCP) by the close of business on Friday, **February 15, 2002**, in order to be reviewed by the 2002 board. *Note: Please see page 4 of the December 2001 issue of the Commissioned Corps Bulletin for more information.*

If you have any questions regarding assimilation, please contact LT Teresa Watkins in the Officer Support Branch, DCP, at 301-594-3108 (or toll-free at 1-877-INFO-DCP, listen to the prompts, select option #1, dial 43108).

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Commissioned Corps Readiness Force

Changes in the CCRF Operations Plan

Submitted by CAPT John Babb

On January 1, 2002, changes were scheduled to go into effect regarding the definition of a "deployable" officer in the Commissioned Corps Readiness Force (CCRF). For a variety of reasons, we found that many CCRF members had not met these new requirements. In that regard, the CCRF recently met with the CCRF Policy Advisory Board (Chief Professional Officers and the Office of the Surgeon General) to obtain their approval for a waiver request to go forward to Dr. David Satcher, Surgeon General. The CCRF Policy Advisory Board endorsed the request, and on December 11, 2001, it was approved by the Surgeon General. The approved changes are addressed below.

Discussion: Even though the current membership requirements for CCRF officers were approved by the Surgeon General in February 2001, we have found that many officers have not fulfilled those requirements. I will be the first to admit that those requirements are ambitious. We advocated moving from deployment requirements wherein officers only needed current licensure, Basic Life Support certification, and a record of logging into our Web site on a regular basis, to requirements that stressed training, fitness, appearance, public health protection (immunizations), and clinical currency. While many CCRF officers applauded these concepts, and vigorously applied themselves toward attaining this new level of readiness, many did not. Some of this is our fault. Regarding clinical currency, we have been unable to finalize agreements with some Agencies/Operating Divisions (OPDIVs)/Programs to accept officers for temporary duty (TDY) assignments. In fact, St. Elizabeths Hospital has offered opportunities to officers in all categories, the Indian Health Service has extended opportunities to pharmacists, and the Division of Immigration Health Services has TDY assignments for physicians, nurses, and physician assistants to satisfy their currency requirements. Agreements with other Agencies/OPDIVs/Programs are still not quite finalized. This is not to imply that many of you did not find opportunities on your own initiative—whether in other PHS Agencies/OPDIVs or in the private sector. But again, many did not.

Also, some of the requirements we have asked you to meet have not been tracked on our Web site. For several months we have been awaiting the implementation of a new enterprise information system, and it seemed like a duplication of effort for us to create a new program to collect this data rather than wait on the new system. The events of the last 3 months, plus our response to Tropical Storm Allison during the summer, delayed all our well-laid plans. Hence, until recently we have not had any way to record officers' height/weight nor currency information.

The net result is that we went to the CCRF Policy Advisory Board with an adjusted plan to implement the improvements to our program. This body approved the changes, which we then forwarded to the Surgeon General for his endorsement.

Recommendation: Make the following changes to the CCRF Operations Plan, such that members of the CCRF are divided into *Candidates (*not normally deployable*), Roster-Qualified (*conditionally deployable*), and Fully-Qualified (*deployable and eligible to receive the Field Medical Readiness Badge):

Roster-Qualified

- Completed Basic Life Support.
- Completed CCRF Physical Fitness Test.
- Completed four (4) basic Web-based training modules.
- Physical exam on file no older than 5 years.
- Report annual practice hours per deployment role.
- Height/weight reported on CCRF Web site.
- Hep A and Hep B started, all other immunizations completed.

Fully-Qualified

- Completed Basic Life Support.
- Completed CCRF Physical Fitness Test.
- Completed **all** Web-based training modules.
- Physical exam on file no older than 5 years.
- Completed 112 hours annually in deployment role.
- Height/weight meet the Commissioned Corps commissioning standards.
- All immunizations completed.

Let me address the specific changes—

A CCRF *Candidate* will, as previously, be considered such if the officer possesses a current license, has currency in Basic Life Support, and has updated his/her information on the CCRF Web site within the last 6 months. CCRF candidates' names will be provided to our contractor, the University of Maryland, Baltimore County, to allow them access to the Web-based training modules available on the CCRF Web site on a monthly basis.

In order to be considered eligible to deploy, officers must be either *roster-qualified* or *fully-qualified*.

In order to be designated as roster-qualified, officers must complete a minimum of the following Web-based training modules: CCRF Overview, Disaster Response, National Disaster Medical System (NDMS) in Review, and Disaster Medical Assistance Team (DMAT) Roles and Responsibilities. **This represents a temporary change.** In order to be designated as fully-qualified, officers must complete all Web-based training modules. Not all modules have been posted to the Web site. Until all modules are posted, no one is considered fully-qualified. Several of you have completed all the courses that are currently posted. We are certainly pleased with that. However, please bear with us. Other modules will soon be posted that will complete the program. Furthermore, officers in many

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Commissioned Corps Readiness Force

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categories will receive continuing education credits for many of the courses, once the entire program is completed. You should also know that we reserve the right to make deployment selections based on whether or not officers have completed specific modules (i.e., officers deploying to the Winter Olympics are required to take a number of modules, among them "Cold Weather Injuries").

Both roster-qualified **and** fully-qualified personnel will be required to have a physical exam on file with the Medical Affairs Branch in the Division of Commissioned Personnel (DCP) no older than 5 years. **This represents a change.** Previously, our Operations Plan called for a physical exam every 2 years. The 2-year time frame is not compatible with other branches of the Uniformed Services, nor with the current policy of DCP.

Officers designated as roster-qualified must report their annual practice hours on the CCRF Web site before January 1, 2002. Officers who are fully-qualified must record a minimum of 112 hours annually in their category role. **This represents a temporary change.** Previously, all officers on a roster were to have completed a minimum of 112 clinical hours annually, starting January 1, 2002. Once again, we reserve the right to make deployment selections based on whether or not officers have sufficient clinical practice hours in their deployment role. It is certainly in everyone's best interest if all officers move toward fully-qualified status in this requirement.

