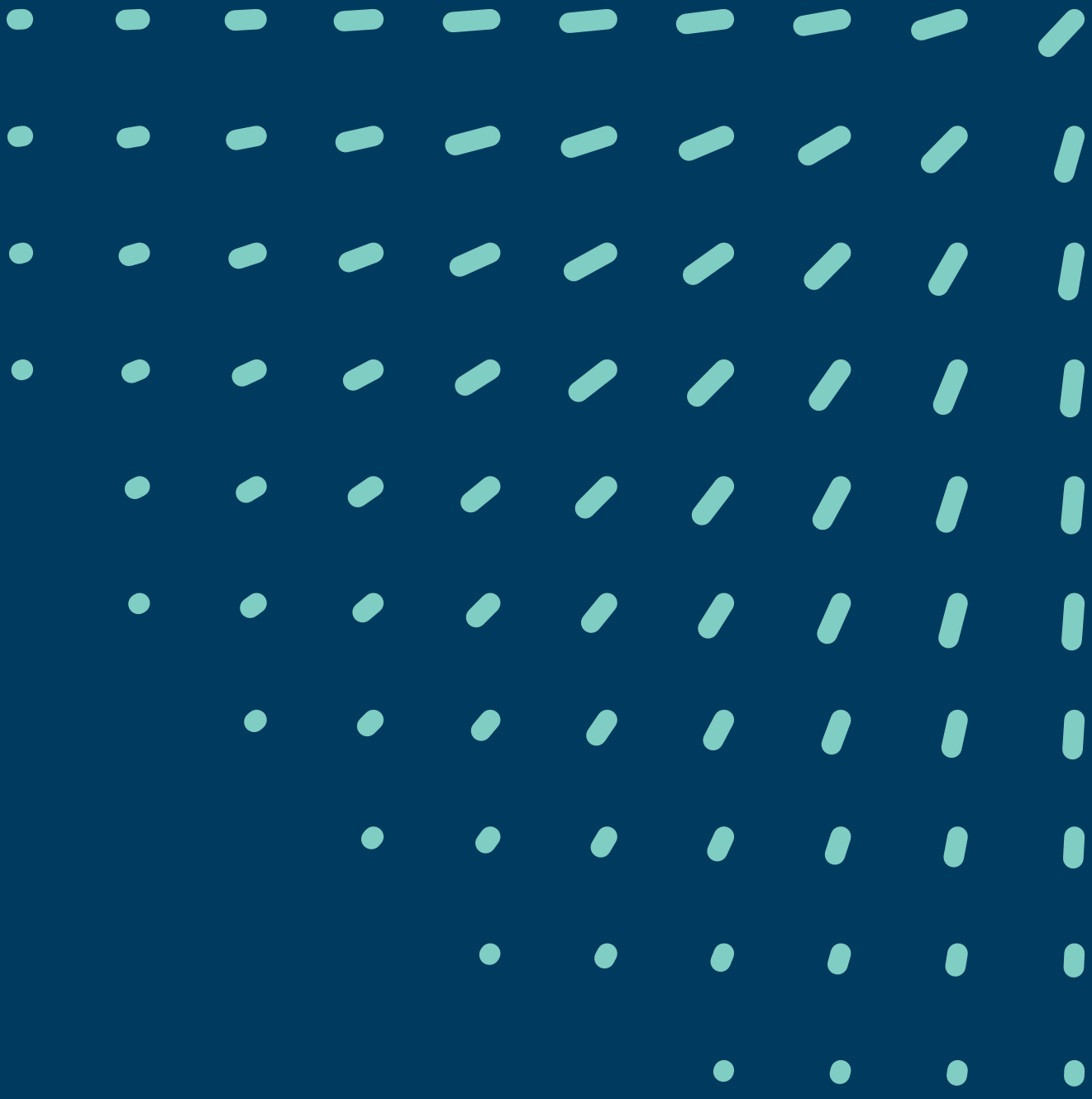
IBM Watson Health™

WHITE PAPER

Opioid Misuse

What employers need to know



Contents

Background

The opioid epidemic in the United States is a growing challenge for families and communities. Findings from the President's Commission on Combating Drug Addiction and the Opioid Crisis[1] spurred a declaration from the President[2] and the Acting Health and Human Services Secretary[3] that the opioid crisis is a national public health emergency. According to the National Survey on Drug Use and Health, an estimated 2.6 million people in the US had a prescription opioid or heroin use disorder in 2015[4].

