PCCI

2022 ANNUAL IMPACT REPORT

LEVERAGING CLINICAL EXPERTISE, DATA SCIENCE, AND SOCIAL DETERMINANTS OF HEALTH TO ADDRESS THE NEEDS OF VULNERABLE POPULATIONS.

Steve Miff, PhD
President and CEO

A MESSAGE FROM STEVE MIFF, PHD PRESIDENT AND CEO

What a difference a decade makes. 2022 marks the 10th anniversary of PCCI and our work leveraging clinical, advanced data science, and social determinants of health expertise to advance the health and well-being of the most vulnerable members of our communities. During this memorable year, we have had the opportunity to reflect on—and celebrate—ten years of successful collaborations and innovative projects designed to build healthier and more equitable communities. From our powerful data-driven applications contributing to the regional pandemic response, to using AI to predict trauma mortality in the emergency department, to reducing avoidable asthma-related ED visits and hospitalizations through data science and community outreach, we've been successful in putting data to work to improve health. This report highlights just a sample of this work, but none of PCCI's successes would have been possible without a clear vision and a connected community dedicated to realizing it. This includes collaborations and support across the clinical-community continuum, from organizations locally, like Parkland Health, the Parkland Community Health Plan (PCHP), and Dallas County Health and Human

Services (DCHHS), and from many other organizations across Texas, national organizations like the Institute for Healthcare Improvement (IHI), and the many community-based organizations that have supported our efforts and expanded our outreach. We are incredibly grateful for these partners that have played a crucial role in our organization's history and our collective accomplishments. In addition, our successes would not have been possible without the creativity, intelligence, and commitment of our tremendously talented team that has been simply second to none.

We have continued to invest in critical technology infrastructure and cutting edge analytics that have helped to advance and expand our collaborations in Texas and beyond. We have also continued to focus on sharing what we learn to ensure that findings from our innovative work can be utilized by other stakeholders toward the improvement of health.

We know that as a country we face unprecedented health and healthcare challenges. While data science has made significant strides in terms of accelerating care efficiencies and health improvements, these advances continue to evolve and expand to ensure whole person insights are equitable across populations. We need to use technology, data, and personalized insights as foundational levers for shifting the focus of engagement (and empowerment) further upstream in one's life journey and in the management of specific clinical conditions, particularly in this fast-changing digital age. These pressures present challenges but also opportunities to transform by developing innovative and sustainable solutions. PCCI aims to be at the vanguard of this transformation through creation of a new Data Science Institute to further expand our capabilities and—through existing and expanded collaborations across our region and beyond— to address some of the pivotal issues that hamper good health for all, particularly the most vulnerable and underserved. Our vision and mission are clearly defined and will power our efforts. We will continue building upon our established expertise, collaborations, and influence to expand our impact. Now more than ever, it is important to work together to make accessible, equitable health care for all a reality.

"ALTHOUGH 2022 HAS BEEN A YEAR OF REFLECTION AND CELEBRATION, IT HAS ALSO BEEN AN IMPORTANT YEAR OF PREPARATION AND EXPANSION OF OUR WORK AS WE STAND ON THE PRECIPICE OF THE NEXT TEN YEARS."

Using our advanced skills in data science (combined with our clinical expertise and social determinants of health experience), PCCI accelerates innovation through data-driven applications that guide action across the clinical-community continuum and advance the health of communities both within our region and beyond.

TECH AND DATA SCIENCE INNOVATION

AUG '13
PCCI officially launched the Pieces™ system at Texas Health Resources

SEPT '15
Patent Awarded: "Clinical Dashboard User Interface System And Method"Patent Number: US 9,147,041 B2"

OCT '19
PCCI's predictive model helps prevent adverse drug events (PARADE)

DEC '19
Patent Awarded for "Holistic Hospital Patient Care And Management System And Method For Automated Patient Monitoring"; Patent Number: US 10,496,788 B2

MAY '21
PCCI's Parkland Trauma Index of Mortality (PTIM) went live. The PTIM is an EHR-integrated real-time trauma mortality predictive model

AUG '21
PCCI's IP Sepsis model went live with Parkland partners. This predictive model runs in real time and identifies and triggers intervention of patients with high risk of sepsis development after hospital admission

DEC '21
ISTHMUS™, our next generation digital data environment is integrated into PCCI programs. It synthesizes a wide variety of healthcare data to provide contextual, targeted, and actionable insights enabling coordinated, personalized care

2022
PCCI's cutting edge data science technology enables the evolution and implementation for COVID-19, Community Vulnerability Compass and Know Thy Patient programs

In 2022, PCCI has continued to make significant investments that expand our capabilities to ingest diverse data sets, create innovative processes to make sense of social and clinical data, and deliver contextualized insights providing meaningful, actionable information that diverse organizations across a community can integrate into their strategic decision-making and program design.