Officers designated as roster-qualified must report their height/weight on the CCRF Web site. Officers who are fully-qualified must meet the Public Health Service (PHS) Commissioning Standards for height/weight. **This represents a temporary change.** Discussions are ongoing about moving toward utilizing the body mass index (BMI) as a qualifier rather than height/weight. If and when DCP elects to use BMI in the PHS Commissioning Standards, CCRF will follow suit. Again, CCRF reserves the right to make deployment selections based on height/weight when the officer's role puts him/her in the public eye.

You should also know that CCRF will utilize officers who are fully-qualified first, before going to those who are roster-qualified.

In addition to the above qualifications, to be considered roster-qualified or fully-qualified, officers must be screened and approved by DCP, their respective Chief Professional Officer, and their current supervisor before being placed on a roster.

When the Surgeon General approved these changes, he added the following condition, "The criteria for Roster-Qualified will expire on January 1, 2003. On that date, all CCRF members must be Fully-Qualified." I interpret that to mean that in 1 year, officers will either be *Candidates* or they will be *Fully-Qualified*. There will be no transitional status. That is why three changes cited above state, "This is a temporary change." In order to deploy after January 1, 2003, officers must be fully-qualified. You are referred to the listings above for the description of a fully-qualified CCRF member.

CCRF officers continue to support the Department of Health and Human Services Secretary's Command Center and the Office of Homeland Security's Emergency Operations Center. If you live within daily commuting distance of downtown Washington, DC, and would like to serve in either of these areas, please contact us—ccrf@osophs.dhhs.gov.

Several actions are being pursued regarding the utilization of the CCRF since September 11, 2001.

- Supervisors of deployed officers may have already received a letter expressing appreciation for their support of the program.
- Chief Professional Officers are encouraging Agency/OPDIV/Programs decision-makers to continue to support their officers' involvement in CCRF.
- CCRF staff will continue to make presentations to Agencies/OPDIV/Programs, PHS Regional Offices, and professional groups regarding the contributions of CCRF officers.
- Several articles are being published in professional journals to address the involvement of PHS commissioned officers in the Department's response.
- Recognition for deployed officers is being sought through the PHS awards program.

To those hundreds of CCRF officers who made so many contributions to our Nation in these past 3 months, I can't begin to thank you enough. To those of you who were not able to participate, we will undoubtedly be calling you in the future. Review the roster requirements and prepare yourself—the President says we've only just begun.

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Recent Deaths

Note: To report the death of a retired officer or an annuitant to the Division of Commissioned Personnel (DCP), please phone 1-800-638-8744.

The deaths of the following retired officers were recently reported to DCP:

Title/Name	*Date*
MEDICAL	
CAPTAIN	
Milo O. Blade	11/30/01
Lydia B. Edwards	11/07/01
DENTAL	
CAPTAIN	
Isadore J. Jarin	11/12/01
H. R. Stanley, Jr.	11/10/01
ENGINEER	
CAPTAIN	
Henry J. L. Rechen	11/22/01
SCIENTIST	
CAPTAIN	
Bernard Brookman	11/13/01

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12/12/2001 MANUAL CIRCULAR - COMMISSIONED CORPS PERSONNEL PHS NO. 368

SUBJECT: Annual Leave-Implementation of Special Leave Accrual Policy and Amendment

1. Purpose

   The purpose of this Manual Circular is to implement the Public Health Service (PHS) Commissioned Corps' special leave accrual policy and amend INSTRUCTION CC29.1-I2-D2 in order to assist active-duty officers who would lose entitlement to excess annual leave because of the September 11, 2001 attacks on the United States and its aftermath. The policy will authorize active-duty officers who were unable to take annual leave because of the national emergency to carry up to 90 annual leave days from one calendar year to the next: Provided, that all officers will be required to use accumulated annual leave in excess of 60 days before the end of the third calendar year after service is terminated (before December 31, 2004).

   This Manual Circular will remain in effect for 1 year from the date of issuance or until the INSTRUCTION is revised and signed, whichever occurs earlier.

2. Authorities
   a. Section 215 (b) of the PHS Act (42 U.S.C. 216(b)); Note that authority to administer the PHS Commissioned Corps personnel system has been delegated to the Surgeon General (SG). See 53 FR 3457 (February 5, 1988) and 53 FR 5046-5047 (February 19, 1988).
   b. Section 219 of the PHS Act (42 U.S.C. 210-1).
   c. 10 U.S.C. 701(f)(1). See also Historical and Statutory Note referencing the PHS.
   d. INSTRUCTION CC29.1-I2, "Annual Leave."

3. Policy

   On September 14, 2001, President George W. Bush declared a "National Emergency by Reason of Certain Terrorist Attacks" on the World Trade Center and the Pentagon in response to the unprecedented attacks which occurred on September 11, 2001. Since then, the efforts toward response and recovery, and the continuing and immediate threat of further attacks on the United States have found many Federal agencies and the PHS Commissioned Corps involved in activities vital to our Nation. Therefore, under the current circumstances active-duty PHS officers who were unable to take annual leave from September 11, 2001 until December 31, 2001 are hereby deemed to fall within the scope of 10 U.S.C. 701 (f)(1) and may accumulate in excess of 60 days annual leave (up to 90 days annual leave) beyond December 31, 2001. Officers relying upon this policy are required however, to use their accumulated leave in excess of 60 days before the end of the third calendar year after service is terminated (not later than December 31, 2004).

   In addition, while this policy grants officers the right to accumulate in excess of 60 days annual leave under the circumstances specified above, this Manual Circular does not grant authority for officers to accumulate more annual leave days than they had accumulated as of December 31, 2001. For example, if an officer has 75 days of annual leave as of December 31, 2001, the officer may carry 75 annual leave days into the next calendar year (January 1, 2002-December 31, 2002), but may not carry more than 75 days of annual leave into the succeeding calendar year (starting January 1, 2003). As a result, if the officer has 80 days of annual leave at the end of calendar year 2002 (December 31, 2002), the officer would lose 5 days of annual leave starting on January 1, 2003. Because of this potential loss of annual leave days, officers are reminded that each officer has a responsibility to manage his or her leave program and should take measures to insure that his or her annual leave days are used on an ongoing basis in accordance with INSTRUCTION CC29.1-I2.

