Learning Objectives

- Describe the many different levels of Population Health
- Discuss the drivers & opportunities available to improve Population Health
- Identify the CDC’s and other Federal initiatives designed to support Population Health
CDC Strategic Directions

Improve health security at home and around the world

Better prevent the leading causes of illness, injury, disability, and death

Strengthen public health/health care collaboration
Definition of Population Health

- Kindig et al (adapted)
What are the Drivers?

**Leading Causes of Death†**
United States, 2008

- Heart Disease
- Cancer
- Chronic lower respiratory diseases
- Stroke
- Unintentional Injuries
- Alzheimer’s disease
- Diabetes
- Pneumonia/influenza
- Kidney Disease

**Actual Causes of Death†**
United States, 2000

- Tobacco
- Poor diet/Physical inactivity
- Alcohol consumption
- Microbial agents
- Toxic agents
- Motor vehicles
- Firearms
- Sexual behavior
- Illicit drug use


County-level Estimates of Diagnosed Diabetes among Adults aged ≥ 20 years: United States 2009

Age-adjusted percent

- 0 - 6.3
- 6.4 - 7.5
- 7.6 - 8.8
- 8.9 - 10.5
- ≥ 10.6

www.cdc.gov/diabetes
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010
(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
Graphs are state- and indicator-specific. State vs. US comparison, and racial/ethnic and education disparities depicted. Some estimates suppressed due to small sample sizes.
Map: Blood Pressure (Pennsylvania)

Percentage of Adults Aged >= 18 Years Who Reported Having High Blood Pressure, by County: 2011
Portable Network Graphics (.PNG) file format. One graphic file per mapped measure for each state. Total of 12 or 15 maps per state.
Map: Smoking Prevalence (Pennsylvania)
The context in which people make decisions about their health often depends on the risks and the resources in their neighborhoods.
PLACEMATTERS

Obesity (%)
- 16.1 - 27.3
- 27.4 - 29.8
- 29.9 - 31.6
- 31.7 - 33.8
- 33.9 - 45.6
Expanded Chronic Care Model

Community
- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action
- Self-Management/Develop Personal Skills
- Delivery System Design/Re-orient Health Services
- Decision Support
- Information Systems

Health System

Activated Community
- Informed Activated Patient

Population Health Outcomes/Functional and Clinical Outcomes

Productive Interactions and Relationships
Growing Challenges
Improving the Health of Attributed/Accountable Populations

State

Health System

Physician

State Population
State Employees
Medicaid Beneficiaries
Dual-Eligible Beneficiaries

Health Care Delivery System
Inpatients/Outpatients
Residents in Regions/Communities
ACO Enrollees

Patients (ambulatory/hospitalized)
Attributed in population based models
Dual-Eligible Beneficiaries
Categorization of Population Health Activities

- Bucket #1: Traditional Clinical Approaches
- Bucket #2: Innovative Patient-Centered Care
- Bucket #3: Community-Wide Health
#1: Traditional Clinical Approaches

Focused on Preventive care
Million Hearts – The Clinical Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>People at increased risk of cardiovascular events who are taking aspirin</td>
<td>47%</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>People with hypertension who have adequately controlled blood pressure</td>
<td>46%</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>People with high cholesterol who are effectively managed</td>
<td>33%</td>
</tr>
<tr>
<td>Smoking</td>
<td>People trying to quit smoking who get help</td>
<td>23%</td>
</tr>
</tbody>
</table>

*MMWR. 2011;60:1248-51*
#2: Innovative Patient-Centered Care

Focused on Preventive care
Community Health Workers

- Links health systems and communities
- Facilitates access to and improve quality and cultural competence of medical care
- Builds individual and community capacity for health by:
  - Increasing health knowledge and self-sufficiency of the patients
  - Serving as community health educators
  - Providing social support
  - Advocating for the health care needs of patients and communities
#2: Community-Wide Health

Focused on Preventive care
Million Hearts: Community-Wide Components

COMMUNITY PREVENTION
Reduce need for treatment

- Tobacco control
- Sodium reduction
- Trans fat elimination
CDC Supports Bucket 3: Partnerships to Improve Community Health (PICH)

- PICH (39 Awardees)
  - Multi-sectoral community coalitions in:
    - Large Cities and Urban
    - Small Cities and Counties
    - American-Indian tribes

Examples of Activities:
- Boston Public Health Commission - implement citywide strategies to improve built environment - opportunities for walking & biking
Scenario – Patient with asthma

- Bucket 1 – Diagnosis, rx action plan, medications, clinical guidance.