Through *Islet,* bringing what matters into focus

Today we have access to unprecedented amounts of healthcare data. But this is of little value without data visualization that helps medical staff understand data insights and use the right data faster, resulting in better decision-making and improved care. Based on interoperable, SMART-on-FHIR standards, Islet (a tool) provides cutting-edge data visualization capabilities and highly contextual, timely, real-time analytics right at the point of care. It is used to efficiently develop and deploy web applications intended to better visualize patient-specific predictive model results. This allows care teams to receive and interpret information faster and recognize trends and patterns that may reduce risk and improve diagnoses and treatment.

In 2022, we developed a generalized Islet tool to provide a real-time predictive clinical decision visualization support for virtually any predictive model integrated in the EHR. Its first use case is for the inpatient sepsis predictive model at Parkland, to assist in predicting a patient's sepsis risk level and to enable care teams to collaborate more efficiently and standardize patient care management. Islet is independent of any specific predictive model but enables the development and deployment of model-specific visualization applications at a significantly reduced cost and with significantly reduced development time.

Parkland program targets prevention of hospital infections and improved sepsis care

Visit: bit.ly/3uOGAmo

TODAY, PCCI'S TOOLS ARE HELPING TO PROVIDE CUTTING-EDGE, HIGHLY CONTEXTUAL, REAL-TIME, PATIENT-SPECIFIC DATA AT THE POINT OF CARE

PCCI'S DATA-DRIVEN APPROACH HAS CONTINUED TO HELP DALLAS LEADERS MANAGE COVID-19 PANDEMIC ACTIVITIES SUPPORTING TRANSPARENT AND PRECISE DISEASE PREVENTION AND MITIGATION

2022 Cutting Edge *COVID-19* Analytics

Dynamically capturing the latest COVID insights through the COVID-19 Community Protection Dashboard

PCCI's groundbreaking COVID-19 predictive model, the Community Vulnerability Index, evolved to national standing as PCCI joined in a partnership between the Institute for Healthcare Improvement (IHI), Civitas Networks for Health (Civitas), and Cincinnati Children's Hospital (Cincinnati Children's) to establish the COVID-19 Community Protection Dashboard. The Dashboard offers an aggregate Community Protection Index (CPI) for nearly all of the counties in the U.S. in the form of a score combining data sources and multiple factors (% of population that has received a booster, % of cumulative and presumed cases, etc.) and accounting for the most recent dominant COVID-19 variant characteristics, vaccine, and natural immunity effectiveness, and modeled with time-based variables and waning immunity factors.

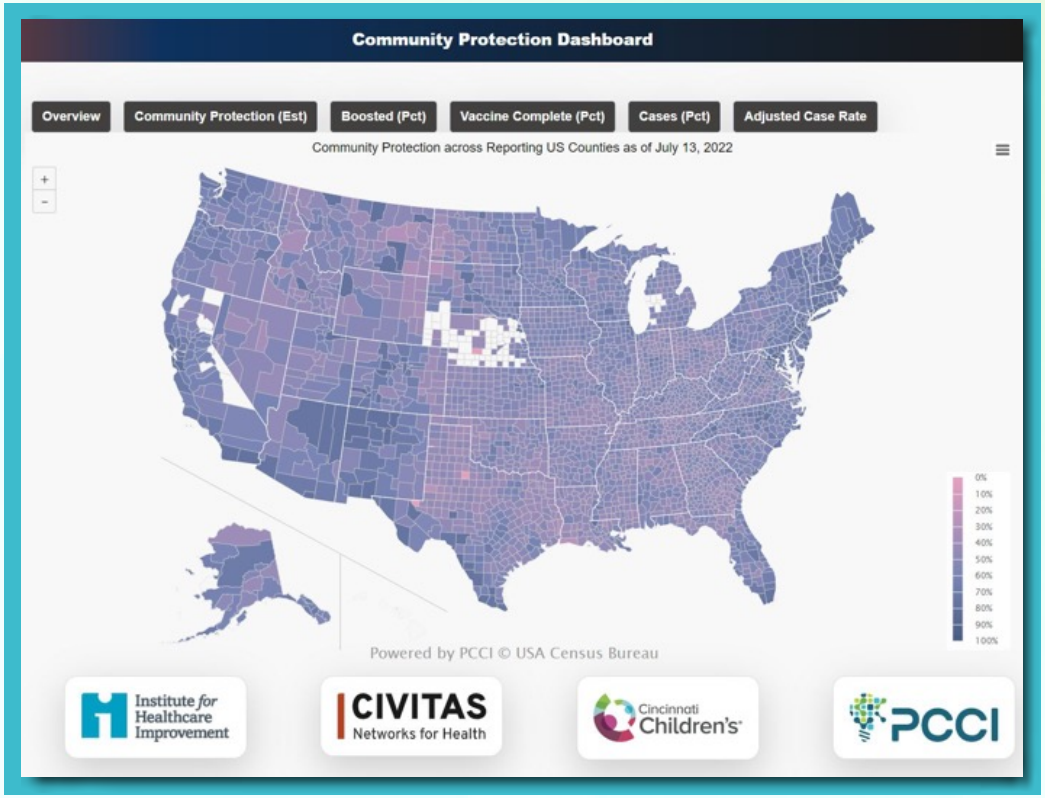
The COVID-19 Community Protection Dashboard Has National Implications:

"This Locally Developed Dashboard Could Revolutionize Public Health"
– DCEO Healthcare, August 2022

"New COVID-19 Analytics Dashboards Tracks Levels of Protection Against the Virus at the County Level"
– HIT Consultant, August 2022

"County-level COVID immunity scores can help us get the pandemic under control"
– Dallas Morning News, August 2022

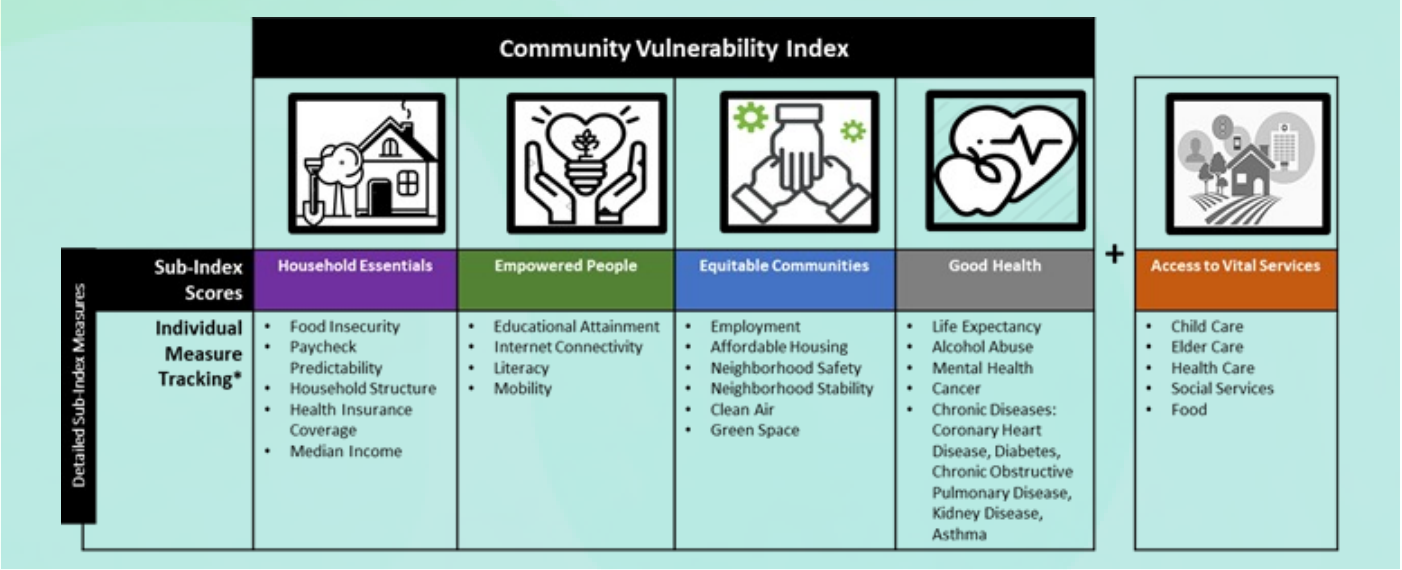
"The goal of the analytics within the dashboard is to contextualize what is being observed locally to what is happening concurrently across surrounding counties, state and nation."
– Steve Miff, PhD, CEO and President at PCCI



TODAY, PCCI USES TECHNOLOGY, DATA, AND PERSONALIZED INSIGHTS AS FOUNDATIONAL LEVERS FOR SHIFTING THE FOCUS OF ENGAGEMENT FURTHER UPSTREAM

2022 Through the *Community Vulnerability Compass,* accessing Social Determinants of Health insights at the block level to pinpoint needs across a community

Despite the increasing awareness of the connection between Social Determinants of Health (SDOH), health, and health equity, few organizations who work with vulnerable populations have access to the SDOH insights needed to meaningfully reduce disparities gaps and address both health and non-health needs. Leveraging Isthmus, our cutting-edge digital data environment, PCCI created the Community Vulnerability Compass (CVC), a web-accessible toolkit, which in 2022 has been expanded to enable stakeholders across Texas to visualize key SDOH indicators (curated, normalized, and indexed) that can be used to measure health, resiliency, and economic vibrancy of neighborhoods at the ZIP code, census tract, or block-group levels. This tool calculates one aggregated Index measure – Community Vulnerability Index (CVI) and five clustered sub-indices. This data can be 'zoomed up' or 'drilled down' to reveal the mosaic of needs present in a community and better pinpoint where needs are the greatest, what those needs are, and accessibility of vital resources that fulfill those needs.



