

Appendix

CASE EXAMPLE

Ensuring Patient-Centered Financial Practices: A Hospital Perspective (Parkland Health)

Core Problem: Are our financial practices causing harm?

Background

Parkland Health (Parkland) is one of the largest public safety-net health systems in the United States. Governed as a public hospital district with a [population health mission](#), Parkland serves Dallas County through a longstanding commitment to improving community health and reducing barriers to care. Prior to the work described in this case, the organization had already established strong community relationships through an extensive community engagement infrastructure, including Community Health Needs Assessments (CHNAs), patient and family advisory councils (PFACs), Community Health Workers (CHWs), and community relations staff embedded in primary care settings. As an [anchor institution](#), Parkland’s strategic plan also emphasizes hiring from the communities it serves and aligning organizational practices with its mission and values.

The work described in this case began when Parkland leaders questioned whether longstanding organizational practices fully reflected the health system’s mission as a public safety-net institution. Rather than assuming existing policies were achieving the intended balance between financial stewardship and patient well-being, they examined how those practices affected patients and whether alternative approaches could better support both organizational and community goals.

Health systems considering similar efforts should consider the context in which Parkland’s approach was developed, including its size, location, patient population, payer mix, leadership commitment, and capacity to implement change (**Table 1**).

Table 1. Contextual Factors Influencing Parkland’s Implementation Process

Contextual Factor	Parkland
Health system size	Large, integrated public health system with substantial operational capacity
Location and service area	Urban safety-net health system serving Dallas County
Patient population and payer mix	Large proportion of uninsured and Medicaid patients; self-pay collection represented very little revenue
Community context	Serves communities with significant financial and social needs, which shapes organizational priorities
Leadership commitment	CEO was already motivated to eliminate the practice and championed the change
Internal relationships	Strong collaboration across finance, operations, legal, health equity, and clinical teams enabled rapid implementation
Organizational mission and values	Patient-centered mission aligned closely with reducing medical debt burden
Change readiness	Existing systems and alignment allowed the organization to move quickly

In addition to these contextual factors, several organizational qualities enabled Parkland to move quickly once leadership decided to pursue the change. These included strong executive commitment, internal collaboration, and existing operational infrastructure to support change:

- **Strong Executive Leadership and Commitment to Mission:** Sustained executive support from CEO Fred Cerise, M.D., who signaled that reducing patient financial harm was an organizational priority rather than solely a revenue-cycle issue, along with governance and mission structures that prioritized community health, access, and public accountability.
- **Internal Collaboration and Communication:** Existing internal relationships among revenue cycle, patient experience, community health, and operational leaders.
- **Capacity to Drive Change:** Established financial assistance programs and internal capacity to redesign workflows and implement changes within the electronic health record.

This case illustrates how context can influence implementation strategy, timelines, and executive engagement. Organizations should consider how their own circumstances may require different sequencing, resources, or approaches to achieve similar outcomes. This case focuses on the decisions Parkland made, the challenges encountered, and the sequence of implementation (**Table 2**), while accompanying implementation tools provide more general guidance for adapting these lessons to other settings.

Table 2. Snapshot of Parkland's Implementation Process

Recognizing a Misalignment Between Mission and Practice	After reading <i>Your Money or Your Life</i> , CEO Dr. Fred Cerise leveraged his leadership role to initiate an organization-wide review of whether Parkland's financial practices reflected its mission and commitments to patients. The review examined billing and collection practices alongside CHNA findings and community feedback about patients' experiences with medical debt. Together, these findings highlighted concerns about the potential impact of financial practices and prompted leadership to engage revenue cycle leaders, frontline staff, clinicians, CHNA findings, and broader community feedback channels to identify opportunities to better align organizational practices with patient needs.
Decision Point 1: Should Parkland Continue Credit Reporting?	After learning that an external vendor was reporting unpaid medical debt to credit bureaus, Parkland leadership considered whether the practice should continue and whether the potential financial benefits justified its potential consequences for patients. As part of this broader assessment, Parkland analyzed approximately \$9 million in annual self-pay collections from patients who could have qualified for expanded financial assistance, including a potential increase in eligibility to 400% of the federal poverty level. For a health system with roughly \$3 billion in annual revenue, these collections represented less than one-half of one percent of total revenue. The analysis, together with feedback from patients, staff, and community members, helped leadership assess whether the financial benefit of its collection practices justified their potential impact on patients. Ultimately, leadership concluded that continuing to report medical debt to credit bureaus was inconsistent with Parkland's organizational values and that the potential financial benefit did not outweigh the potential for patient harm. Note: This type of analysis can be revisited periodically as financial assistance policies, collection practices, and patient needs evolve.
Decision Point 2: How Could We Operationalize Change?	Vendor contracts, policies, workflows, and EPIC rules were revised, with ongoing collaboration among revenue cycle, health equity, legal, compliance, and operational leaders. Staff programs were implemented to help address shared experiences with medical debt and promote empathy and culture change. Revenue cycle leaders reinforced the message that "health care is our primary goal, not collections" and worked to increase staff autonomy in addressing patient financial needs.
Decision Point 3: How Could Financial Harm Be Identified Earlier?	Parkland simplified financial assistance applications, established an eligibility call center, and offered self-pay discounts for eligible patients. Financial counselors and registration staff were trained to identify financial concerns early in the patient journey, connect patients with appropriate resources, and facilitate referrals through standardized EPIC-based screening and referral workflows.
Organizational Learning and Refinement	Ongoing feedback from patients, communities, clinicians, and employees was used to continually refine workflows and continue expanding awareness of available resources.

