CFO strategies for balancing fee-for-service and value

How leading healthcare organizations are financing the shift to value-based care

IBM

Introduction

As the US healthcare system begins to shift toward a value-based reimbursement model, healthcare organizations need to adjust their thinking about the concept of return on investment (ROI).

Conventional ROI measures the ratio between the cost of new equipment, software, or staff and the savings and/or revenues they generate. But in a world where providers are rewarded for meeting quality targets and/or are at financial risk for medical costs, the definition of ROI has to change. It should reflect the ability of solutions to increase staff efficiency and contain healthcare costs.

Analytic and automation tools can be used to manage population health, and they're now indispensable in helping providers obtain higher value-based payments. The best technological solutions designed for population health management offer four types of ROI:

- Medical cost savings and quality improvements that increase revenue under risk contracts
- Bigger pay-for-performance rewards because of patient outreach and higher quality care
- Reduced long-term cost of care by improving chronic care and prevention
- Operational savings that can be reinvested in care management

What follows is a discussion of how healthcare organizations should measure health IT ROI in the new environment. Examples of how specific healthcare providers approach this issue are included. The paper concludes with a hypothetical scenario that shows how all four sources of ROI can be calculated.

Background

Hospitals and healthcare organizations face an increasingly adverse financial environment

Hospital margins returned to pre-recession levels in 2012, mainly because of increased emergency department and outpatient business.[1] But healthcare reform and value-based reimbursement are creating new challenges.

The Affordable Care Act (ACA) has proved to be a mixed blessing for healthcare organizations so far. Fewer of the uninsured are signing up for coverage than expected.[2] Only about half of the states have expanded Medicaid.[3] High deductibles in many insurance exchange plans are expected to discourage some members from seeking care.[4] And some insurance companies are keeping costs down in the exchange plans by selectively contracting with lower-cost providers.[5]

Meanwhile, Medicare and Medicaid payments continue to cover only part of care delivery costs.[6] The percentage of hospital expenses that go to bad debt and charity care is rising.[7] And the ability of hospitals to bargain with commercial payers depends largely on their market clout – a key reason for the new wave of consolidation among healthcare providers.[8] Physicians have little bargaining power: their average reimbursement from private plans fell 9 percent in 2012 and 10 percent in 2011.[9]

Healthcare organizations also must bear growing costs that result from unfunded government mandates. These include investments in health IT to meet Meaningful Use requirements that, for hospitals and large physician practices, can be in the multimillion-dollar range.[10] The industry-wide conversion to ICD-10 diagnostic codes will also be very expensive when software and training costs and productivity losses are included.[11]

While fee-for-service still dominates, healthcare providers can expect to see value-based payment methods account for a progressively larger amount of their revenue in coming years.

Hospitals have absorbed $113 billion in legislative and regulatory payment cuts since 2010.[12] The Centers for Medicare & Medicaid Services (CMS) is also reducing payments to hospitals that have excessive readmission rates.[13] Many hospitals are being penalized financially under Medicare's value-based payment program if their costs are too high or if they miss quality targets.[14] Starting next year, groups of 100 or more eligible professionals will be subject to CMS' value-based modifier.[15]

Transition to value-based payments

The introduction of the value-based modifier is part of a larger trend in the industry: the move to value-based reimbursement. While fee-for-service still dominates, healthcare providers can expect to see value-based payment methods account for a progressively larger amount of their revenue in coming years.

Value-based reimbursement started 15 years ago with the introduction of pay-for-performance programs. Under these programs, health plans offer financial incentives to physicians for meeting their targets on a number of quality measures.[16] To reach these targets, practices must regularly measure their performance – a nearly impossible task without the use of information technology.

Several years ago, the patient-centered medical home (PCMH) movement began to gain traction. As payers started to see the potential of this approach for lowering costs, they began to reward physician practices for gaining PCMH recognition. The National Committee on Quality Assurance (NCQA), which recognizes the bulk of medical homes, requires that practices show 27 elements in six categories for the highest level of PCMH recognition. The majority of those criteria involve the use of health IT in one way or another. [17]

Meanwhile, both CMS and private payers are encouraging the development of accountable care organizations (ACOs), networks of hospitals and practices that take responsibility for the cost and quality of care. From 2012 to 2013, the number of ACOs doubled to nearly 500; one recent estimate puts the number at over 700.[18, 19] Some ACOs participate in the Medicare shared savings program (MSSP), which allows them either to share savings only or to take financial risk from CMS.[20] Many ACOs have shared savings or risk contracts with commercial insurers, some of which are also ACO co-developers.[21]

The MSSP requires ACOs to meet quality goals on 33 measures.[22] Because of this and because they must coordinate care among disparate providers, ACOs are heavily dependent on health IT. As explained later, they must also use specialized solutions to manage population health, which is especially important if they're taking risk.