Several factors are believed to have contributed to the rising national trends in opioid-related morbidity and mortality, including changes in pain assessment standards in 2001[5], drug marketing by pharmaceutical companies, increased prescribing of opioids, low perceived risk of dependence on prescription opioids, increased accessibility and decreased prices of heroin, and increased availability of illicitly manufactured fentanyl and fentanyl analogues.

Opioid misuse and dependence have also resulted in a significant and growing burden on the healthcare system. From 2005 to 2014, the rate of opioid-related inpatient hospital admissions increased by 64 percent (224.6 stays per 100,000 population in 2014), and the rate of opioid-related emergency department visits doubled (177.7 visits per 100,000 population in 2014)[6].

The toll of opioid misuse and dependence can lead to a myriad of issues for employers, such as absenteeism, workplace injuries, lost productivity and higher healthcare costs. Employers may not fully understand steps that they can take to proactively address this challenge. For example, employer-paid health plans may not cover all opioid treatment — particularly residential services — leaving the out-of-pocket cost burden for individuals or their families, or possibly resulting in under-treatment or treatment at a less-than-optimal setting. To date, state Medicaid programs have been at the forefront of addressing this challenge, and there are important lessons that can be learned from their experiences that can be applied in the private sector.

This paper examines the effect this disease is having on employers today and outlines ways that employers can begin to better understand and address this challenge.

Effect of opioids on employers

The effects of opioid misuse and dependence are very real for employers. Nearly 80 percent of businesses that responded to a poll conducted by the National Safety Council reported that they have been impacted by prescription drug misuse and dependence[7]. About two-thirds of businesses believed prescription painkillers are a bigger problem than illegal drugs. Indeed, the rates of diagnosed opioid use disorder among commercial enrollees has doubled since 2010 from two to four per 1,000[8], and the literature shows actual rates may be two to six times higher[9].

Individuals prescribed opioids are at risk for dependence[10], and many employees receive such prescriptions. For example, nearly 40 percent of individuals who seek help for lower back pain, one of the most common workplace ailments, were prescribed prescription painkillers by doctors according to a 2017 Truven Health Analytics® – NPR Health Poll[11]. Analysis of 2016 Truven Health* data, which covers over 100 million lives of employer-based health insurance claims, shows that about 22 percent of the workforce fills an opioid prescription each year and that opioids are prescribed during approximately 5 percent of medical encounters. Opioids are even more commonly prescribed to employees with injury-related workers' compensation/short-term disability claims, making this population particularly at risk[12].

Employees may receive dangerous combinations of opioid and other prescriptions or extremely high doses of opioids (greater than 50 morphine milligram equivalents [MMEs]) that put them at risk of overdose[13,14]. Truven Health data shows that in 2015, 7.1 percent of commercial enrollees had an overlapping opioid and benzodiazepine prescription, 5.7 percent had an overlap of two or more opioid prescriptions, and 1 percent had an extremely high dose of opioids (greater than 120 MMEs) for 90 or more continuous days. About 3.5 percent of commercial enrollees were prescribed opioids from three or more providers, making the incidence of these problematic prescriptions difficult to monitor.

Two other drivers of the opioid epidemic are leftover pills and poor storage of prescribed opioids. For example, the average opioid days' supply for commercial patients with more than one opioid prescription in 2016 was 51[15]. Excess pills may be misused by family members or others with access to an unsecured household medicine cabinet. Dependents appear to be particularly at risk for misusing opioids from leftover prescriptions[16].

*Solutions from Truven Health Analytics are being rebranded as IBM Watson Health™.

Once addicted, employees and family members may find that connecting to treatment is a challenge because there is a shortage of substance use disorder treatment providers in most areas[17]. Further, many frontline providers are not adequately trained or lack the resources to initiate withdrawal management and refer to primary treatment. A study of opioid-related inpatient admissions found that less than one-fifth (16.7 percent) of patients received any US Food and Drug Administration-approved opioid dependence treatment medication in the 30 days following discharge[17].

According to a recent study[18], opioid misuse could cost the private sector up to $50 billion per year, primarily in lost productivity and medical expenses. Health plan enrollees diagnosed with opioid use disorder cost over $15,000 more in annual healthcare costs relative to matched enrollees[19]. Healthcare costs of those with undiagnosed opioid use disorder are also elevated compared to individuals without opioid use disorder[20]. There are substantial health disparities between individuals with opioid use disorder and the general population, as noted below[21].