   Officers are also reminded that there is a lifetime limit of 60 days of unused annual leave for which the officer may receive a lump sum leave payment at the time of his or her separation from active duty. (See 37 U.S.C. 501(f)). Accordingly, it is imperative that each officer exercise due diligence with respect to his or her leave program so that the officer does not lose any benefits that he or she may have accrued under the commissioned corps' annual leave program.

   Since the national emergency is still ongoing, determinations for leave accrued during calendar year 2002 will be addressed at a later date.

   Finally, INSTRUCTION CC29.1-I2-D2, "Annual Leave" is hereby amended as follows:

   2. Maximum Accumulation and Special Leave Accrual Policy

      Annual leave days that have accrued during a leave year but are unused at the end of such year are to be carried forward as accumulated leave for use in succeeding leave years. The maximum annual leave amount that may be carried forward from one leave year to the next is 60 days: Provided however, that an officer may be authorized to accumulate up to 90 annual leave days in circumstances where the special leave accrual provisions of 10 U.S.C. 701 apply.

Surgeon General

EXPIRATION DATE: December 12, 2002 or until INSTRUCTION is revised.

DISTRIBUTION: MS:CC1-1A (Management and Administrative Audience)
MS:CC2 (Active-Duty Commissioned Officer Audience)

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BCOAG's Call for Nominations for Awards

Call for Nominations for BCOAG's Annual George I. Lythcott Award

The Black Commissioned Officers Advisory Group (BCOAG) established the George I. Lythcott Award in May 1996 in memory of RADM George I. Lythcott, M.D. (1918-1995). RADM Lythcott was the first African American Public Health Service (PHS) Commissioned Corps officer appointed to head a PHS agency, the Health Services Administration. Throughout his PHS career, he championed career ladder opportunities for junior grade PHS employees and significantly expanded initiatives to assist the Nation's medically underserved.

This award is designed to recognize an individual who demonstrates a genuine sense of public service and leadership initiative, and whose contributions enhance the health status of medically underserved populations. Any PHS Commissioned Corps officer (Grade O-2, O-3, or O-4) with a minimum of 5 years of service in the corps is eligible.

Nominations are encouraged from all Agency/Operating Divisions (OPDIVs)/ Programs and must describe how the candidate has met the following criteria:

- Contributions to program and Agency/ OPDIV/Program objectives have reflected sustained high performance;
- Work performance or a single important achievement has been characterized by outstanding leadership initiative and/or the application of unique skills and creativity;
- Overall work performance or a single activity has clearly contributed to the mission of PHS;
- Participation in activities within or outside PHS that had a positive impact on improving the health status of the Nation's medically underserved populations; and
- Performance has continuously demonstrated a genuine sense of public service and professional integrity.

An original and four copies of the nomination form and a narrative justification (not to exceed two pages) are required. The nominee's curriculum vitae will be requested at a later date if needed.

Call for Nominations for BCOAG's Annual Hildrus A. Poindexter Award

BCOAG established the Hildrus A. Poindexter Award in 1990 in memory of the late CAPT Hildrus A. Poindexter, M.D., Ph.D., M.S.P.H., Sc.D., (1901-1987). CAPT Poindexter was an exemplary PHS Commissioned Corps officer, humanitarian, clinician, educator, and world renowned scientist. His commitment and service record in support of the medically underserved throughout the world significantly enhanced the positive image of the PHS. He was an excellent role model for all involved in service to the world's disenfranchised.

This award was established to recognize a commissioned officer or civil servant (with a minimum of 7 years service within PHS) for continued outstanding service that enhanced the health of minority or underserved populations.

Each nominator must describe how the candidate has met four of the following criteria:

- Demonstrated significant contributions toward improving the health status of African Americans and other minorities in the United States;
- Continually demonstrates exceptional dedication to the mission of PHS;
- Demonstrated outstanding leadership (academically, administratively, programmatically, and/or internationally);
- Demonstrated excellence in his/her professional field; and
- Demonstrated significant professional and humanitarian contributions to raising the living standards of the disenfranchised in communities within the United States and abroad.

An original and four copies of the nomination form and a narrative justification (not to exceed two pages) are required. The nominee's curriculum vitae will be requested at a later date if needed.

Call for Nominations for BCOAG's Annual Retired Officers Recognition Award

The BCOAG Retired Officers Recognition Award was established in 1998. This award is designed to recognize retired African American PHS Commissioned Corps officers who served with distinction for a decade or more and fostered the mission of the PHS.

Two individuals are recognized each year by their peers. The nomination must include documented evidence of outstanding service as a corps officer, and significant contributions to community and/or public health that served to enhance the quality of life for the disenfranchised in the United States and/or abroad. Priority is given to those nominees who have continued to make significant public health contributions during their retirement from the PHS.

How to Request Blank Nomination Forms

Please request that the appropriate blank nomination form(s) be faxed to you by using the Faxback feature of *CorpsLine*. You can reach *CorpsLine* at 301-443-6843. Listen to the menu and choose the option "To retrieve documents through Faxback," and request document number—

6532 for the Lythcott Award;

6531 for the Poindexter Award; and

6601 for the Retired Officers Recognition Award.

Deadline Date and Address to Send Nominations

To be considered, nominations for any of the above awards must be received at the following address by the close of business on Friday, **February 1, 2002**:

CAPT Wendell Wainwright
5600 Fishers Lane, Room 7A-30
Rockville, MD 20857-0001
Phone: 301-443-1325
Fax: 301-443-1884

Presentation of Awards

The George I. Lythcott Award, Hildrus A. Poindexter Award, and Retired Officers Recognition Award will be presented at the Commissioned Officers Association's 2002 Public Health Professional Conference in Atlanta, Georgia, April 21-24, 2002. The actual time and location will be announced later.