- Bucket 2 – Community health worker does home visit; assesses triggers, counsels patient; offers limited remediation.

- Bucket 3 – Community standards on housing; limits to indoor and outdoor pollutants; reductions in smoking rates.
Emerging Opportunity: Worksite Wellness
National Healthy Worksite Program (NHWP) – 2011-2015

A Comprehensive Workplace Health Program to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace established and evaluated comprehensive workplace health programs to improve the health of workers and their families.

The main program goals included:

– Reducing the risk of chronic disease among employees through science-based workplace health interventions and promising practices.
– Promoting sustainable and replicable workplace health activities such as establishing a worksite health committee, having senior leadership support, and forming community partnerships and health coalitions.
– Promoting peer-to-peer business mentoring.
What is The CDC Worksite Health ScoreCard?

A tool designed to help employers assess evidence-based health promotion interventions in their worksites to prevent heart disease, stroke, and related chronic conditions.

Available at:
http://www.cdc.gov/workplacehealthpromotion
http://www.cdc.gov/healthscorecard/index.html
http://www.cdc.gov/hsc
125 Yes/No questions assesses best practice health promotion interventions (policies, programs, environmental supports) in 16 topic areas

- Organizational supports
- Tobacco control
- Nutrition
- Physical activity
- Lactation Support
- Weight management
- Stress management
- Depression
- High blood pressure
- High cholesterol
- Diabetes
- Signs and symptoms of heart attack and stroke
- Emergency response to heart attack and stroke
- Occupational Health & Safety
- Vaccine-Preventable Diseases
- Community Resources
Program Strategies and Interventions

- Leadership support
- Culture
- Work climate
- Facilities that support health
- Access and opportunities
- Relationship with management / coworkers
- Social support
- Health behaviors
- Risk factors
- Current health status
- Leadership support
- Culture
- Work climate
- Health behaviors
- Risk factors
- Current health status
- Facilities that support health
- Access and opportunities
- Relationship with management / coworkers
- Social support
Somerset County, ME
Pierce County, WA
Kern County, CA
Shelby County, TN
Buchanan County, MO
Marion County, IN
Philadelphia County, PA
Somerset County, ME
Shelby County, TN
Harris County, TX
# Changes in Health ScoreCard Score of Active in Philadelphia Employers

<table>
<thead>
<tr>
<th>Employer Site</th>
<th>Employer Size</th>
<th>Employer Sector</th>
<th>2013 Overall Score</th>
<th>2015 Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer A</td>
<td>Large</td>
<td>Finance, Insurance &amp; Real Estate</td>
<td>128</td>
<td>201</td>
</tr>
<tr>
<td>Employer B</td>
<td>Large</td>
<td>Finance, Insurance &amp; Real Estate</td>
<td>128</td>
<td>201</td>
</tr>
<tr>
<td>Employer C</td>
<td>Large</td>
<td>Finance, Insurance &amp; Real Estate</td>
<td>131</td>
<td>201</td>
</tr>
<tr>
<td>Employer D</td>
<td>Large</td>
<td>Finance, Insurance &amp; Real Estate</td>
<td>126</td>
<td>200</td>
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</tbody>
</table>
## Changes in Health for Philadelphia Employees Who Participated in Both Assessments (2013 & 2015)