2022 Through *Know Thy Patient,* grouping patients in a new way to enable more holistic approaches to care

Traditional disease-based clinical programs have been effective in managing and treating specific medical conditions, but often fail to effectively address the complex needs of patients, particularly with respect to barriers to healthcare access (e.g., social vulnerabilities, transportation barriers, lack of insurance coverage). In close collaboration with Parkland, PCCI developed a novel, advanced analytics process called Know Thy Patient (KTP) to group patients other than by their primary disease or diagnoses (e.g., diabetes, hypertension).

By integrating and analyzing metrics associated with barriers to health care access — social vulnerabilities, transportation barriers, lack of insurance coverage — into the clinical context, health strategies adopting these cohort-similarity approaches can more readily incorporate a wider variety of patient-centered, whole-person approaches to care, such as integrated practice units, targeted digital programs, virtual and in-person support groups, and focused outreach and communication.

> "A critical step toward creating a holistic health care intervention plan is to understand and eliminate access barriers. Access for individuals and groups in health care is defined as "the timely use of personal health services to achieve the best possible health outcomes."
>
> *- New England Journal of Medicine Catalyst, August 23, 2022*

> "These KTP insights drove a decision to explore the individuals/clusters who were cardio-metabolically high risk (CMHR) and individuals with both diabetes and hypertension diagnoses to design access sites and programs consolidating clinical expertise and diagnostics to meet these patients' complex needs and better manage their health."
>
> *- New England Journal of Medicine Catalyst, August 23, 2022*

Since 2015, PCCI has been working with stakeholders (like PCHP and Parkland) to design and implement innovative programs to improve health outcomes for children with asthma. Emergency room and hospital care consume more than half of the annual asthma-related U.S. healthcare costs, and asthma is the most common chronic childhood condition and a leading cause of death in Dallas County.

GROUNDBREAKING WORK FOCUSING ON PEDIATRIC ASTHMA

OCT '15

New research from PCCI shows reduced impact asthma has on patients & hospitals in joint program with the PCHP

MAY '18

Leveraging PCCI's Innovation Bridge at Parkland, PCCI announces early results of predictive modeling, patient engagement to address pediatric asthma

MAY '19

Parkland Health adapts PCCI's pediatric asthma model to its CHNA program

DEC '19

PCCI and PCHP's program on asthma and preterm birth prevention was featured as a poster presentation at December's Institute for Healthcare Improvement (IHI) Scientific Symposium

JUN '20

PCCI and Parkland Health introduce "Breath for Life & Learn for Life" initiative focusing on upstream asthma interventions to engage and improve patient care

2022

PCCI's collaborations with Parkland Health continue with initial results from Breath for Life & Learn for Life and initiation of the Pediatric Asthma Surveillance System (PASS) to further drive improved health outcomes for children with asthma

2022 Through *Breath for Life & Learn for Life,* improving pediatric asthma management with community collaboration

The Community Health Needs Assessment (CHNA) Breath for Life & Learn for Life program (began in 2020), is an upstream, community-based collaborative effort between Parkland, PCCI, DCHHS, and multiple other community organizations to identify high-risk asthmatic kids early and improve their asthma management. Targeted to children in six high-risk ZIP codes, the engagement model implements an educational text-messaging program that includes patient symptom and medication adherence monitoring, utilizes a predictive model for data-driven risk assessment and interventions, incorporates broad collaboration with DCHHS and other organizations to improve asthma self-management capacity, and helps reduce asthma-related Emergency Department utilization through enhanced community engagement.

4,696 patients were risk-stratified, of whom 1,793 were very-high- or high-risk:

- **2,496 children were enrolled in a text-messaging program, which resulted in 36% reduction in asthma-related ED visits**

Home-based visits were associated with

- **29% increase in Asthma Action Plan uptake**
- **26% improvement in asthma symptoms control.**

WE ARE CONTINUING TO MOVE UPSTREAM TO COLLECTIVELY IMPACT HEALTH THROUGH DATA-DRIVEN, COMMUNITY-WIDE EFFORTS

Families find value in the Breath For Life program as it helps manage appropriate delivery of medications to their children, facilitates timely notification when their children's asthma is acting up, and prompts them to monitor their children's asthma more proactively:

"It reminds me to ask my child about his asthma symptoms on a regular basis. I used to wait for [my child] to tell me when his symptoms were bad."

The program also facilitates coordination across providers for timely access to needed care:

"My child was out of his medication, and I couldn't get an appointment with his lung doctor. I was able to get an appointment with one of the Parkland clinics and get refills on all his asthma meds."