Bundled payments, which are budgets for episodes of care, are also growing in importance. CMS recently launched a bundled payment demonstration project,[23] and many healthcare organizations are entering or considering entering bundled payment agreements with private payers.[24] Typically, these arrangements involve a hospitalization and post-acute care for a specified period, although some providers are also experimenting with payment bundling for episodes of chronic care. Again, health IT is indispensable, not only for communications between hospitals and other providers, but also for tracking services and dividing payments.

At this point, most healthcare organizations recognize that the payment system is changing and that they must prepare for value-based reimbursement. They know they can't do it without health IT. But in the current economic climate, they must be sure that they will see a return on their investment in software. So their financial officers ask, "How do we measure ROI?" The answer depends on the kinds of IT tools they acquire and how those tools can help them achieve their strategic goals.

Definitions

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The new return on investment

The evidence of "hard" ROI from legacy healthcare IT is mixed,[25,26] and the "soft" return from quality improvement has been difficult to prove. But when new applications for population health management (PHM) are combined with existing clinical data, the case that health IT can generate ROI is much stronger.

Today's clinical applications are typically designed for traditional fee-for-service sick care, not for PHM.[27] For a practice to become a patient-centered medical home or function effectively within an ACO, or for a healthcare organization to form a well-coordinated, high-quality ACO, it needs ancillary applications that can use clinical and claims data to manage population health. By automating the process of validating that all patients receive the right care at the right time, these tools can help organizations increase their value-based reimbursement, thereby achieving ROI.

Even in a fee-for-service environment, some ROI can be expected from the use of patient outreach applications that spur patients to make appointments for needed preventive and chronic care. But the majority of the ROI from PHM solutions emerges in the business models that reward higher quality and efficiency. These rewards include pay-for-performance (P4P) incentives, patient-centered medical home payments, ACO shared savings and risk contracts, bundled payments, and the potential upside of Medicare's value-based modifiers.

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According to the Health Information Management and Systems Society (HIMSS), health IT can create five kinds of value, including:

- **Satisfaction** of patients, providers, staff, and others
- **Treatment/clinical** – patient safety, quality of care, and efficiency
- **Electronic information/data** – use of evidence-based guidelines, data sharing, population health, and quality reporting
- **Prevention/patient education** – improved disease surveillance and patient compliance with therapies
- **Savings** from improvements such as reduced days in accounts receivable, patient wait times, and emergency department admissions[28]

In HIMSS' schema, value extends far beyond the hard ROI of prompt savings and revenue increases. The value created by health IT benefits not only providers, but also patients, payers, and the community – in other words, those who determine what providers are worth and what they should be paid. If value-based reimbursement is framed in these terms, PHM solutions hold the key to ROI in the new healthcare environment.

Automated population health management

Population health management requires healthcare organizations to optimize the health of their patients. Instead of focusing mainly on diagnosis and treatment, providers must also try to prevent patients from getting sick or sicker. They must do this as efficiently as possible to conserve the limited amount of healthcare resources.

The Population Health Alliance defines PHM as an approach to care delivery that includes these components:

- The central care delivery and leadership roles of the primary care physician
- An emphasis on patient activation, involvement, and personal responsibility
- The patient focus and capacity expansion of care coordination provided through wellness, disease, and chronic care management programs[29]

To achieve these goals, a provider organization must make sure that all its patients receive appropriate preventive and chronic care. Since not all patients visit their providers on a timely basis or adhere to their care plans, organizations engaged in PHM have to reach out to engage patients between visits. They must also monitor their patients' health, engage them in self-care, and provide them educational materials about their conditions. They have to stratify their populations by health risk and provide care management to their highest-risk patients. And they must supply clinical decision support to their providers so that they know which patients need preventive and/or chronic care when they come to the office.