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COMPENSATION BRANCH NEWS

Commissioned Officer Compensation

Changes in Active-Duty Compensation

As of the date this article went to press, the 2002 National Defense Authorization Act (NDAA) had not been approved but was projected to be signed by the President on December 26, 2001. With this in mind, the compensation changes presented in this article are based on the bill presented to the President for signature.

Effective January 1, 2002, the rate for Basic Pay increases by 5.0% for most officers; however, the increase will be as much as 6.5% for some mid grade officers. A draft of the pay table for 2002 is published in this issue of the *Commissioned Corps Bulletin* and can also be found on the Division of Commissioned Personnel's (DCP) Web site—http://dcp.psc.gov. Recently, a separate "Payroll Issues" section was added to the DCP home page, and is being used to post current information pertaining to Public Health Service (PHS) compensation.

The 2002 Basic Allowance for Housing (BAH) rates are based on the fiscal 2001 authorization. Therefore, the new rates will take effect regardless of the fiscal 2002 NDAA status. BAH rates are calculated based on median rent (not mortgage costs) plus average utilities and insurance in each local area for rank and dependency status. Last year marked the beginning of a multiyear effort to reduce the out-of-pocket housing cost burden currently placed on Service members. Rates for 2002 are to increase an average of 10%, but local market declines may prevent a BAH rate increase in some areas. Rates will not decline in any location. Refer to the *"Allowances"* portion of this article to find out more about BAH and where to check the rate at your duty assignment.

Like with BAH rates, fiscal 2002 Basic Allowance for Subsistence (BAS) rates are also based on last year's NDAA. BAS rates are now linked to a food cost growth index measured by the U.S. Department of Agriculture. The 2002 BAS monthly rate is estimated at $166.37.

The Thrift Savings Plan (TSP) for Uniformed Service members has begun. The TSP is intended to be a supplement to existing Uniformed Services retirement plans, not a replacement. Under the plan, officers will be able to deposit up to 7% of base pay, along with 100% of special pay and bonuses up to a combined ceiling of $11,000 per year (there are ongoing attempts to legislate an increase in the annual TSP deposit limit). The initial open season for TSP enrollment began October 9, 2001, and will continue through January 31, 2002. The first TSP account deposits will occur in January 2002. Additional details on the TSP are available at the TSP Web site at – http://www.tsp.gov. Information specific to PHS officers can be found at the DCP Web site.

Information on changes in medical officers special pay, including the new rates, can be found in a separate article on page 16 of this issue of the *Commissioned Corps Bulletin*.

Information concerning changes in pay will be published in the *Commissioned Corps Bulletin* throughout the year. Current information on pay will also be placed under "Payroll Issues" on the DCP Web site at – http://dcp.psc.gov. Enrollment on the DCP Listserver will provide you with e-mail notification of all significant new postings on the DCP Web site. Go to the DCP Web site for instructions on how to enroll.

Retired Cost of Living Adjustment

Effective December 1, 2001, payable January 2, 2002, retirees will be receiving a 2.6% cost of living adjustment (COLA) if their retired pay was computed using the active-duty rates that were in effect prior to January 1, 2001. Officers that initially became a member of a Uniformed Service before September 8, 1980, and whose retired pay is computed on a pay cell of the January 1, 2001 pay table, will receive a COLA of 2.0%. Officers first called to active duty after September 8, 1980, and retiring in the 1st quarter of 2001 will receive a COLA of 2.0%, while those with 2nd, 3rd and 4th quarter retirements will receive 1.1%, 0.0%, or 0.0% respectively.

Most survivors who are receiving an annuity under the Survivor Benefit Plan (SBP) or the *indexed* Retired Servicemember's Family Protection Plan (RSFPP) will receive an increase of 2.6% while the rest will receive lesser amounts depending on the Servicemember's initial call-to-duty date, retirement date, and date of death.

Annual Earnings Statements (Form W-2 or 1099R)

Annual earning statements (W-2 for active duty and 1099R for retirees) are scheduled to be mailed at the end of January. Officers should receive their Form W-2 and retirees their Form 1099R by the first week of February for use in filing their income tax returns. If you do not receive an earnings statement or if there are errors, please contact the Compensation Branch in writing or by phone. Also be sure to notify the Compensation Branch, in writing, if you have changed your payroll address. The statements will be mailed to the same address as your monthly earnings statement, i.e., your payroll address.

The address and phone number for the Compensation Branch are as follows:

Division of Commissioned Personnel
ATTN: Compensation Branch
5600 Fishers Lane, Room 4-50
Rockville, MD 20857-0001
Phone: 301-594-2963 (or toll-free 1-877-INFO-DCP, listen to the prompts, select option #1, dial 42963)

General Payroll Information

The compensation of commissioned officers consists of two elements – pay and allowances. The pay portion is taxable income while the allowances are usually non-taxable. This section describes the various pay elements and reflects the changes authorized by the proposed NDAA for Fiscal Year 2002.

Basic Pay

Basic Pay is considered to be the officer's actual salary. It is subject to Federal income tax, Social Security tax (FICA), and in most cases, State income tax. The rate of Basic Pay received is based on the officer's temporary grade and the Base Pay Entry Date (BPED) printed on the officer's call-to-active-duty personnel order. The BPED date is usually your call-to-active-duty date; however, it may be adjusted for prior service in other Uniformed Services. The second date that is important to you is the Training and Experience Date (TED). This date appears on your call-to-active-duty personnel order and reflects your creditable training and experience related to your health specialty and determines your rank and eligibility for promotion. Your initial rate of Basic Pay is determined by your BPED and your rank. Subsequent increases in base pay result from length of service and promotion to the next higher rank.