2021 Through *PASS,* combining clinical and social risk to support a comprehensive, whole-person approach to ensure the best possible health outcomes for kids with (or at risk for) asthma

Strong evidence supports the role of structural as well as social factors in the development and progression of asthma. And implementing both social and structural interventions have the most significant potential for major impact on asthma outcomes and closing the asthma disparity gap. Given this need, the scope and expanding intervention touchpoints of our ongoing community-wide collaboration and the need to reduce the disparity gap and impact asthma long-term, it is extremely important to ensure that all stakeholders have a single source of the most accurate, in-depth, real-time data that they can quickly access, understand, disseminate and act upon to ensure the most effective, coordinated, evidence-driven programs and the best possible health outcomes.

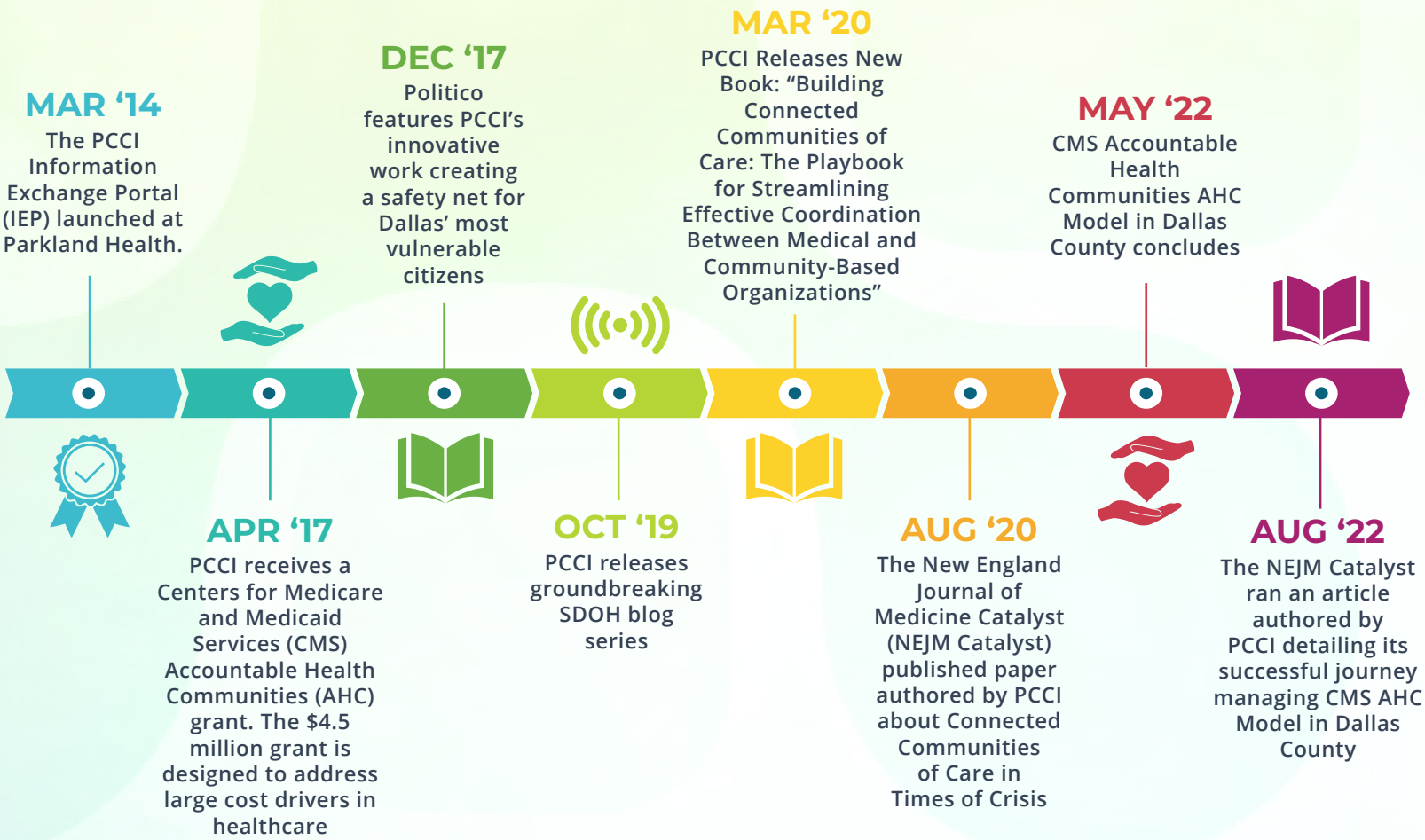
To address this important need, PCCI is working to build the Pediatric Asthma Surveillance System (PASS), a dynamic dashboard to track and monitor pediatric asthma at the community, neighborhood, and individual levels in real time to decrease asthma morbidity and increase prevention awareness. We are creating a Pediatric Asthma Risk Index and public-facing dashboard that reveals both where children with uncontrolled asthma live and their related risk factors based on geographic location. The Pediatric Asthma Risk Index will utilize relevant hyperlocal data, including air quality, healthcare utilization and costs, housing and transportation data, and other neighborhood conditions to identify asthma hotspots and highlight vulnerable areas in our Dallas community. Following this, we plan to build a provider-facing dashboard that provides real-time, patient level data to facilitate more effective and comprehensive whole-person interventions.