4.5 times

costlier ($26,501 versus $5,844 per member per year)

Almost **5 times**

more emergency room visits (1.07 versus 0.23 visits)

9 times

as many hospital admissions (0.47 versus 0.05 admissions)

3 times

more likely to have depression (59 percent versus 18 percent prevalence)

3 times

as likely to have back pain (52 percent versus 16 percent prevalence)

Workers who are dependent on opioids also have reduced at-work productivity, which costs employers approximately $16 million a year[22]. Workers who have a dependent or spouse with opioid use disorder may also experience reduced productivity if they are responsible for identifying and coordinating treatment for their loved one. Employees who use prescription opioids are more likely to have high workers' compensation claims[23] and are at risk for losing employment[24].

A multifaceted, coordinated approach

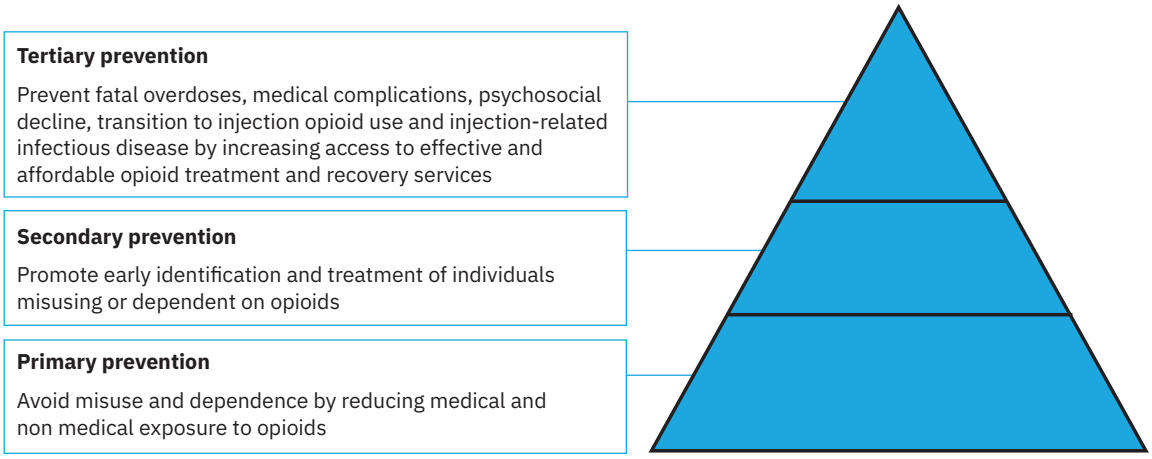
A multilevel, coordinated strategy is critical to tackling the opioid epidemic. Such a strategy would ideally prevent new cases of opioid misuse, identify possible opioid dependence early, link individuals to effective treatment and incorporate harm-reduction techniques.

A public health model can be used to identify opportunities for intervention: (1) primary prevention to decrease the incidence of the problem before it begins, (2) secondary prevention to reduce the prevalence upon early signs of the problem and (3) tertiary prevention to intervene after the problem exists and causes harm.

Lessons from Medicaid

Medicaid, which provides health coverage for 68 million Americans[25], has been on the forefront of responding to the opioid crisis through coverage and enhanced state capacity to provide early interventions and treatment. State Medicaid programs have used data and analytics to better understand the extent of the opioid crisis among beneficiaries, develop prevention and management strategies, and monitor outcomes to manage the epidemic. Employers, many of which also provide health coverage for employees and their dependents, may benefit from Medicaid strategies that address opioid misuse and dependence and prevent opioid-related harms. Specifically, here are several best practices that employers may want to consider:

Increase access to naloxone. In response to the opioid epidemic, states are expanding access to the opioid antagonist naloxone[26]. It is estimated that, on average, there is one overdose reversal for every 14.6 naloxone doses prescribed; this translated to nearly 7,000 life-saving reversals covered by Medicaid in 2016[27]. However, there is variability between states in covering the cost of naloxone. Some state Medicaid programs only cover the cost of the drug itself while other states — such as Colorado and Michigan — provide more complete coverage of naloxone products (such as medication vials, syringes, nasal spray and atomizers)[28].



Many states allow a layperson to possess and administer naloxone and have Good Samaritan laws, which provide immunity from liability when assisting in an overdose. In response to the epidemic, several states, such as Pennsylvania[29], provide coverage for naloxone prescribed to a family or friend. States have also purchased naloxone kits that can be administered in the community setting; for example, the Arizona Medicaid program reported it purchased 4,600 naloxone kits, which enabled 305 overdose reversals[30].