It is too expensive and time-consuming for healthcare organizations to do all this work manually. For example, many organizations have hired care managers to manage severely ill patients. These care managers may not be able to serve all the people who need their help because they must spend so much time doing routine tasks like searching for patient data and trying to contact patients.

The addition of care managers and other health professionals required to do population health management substantially increases the ratio of clinical staff to physicians in patient-centered medical homes. In a 2013 study, researchers interviewed nine administrators of primary care practices, seven of which included at least one PCMH. Based on the results of those interviews and other data, they calculated that a PCMH requires 4.25 FTE staff members per FTE physician, 1.57 staffers more than the average primary care doctor does in a non-PCMH practice. Most of this difference represents the hiring of nurse care managers. The incremental cost of this proposed infrastructure is $4.68 per member per month.[30]

Healthcare systems and group practices can't afford this many care managers, so they must consider ways to automate the process. Based on time-motion studies at Prevea Health, a multi-specialty group in Green Bay, Wisc., automation enables care managers to manage two to three times as many patients as they can with manual methods. Routine tasks such as chart prep and patient follow-up communications take less time when they're automated, the internal studies show.

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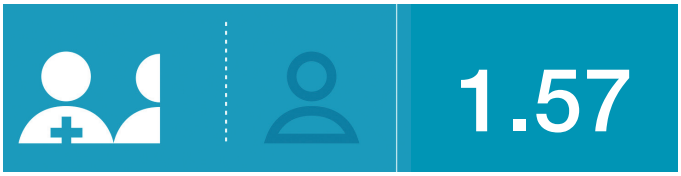
Research shows that a patient-centered medical home (PCMH) requires more care managers per practicing physician.



Automation saved Prevea Health from having to hire extra care managers.

By leveraging PHM technology to scale care management, the staff at Prevea Health is able to manage 2-3 times as many patients as they can using manual methods.

Automation software can enable organizations to reach the entire patient population on a periodic or as-needed basis, whether or not patients seek care.

It can provide care managers with near real-time information on patient health needs that allows them to prioritize their interventions. And it can provide timely alerts to providers about patient care gaps so they can be addressed during office visits.

The ROI of automation tools comes from multiple sources. Among other things, these applications can be used to:

- Message patients to make office appointments for necessary care
- Streamline operations, reducing the cost of labor
- Enable care managers to work with additional patients
- Improve the patient experience, helping organizations retain patients and increase market share
- Improve healthcare quality and reduce costs, enabling providers to qualify for higher value-based reimbursement

The literature on the ROI of these automation tools is slim. However, there is evidence that the PCMH – which relies on health IT as the basis of care coordination and quality improvement – has helped some healthcare organizations cut the cost of care. For example:

- Blue Cross Blue Shield of Michigan found that practices with full PCMH implementation had savings of $26.37 per member per month.
- In the Military Health System, the PCMH model led to 6.8 percent fewer ED visits, a 13 percent reduction in pharmacy costs, and a 16 percent decrease in ancillary costs.
- At UPMC Health Plan in Pennsylvania, a PCMH pilot was associated with 5.1 percent fewer ED visits, a smaller increase in hospitalizations than in non-PCMH practices; 12.5 percent fewer readmissions; and a 160 percent return on investment.
- CareFirst BlueCross BlueShield of Maryland saved $98 million on its PCMH initiative.[31]

Where provider organizations participate in shared savings programs, a part of these savings goes back to them. The initial progress report of the Medicare Shared Savings Program shows that these gains are real for some ACOs. In the first year of the MSSP, savings exceeded $380 million, and nearly half of the participating ACOs had lower expenditures than predicted. Of those 54 ACOs, 29 generated $128 million in savings that they shared with Medicare.[32]

Highlights

Population health management (PHM), which is intertwined with value-based reimbursement, requires healthcare organizations to optimize the health of their patients.

There is evidence that the PCMH – which relies on health IT as the basis of care coordination and quality improvement – has helped some healthcare organizations cut the cost of care.

How automation produces ROI

Patient outreach

Population health management requires a healthcare organization to maintain regular contact with all its patients, whether or not they visit their providers. To do this kind of outreach efficiently and in a way that results in better health outcomes, organizations need several kinds of automation tools. First, they must have patient registries that list all patients, their health problems, and what has been done for them. Combined with software that stratifies the patients by health risk and that shows their care gaps, these registries can be used to trigger automated messaging to patients who need preventive and/or chronic care.