Recognizing a Misalignment Between Mission and Practice

The effort began when Parkland CEO Fred Cerise, M.D. read *Your Money or Your Life: Debt Collection in American Medicine* by Luke Messac, M.D., Ph.D., and was struck by a story describing a physician who routinely reassured patients that financial assistance was available, only to later learn that some of those same patients were being pursued through legal collection actions. This prompted Dr. Cerise to question whether Parkland's financial practices aligned with its mission.

Rather than assuming they were, leadership initiated a review of existing billing and collection practices, which revealed that although Parkland was not directly reporting debt to credit reporting agencies, an external vendor was reporting unpaid medical debt to credit bureaus on its behalf.

At the same time, CHNAs and community feedback showed that financial concerns were shaping care-seeking behavior:

- Patients delayed care due to fear of unaffordable bills
- Patients shared concerns about leaving debt to family members
- Community “word-of-mouth” discouraged care-seeking

Together, these findings reframed medical debt from a revenue-cycle issue to a barrier to access and trust, and ultimately, a question of mission alignment. Leadership began considering what changes to its financial assistance and collection practices might better align with Parkland's mission while also examining the financial implications of those changes.

DECISION POINT 1: SHOULD PARKLAND CONTINUE CREDIT REPORTING?

Once leadership understood that an external vendor was reporting patients' medical debt to credit agencies, they had to decide whether the practice should continue.

As part of this broader assessment, Parkland also considered whether they could expand eligibility for financial assistance, including potentially extending discounts to patients with incomes up to 400% of the federal poverty level (FPL).

Key Activities

Revenue-cycle and finance leaders analyzed collections from self-pay patients who would be affected by a potential expansion of Parkland's financial assistance criteria to 400% FPL. The analysis found that these collections generated approximately \$9 million annually. For Parkland, a large, safety-net health system with roughly \$3 billion in annual operations, this represented less than one-half of one percent of total organizational revenue. In a smaller system, or one with a different self-pay population, the same category could represent a meaningfully larger share of revenue. The relevant lesson is not that self-pay collections are financially negligible in general, but that their actual contribution should be measured in context and weighed directly against potential patient harm.

This analysis fundamentally changed the conversation about credit reporting. Rather than asking whether the organization could afford to discontinue the practice, leaders began asking whether the limited amount of money at stake justified using credit reporting as a collections tool, especially given the potential consequences for patients, including effects on housing, employment, financial stability, and trust in the health system. Ultimately, leadership concluded that allowing medical debt to be reported to credit agencies was inconsistent with Parkland's organizational values and that the potential financial benefit of using credit reporting to encourage repayment did not outweigh the potential for patient harm.

Interviewees emphasized that visible, early support from CEO Fred Cerise, M.D. was instrumental to implementation. Whereas efforts to modify billing and collections practices often require staff to build support among organizational leadership, Parkland's changes were championed from the highest levels of the organization. Combined with Parkland's longstanding mission-driven culture, this executive sponsorship facilitated implementation.

Because the changes aligned closely with organizational values related to access and patient care, relatively little will-building was required to gain support among leadership, clinicians, and staff. It was noted that while Parkland's Chief Financial Officer did not initiate the activity, his team was positively engaged once asked to address the concern. And while board approval was neither required nor formally sought, board members indicated they strongly supported the new policy.

Friction Points

Leaders faced operational and legal complexity given that credit reporting was embedded in longstanding workflows and vendor relationships, requiring cross-functional coordination to assess contractual and compliance implications of discontinuing the practice.



Leadership Insight

“When you attempt to change your financial assistance policies, you learn quickly that it is not simple and must involve legal and compliance early.

For example, we provide free mammography screening. There is a compliance concern that if we make services free, that is an inducement — even when most of the people involved are uninsured or on Medicaid. When someone has an abnormality that requires follow up, we don't want to charge them because we invited them in for free screening. We had to be cognizant of legal and compliance issues just to provide free care to our community.