To facilitate increased access to and use of naloxone, employers should consider using existing communication channels to increase awareness of naloxone and methods for administration (intranasal spray, auto-injector or syringe). Employers with concerns about addicted employees in the workplace should also consider stocking naloxone kits and providing training to recognize and respond to opioid overdose with naloxone at worksite locations in areas with higher risk for opioid overdoses.

Expand coverage and access to treatment services. Medication-assisted treatment (MAT) for opioid use disorder, which combines medication (methadone, buprenorphine, or either oral or long-acting injectable naltrexone) with counseling, behavioral therapy and recovery support services, is a cost-effective and evidence-based treatment that has been shown to decrease general healthcare expenditures and utilization among individuals with opioid dependence[31]. To facilitate use of MAT, several state Medicaid programs (such as Ohio and Texas) have made available detailed provider guidance on billing procedures for MAT[32]. Delivery system reform initiatives have also improved access to MAT; for example, Vermont's Hub-and-Spoke Model has been praised as facilitating effective and coordinated treatment through integrating opioid use into mainstream medicine[33,34].

Medicaid agencies are also considering promoting the use of opioid alternatives for pain management[35]. While many state Medicaid programs cover alternative treatments, less than half of states have promoted or required their use[36]. Data from a pilot study in Vermont shows that acupuncture improved health outcomes for Medicaid patients with chronic pain[37], and Oregon reports that Medicaid coverage of alternative therapies for pain management has reduced prescription opioids[38].

Employers should work with benefit plans to ensure full coverage of MAT services, including residential services, and should engage with key stakeholders to address gaps between treatment need and capacity. Employers should also seek to provide benefit packages that include coverage of non-opioid and non-pharmacological pain management treatments (for example, chiropractor, meditation, acupuncture and therapeutic massage) to reduce the use of opioid pain relievers and facilitate provider and patient awareness about the availability of non-opioid analgesic pain management options.

Increase access to and use of State Prescription Drug Monitoring Programs. Some state Medicaid programs are able to access Prescription Drug Monitoring Program (PDMP) data to identify possible problematic prescribing and inappropriate use of controlled prescription drugs by patients. In some states, Medicaid agencies require prescribers and pharmacists to review the patient's history of controlled prescriptions prior to prescribing opioids, and this has resulted in a decline in prescription drug shopping and opioid-related deaths, and decreases in controlled substance prescriptions[39]. Unfortunately, PDMP functionality varies by state due to reporting lag time, as well as legal, administrative and technical limitations[40]. In states with accessible PDMPs, employers may work with health insurance plans to determine the feasibility of updating provider agreements and contracts to require providers to access the state PDMP as a condition of agreement and payment.

Key recommendations for employers

Based on our learnings from working extensively with large companies, states and other partners, we believe there are three steps employers can take to assess and manage the opioid epidemic in the workplace.

1. Take a data-driven approach.
Knowledge is power when it comes to taking steps to understand what is happening within the workplace. Analytic tools can be used to look at employer and health plan data in aggregate to understand the scope of opioid misuse and diversion, and to identify opportunities to address employee and dependent health needs. Large employers can leverage aggregate data and analytics to examine patterns of misuse and diversion; for example, by geographic location, condition type, demographics or job role. Once an employer understands the scope of the issue, it can begin to create strategies to proactively manage the problem within the organization.

2. Partner effectively with benefit program providers.
An important aspect of combating the opioid epidemic in the workplace is ensuring that benefit plans are designed to support employees and their covered dependents. Conducting a data-driven needs assessment and working directly with benefit providers (that is, health insurance, pharmacy benefit programs and employee assistance programs) will help ensure coverage plans are set up to best meet employee and dependent needs.

Excess supply of medically indicated prescribed opioids can lead to misuse. Employers could consider working with pharmacy benefit programs to set limits on the type and amount of opioids dispensed to curtail excess supply. Employees and their families can be provided educational and training programs related to prescription drugs; their appropriate use, storage and disposal; and resources about interactions with and reactions to opioids and other prescription drugs. In some cases, fraud and tip hotlines can also be established. Pharmacy benefit programs also can be adjusted to assist in managing opioid dependence. Contracted pharmacy benefit administrators should have a program, such as mandated physician queries of the state PDMP, in place to identify and control prescription drug misuse and doctor shopping.

To help employees in pain reduce the use of opioid pain relievers, employers should increase awareness and access to non-opioid and non-pharmacological pain management treatments (such as chiropractor, meditation, acupuncture and therapeutic massage). Confidential screening for prescription drug use can be offered to identify misuse and dependence, and permit early intervention.