PASS will improve the capacity of community stakeholders (including providers) to incorporate upstream, contextual SDOH factors and other important data into local policies, programs, and interventions to prevent asthma and hospitalizations due to asthma and close the asthma disparity gap. It will also promote coordination and synergy with partners across Dallas County as a single source of truth for pediatric asthma, enabling these stakeholders to meaningfully evaluate the impact of their efforts on the long-term health outcomes, quality of life, and care experience of kids with asthma (and their families).

PASS WILL TRACK AND MONITOR PEDIATRIC ASTHMA AT THE COMMUNITY, NEIGHBORHOOD, AND INDIVIDUAL LEVELS IN REAL TIME, ALLOWING OUR TEAMS TO TRACK PATIENT OUTCOMES.

PCCI was one of the first in the nation to design and build a cross-sector enrollment, referral, and navigation network—or Connected Community of Care (CCC)—to address the critical gap between clinical care and community services. There are now a number of different variations of a CCC or similar models that commuanities can utilize to achieve this goal. PCCI is one of the only organizations in the country that has participated in multiple CCC models to advance whole person health.

BUILDING CONNECTED COMMUNITIES OF CARE



2022 Through the *Accountable Health Communities,* proving that identifying and addressing a patient's health-related social needs through cross-sector collaboration and patient navigation DOES make a difference

In 2022, we concluded the CMS Accountable Health Communities (AHC) Model, a five-year initiative to test whether systematically identifying and addressing health-related social needs (HRSNs) of Medicare and Medicaid beneficiaries (housing instability and quality, food insecurity, utility needs, interpersonal safety, and transportation) through screening, referral, and community navigation would reduce utilization and reduce inpatient and outpatient utilization. [1]Bridge organizations (such as PCCI) served as 'hubs' in their communities, forming partnerships with their state Medicaid Agencies, local clinical delivery sites (such as Parkland, our largest site), and community service providers to conduct HRSN screenings, navigate beneficiaries to community service providers in their communities, and align model partners to optimize community capacity to address the HRSNs. PCCI partnered with 17 clinical sites, representing the region's top healthcare providers (e.g., Parkland) and more than 100 local community-based organizations (CBOs) to establish the Dallas Accountable Health Community (DAHC).

> **"Importantly, the DAHC showed that combining clinical care with appropriate social services to address HRSNs — at the right time and by the right personnel — resulted in lower utilization and a decrease in health care expenditures. These two factors alone argue for the expansion of the initiative to other at-risk populations while establishing the initiative's long-term sustainability."**
>
> ***- New England Journal of Medicine Catalyst, August 2022***

CONTINUING TO FIND WAYS TO DEMONSTRATE THE POSITIVE IMPACT OF CONNECTED COMMUNITIES OF CARE ON THE HEALTH AND WELL-BEING OF OUR MOST VULNERABLE RESIDENTS

[1]This project was supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4.5M with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

“Results show that actively navigated individuals experienced a greater decrease in per-person ED visits than those in a comparable control cohort, with the navigation cohort having a statistically significant reduction in average ED utilization, both while actively navigated and in the 12 months after navigation. The navigated cohort also demonstrated a greater likelihood to seek — and keep — outpatient visits compared with thecontrol cohort.”

- New England Journal of Medicine Catalyst, August 2022

2022 DAHC *Impact* from the viewpoint of those it serves

The DAHC also demonstrated the importance of experienced navigators who regularly engaged with the local beneficiaries to ensure their HRSNs were resolved. To better understand this relationship and the impact of DAHC on those participating Dallas County residents,we surveyed program participants.

What they liked most about the program:

38% (n=161)
liked the personal connection and calls the Community Health Workers performed

35%(n=142)
liked the help they were given

25%(n=102)
liked the information given to them

2% (n=6)
didn't like anything the most

How the program helped or made a difference:

65% (n=69)
said the difference was in the helpful information and access to resources

14% (n=15)
did not feel that it helped

21% (n=23)
felt helped by the care and support of the CHW through phone calls

> **"It was nice to hear that there was help. I didn't feel alone."**

IN THEIR OWN WORDS:

How the program made a difference in the lives of DAHC participants:

> **"It helped me out in so many ways with my first baby. As moms we think everything will be easy, but there was so much I didn't know about that helped me."**