We see the same thing when trying to apply our financial assistance programs to individuals who have poor insurance coverage. Someone who has tried to be responsible and obtain coverage through the ACA may have a \$10,000 deductible they cannot afford. We would like to apply our own financial assistance policy discounts to that deductible, but it gets complicated because of the contractual issues with the insurer.”

—Fred Cerise, CEO

DECISION POINT 2: HOW COULD WE OPERATIONALIZE CHANGE?

Having decided to discontinue credit reporting, Parkland shifted its focus to how the change would be operationalized across vendors, systems, and internal workflows. Perhaps the most notable aspect of this case is that most of the challenges were about implementation, not disagreement about the decision itself. There was little pushback on whether to make the change, and few examples of ongoing internal conflict. Instead, the work focused on practical steps like updating contracts, workflows, and documentation across systems. This was supported by early and visible executive leadership, existing relationships between revenue cycle and patient experience leaders, and alignment between the effort and the organization's mission. Parkland also invested in building shared understanding across departments by creating opportunities for two-way communication between revenue cycle and clinical teams, including during clinical grand rounds. These efforts helped strengthen trust, increase clinician awareness of financial assistance policies and patient financial experiences, and reinforce a shared commitment to supporting patients.

Key Activities

- Revised vendor contracts, policies, workflows, and EPIC rules through collaboration among revenue cycle, health equity, legal, compliance, and operational leaders.
- Established close, ongoing communication between revenue cycle leadership and Parkland's Chief Health Equity Officer, which leaders described as essential for aligning operational decisions with organizational goals related to access and reducing barriers to care.
- Expanded employee support programs to recognize and address staff experiences with medical debt, reinforce organizational values, and promote empathy for patients experiencing financial hardship.
- Created opportunities for ongoing communication and education between revenue cycle and clinical teams, including integrating revenue cycle into clinical grand rounds to strengthen two-way dialogue, increase clinician knowledge of financial assistance policies, and improve coordination in supporting patients.
- Revenue cycle leadership reinforced the message that “health care is our primary goal, not collections,” through ongoing staff training, workflow reinforcement, and engagement in departmental check-ins.

Building Clinician Awareness and Workflow Integration

Historically, financial counseling documentation was not easily visible to clinicians within EPIC. Leaders worked with internal teams to improve how financial assistance information was documented and accessed within the electronic health record. They also partnered with nurse navigators, referral coordinators, physicians, and advanced practice providers to increase awareness of available resources and how to locate them in the EHR (electronic health record) during patient care. Note: EHR systems like EPIC can serve as an important tool for improving transparency and access to financial assistance information. Health systems may consider working with EHR vendors to identify opportunities to improve visibility of available resources for clinicians and other patient-facing staff.

Revenue cycle leaders also participated in departmental meetings and clinical huddles to reinforce workflows and address implementation challenges, particularly within surgical and specialty care settings. Clinicians demonstrated strong awareness of patients' financial barriers, reflecting longstanding organizational emphasis on patient financial well-being.

Supporting Employees

Hospital employee support programs were expanded to include childcare resources, on-site dental services, assistance navigating health benefits, financial wellness programming, upfront tuition assistance, stress management seminars, and resources to reduce reliance on predatory lending.

These investments were viewed as reinforcing organizational values by recognizing clinicians' and staff's exposure to medical debt, while strengthening employee empathy for patients experiencing financial hardship and reducing stigma around medical debt.



Leadership Insight

“We intentionally hired from the communities we serve to create circumstances in which families can advance, experience economic stability, and thrive.”

These individuals brought invaluable lived experiences, and we quickly recognized that the employees were also experiencing barriers to transportation, housing, childcare, food, and other non-medical drivers of health. So beyond recruiting talent from the communities, we needed to create conditions for our employees to succeed.”

—Jessica Hernandez, Senior Vice President and Chief Health Equity

Building a Patient-Centered Culture

Interviewees emphasized that sustaining these changes required an intentional cultural shift within revenue cycle operations and the larger health system, which required explicit messaging from revenue cycle leadership. New employees, particularly those coming from more traditional collections environments, are consistently reminded that “health care is our primary goal, not collections.”

Friction Points

As implementation progressed, leaders encountered operational and policy questions, including eligibility for patients from outside Dallas County who initially presented through emergency care but required ongoing treatment.

Coordination across revenue cycle, legal, compliance, operations, and IT was essential. Vendor contracts required legal review and renegotiation, while financial assistance policies had to align with documentation requirements, annual eligibility reassessments, and outreach and incentive-related regulations.

Leaders also emphasized embedding changes in standardized EPIC workflows to avoid manual processes that could increase administrative burden or staffing needs.