Research has shown that these kinds of outreach programs raise the percentage of patients who visit doctors to obtain the recommended care. Besides improving the health of the population – which can garner value-based incentives – such tools can also reduce the long-term cost of care while capturing revenue for evidence-based chronic and preventive follow-up.

Prevea Health, a 180-physician multispecialty group in Green Bay, Wisc., has made good use of these tools. Since 2009, Prevea has built patient-centered medical homes in 15 primary care sites that include 50 providers and 17 care managers who care for 29,000 patients. But the group found that its medical homes couldn't manage population health effectively without automation.

Prevea automated the processes of identifying gaps in care and performing patient outreach. Patients who needed care received automated messages asking them to make appointments to see their providers. As a result, appointments for preventive and chronic care soared. According to a peer-reviewed study, patients with diabetes who received automated messages were three times as likely to visit their physicians and have an HbA1c test as non-contacted patients. And twice as many patients with hypertension who received this intervention had both a visit and a systolic blood pressure reading recorded in Prevea's EHR.[33]

Prevea hasn't done a formal analysis of its ROI from using automated outreach to bring in additional patients for follow-up care. But Bon Secours Virginia Medical Group did such a study and found that automated messaging generated $7 million in revenues from follow-up visits. Those 40,000 visits created an ROI of 16:1 on the group's technology investment.

Analytics

To use health IT in population health management, an organization must first develop the capability to collect, aggregate, and normalize the data on its patient population. After it has accomplished that task, it needs analytic and other tools to make the information actionable. Among these tools are applications for risk stratification, care gap identification, care planning, and care management. These solutions can be used for multiple purposes, including automated patient messaging, alerting providers, setting priorities for care managers, engaging patients, and evaluating provider and organizational performance.

Bon Secours Virginia Medical Group in Richmond, Va., a group practice with 475 providers – nearly half of them in primary care – has used analytics in conjunction with other health IT solutions in its PHM program. As a result of deploying all these tools, Bon Secours has seen a 6:1 return on investment.

Besides improving the health of the population—which can garner value based incentives—automated outreach tools also drive increases in fee-for-service revenue when patients visit their providers.

With the help of a PHM solutions vendor, Bon Secours aggregated data from its clinical information systems and other sources into a population-wide registry that enabled it to implement multiple quality improvement programs simultaneously. Besides stratifying the population by health risk, the registry allowed care teams to drill down to the data they needed about cohorts and individual patients. This enabled them to monitor their patients' health status and deliver timely, automated interventions.

Bon Secours participates in the MSSP and has value-based contracts with CIGNA and Anthem. These health plans give the organization regular monthly payments for care coordination, and the group has nearly reached the quality threshold necessary for gain sharing with CIGNA. Under its contract with that payer alone, Bon Secours expects to share in annual savings of $4 million.

Care management

A growing number of group practices have staff members who are dedicated to providing team-based primary care. But these care managers find it difficult to serve all their high-risk patients. Automated solutions can make the difference between success and failure in this all-important area.

One organization that has made significant progress in automating care management is Northeast Georgia Physicians Group (NGPG). Using a grant from the Center for Medicare & Medicaid Innovation (CMMI),[34] the 200-provider group combined a patient registry and automated messaging with a care management program for high-risk individuals.

Focusing first on out-of-control diabetic patients, NGPG assigned a nurse care manager to each one and gave the nurses authority to make certain clinical decisions, such as adjusting medications or dosages. In 120 days, NGPG decreased the HbA1c levels of its nearly 7,000 uncontrolled diabetics by an average of 1.6 points. More than half of the patients achieved significant reductions in A1c levels.

The group used the same automated solutions to engage the patients who visited the ER most frequently. With care managers contacting these patients to determine the reasons for their visits, NGPG was able to decrease their trips to the ER significantly within just three months.

While NGPG didn't measure its ROI directly, it's clear that the ability to prevent diabetic complications and keep people out of the ER can save money for the healthcare system. And when payers save money, they will share that with providers under value-based contracts.

Automated solutions can make the difference between success and failure in managing high-risk patients.