Special Pay

There are a number of special pays that are applicable to several categories. Veterinary and optometry officers are eligible to receive $100 per month special pay. Special pays for medical officers include Retention Special Pay (RSP), Variable Special Pay

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Commissioned Officer Compensation

(Continued from page 9)

(VSP), Board Certified Pay (BCP), Incentive Special Pay (ISP), and Multiyear Retention Bonus (MRB). Note: Included in this issue of the *Commissioned Corps Bulletin* is an article titled "*Changes Announced for Medical Officers Special Pays.*" Dental officers are eligible for VSP, BCP, MRB, and Additional Special Pay (ASP) as well as an accession bonus. Engineering and scientist officers may be eligible to receive Engineering and Scientific Career Continuation Pay (ESCCP). Nurse Special Pay (NSP) includes a special pay for nurse anesthetists as well as an accession bonus. Pharmacist officers receive VSP and may be eligible for an accession bonus upon call-to-duty. Non-physician BCP may be authorized for certain officers, as defined below.

Variable Special Pay (VSP) is a monthly pay based on the pharmacy, medical, or dental officer's years of creditable service. The creditable service entry date (CSED) reflects the officer's years of active duty as a pharmacy, medical, or dental officer in any of the Uniformed Services. For medical and dental officers, CSED also includes the years spent participating in an accredited medical or dental internship/residency while not on active duty in a Uniformed Service. VSP rates range from $5,000 to $12,000 annually for medical officers and $3,000 to $12,000 for pharmacy and dental officers. The rate is determined by the length of creditable service.

Board Certified Pay (BCP) is a monthly pay based on the medical, dental, or veterinary officer's CSED and board certification. BCP ranges from $2,500 to $6,000 annually for medical officers or dental officers and $2,000 to $5,000 annually for veterinary officers. Officers must provide documentation in support of certification to receive this special pay.

Non-physician Board Certified Pay (NBCP) has been implemented by the PHS Commissioned Corps in the same manner as it has been in the other Uniformed Services. The payment of NBCP is authorized for recognized specialties that are above the normal entry level, and to be eligible a recipient must:

(1) be a healthcare provider in a specialty that is authorized to receive NBCP;

(2) have a post-baccalaureate degree in his or her clinical specialty; (MPH or MHA degrees do not substitute for your clinical specialty);

(3) be certified by a professional board in his or her clinical specialty; and

(4) meet the applicable criteria recognized by specialty boards.

The rates of pay range from $2,000 to $5,000 per year based on years of creditable service. NBCP is a taxable monthly pay, as are the other special pays.

Specialties eligible to receive NBCP include: nurse anesthetist, nurse practitioner, nurse midwife, radiological physics, dietetics, occupational therapy, optometry, pharmacy, physical therapy, podiatry, psychology, social work, audiology/speech pathology, and physician assistant.

If you meet the above criteria and are not already receiving NBCP, please submit a copy of your advanced degree certificate along with documentation of your board certification to the Compensation Branch.

Retention Special Pay (RSP) is a payment of $15,000 annually for medical officers who execute a contract to remain on active duty for a specified term of 1 or more years. The payment is made in a lump sum usually within 90 days of the effective date of the contract. If other bonus pay contracts are negotiated, they will have concurrent dating.

Incentive Special Pay (ISP) is a special bonus for certain medical officers that is paid annually based on medical specialty. ISP rates authorized by law, range from $2,000 to $36,000 per year for a 1-year contract. There is a provision to pay ISP for medical officers who execute an ISP contract to stay on active duty for a minimum of 1 year at an isolated hardship site or a hard-to-fill location. Officers serving at the eligible sites are notified of their eligibility when they are assigned. The amount for isolated hardship sites ranges from $11,000 to $19,000 annually based on the category of the site. The payment is made in an annual lump sum.

Multiyear Retention Bonus (MRB) is payable to medical officers at the rate of $2,000 to $14,000 depending on the specialty training and the duration of the contract.

Eligibility requirements for ISP and MRB include that a medical officer:

(1) Be entitled to receive RSP;

(2) Be in pay grade O-6 (CAPT) or below;

(3) Not be participating in Department of Health and Human Services (HHS)-supported long-term training as defined in INSTRUCTION 1, Subchapter CC25.2, "Extramural Training," of the Commissioned Corps Personnel Manual (CCPM);

(4) Be eligible to remain on active duty for the duration of the contract;

(5) Be board certified or fully trained in a recognized medical specialty;

(6) Have a current license to practice medicine or osteopathy;

(7) Not be serving obligated service as a result of training (applies to MRB only); and

(8) Enter into a contract to remain on active duty for 2-4 years. (Note that MRB and RSP contracts must have concurrent dates.)

Multiyear Retention Bonus (MRB) for dental officers is payable at the rate of $3,000 to $14,000 annually depending of the specialty training and the length of the contract. Eligibility criteria are similar to those for medical officers, listed above.

Additional Special Pay (ASP) is payable to dental officers who execute a contract to remain on active duty for at least 1 year. Amounts range from $4,000 to $15,000 per year payable in a lump sum annual payment.

Nurse Special Pay is a contract special pay for nurse anesthetists. At the discretion of the Agency/Operating Division/Program to which they are assigned, qualified nurse officers may sign a contract to remain on active duty for 1 year and may be paid an amount of $6,000 or $15,000 depending on their obligation to the Service.

Eligibility requirements include that a nurse officer must:

(1) Be a Certified Registered Nurse Anesthetist (CRNA);

(2) Be on active duty under a call or order to duty for not less than 1 year;

(3) Have a current and unrestricted State license as a registered professional nurse; and

(4) Sign an agreement to remain on active duty for 1 year.

Any questions regarding the nurse special pay should be directed to your Agency/Operating Division/Program Commissioned Corps Liaison or the Compensation Branch.