<table>
<thead>
<tr>
<th>Health Issues and Lifestyle Risks</th>
<th>2013</th>
<th>2015</th>
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</thead>
<tbody>
<tr>
<td><strong>Self-Reported Health Assessment Survey</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Smoker</td>
<td>10.0%</td>
<td>7.9%</td>
</tr>
<tr>
<td>No/low exercise</td>
<td>55.7%</td>
<td>45.0%</td>
</tr>
<tr>
<td>Fruit and Vegetable consumption (5+ per day)</td>
<td>7.9%</td>
<td>10.7%</td>
</tr>
<tr>
<td><strong>Biometric Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI: % overweight (BMI between 25.0 – 29.9)</td>
<td>37.1%</td>
<td>33.6%</td>
</tr>
<tr>
<td><strong>Culture &amp; Climate Survey</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, how safe do you think your workplace is (1 - extremely unsafe to 10 - extremely safe)</td>
<td>7.70</td>
<td>8.11</td>
</tr>
<tr>
<td>Overall, how supportive is your company of your personal health, (from 1 - extremely unsupportive to 10 - extremely supportive)?</td>
<td></td>
<td></td>
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<tr>
<td>N=140</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6.84</td>
<td>7.45</td>
</tr>
</tbody>
</table>
FEDERAL RESOURCES
What is State Innovation Model (SIM)?

- Testing the ability of state government to use their regulatory and policy levers to accelerate health transformation
  - Improve population health
  - Transform healthcare payment & delivery systems
  - Decrease total per capita health care spending

- Public and private collaboration with multi-payer and multi-stakeholder engagement

- Cooperative agreement between awardee and the Innovation Center

- Provides technical and financial assistance to provide better care and better health at lower cost through quality improvement to the state population
Note: The following R2 Model Design Awardees are NOT captured in this graphic: Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana Islands and the District of Columbia.
Health Care Innovation Award (HCIA)

Priority Areas: High Value Targets of Change

- Hypertension and Cardiovascular Disease, Diabetes, COPD, Asthma, HIV/AIDS
- Fall prevention in older adults
- Behaviors that reduce the risk for chronic disease
- Adherence and self management skills
- Broader models that link clinical care with community-based interventions
Health Care Innovation Award
HCIA
There are a number of programs in place focused on CMMI – identified priorities.

Examples include focusing on improving population health and outcomes with regard to childhood obesity, tobacco use, diabetes, behavioral health, oral health, and drug use.
Chronic Disease Self-Management Program

- Low-cost, community-based class for people with chronic diseases developed at Stanford University
- A CDC meta-analysis of CDSMP showed improvements in fatigue, depression, health distress, etc.
- CDC’s Arthritis Program funds 12 state arthritis programs that can offer CDSMP as a proven intervention
Health Resources and Services Administration
Community Health Workers Evidence-based Model Toolbox

COMMUNITY HEALTH WORKERS EVIDENCE-BASED MODELS TOOLBOX
HRSA OFFICE OF RURAL HEALTH POLICY

U.S. Department of Health and Human Services
Health Resources and Services Administration

August 2011
CDC Tools and Resources
Our health and well-being are products of not only the health care we receive and the choices we make, but also the places where we live, learn, work, and play. Community health improvement (CHI) is a process to identify and address the health needs of communities. Because working together has a greater impact on health and economic vitality than working alone, CHI brings together health care, public health, and other stakeholders to consider high-priority actions to improve community health.

The CDC Community Health Improvement Navigator (CHI Navigator) is a website for people who lead or participate in CHI work within hospitals and health systems, public health agencies, and other community organizations. It is a one-stop-shop that offers community stakeholders expert-vetted tools and resources for:

- Depicting visually the who, what, where, and how of improving community health
- Making the case for collaborative approaches to community health improvement
### Sortable Risk Factors and Health Indicators

The thirty three indicators are categorized in four groups. Click a column header to sort on that value.