Employers should evaluate the behavioral health portions of health insurance policies to ensure adequate coverage for mental health and substance use screening and treatment.

Additionally, employers could work with health plan vendors to consider and address gaps in network adequacy to ensure employees have adequate access to in-network providers and treatment facilities for different levels of care. Increasingly, employers can offer information on treatment programs that are using data-driven approaches and are proven to be more effective. For example, employers may engage with vendors to review rate-setting strategies and revise rates to ensure adequate reimbursement to behavioral health providers, promote in-network coverage and decrease cash-only provider payment arrangements.

Employee Assistance Programs (EAPs) are another valuable tool for employers because they can provide employees with services to assist them in coping with personal or work-related problems, and should also support employees with confidential access to treatment for behavioral health and substance use concerns. EAPs are often underutilized, and represent an opportunity to educate and screen employees and their dependents for misuse of and dependence on prescription opioids. Employers can work with the vendor to ensure the EAP includes substance use assessment tools and can integrate with other benefit programs to appropriately direct employees to resources and treatment programs. To maximize EAP utilization, employers must ensure confidentiality and ease of access, and ensure that employees actually trust that confidentiality.

3. Educate and communicate with the workforce.

Raising awareness and education are critical to managing the opioid crisis within the workforce. Integral to this is empowering staff to recognize the signs of misuse and dependence, what they can do to help and where they can seek more information. For example, educational workshops can be held to discuss opioid misuse and dependence, to learn to recognize signs, and publicize available services and support (such as EAPs, health insurance benefits and naloxone access). Managers and supervisors should also be given training, so they can better understand prescription drug misuse and dependence, as well as what actions they can take if they suspect an employee has a problem. If employers have an EAP program in place, special educational workshops should be held specific to explaining EAP, and the program should be promoted and championed by leadership to help ensure use by employees.

Summary

Employers are uniquely poised to play an important role in helping to curb the opioid crisis in the US. Data and analytics can help by highlighting paths forward and key learnings to address this epidemic in the short term. Partnerships with benefit program providers to ensure appropriate offerings and working with employees at all levels to raise awareness of opioids and services will enable employers to play a pivotal role in reversing the opioid crisis.

In a future white paper, we will describe the role that artificial intelligence and technologies like blockchain — a shared, immutable health transaction ledger technology — may play in helping address the opioid epidemic, improve employee and dependent health and quality of life, reduce costs, and increase employee productivity.

References

[1] The President's Commission on Combating Drug Addiction and the Opioid Crisis. November 1, 2017. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[2] The White House, Office of the Press Secretary. President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis. October 26, 2017. https://www.whitehouse.gov/the-press-office/2017/10/26/president-donald-j-trump-taking-action-drug-addiction-and-opioid-crisis.

[3] Department of Health and Human Services, Office of the Secretary. Determination that a public health emergency exists. October 26, 2017. https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf.

[4] Center for Behavioral Health Statistics and Quality. Key substance use and mental health indicators in the United States: Results from the 2015 national survey on drug use and health. HHS Publication No SMA 16-4984, NSDUH Series H-51. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf.

[5] Baker DW. The Joint Commission's Pain Standards: Origins and Evolution. Oakbrook Terrace, IL: The Joint Commission; 2017. https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf.

[6] Weiss AJ, Elixhauser A, Barrett ML, Steiner CA, Bailey MK, O'Malley L. Opioid-related inpatient stays and emergency department visits by state, 2009–2014. HCUP Statistical Brief #219. January 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf.

[7] National Safety Council and the Indiana Attorney General's Office. Results from a Survey of Indiana Employees. https://www.in.gov/bitterpill/files/FINAL_Media_briefing_PPT.pdf.

[8] Scarpati LM, Kirson NY, Zichlin ML, Jia ZB, Birnbaum HG, Howard JC. Drivers of excess costs of opioid abuse among a commercially insured population. *The American Journal of Managed Care*. 2017 May;23(5):276.

[9] Kirson NY, Shei A, Rice JB, Enloe CJ, Bodnar K, Birnbaum HG, Holly P, Ben-Joseph R. The burden of undiagnosed opioid abuse among commercially insured individuals. *Pain Medicine*, 2015; 16:1325-1332.

[10] Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA and Blow FC. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA*, 2011; 305(13):1315-1321.

[11] Shute N. Poll: Doctors are still prescribing lots of opioids for low back pain. National Public Radio; Shots Health News from NPR. May 19, 2017. https://www.npr.org/sections/health-shots/2017/05/19/528516985/poll-doctors-are-still-prescribing-lots-of-opioids-for-low-back-pain.