Accession Bonuses are authorized for registered nurses, pharmacists, and dentists who accept a commission as officers. Officers must sign a contract within 60 days of their call-to-active-duty, and agree to remain on active duty for a period of not less than 4 years. The amount of the accession bonus is $5,000 for nurses and $30,000 for pharmacists and dentists. To be eligible for the accession bonus, the officer must:

(1) Have a current and unrestricted license as a registered professional nurse, pharmacist, or dentist;

(Continued on page 11)

Commissioned Officer Compensation

(Continued from page 12)

in the Compensation Branch paying you at the "without" dependent rate. You will find that noting the MESSAGE on your pay slip may be as important as looking at the deposited amount!

Designation of Address -The PHS commissioned officer payroll system requires you to have your net salary credited directly to your account at a financial institution and to receive your Statement of Earnings and Deductions, U.S. Savings Bonds, and other personnel/payroll documents at a separate address of your choice. This method increases your privacy and provides for prompt, reliable, and secure delivery of important and confidential personnel/payroll documents.

To have your net salary credited to your account, complete form SF-1199A, "Direct Deposit Sign-Up Form," and have it authorized by the financial institution holding the account to which you want your salary credited. You must then submit the form to the Compensation Branch, along with the designation of an address for your other payroll documents. We recommend the address you designate be the same address you use to receive other types of mail. Our experience has shown that officers who use the duty organization address to receive the earning statements usually do not receive these documents as timely as those using a personal address.

The payroll address does not change when you transfer. You must notify the Compensation Branch, in writing, when you want your payroll address changed.

DO NOT FAX PAYROLL INFORMATION. Unless specifically requested, the Compensation Branch does not accept faxed information for updating pay records. Requests for changes to pay records, i.e., address changes, changes in marital status, and tax withholding must be in writing with an original signature in order for the Compensation Branch to process them. Changes should be received by the 10th of the month in order to provide time for the changes to be processed for the current month.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PAY AND ALLOWANCES OF PUBLIC HEALTH SERVICE
COMMISSIONED CORPS OFFICERS
EFFECTIVE JANUARY 1, 2002

MONTHLY RATES OF BASIC PAY
CUMULATIVE YEARS OF SERVICE

PAY GRADE	*2 OR LESS*	*OVER 2*	*OVER 3*	*OVER 4*	*OVER 6*	*OVER 8*	*OVER 10*	*OVER 12*	*OVER 14*	*OVER 16*	*OVER 18*	*OVER 20*	*OVER 22*	*OVER 24*	*OVER 26*
O-10												11601.90	11659.20	11901.30	12324.00
O-9												10147.50	10293.60	10504.80	10873.80
O-8	7180.20	7415.40	7571.10	7614.90	7809.30	8135.10	8210.70	8519.70	8608.50	8874.30	9259.50	9614.70	9852.00	9852.00	9852.00
O-7	5966.40	6371.70	6371.70	6418.20	6657.90	6840.30	7051.20	7261.80	7472.70	8135.10	8694.90	8694.90	8694.90	8694.90	8738.70
O-6	4422.00	4857.90	5176.80	5176.80	5196.60	5418.90	5448.60	5448.60	5628.60	6305.70	6627.00	6948.30	7131.00	7316.10	7675.20
O-5	3537.00	4152.60	4440.30	4494.30	4673.10	4673.10	4813.50	5073.30	5413.50	5755.80	5919.00	6079.80	6262.80	6262.80	6262.80
O-4	3023.70	3681.90	3927.60	3982.50	4210.50	4395.90	4696.20	4930.20	5092.50	5255.70	5310.60	5310.60	5310.60	5310.60	5310.60
O-3	2796.60	3170.40	3421.80	3698.70	3875.70	4070.10	4232.40	4441.20	4549.50	4549.50	4549.50	4549.50	4549.50	4549.50	4549.50
O-2	2416.20	2751.90	3169.50	3276.30	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10	3344.10
O-1	2097.60	2183.10	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50	2638.50

COMMISSIONED OFFICERS WHO HAVE BEEN CREDITED WITH OVER 4 YEARS ACTIVE SERVICE AS AN ENLISTED MEMBER

PAY GRADE	*OVER 4*	*OVER 6*	*OVER 8*	*OVER 10*	*OVER 12*	*OVER 14*	*OVER 16*	*OVER 18*	*OVER 20*	*OVER 22*	*OVER 24*	*OVER 26*
O-3E	3698.70	3875.70	4070.10	4232.40	4441.20	4617.00	4717.50	4855.20	4855.20	4855.20	4855.20	4855.20
O-2E	3276.30	3344.10	3450.30	3630.00	3768.90	3872.40	3872.40	3872.40	3872.40	3872.40	3872.40	3872.40
O-1E	2638.50	2818.20	2922.30	3028.50	3133.20	3276.30	3276.30	3276.30	3276.30	3276.30	3276.30	3276.30

Basic Allowance for Subsistence is $166.37 (Estimated amount; final amount not yet determined by the Department of Defense.)
Basic Pay for O-7 to O-10 is limited to Level III of the Executive Schedule
Basic Pay for O-6 and below is limited to Level V of the Executive Schedule

Air Transportation to the 2002 Public Health Professional Conference

The Health Services Professional Advisory Committee is again teaming with the Scientist Professional Advisory Committee to determine the level of interest of officers for military air transportation to the Public Health Professional Conference to be held in Atlanta, Georgia, April 21-25, 2002. As in the past, if a flight can be arranged, officers will be able to travel at no cost to themselves or their Agencies/Operating Divisions/Programs. However, the level of interest must be sufficient before a request will be considered. If a sufficient number of officers express an interest, transportation will be requested from Andrews Air Force Base in Maryland to Atlanta, Georgia. There is the possibility of a request to stop en route if there is enough participation to warrant it.

If you are considering attending the Atlanta meeting and are interested in this offer, please call or e-mail one of the officers listed below and leave the following information: name, rank, social security number, office telephone number, Agency/Operating Division/Program, location, and e-mail address. Once signed up, you will be kept informed of the flight status.