<table>
<thead>
<tr>
<th></th>
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<td><strong>National Value</strong></td>
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<tr>
<td>National</td>
<td>6.1</td>
<td>173.7</td>
<td>37.9</td>
<td>12.5</td>
<td>5.3</td>
<td>13.2</td>
<td>10.7</td>
<td>169.0</td>
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<tr>
<td><strong>State Values</strong></td>
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<td></td>
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<tr>
<td>Alabama</td>
<td>8.2</td>
<td>228.7</td>
<td>49.4</td>
<td>13.3</td>
<td>8.3</td>
<td>11.8</td>
<td>17.9</td>
<td>187.8</td>
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<tr>
<td>Alaska</td>
<td>3.8</td>
<td>149.6</td>
<td>39.4</td>
<td>20.0</td>
<td>4.8</td>
<td>14.2</td>
<td>8.1</td>
<td>175.5</td>
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<tr>
<td>Arizona</td>
<td>5.9</td>
<td>150.3</td>
<td>30.6</td>
<td>17.9</td>
<td>6.4</td>
<td>16.9</td>
<td>12.6</td>
<td>148.5</td>
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<tr>
<td>Arkansas</td>
<td>7.4</td>
<td>213.8</td>
<td>50.6</td>
<td>16.1</td>
<td>7.4</td>
<td>12.6</td>
<td>18.7</td>
<td>191.1</td>
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<tr>
<td>California</td>
<td>4.8</td>
<td>159.0</td>
<td>36.4</td>
<td>10.5</td>
<td>5.0</td>
<td>10.7</td>
<td>7.5</td>
<td>152.0</td>
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<td>Colorado</td>
<td>5.6</td>
<td>129.8</td>
<td>34.6</td>
<td>17.6</td>
<td>3.7</td>
<td>16.1</td>
<td>9.1</td>
<td>143.9</td>
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<td>Connecticut</td>
<td>5.1</td>
<td>155.1</td>
<td>28.3</td>
<td>9.8</td>
<td>4.1</td>
<td>11.2</td>
<td>6.6</td>
<td>158.4</td>
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<td>Delaware</td>
<td>8.7</td>
<td>175.2</td>
<td>40.5</td>
<td>11.0</td>
<td>5.4</td>
<td>17.6</td>
<td>12.4</td>
<td>179.8</td>
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<tr>
<td><strong>District of Columbia</strong></td>
<td><strong>7.5</strong></td>
<td><strong>194.4</strong></td>
<td><strong>34.2</strong></td>
<td><strong>5.9</strong></td>
<td><strong>15.5</strong></td>
<td><strong>13.5</strong></td>
<td><strong>2.4</strong></td>
<td><strong>180.7</strong></td>
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<tr>
<td>Florida</td>
<td>6.4</td>
<td>153.1</td>
<td>31.5</td>
<td>14.1</td>
<td>6.3</td>
<td>15.4</td>
<td>12.6</td>
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<td>Georgia</td>
<td>6.8</td>
<td>182.5</td>
<td>42.6</td>
<td>11.8</td>
<td>6.3</td>
<td>10.7</td>
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<td>132.9</td>
<td>35.6</td>
<td>12.9</td>
<td>N/A</td>
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<td>9.1</td>
<td>138.1</td>
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<td>156.6</td>
<td>38.0</td>
<td>18.2</td>
<td>8.8</td>
<td>13.9</td>
<td>11.5</td>
<td>173.4</td>
</tr>
</tbody>
</table>
About the Prevention Status Reports

PSR | 2013  The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address the following important public health problems and concerns:

- Excessive Alcohol Use
- Food Safety
- Healthcare-Associated Infections
- Heart Disease and Stroke
- HIV
- Motor Vehicle Injuries
- Nutrition, Physical Activity, and Obesity
- Prescription Drug Overdose
- Teen Pregnancy
- Tobacco Use

