Howard Brown Health Success Story

2026

Impact Summary

Howard Brown Health Center (HBH) successfully launched its first National Diabetes Prevention Program (NDPP) cohort in May 2025, reaching its enrollment goal of 15 participants through MyChart outreach and provider referrals. Throughout the program, HBH monitored participant progress and documented the following outcomes:

8
Participants lost weight

9.7
Average weight lost (in pounds)

7
Participants increased physical activity

151
Average physical activity increase (in minutes)

Background

In May 2025, HBH launched its first NDPP cohort to expand access to diabetes prevention services for patients who may benefit from additional support managing their health. Prior to the launch of its first cohort, the HBH team conducted significant recruitment efforts across its six clinic sites. The team attended staff meetings and huddles, shared information through the provider newsletter, presented at provider meetings to encourage referrals, and used visual advertising, including flyers, palm cards, and clinic lobby screens.

Support

Along with support from the Illinois Public Health Institute (IPHI), the CDC provided significant content through its NDPP Customer Service Center, which supported HBH's implementation and technical assistance-related questions.

IPHI provided HBH with meaningful insight on NDPP implementation and what to expect based on data and experiences from other partners. This support helped HBH implement the program with an understanding that participant retention can be a challenge across many NDPPs. HBH was able to prepare for this by recruiting more participants than needed and providing a raffle as an incentive for engagement.

*CARES Cook County is a Centers for Disease Control and Prevention (CDC)-funded initiative convened by the Illinois Public Health Institute (IPHI) in partnership with healthcare and community-based partners across Cook County.



Illinois Public Health Institute

Approach

A strong project management foundation was needed for the successful launch of the NDPP. HBH began with a project design document outlining the following components:

- **Project summary**
- **Background on the issue**
- **Scope of work**
- **Objectives**
- **Constraints & assumptions**
- **Key stakeholders**
- **Key team members**
- **Deliverables**
- **Project details**
- **Timelines**
- **Program costs**

This document served as the central project resource, supporting the team's ability to remain organized and successfully launch the program, and continues to be updated to meet the program's needs. Creating a timeline was particularly useful, as it can now be replicated for each new cohort without duplicating work. The timeline specifies actions that should occur at the two-month mark, one-month mark, three-week mark, and other key milestones to keep the program on track.

For the first cohort, HBH established several referral pathways, including provider referrals, self-referrals through MyChart, self-referrals through printed materials with QR codes, and staff outreach using an electronic medical record (EMR) patient registry. The program also included raffles to encourage enrollment and participation. Interest in the program was high, resulting in more than 300 responses to the mass MyChart message.

Based on the experience of the first cohort, HBH adjusted its approach for the second cohort by focusing on provider referrals and printed materials. Participant feedback and staff lessons learned also informed several program updates:

1. **Attendance at session zero is a requirement to better gauge engagement and motivation of enrolled participants.**
2. **Participants must attend the first three sessions prior to receiving their introductory kit.**
3. **The first three sessions are in-person to kick off the program, then shift to Zoom while still offering a cadence of in-person sessions on a monthly or bi-monthly basis.**

Next Steps

For FY27, HBH is proposing a role realignment within its team to develop a Chronic Disease Prevention Education Specialist (CDPES) role to lead the NDPP, as well as other chronic disease prevention and management initiatives. Staff capacity has been one of the program's primary limitations, with most staff working outside of their core job responsibilities to support the project.

For the program's second cohort, which begins in May 2026, HBH will initiate Medicaid billing for NDPP services. The organization has established workflows within the EMR to support billing and has been meeting regularly with the EMR and billing teams to implement the process. Over time, HBH plans to gradually incorporate billing for Medicare and private insurance plans.