Patient engagement

One of the most potent tools in the population health management toolkit is not a piece of software. It's the patient, whose health behavior often holds the key to his or her future health status. But automation solutions can help care managers reach patients and motivate them to become active participants in their own healthcare.

A large regional health care organization demonstrated the power of patient engagement when their ambulatory group decided to initiate contact with patients prior to office visits and to get them involved in taking better care of themselves between visits.

This organization had an advanced EHR, but that system lacked the population health management tools required to make a difference in patient outcomes. In addition, the patient registry it had been using for years tracked only the patients a physician had seen in the previous 30 days.

After putting a more robust, population-wide registry in place, they initiated a pilot project aimed at improving the outcomes for a group of their patients with diabetes who had HbA1c levels >9. The group used analytics with their registry to identify these patients and alert care managers so they could intervene with them prior to office visits.

Once their nurses had their work list, they called the patients and encouraged them to get their lab tests done prior to seeing their providers. This organization's care managers were also able to educate these patients face-to-face after they'd seen their providers. Finally, they sent automated messages to the patients to thank them for their visits and urge them to call back if they had any questions about their plan of care.

The results of this campaign were positive. Approximately one-third of their patients who originally had HbA1c levels>9 are now below that level and most of the other at-risk patients have received specific education on how to manage their diabetes more effectively.

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Transistions of care

Many hospitals and healthcare systems are trying to reduce readmissions to avoid CMS penalties.[35] Hospitals are also paying increased attention to patient satisfaction, which can affect both their reimbursement and their marketing effectiveness. Scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the government's 27-item patient experience survey, are being

posted on HospitalCompare, a CMS website for Medicare beneficiaries.[36] And HCAHPS scores are factored into CMS' new value-based purchasing program, which can result in financial bonuses or penalties for hospitals.[37]

Hospitals are also concerned about the patient experience in their emergency departments. When people are satisfied with their ED experience, they're more likely to use the hospital for other procedures or tests they may need in the future. Many hospitals use the Press Ganey patient satisfaction survey to find out how well their EDs are doing.

Automation tools can be used to boost patient experience ratings while reducing the likelihood of readmission. One such application sends automated messages to patients within 24 hours after discharge from the hospital or ED. The messages ask the patients to complete a short assessment of their experience. They're asked how they're feeling and whether they understand their discharge instructions, have questions about their medications, and have made an appointment to see their primary care doctor. If they have questions, a care manager contacts them later.

Riverside Health System in Newport News, Va., has used this system in the ED at Riverside Regional Medical Center (RRMC) since 2012. In the first year, RRMC raised its ED's overall Press Ganey score from 58 percent to 63 percent and increased its patient recommendation score from 60 percent to 64 percent. At the same time, it improved the quality of care by providing additional support to patients who needed it. Riverside Health System has introduced the solution in the EDs of three other hospitals and plans to launch it in RRMC's inpatient units to boost its HCAHPS scores.

Prevea Health has also applied automation to transitions of care with the help of its two partner hospitals, St. Mary's Hospital Medical Center and St. Vincent's Hospital. Using an automation tool to identify at-risk patients who have just been discharged, Prevea has its care managers contact those patients within 24-72 hours after they leave the hospital. The care managers make sure that the patients understand their medications and their care instructions. This extra attention helps smooth care transitions and prevent readmissions.

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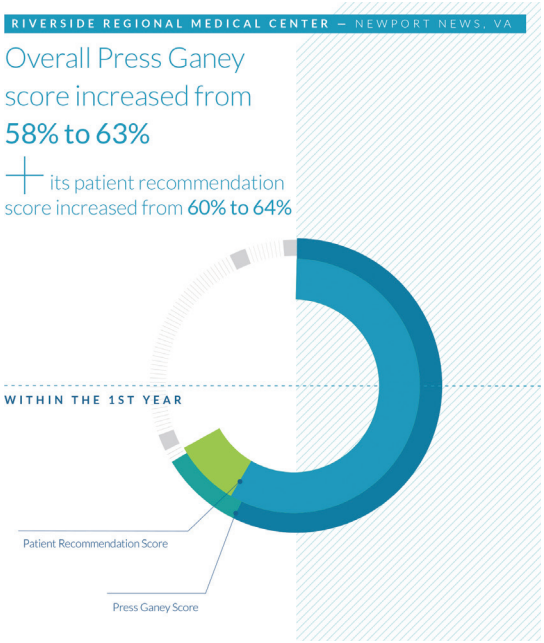

Figure 1: RRMC raised its overall Press Ganey score using automation

How to calculate ROI

Phytel has calculated the ROI that a group of 200 physicians can expect to derive from using its Outreach, Insight, and Coordinate solutions. This ROI comes from a combination of fee-for-service revenue, pay-for-performance incentives, and savings that represent increased revenues under risk contracts.