Priority for available seats will be on a first-come, first-served basis. Officers should understand that accepting transportation on military aircraft entails the following obligations: (1) you must have a valid ID card and the rank on your card must match the rank on your uniform; (2) in adherence to the policy of the Office of the Surgeon General, you must fly in the uniform of the day; (3) there may be limitations on the amount and type of luggage transported; (4) there are items which may not be transported, e.g., alcohol, firearms, or ammunition; and (5) dependents may not take this flight unless they are eligible in their own right based upon service in the Uniformed Services.

Remember, this solicitation is being used only to determine the level of interest. It is not a guarantee of transportation.

CAPT Linda Morris Brown
Phone: 301-594-7157
E-mail: brownl@mail.nih.gov

CAPT Ray Clark
Phone: 202-564-9198
E-mail: clark.ray@epa.gov

CAPT Mark Paris
Phone: 703-681-1133
E-mail: mark.paris@tma.osd.mil

LCDR Nelson Adekoya
Phone: 770-488-4642
E-mail: nba7@cdc.gov

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PHS Flag Flies Over the World Trade Center Site

CAPT Robert Davidson (left) and CAPT Bryan Jones (right) at the top of the Merrill Lynch Building as the Public Health Service flag flies over the World Trade Center site.

On October 3, 2001, the Public Health Service (PHS) flag began flying over the site of the World Trade Center disaster. CAPT Robert Davidson, the Deputy Regional Health Administrator for Region 2, and CAPT Bryan Jones, the Emergency Coordinator for Region 3, raised the flag beside the flags of the other Uniformed Services and the National Ensign on top of the Merrill Lynch Building. As part of the World Financial Center, the Merrill Lynch Building overlooks Ground Zero. It has been photographed many times because of a banner hanging over its side which reads, "We Will Never Forget."

Efforts to fly the PHS flag began when the flags of the five Armed Services had been hoisted over Ground Zero. RADM Robert Knouss, Director of the Office of Emergency Preparedness (OEP), was informed of the activity and he asked CAPT Davidson to put up a PHS flag with the others. However, there did not seem to be an appropriate PHS flag available for the situation.

CAPT Davidson located a flag maker. After a quick study of PHS flag regulations and a trip up a stairwell, accompanied by CAPT Jones, to the tenth floor of the Merrill Lynch building, he ordered a storm flag. The storm flag is the smallest flag described in the Commissioned Corps Personnel Manual and was most appropriate for this situation since it can be flown at all times because it is made of nylon. The storm flag is slightly larger than some of the flags it accompanies, but its measurements are the same as that of the U.S. Army flag.

The storm flag would take 2 weeks to be produced, so a temporary cotton flag was made within one day and was raised on October 3.

On October 16, CAPT Davidson, Mr. Ron Martin (a reservist from OEP), and Mr. Tim Tackett, the team leader of the Arkansas-1 DMAT (Disaster Medical Assistance Team), changed the temporary flag to the ensign that is still flying today.

On October 28, a memorial service was held at Ground Zero and was televised nationwide. During the service, the television cameras panned the area several times and focused on the flags as they flew over the rubble and over the "We Will Never Forget" banner.

CAPT Davidson remarked, "PHS has received more praise, I think, for its response to this disaster than I can ever recall. I hope that our flag will be recognized a little more as well."

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COMPENSATION BRANCH NEWS

Changes Announced for Medical Officers Special Pays

On **January 1, 2002**, the new rates for Medical Special Pay (MSP) went into effect. A major restructuring of special pay has been put in place for the 2002 contract rates. In a table at the end of this article, the new rates are listed by specialty and show the Incentive Special Pay (ISP) contract rate, the 2-year, 3-year, and 4-year Multiyear Retention Bonus (MRB) contract rates, and the amount of the change for the 2002 4-year rate compared to the 2001 4-year rate.

MSP has two major purposes. The first is to enhance retention and to attain an appropriate experience mix of physicians in each specialty. The second is to bring compensation levels for Uniformed Services physicians in line with their civilian counterparts. The MRB portion is designed to accomplish the first purpose, and the ISP portion is designed for the second. The rates for MRB and ISP are the same for all Uniformed Services.

Specific information regarding the rates will be distributed to the Agency/Operating Division (OPDIV)/Program Commissioned Corps Liaisons. Medical officers have two methods of receiving payment for special pay contracts. The **first method** is to receive the next annual installment of the present contract through the normal process of **recertification**. Medical officers are sent (via Commissioned Corps Liaisons) a recertification form. The recertification form must be processed through the officer's supervisory channels as in previous years. The **second method** is for medical officers to enter into a new MSP contract, subsequent to the expiration of the current contract, or as a renegotiation into a new MSP contract, if it is financially advantageous to them.

Renegotiations are authorized provided that the new contract extends beyond the current contract expiration date and the new rates are higher. When the medical officer has both MRB and ISP, **both rates must be for the same year and specialty**.

If you wish to renegotiate and you have not received a contract, you should:

- contact your Commissioned Corps Liaison to obtain a new medical special pay contract, *and*
- complete, sign, and notarize the contract, *and*
- submit it through the appropriate Agency/OPDIV/Program supervisory channels to the Compensation Branch, Division of Commissioned Personnel.

NOTE: Contracts must be notarized on or before January 1 in order to receive a January 1 effective date.

Eligibility requirements are unchanged and include:

1. Be entitled to Retention Special Pay (RSP);
2. Be in pay grade O-6 or below;
3. Not be participating in Department of Health and Human Services (HHS)-supported long-term training;
4. Not be serving obligated service pursuant to participation in an HHS-supported scholarship or training program (applies to MRB only);
5. Be eligible to remain on active duty for the specified term of the contract;
6. Hold a current, valid license to practice medicine or osteopathy;
7. Be board certified or fully trained in a medical specialty; and
8. Be capable of undertaking the clinical practice of his/her specialty.

Officers are reminded that they **cannot retire** for the duration of their MSP contracts. However, you may prospectively renegotiate your contract to align for a planned future retirement date.