DECISION POINT 3: HOW COULD FINANCIAL HARM BE IDENTIFIED EARLIER?

Leadership recognized that eliminating credit reporting addressed only one aspect of patient financial harm, which led to a shift from a reactive collections model to an upstream preventative approach focused on identifying and addressing financial needs as early as possible in the patient journey.

Key Activities

Parkland implemented several changes to identify and address financial needs earlier in the care process:

- Established an eligibility call center to help patients understand available resources, answer billing questions, develop payment plans, apply for financial assistance, enroll in Medicaid when eligible, and connect with grant-funded assistance programs.
- Simplified the financial assistance application to fewer than two pages, focusing primarily on demographic and income information. The application serves as an entry point for multiple assistance pathways, including hospital financial assistance, Medicaid enrollment, and grant-funded programs.
- Trained financial counselors on eligibility requirements across multiple programs so they could triage patients toward the most appropriate resources and identify when additional applications were needed.
- Trained registration staff to identify potential financial concerns and connect patients with financial counselors early in the care process.
- Embedded standardized financial screening and referral workflows within EPIC, allowing clinicians and staff to initiate referrals to financial counselors and facilitate follow-up.
- Offered self-pay discounts for eligible patients.
- Created various application pathways to help patients find the one that suited them best (e.g. through EPIC MyChart, online via the Parkland website, in-person on campus, through community health centers, by mail-in, etc.).

Leaders reported that call volumes subsequently declined, which they attributed in part to improved patient education regarding financial responsibility, good-faith estimates, available discounts, and financial assistance options.

Friction Points

Obtaining required documentation can present challenges for patients, particularly individuals experiencing homelessness, earning cash income, or those with limited documentation.

Financial counselors emphasized the importance of flexibility and creative problem-solving, including:

- Identifying alternative forms of documentation, including, when appropriate, contacting employers directly rather than requiring additional paperwork from patients.
- Empowering financial counselors and revenue cycle staff to work with patients to balance organizational requirements with individual circumstances, prioritizing affordability and problem-solving over a one-size-fits-all approach.



Leadership Insight

“When we talk directly to financial counselors, one of their biggest concerns is straying from strict policy and being exposed to discipline based on audit findings.

That’s why there’s an ongoing effort to increase autonomy: we want staff to feel empowered to navigate these situations rather than relying solely on rigid rules. We want to give front-line counselors the benefit of the doubt when they’re working with patients and families to get the necessary documentation to support eligibility for our assistance programs.”

—Fred Cerise, CEO

Organizational Learning and Refinement

Parkland used multiple ongoing mechanisms to understand patient experiences, build trust, and identify barriers to care.

Key sources of continuous feedback included:

- CHNAs
- Patient and family advisory councils
- Community conversations
- Press Ganey surveys
- Community Health Workers
- Community relations staff assigned to primary care clinics

Interviewees viewed Community Health Workers as particularly important because they conduct outreach and screening activities in nontraditional settings, often identifying barriers among individuals who have not yet entered the health system. Community relations staff embedded within clinics also provided ongoing insight into community concerns and patient experiences.

Measuring Progress

Because many consequences of medical debt, such as reduced trust, financial stress, or delayed care, are not routinely captured in health system data, Parkland relied on both operational measures and community feedback to understand whether changes were working.

Early indicators included:

- Elimination of credit-reporting activities
- Reduced administrative barriers to financial assistance
- Lower patient call volumes related to billing questions
- Faster connection to financial counseling and support services
- Increased staff, clinician, and community engagement with financial assistance resources
- Greater alignment between operational practices and organizational mission

Leaders also continued to monitor information gathered through CHNAs, community engagement activities, and patient feedback mechanisms to understand how patients, staff, and clinicians experienced these changes.

Additional quantitative measures, including changes in financial assistance utilization, application completion rates, navigation times, and other operational indicators may provide useful information for organizations pursuing similar efforts.

Lessons for Other Health Systems

“Take time to understand the impact of your financial assistance policies on individuals and their access to care (including talking to the physicians who are your strongest patient advocates). I suspect in many situations, more liberal financial assistance policies (particularly for uninsured individuals) will not have a significant effect on collections but will have a significant impact on individuals seeking care. A health system’s philosophy on care and access can be defined by your financial assistance policies and that needs to be driven by the board and executive leadership; don’t put the expectation and burden to define that philosophy and drive the changes needed to effect it all on revenue cycle staff.” – Fred Cerise, CEO

“As organizations pursue health equity, it is important to recognize that financial policies are health policies. I encourage leaders to engage and empower staff to work collaboratively with patients to solve problems rather than simply enforce policy. Placing patients first means creating a patient-centered approach that advances trust, the patient experience, access, and equity.” – Jessica Hernandez, Senior Vice President and Chief Health Equity Officer