In brief, Phytel Outreach™ uses a population-wide registry and evidence-based clinical protocols to identify care gaps, send automated messages to all patients, and track the results of the contacts.

Phytel Insight™ applies analytics to the registry, allowing users to drill down to individuals and subpopulations and identify opportunities for care improvement. Phytel Insight also makes it easier to gather data and report on quality measures for value-based payment programs.

Phytel Coordinate™ stratifies populations by health risk. It identifies high-risk patients and gives care managers tools to execute focused interventions that help lower risks and improve outcomes. Phytel Coordinate also allows care managers to view care gaps prior to, during, and after a patient's visit to his or her provider. And it enables users to target outreach campaigns to subpopulations that need help, such as diabetic patients who have not received an A1c test in the past six months.

Patient outreach: Improve chronic and preventative care

Phytel's hypothetical physician group, divided evenly between primary care doctors and specialists, is caring for about 200,000 active patients. Twenty percent of the population, or 40,000 patients, are covered by insurance contracts that include pay-for-performance (P4P) incentives. Another 15 percent, or 30,000 patients, are covered by risk contracts.

About 45 percent of the fee-for-service population, or 76,500 patients, have not received all recommended care. Automated messaging can successfully contact 80 percent of the patients with care gaps, based on Phytel's experience. Of those people, 20 percent, or 12,240, will make appointments with their provider to receive necessary services, and 15 percent, or 11,475, will return for follow-up visits.

At an average office charge of $85, those visits to fill care gaps generate $2,015,775 in additional revenue for the group. That includes $1,040,400 in revenue from initial visits to help patients adhere to their care plans and $975,375 from follow-up encounters.

Pay for performance: Optimizing incentives

Phytel Coordinate drives automated messaging to the entire population, across the gamut from healthy people to those with advanced illnesses. In a P4P population of 40,000 patients, care managers would have to make 247,200 phone calls to reach 80 percent of the patients. At an average 1.5 minutes per call, that task would require 6,180 hours. By not having to make those calls, care managers would be freed to work closely with patients at risk of complications, improving the group's P4P scores.

Let's assume that, by using manual methods of care management, the group was able to qualify for 25 percent of available P4P incentives. At an average rate of $1.50 per member per month (PMPM), the practice would receive just $165,000 of an incentive pool of $660,000 for the year. But if the increased productivity of care managers could help raise that percentage to 95 percent, the group would get $627,000, representing additional P4P revenue of $462,000. If the incentive were raised to $2.00 PMPM in the second year, the extra income would be $616,000; if it rose to $2.50 PMPM, the group would receive an extra $770,000.

Risk contracts: Lowering overall costs

As in the P4P example, automated messaging would also give care managers additional time to work with high-risk patients covered by prepaid contracts. Assuming that 30,000 patients were covered under these agreements, 185,400 calls would be required to reach 80 percent of them. At 1.5 minutes per call, the automated messaging would save the nurses 4,635 hours that they could use in care management.

Based on the average costs of care delivery, the calculation indicates that this population would generate medical expenses of about $165 million a year. If a care management program powered by automation tools could save only 0.5 percent more than could be achieved through manual efforts, that increment would represent a cost decrease of $825,000. Under a financial risk contract, that additional money drops straight to the group's bottom line.

ROI summary

Looking at the three sources of ROI for Phytel's 200-doctor group, projections indicate that the use of PHM automation tools would produce annual revenues of $2,015,775 from fee-for-service visits, $462,000 from P4P, and $825,000 from at-risk contracts. Those amounts add up to $3.3 million, many times the cost of the software for a group of this size.

The staff efficiencies created by automation can also be measured. In the scenario described, the group would save 10,815 hours that could otherwise be spent contacting patients. That's equivalent to the annual work of 5.6 full-time care managers. However, no organization would assign nurses to do nothing but dial patients all day long. What often happens in groups without automation tools is that most patients simply do not hear from their providers between visits.