See Also
- PSR Quick Start Guide
- PSR Fact Sheet [PDF 341K]
<table>
<thead>
<tr>
<th>HIV</th>
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<tbody>
<tr>
<td>State Medicaid reimbursement for routine HIV screening</td>
<td>Green</td>
</tr>
<tr>
<td>State HIV testing laws</td>
<td>Green</td>
</tr>
<tr>
<td>Reporting of CD4 and viral load data to state HIV surveillance program</td>
<td>Yellow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Motor Vehicle Injuries</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Seat belt law</td>
<td>Red</td>
</tr>
<tr>
<td>Child passenger restraint law</td>
<td>Yellow</td>
</tr>
<tr>
<td>Graduated driver licensing system</td>
<td>Red</td>
</tr>
<tr>
<td>Ignition interlock law</td>
<td>Yellow</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition, Physical Activity, and Obesity</th>
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<tbody>
<tr>
<td>Secondary schools not selling less nutritious foods and beverages</td>
<td>Yellow</td>
</tr>
<tr>
<td>State nutrition standards policy for foods and beverages sold or provided by state government agencies</td>
<td>Red</td>
</tr>
<tr>
<td>Inclusion of nutrition and physical activity standards in state regulations of licensed childcare facilities</td>
<td>Red</td>
</tr>
<tr>
<td>State physical education time requirement for high school students</td>
<td>Red</td>
</tr>
<tr>
<td>Average birth facility score for breastfeeding support</td>
<td>Red</td>
</tr>
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<table>
<thead>
<tr>
<th>Prescription Drug Overdose</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>State pain clinic law</td>
<td>Red</td>
</tr>
<tr>
<td>Prescription drug monitoring programs following selected best practices</td>
<td>Red</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Teen Pregnancy</th>
<th></th>
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<tbody>
<tr>
<td>Expansion of state Medicaid family planning eligibility</td>
<td>Yellow</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco Use</th>
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</tr>
</thead>
<tbody>
<tr>
<td>State cigarette excise tax</td>
<td>Yellow</td>
</tr>
<tr>
<td>Comprehensive state smoke-free policy</td>
<td>Red</td>
</tr>
</tbody>
</table>
New Publication: High School Completion Programs Improve Health
Programs improve long-term health for minority and low-income groups. Peer-reviewed journal publication now available online.

2015 Meetings
June 17–18
October 28–29

2016 Meetings

Annual Reports to Congress

Topics
Adolescent Health
Alcohol - Excessive Consumption
Asthma
Birth Defects
Cancer
Cardiovascular Disease
Diabetes
Emergency Preparedness
Health Communication
Health Equity
HIV/AIDS, STIs, Pregnancy
Mental Health
Motor Vehicle Injury
Nutrition
Obesity
Oral Health
Physical Activity
Social Environment
Tobacco
Vaccination
Violence
Worksites

What is The Community Guide?
The Guide to Community Preventive Services is a free resource to help you choose programs and policies to improve health and prevent disease in your community. Systematic reviews are used to answer these questions:

- Which program and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

Learn more about The Community Guide, collaborators involved in its development and dissemination, and methods used to conduct the systematic reviews.

Contact Us
- Email
- Address
# CDC Fellowship Opportunities

**Office of Public Health Scientific Services**  
**Center for Surveillance, Epidemiology and Laboratory Services**  
**Division of Scientific Education and Professional Development**

