

Partnering with Patients and Hospitals on Financial Navigation: A Community-Based Organization Perspective (DuPage Health Coalition)

Core Problem: Why are patients who are qualified for financial assistance still accumulating medical debt?

Background

The DuPage Health Coalition (DHC) is a community-based health organization in DuPage County, Illinois that brings together hospitals, clinics, and local organizations to improve access to care for uninsured and underinsured residents. DHC functions as a systems coordinator and intermediary organization, aligning hospital financial assistance policies, supporting enrollment and navigation services, and helping patients move more seamlessly through insurance and billing systems. Over time, it has also played a role in identifying administrative barriers to care and working with health system partners to address them.

DHC's flagship program, [Access DuPage](#), has helped coordinate affordable health care services for more than 75,000 uninsured residents since it was established in 2001, including many who are ineligible for public insurance because of immigration status or other eligibility restrictions. Although DuPage County is an affluent community with high overall insurance coverage, Access DuPage continues to serve approximately 6,000 patients each year, reflecting persistent coverage gaps among lower-income residents and immigrant communities.

When developing Access DuPage, DHC leaders intentionally aligned program eligibility with participating hospitals' financial assistance policies so that eligible patients could access financial assistance and health care through a single, coordinated pathway. Although Illinois law [establishes](#) minimum financial assistance requirements for hospitals, individual hospitals may offer additional levels of assistance. DHC therefore works closely with hospital partners to maintain shared eligibility criteria and update them when hospital financial assistance policies change, keeping Access DuPage eligibility aligned with the assistance available through its hospital partners.

Because of these longstanding partnerships and aligned systems, DHC leaders initially assumed that relatively few enrolled patients would experience significant medical debt. A 2022 survey challenged that assumption, revealing that many households, including those already connected to Access DuPage services, continued to carry substantial medical debt from hospitals, physician practices, ambulance services, and other providers. Many families faced debts that exceeded what they could reasonably repay and were delaying or avoiding care.

Rather than viewing these findings as evidence that patients were not seeking financial assistance, DHC saw them as an indication that people were struggling to navigate an increasingly complex system of financial assistance programs, provider billing practices, and insurance rules. Instead of creating a new financial assistance program, DHC developed [Medical Debt Care DuPage](#), an initiative focused on helping patients access existing assistance programs while simultaneously working with health systems to identify and address barriers that prevented eligible patients from receiving financial relief.

Several contextual factors supported implementation of Medical Debt Care DuPage (**Table 3**). These conditions, including longstanding relationships with hospital partners and the state policy environment, shaped the strategies available to DHC and may influence how readily similar approaches can be implemented in other communities.

In addition to these contextual factors, DHC had developed organizational capabilities that supported implementation, including:

- Bilingual and bicultural certified financial counselors
- Expertise in insurance enrollment and financial assistance
- Established processes for coordinating care and patient navigation across multiple organizations

Table 3. Contextual Factors Influencing DuPage's Implementation Effort

Longstanding cross-sector relationships	DHC had worked with local hospitals and community organizations for more than two decades before launching Medical Debt Care DuPage. Hospital leaders participated in organizational governance, creating established channels for collaboration, trust, and problem-solving that facilitated later systems change efforts.
State policy environment	Illinois law supports presumptive eligibility for financial assistance through qualifying community organizations, allowing some hospitals to accept eligibility determinations made by trusted partners rather than requiring duplicative financial assistance applications. Interviewees noted that implementation still varied across health systems.
Community intermediary role	DHC already served as a trusted intermediary coordinating hospitals, clinics, and community organizations through programs such as Access DuPage. This existing role positioned the organization to identify recurring barriers across multiple organizations and convene partners to address them.
Aligned financial assistance structure	Access DuPage eligibility had intentionally been aligned with participating hospitals' financial assistance policies, creating a shared eligibility pathway that simplified enrollment and reduced administrative burden for many patients.
Community characteristics	Although DuPage County has relatively high overall insurance coverage and household income, DHC serves uninsured and underinsured residents, including many immigrant communities who continue to experience barriers to insurance, financial assistance, and affordable care.

Although every organization operates within a different context, this case highlights how local partnerships, organizational capacity, and available resources shaped DuPage's approach. Organizations seeking to implement similar strategies should consider how their own circumstances may require different sequencing, partnerships, or resource investments. This case describes DuPage's experience, the challenges encountered, and key implementation lessons (**Table 4**), while the accompanying implementation tools provide broader guidance for adapting these lessons to other settings.