> **"It made a big difference for me both emotionally and with my physical needs like food and bills. To know Parkland cares about us means so much!"**

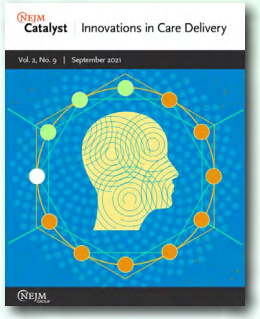
THOUGHT LEADERSHIP: PUBLICATIONS

PCCI makes a concerted effort, as part of its mission, to share its innovative programs, concepts, and successes with the widest audiences possible. We seek to accomplish this through actively publishing in respected, peer-reviewed publications, making direct presentations to other healthcare leaders at conferences and seminars, and building relationships with media that carry our messages directly to the public.

In 2021-2022, PCCI's media outreach program generated 571 articles about the organization, its programs and staff, reaching millions. This includes national and local media: broadcast television, radio, print and online media. PCCI appeared in the media more than two times for every workday in FY 2021-2022. Highlights include appearing regularly in Kaiser Health News, front page stories and editorials in the Dallas Morning News, and coverage by top national healthcare trade media.

PCCI's Xiao Wang, PhD and Yolande Pengetnze, MD, contributed to this important article examining the role of Medicaid in postpartum cases.

Extending Postpartum Medicaid Beyond 60 Days Improves Care Access and Uncovers Unmet Needs in a Texas Medicaid Health Maintenance Organization



The New England Journal of Medicine/ Catalyst article authored by members of PCCI, the Institute for Healthcare Improvement and the Cincinnati Children's Hospital Medical Center examines PCCI's approach to determining #covid-19 #herdimmunity in #Dallas County.

Rethinking Herd Immunity: Managing the Covid-19 Pandemic in a Dynamic Biological and Behavioral Environment

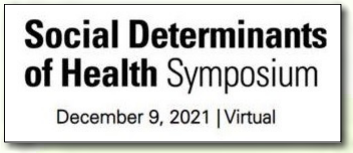
NEJM Catalyst features PCCI's "Know Thy Patient" program that provides an important step towards identifying #Dallas County residents' needs for access to Parkland Health, advancing Parkland's strategic plan to achieve a healthier community.

Know Thy Patient: A Novel Approach and Method for Patient Segmentation and Clustering Using Machine Learning to Develop Holistic, Patient-Centered Programs and Treatment Plans

The New England Journal of Medicine/ Catalyst published a paper by PCCI on the challenges and successes during PCCI's 5-year involvement in a federally supported study of care delivery efforts to address SDOH through community collaboration and patient navigation.

The Dallas Accountable Health Community: Its Impact on Health-Related Social Needs, Care, and Costs

THOUGHT LEADERSHIP: PRESENTATIONS AND RECOGNITIONS



Modern Healthcare's Social Determinants of Health Symposium

PCCI's Steve Miff, PhD and Leslie Wainwright, PhD and Parkland Hospital's Brett Moran and Texas Health and Human Services Commission's Dan Culica presented at last December's Modern Healthcare's Social Determinants of Health Symposium where they shared the innovative concept: "Addressing the Personal Determinants of Health."

NIH Pragmatic Trials Collaboratory

PCCI's George (Holt) Oliver, MD, presented "ICD-Pieces: Improving Care for CKD, Diabetes and Hypertension in Health Systems" at the Pragmatic Clinical Trials Grand Rounds in April.

DFW Hospital Council Foundation

PCCI's Chief Digital Officer, Rusty Lewis, was a featured panelist at the DFW Hospital Council Foundation's second meeting of its new Healthcare Performance Improvement Group. The panel Lewis contributed to was called "Quantification of Performance Improvement/Quality Outcomes ROI."

ECRI Podcast: Identifying and combating disparities

In this podcast hosted by ECRI, Parkland Health's Brett Moran, MD, and PCCI's CEO Steve Miff, PhD, discuss their data-driven approach to identify and combat disparities and realize their vision of creating a Dallas County with equitable, accessible healthcare for all.

SMU Dedman School of Law's program: Emerging Frameworks for A.I. in Medicine

PCCI's Steve Miff, PhD, was one of several luminaries to speak at the SMU Dedman School of Law's program: Emerging Frameworks for A.I. in Medicine. Dr. Miff contributed his expert views in its panel "Applying Medical A.I." where he noted that when modeling, to be extremely cautious of filtering or screening data in ways that may introduce unanticipated bias even when the aim is to do good.

TCU School of Medicine

PCCI's Steve Miff and Leslie Wainwright, PhD joined TCU School of Medicine's Dean Stuart Flynn teaching a course on artificial intelligence and social determinants of health for first year medical school students.

HealthLeaders Exchange podcast

PCCI CEO Steve Miff, PhD, spoke on an episode of HealthLeaders Exchange podcast "Healthcare Makes No Sense," where he talked about his immigration from Romania, and how his work at PCCI helps to address the needs of North Texas' vulnerable populations.