<table>
<thead>
<tr>
<th>Focus</th>
<th>Program</th>
<th>Education Eligibility Criteria</th>
<th>Other Eligibility Criteria</th>
<th>Citizenship</th>
<th>When to Apply</th>
<th>Duration</th>
<th>Program Start</th>
<th>Program Email and Web Address</th>
</tr>
</thead>
</table>
| Informatics in public health practice | Applied Public Health Informatics Fellowship (APHIF) | Master’s degree or PhD in informatics or epidemiology, statistics, computer science, information science, information systems, public health, medicine, nursing, health care, health policy, health services research | Certificate or coursework in public health informatics and experience in public health informatics | U.S. citizen or permanent resident | November to February | 1 year | June | Email: aphf@csue.org  
Web: [http://www.aphf.org](http://www.aphf.org) |
| Assignment at state or local health department | Applied Epidemiology Fellowship | Completed second or third year at an LCME or AOA-accredited school of medicine | N/A | U.S. citizen or permanent resident | September to December | 10 to 12 months | August | Email: CDCExperience@cdcfoundation.org  
Web: [www.cdc.gov/CDCExperienceFellowship](http://www.cdc.gov/CDCExperienceFellowship) |
| Applied epidemiology | The CDC Experience Applied Epidemiology Fellowship | N/A | U.S. citizen or permanent resident | May 1 to September 1 | 2 years | July | Email: FIS@cdc.gov  
Web: [www.cdc.gov/FIS](http://www.cdc.gov/FIS) |
| Applied epidemiology | Epidemic Intelligence Service (EIS) | Physicians, veterinarians, doctoral-level scientists, other health professionals—may require an MPH or equivalent | U.S. citizen or permanent resident | U.S. citizen, permanent resident, or foreign national | May 1 to September 1 | 2 years | July | Email: EpiElective@cdc.gov  
Web: [www.cdc.gov/EpiElective](http://www.cdc.gov/EpiElective) |
| Introduction to applied epidemiology, public health, and preventive medicine | Epidemiology Elective Program for Senior Medical and Veterinary Students | Fourth-year medical or veterinary student enrolled in an LCME, AOA, or AVMA-accredited school | Available a minimum of 6 weeks during the fall or spring semester | U.S. citizen or permanent resident | Fall semester: January to March  
Spring semester: January to May | at least 6 weeks | Fall semester: June  
Spring semester: January | Email: HubberFellowship@cdcfoundation.org  
Web: [www.cdc.gov/HubberFellowship](http://www.cdc.gov/HubberFellowship) |
| Population health in an international setting | CDC-Hubbell Global Health Fellowship | Third- or fourth-year medical or veterinary students enrolled in an LCME, AOA, or AVMA-accredited school | Varies, based on assignment | U.S. citizen or permanent resident | January to February | 6 to 12 weeks | Program starts July 1  
Assignment start dates vary | Email: PMF@cdc.gov  
Web: [www.cdc.gov/PMF](http://www.cdc.gov/PMF) |
| Leadership and management of public policy and programs | Presidential Management Fellows (PMF) Program | Master’s, law, or doctoral degree | N/A | U.S. citizen or permanent resident | November to December | 2 years | Start dates vary | Email: PMF@cdc.gov  
Web: [www.cdc.gov/PMF](http://www.cdc.gov/PMF) |
| Prevention effectiveness: health economics, decision analysis, and quantitative policy analysis | CDC Steven M. Teutsch Prevention Effectiveness Fellowship (PEF) | PhD-level degree in economics, public policy, health services research, operations research, industrial engineering, or other quantitative field. MD with appropriate experience | N/A | U.S. citizen, permanent resident, or foreign national | September to January | 2 years | August | Email: PEF@cdc.gov  
Web: [www.cdc.gov/PEF](http://www.cdc.gov/PEF) |
| Public health, general preventive medicine, leadership | Preventive Medicine Residency & Fellowship (PMRF) | Physicians, veterinarians, dentists, nurses, or physician assistants with an MPH or comparable degree | Must have experience comparable to CDC’s Epidemiologic Intelligence Service Program | U.S. citizen, permanent resident, or foreign national | July | 1 to 2 years | mid-June | Email: PreMed@cdc.gov  
Web: [www.cdc.gov/PreMed](http://www.cdc.gov/PreMed) |
| Informatics in public health practice | Public Health Informatics Fellowship Program (PHIFP) | Master’s degree or above in information or computer science, public health, or health-related discipline | 1 to 3 years experience in information or computer science and also in public health or related health-care profession (depending on degree) | U.S. citizen, permanent resident, or foreign national | July to November | 2 years | June | Email: PHIFP@cdc.gov  
Web: [www.cdc.gov/PHIFP](http://www.cdc.gov/PHIFP) |

For more fellowship opportunities at CDC go to [www.cdc.gov/Fellowships](http://www.cdc.gov/Fellowships).  
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