Table 4. Snapshot of DHC's Implementation Process

Recognizing the Gap Between Eligibility and Access	DHC recognized that eligibility for financial assistance did not always translate into patients successfully receiving available support. A 2022 survey of Access DuPage participants revealed that many households continued to experience medical debt despite existing assistance programs, prompting DHC to examine barriers within financial assistance, billing, and insurance systems.
Implementation Strategy 1: Build Trusted Navigation and Advocacy Services	DHC developed Medical Debt Care DuPage to help patients navigate complex financial assistance and insurance systems. Bilingual and bicultural financial counselors and navigators provided individualized support, helping patients resolve billing issues, access available assistance, correct insurance errors, and address other barriers that contributed to medical debt.
Implementation Strategy 2: Build Partnerships That Reduce Administrative Burden	Leveraging longstanding relationships with local hospitals, DHC worked with health system partners to streamline access to financial assistance. Strategies included creating referral pathways, aligning eligibility criteria, encouraging use of presumptive eligibility for financial assistance, and reducing duplicative processes for patients seeking support.
Implementation Strategy 3: Use Individual Patient Cases to Improve Systems	DHC used patterns identified through patient navigation to inform broader conversations with health systems and other partners. By elevating recurring challenges, such as inconsistent financial assistance practices, billing barriers, and documentation requirements, DHC helped partners identify opportunities for operational and policy improvements.
Organizational Learning and Refinement	Over time, DHC's role expanded from helping individual patients access resources to serving as a trusted intermediary that helped organizations identify and address systemic barriers. The organization continued refining its approach by using patient experiences and partner feedback to strengthen navigation, coordination, and financial assistance processes.

Recognizing the Gap Between Eligibility and Access

DHC found that while many financial assistance programs already existed and many patients were eligible for them, patients were often unable to successfully access those resources.

Interviewees described multiple reasons why eligible patients continued to accumulate debt:

- Financial assistance applications were difficult to navigate.
- Patients often misunderstood insurance benefits or failed to realize additional coverage was available.
- Multiple bills from hospitals and independent providers created confusion.
- Fear surrounding financial assistance applications discouraged patients from seeking help.
- Administrative processes varied substantially across health systems and third-party billing vendors.

As one leader observed, health systems often believed their financial assistance policies were generous but had limited visibility into the practical barriers preventing patients from successfully using them. DHC therefore shifted its focus from creating new financial resources toward helping patients navigate the systems that already existed.

IMPLEMENTATION STRATEGY 1: BUILD TRUSTED NAVIGATION AND ADVOCACY SERVICES

Rather than focusing solely on debt relief, Medical Debt Care DuPage helps patients navigate the financial systems that determine whether debt occurs in the first place.

Key Activities

DHC assembled a bilingual, bicultural team of certified financial counselors and ACA navigators who work directly with patients to:

- Review medical bills from hospitals and other providers
- Determine eligibility for hospital financial assistance programs
- Identify insurance enrollment opportunities
- Resolve insurance billing errors
- Assist with financial assistance applications
- File appeals when appropriate
- Connect patients with transportation, medication assistance, and other supportive services

Beyond explaining available programs, staff frequently contact providers alongside patients, advocate during billing disputes, and help resolve issues that patients often find too challenging to navigate independently.

Interviewees emphasized that health insurance literacy frequently represents a larger barrier than eligibility itself. Many patients arrive with bills resulting from missing secondary insurance, incomplete claims, or misunderstandings about their coverage, not because they were truly responsible for the full cost of their care.

Friction Points

Staff described significant challenges helping patients navigate fragmented billing systems.

- Patients commonly receive separate bills from hospitals, physician groups, pathology laboratories, radiologists, anesthesiologists, and ambulance providers, often without understanding how these services are connected.
- Increasing reliance on outsourced billing vendors further complicated communication, with staff describing long wait times, dropped calls, and limited responsiveness even when experienced navigators contacted billing offices on patients' behalf.
- Interviewees noted that if trained financial counselors struggled to obtain answers, patients facing financial stress and unfamiliar terminology were even less likely to successfully navigate the process independently.

IMPLEMENTATION STRATEGY 2: BUILD PARTNERSHIPS THAT REDUCE ADMINISTRATIVE BURDEN

DHC viewed strong relationships with hospitals as essential to reducing patient burden.

Key Activities

Because DHC has partnered with local hospitals for more than two decades, and because hospital executives participate directly in DHC governance, the organization entered this work with an unusually high level of institutional trust. Interviewees viewed these longstanding relationships as a key enabling condition that allowed DHC to:

- Develop direct communication channels with hospital financial assistance staff
- Create expedited referral pathways
- Encourage hospitals to link DHC services on financial assistance webpages
- Align DHC eligibility criteria with hospital charity care policies
- Promote presumptive eligibility for financial assistance for patients already screened through DHC programs

Instead of requiring patients to submit the same financial information to multiple organizations, DHC leaders encouraged hospitals to accept eligibility determinations already made by trusted community partners whenever possible.