Davies Public Health Award

Parkland Health, PCCI, and DCHHS recognized for Health Technology Innovation; receive first Davies Public Health Award from HIMSS since 2012.

Nonprofit and Corporate Citizenship Awards

PCCI was a finalist in DCEO's fifth annual Nonprofit and Corporate Citizenship Awards, presented in partnership with the Communities Foundation of Texas. PCCI is a finalist for Organization of the Year.

United Way of Metropolitan Dallas Health Innovation Technology Prize

The United Way of Metropolitan Dallas awarded $1M in Health Innovation Technology Prize Funding with Parkland and PCCI earning a portion to provide a new pathway to wellness for at-risk adolescents aged 14 to 17 in the Dallas community.

Excellence in Healthcare Awards

PCCI's CEO Steve Miff, Phd, was named the Outstanding Healthcare Innovator at the DCEO 2022 Excellence in Healthcare Awards.

D500 List

For the third year running, PCCI has been named to the 2023 D500 list. The Dallas500 recognizes influential leaders in North Texas across a variety of industries.

DIVERSITY, EQUITY, AND INCLUSION ARE THE CENTER OF OUR WORK

PCCI continues to celebrate and embrace diversity, equity, and inclusion (DEI) in everything we do both internally and externally. We strive to understand and appreciate the culture and background of everyone. Our mission is to address the needs of vulnerable—and diverse—communities. We know our employees' diversity—"who they are"—is critical to fully understanding the people we serve. Listening to and understanding the needs of the communities we assist is necessary to create innovative solutions to address health equity.

As we believe diversity is as a driver of institutional excellence and innovation, we seek to create a culture of respect that welcomes team members to an environment where each person can grow successfully. We also intentionally seek, recruit, and retain talented staff members who embrace and are representative of diverse populations. In 2022, 50% of PCCI employees are women (up 1% from 2021) and 71% of these women represent diverse ethnicities. Recognizing that STEM fields are often male dominated, PCCI's Advancing Women in Data Science & Technology/Sachs Summer Scholars Internship program continues to be one of the more prestigious internship programs in North Texas. It provides unrivaled opportunities for high school, undergraduate, and doctoral female students from diverse backgrounds to work side-by-side with PCCI data scientists and clinicians and directly contribute to projects benefiting the community. In 2022, we are proud to report that 57% of our participating college interns and 67% of our participating high school interns are from diverse ethnicities.

In service of our diversity goals, we also embed cross-cultural learning opportunities to advance a culture of respect for and appreciation of others. Our 2022 DEI initiatives included: A three-day conference attended by the Chief Diversity Officer, creation of the PCCI DEI Council (which will focus on DEI metrics for annual evaluation), and ongoing celebrations of special cultural events throughout the year, such as Black History Month, Chinese New Year, Ramadan, National Asian American Day, PRIDE day, and National Hispanic Heritage month, through special presentations and messaging from employees.

PROGRESS
We value progress over perfection. Our work is both innovative and practical.

COLLABORATION
We collaborate with our team, our partners and the community enabling us to go further, faster. There is power in diversity and numbers.

CARING
We have a great servant approach and mind frame. Caring about each other, our partners and those we serve in the community is what motivates us every single day.

INITIAVE
We go beyond what is asked of us. Expectations are starting points.

SCIENCE
We balance Innovation with science. Our work is grounded in scientific principels and rigor.

VISION
"We can do it if..." vs. "We can't do it because..." We see healthcare, not as it is but as it can become.

DIVERSITY AND INCLUSION
We celebrate and embrace diversity, equity and inclusion in everything we do internally and externally.

LOOKING AHEAD—BUILDING AN INSTITUTION FOR THE LONG TERM

Despite accelerated advances across health care, as a country we have been unable to equitably implement applications of digital health that address current care access and delivery challenges. Unless action is taken, groundbreaking advances in uses of data to radically change care delivery models (e.g., to personalize care and make it more accessible) will only benefit the economically advantaged and leave vulnerable populations behind. This is not a new or unrecognized problem, but we have made little progress in solving it. But we are now squarely in the middle of the digital revolution and advanced uses of data, applied data science, and creation of relevant digital tools offer solutions that up until now have not been possible. Better health care for all is within reach, but requires deeper, data-informed insights into the barriers/challenges facing vulnerable populations and the coordinated creation of digital solutions that are equitably built and scaled to drive regional impact and systemic change.

The aim of PCCI's new Data Science Institute will be to harness the power of data in fundamentally new (and democratized) ways to better understand hyper-local community and individual context, to address immediate (and foundational) regional access issues, and to co-create and collaboratively deploy/scale culturally-relevant digital solutions that lead to good health for all.


PCCI