The time savings created by automation could result in a hard ROI from lowering the number of care managers. But an organization that is trying to optimize its value-based reimbursement would be wiser to reinvest the time savings in greater productivity for its care managers. By enabling them to intervene with more patients, the organization can achieve ROI by providing more value to payers.

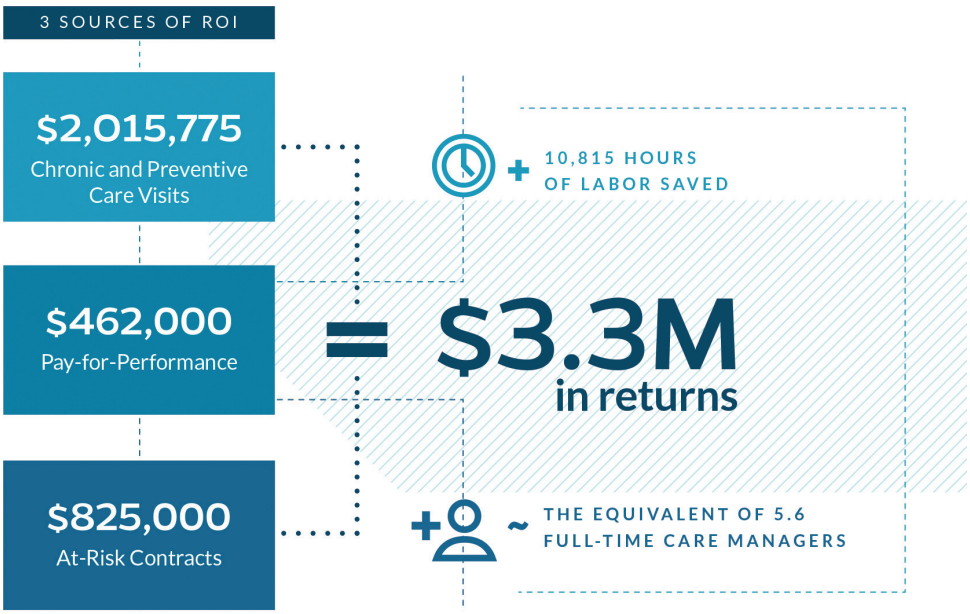

Figure 2: Three sources of population health management ROI

Conclusion

The transition to value-based payment requires a new kind of thinking that equates waste reduction and quality improvement with income. This new approach must also be applied to thinking about return on investment. The investments that used to produce revenue – and that still do, in many cases – will not necessarily be the ones that will lead to financial success in this new world.

What will generate ROI are investments in information technology that helps organizations work with patients to produce better health outcomes. Care managers are an essential part of this approach, but population health management initiatives that rely on manual methods are likely doomed to failure. Organizations need electronic tools that automate routine outreach tasks, and they need analytics that automate the process of risk stratification, care gap identification, and performance measurement. With these tools in hand, they can move forward more confidently to claim their share of value-based reimbursement.

Footnotes

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About Phytel, an IBM Company

Phytel, an IBM Company, is a leader in physician-led population health management software that develops and sells cloud-based services that improve long-term health outcomes by helping healthcare providers and care teams coordinate care and engage patients to positively influence population health. Phytel also enables providers to meet the new healthcare quality requirements and reimbursement models by delivering proven quality care to patients based on evidence of what works best.

About IBM Watson

In January 2014, IBM launched the IBM Watson unit, a business dedicated to developing and commercializing cloud-delivered cognitive computing technologies. The move signified a strategic shift by IBM to deliver a new class of software, services and apps that improves by learning, and discovers insights from massive amounts of Big Data. For more information on IBM Watson, visit: ibm.com/watsonecosystem.

About IBM Watson Health

In April 2015, the company continued to build on its strengths in cognitive computing, analytics, security and cloud with the launch of IBM Watson Health and the Watson Health Cloud platform. The new unit will help improve the ability of doctors, researchers and insurers to innovate by surfacing new insights from the massive amount of personal health data being created daily. The Watson Health Cloud allows this information to be anonymized, shared and combined with a dynamic and constantly growing aggregated view of clinical, research and social health data. For more information on IBM Watson Health, visit: ibm.com/watsonhealth

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