Specific information for both MRB and ISP are detailed in INSTRUCTIONs 9 and 10, Subchapter CC22.2 of the Commissioned Corps Personnel Manual (CCPM). You may review the CCPM online by accessing the DCP Web site (http://dcp.psc.gov). The RSP, MRB, and ISP contracts are combined into a single contract, form PHS-6300-1, "Medical Special Pay (MSP) Contract Request," which requires the officer's signature and notarization on the front, and the Agency/OPDIV/Program's approval on the reverse of the first page. The forms are available through your Commissioned Corps Liaison. Please note that the recertification forms for MSP have a section that must be completed by all officers who are on MRB and/or ISP contracts and who are not in a clinical billet (primary job = 81). This section requires the officer to specify where, when, and how much time was completed toward his/her clinical requirement. Officers in clinical billets or those officers whose billets have been approved as satisfying the clinical requirement are not required to complete this section. Specific instructions for completing form PHS-6300-1 and the recertification sheet will be sent to officers. Should you have any questions, please contact your Commissioned Corps Liaison.

Distribution of materials for recertification and renegotiation was accomplished in December 2001. Your request for a new contract or recertification should be submitted **through your supervisor and Commissioned Corps Liaison** for approval/processing prior to submission to the Compensation Branch.

The Compensation Branch has **90 days** from the date of receipt of the completed contract (including required attachments) or from the anniversary date, whichever is later, to process the contract. Every effort is made to process contracts and payments as quickly as possible, however, officers should not expect payment earlier than the February 2002 payroll (payable March 1). Contracts are processed in the order that they are received with processing priority given to recertifications in January and renegotiations in February. Payments are authorized by the issuance of personnel orders, so payment should not be expected until after personnel orders are issued and received.

For additional information, contact your Commissioned Corps Liaison or go to the DCP Web site—http://dcp.psc.gov—and visit the "Payroll Issues" menu where you can also obtain information on the Thrift Savings Plan.

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Call for Nominations for the Nursing PAC

The Nursing Professional Advisory Committee (PAC) is seeking new members. The Nursing PAC is composed of both Public Health Service (PHS) Commissioned Corps nurse officers and civil service nurses working in the Operating Divisions (OPDIVs) of the Department of Health and Human Services (HHS). The Nursing PAC serves as an active link between the Office of the Surgeon General and the nurses working in the various HHS and non-HHS programs.

The Nursing PAC is seeking dedicated, hardworking individuals for membership. You must be willing to actively participate for the duration of your term. The PAC encourages advance practice nurses to apply. Additionally, the PAC encourages those with less than 5 years of PHS experience to apply. To be eligible for membership, you must currently be a full-time nurse employee in one of the following OPDIVs/Programs where vacancies exist on the Nursing PAC:

- Health Resources and Services Administration (Two Representatives: One Field/One Headquarters)
- Indian Health Service (One Representative: Field)
- National Institutes of Health (Two Representatives: One Clinical/One Institutes)
- DC Commission on Mental Health (One Representative)

Please request that a blank nomination form be faxed to you by using the Faxback feature of *CorpsLine*. You can reach *CorpsLine* at 301-443-6843. Listen to the menu and choose the option "To retrieve documents through Faxback," and request document number **8000**.

Interested individuals should complete the form, have your supervisor sign, and submit it with a copy of your current curriculum vitae by **January 30, 2002**, to the address below. Submissions sent by facsimile machine or e-mail will also be accepted.

CDR Cheryl Chapman
Executive Secretary, PAC-N
5600 Fishers Lane, Room 4-04
Rockville, MD 20857-0001
Phone: 301-594-2729
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Mental Health Coordinator's Experience at the World Trade Center Terrorist Disaster Site

Submitted by CAPT Carol Coley,
Substance Abuse and Mental Health Services Administration

For a 2-week period beginning in early October, I was deployed through the Public Health Service's (PHS) Office of Emergency Preparedness to the World Trade Center Terrorist Disaster Site as the Mental Health Coordinator. My intention here is to provide a brief overview of my duties. But also, I want to share my experience with you from a heart and senses level.

Within my role as coordinator, I was responsible for providing mental health crisis services (including substance abuse) to the Federal agencies that were involved. Over the course of my stay I had a variety of PHS Commissioned Corps officers as team members. These clinicians and public health administrators came from St. Elizabeths, Indian Health Service, Immigration Health Services, Federal Bureau of Prisons, and the Substance Abuse and Mental Health Services Administration (SAMHSA). We came from all areas of the country.

My main "home" was the Management Support Team which occupied the top floor of a local Manhattan hotel. There we joined administrators, planners, physicians, nurses, pharmacists, morticians, veterinarians, logistics specialists, and many others. Within the Mental Health Assistance Team, we provided support to the Federal staff at Ground Zero (Disaster Medical Assistance Teams), the Medical Examiners (Disaster Mortuary Operations Response Teams), the local Burn Unit which had supplemental Veterans Affairs' nurses assisting, and the multitude of Federal agencies at the Disaster Field Office. One major service that we provided was Crisis Debriefing as the staff left New York City. As a related coordinator duty, I was the prime support for one of my colleagues during an emergency appendectomy. You just never know what may get put on your plate.

In addition, consultative services were provided at the City/State Office of Emergency Management and often included numerous New York City and New York State public agencies. One example of this collaboration was six Wellness Centers that New York City established. We provided a wealth of SAMHSA and other agencies' materials. On another occasion, New York City mobile crisis counselor services were arranged to assist the Federal Emergency Management Agency workers who were responding to toll-free calls from distraught survivors and their families.

Throughout this entire endeavor two things worked well for me as a mantra. One was to be very clear as to the mission and the other was to frequently think of the Serenity Prayer!

Let me help you to envision the sights, sounds, and smells. About a half mile out you begin to smell Ground Zero. The best way to describe it is a huge electrical fire combined with dust, asbestos, wet concrete, and diesel fumes. Reports continue to be released regarding other contaminants. There is a small perimeter where respirators are mandatory, but depending on the winds, you may need this equipment much earlier. There is a haze, but you really can't see anything in the air. However, if you look up you feel material falling into your eyes and they

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