Interviewees described this approach as beneficial for both patients and providers by reducing duplicative administrative work while improving access to financial assistance.

Friction Points

Implementation varied across hospitals.

Although Illinois law supports presumptive eligibility for financial assistance through certain community organizations, interviewees reported inconsistent implementation across health systems. Organizational mergers, differing electronic health record workflows, and multistate health system policies sometimes limited hospitals' ability to recognize Access DuPage participants or apply financial assistance consistently.

As a result, patients who should have qualified for financial assistance occasionally continued receiving bills simply because existing eligibility information was not readily visible during registration or billing.

IMPLEMENTATION STRATEGY 3: USE INDIVIDUAL PATIENT CASES TO IMPROVE SYSTEMS

In their work with individual patients, DHC staff also identified recurring operational barriers affecting many others.

Key Activities

Interviewees described using patterns observed through patient navigation to inform broader conversations with health systems and community partners.

Examples included:

- Identifying a hospital financial assistance policy that did not align with Illinois law and working with leadership until the policy was revised
- Collaborating with EMS leaders to resolve recurring ambulance billing challenges that had previously been difficult for patients to address
- Highlighting problems associated with outsourced, third-party billing vendors
- Encouraging hospitals to reduce repeated documentation requirements through greater use of presumptive eligibility for financial assistance

Rather than approaching these issues as isolated patient complaints, DHC used them to identify opportunities for operational improvement across participating organizations.

Friction Points

Unlike organizations working within a single health system, DHC sought to improve policies and operations across multiple independent organizations over which it had no formal authority. Interviewees described relying on relationship-building, persistence, and repeated engagement rather than organizational mandates to advance change.

In some instances, resolving a recurring barrier required months or years of conversations with hospital leaders, EMS agencies, billing vendors, or funding partners before agreement could be reached. Organizational mergers, competing priorities, differing interpretations of policy, and concerns about administrative burden sometimes slowed implementation, even when participants generally agreed on the underlying goal of improving patient access to financial assistance.

Interviewees emphasized that lasting change often depended less on a single conversation than on sustained trust built over years of collaboration.

Organizational Learning and Refinement

Over time, DHC's role expanded beyond helping patients complete applications.

Interviewees increasingly viewed the organization as a trusted intermediary that could help hospitals understand barriers that were often invisible from within health system operations. Patients frequently disclosed concerns or confusion to DHC staff that they had not shared with providers, allowing staff to identify recurring challenges involving health literacy, administrative burden, communication, and changing financial circumstances.

Leaders also emphasized that financial assistance eligibility is not static. Patients whose circumstances worsen following illness or job loss may become eligible for additional assistance months after receiving care, underscoring the importance of ongoing financial reassessment rather than one-time screening.

Measuring Progress

DHC evaluates success through both operational outcomes and patient impact.

Indicators include:

- Approximately \$7–10 million in medical debt relief secured annually through successful financial assistance applications, insurance corrections, resolution of insurance billing errors before patients incur unnecessary financial responsibility, and other patient advocacy efforts.
 - *Note:* Debt relief data reflect best estimates because documentation confirming that individual bills were fully closed is not always available. In these cases, reasonable assumptions are used to estimate the amount of debt relieved. The reported figures therefore represent the best available estimates of debt relief rather than a verified count of every individual bill closed.
- DHC also expanded their program over time to include a team member with a special focus on older adults. In the last year, that advocate successfully navigated 213 unique patients who received just under \$1M in medical debt relief. This client population represented a blend of uninsured and Medicare or third-party insurance enrolled individuals age 60+.
- Hospital policy changes following DHC advocacy.
- Stronger partnerships between hospitals and community organizations.
- Improved patient confidence accessing needed health care.

Interviewees also pointed to growing trust between hospitals and DHC staff, noting that financial counselors increasingly accepted DHC eligibility assessments and referrals, helping patients move more efficiently through financial assistance processes.

Lessons for Other Community Organizations

When asked what advice they would offer other organizations considering how to better support clients experiencing medical debt, DHC emphasized the capacity for even small organizations to have a significant impact, and the need to take the time to ask the families they serve if they have unmet medical debt needs. “There is still so much stigma and shame about debt,” DHC noted. “Creating space and trust to have those conversations revealed a world of opportunity.” DHC also emphasized that collaborative and amicable relationships with provider partners proved incredibly helpful to their efforts. Oftentimes, patient financial services teams were very willing to help, but sincerely unaware of the ways the application process created barriers for patients. “Working together has proven far more helpful than a more contentious approach ever would have.”