[12] Johnston SS, Alexander AH, Masters ET, Mardekian J, Semel D, Malangone-Monaco E, Riehle E, Wilson K, Sadosky A. Costs and work loss burden of diagnosed opioid abuse among employees on workers compensation or short-term disability. *Journal of Occupational and Environmental Medicine*. 2016 Nov 1;58(11):1087-97.

[13] Calculating Total Daily Dose of Opioids for Safer Dosage. Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf.

[14] McClure FL, Niles JK, Kaufman HW, Gudin J. Concurrent Use of Opioids and Benzodiazepines: Evaluation of Prescription Drug Monitoring by a United States Laboratory. *Journal of Addiction Medicine*. 2017;11(6):420-426.

[15] IBM MarketScan® Commercial Claims and Encounters Database, 2016. Analysis of Opioid Use and Utilization Trends Among Broad Sample of Enrollees Covered by Employer Sponsored Insurance with Continuous Enrollment.

[16] McCabe SE, West BT, Boyd CJ. Leftover prescription opioids and nonmedical use among high school seniors: A multi-cohort national study. *Journal of Adolescent Health*. 2013 Apr 30;52(4):480-5.

[17] Naeger S, Ali MM, Mutter R, Mark TL, Hughey L. Prescriptions filled following an opioid-related hospitalization. *Psychiatric Services*. 2016 Jun 1;67(11):1262-4.

[18] Florence CS, Zhou C, Luo F, Xu L. The economic burden of prescription opioid overdose, abuse, and dependence in the United States, 2013. *Medical Care*. 2016 Oct 1;54(10):901-6.

[19] Florence CS, Zhou C, Luo F, Xu L. The economic burden of prescription opioid overdose, abuse, and dependence in the United States, 2013. *Medical Care*. 2016 Oct 1;54(10):901-6.

[20] Kirson NY, Shei A, Rice JB, Enloe CJ, Bodnar K, Birnbaum HG, Holly P, Ben-Joseph R. The burden of undiagnosed opioid abuse among commercially insured individuals. *Pain Medicine*. 2015 Jul 1;16(7):1325-32.

[21] MarketScan Commercial Claims and Encounters Database, 2016. Analysis of Opioid Use and Utilization Trends Among Broad Sample of Enrollees Covered by Employer Sponsored Insurance with Continuous Enrollment.

[22] Florence CS, Zhou C, Luo F, Xu L. The economic burden of prescription opioid overdose, abuse, and dependence in the United States, 2013. *Medical Care*. 2016 Oct 1;54(10):901-6.

[23] White JA, Tao X, Talreja M, Tower J, Bernacki E. The effect of opioid use on workers' compensation claim cost in the State of Michigan. *Journal of Occupational and Environmental Medicine*. 2012 Aug 1;54(8):948-53.

[24] Opioid crisis looms over job market, worrying employers and economists. National Public Radio; Morning Edition. September 7, 2017. https://www.npr.org/2017/09/07/545602212/opioid-crisis-looms-over-job-market-worrying-employers-and-economists.

[25] Medicaid and CHIP Application, Eligibility Determinations, and Enrollment Report. September 2017. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[26] Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP. Chapter 2: Medicaid and the Opioid Epidemic. June 2017. https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

[27] Frank RG and Fry CE. Medicaid Expands Access to Lifesaving Naloxone. To the Point, The Commonwealth Fund, July 5, 2017. http://www.commonwealthfund.org/publications/blog/2017/jul/medicaid-helps-expand-lifesaving-naloxone.

[28] Smith VK, Gifford K, Ellis E, Edwards B, Rudowitz R, Hinton E, Antonisse L, and Valentine A. Implementing coverage and payment initiatives: Results from a 50-State Medicaid budget survey for State Fiscal Years 2016 and 2017. Health Management Associates and Kaiser Family Foundation. October 2016. https://www.kff.org/report-section/implementing-coverage-and-payment-initiatives-benefits-and-pharmacy.

[29] Pennsylvania Department of Drug and Alcohol Programs Website. http://www.ddap.pa.gov/overdose/Pages/Naloxone_FAQ.aspx.

[30] Arizona Health Care Cost Containment System. Opioid Strategies. Undated presentation. http://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/hospital-discharge/2017/ahcccs-opioid-strategies.pdf.

[31] Mohlman MK, Tanzman B, Finison K, Pinette M, and Jones C. Impact of medication-assisted treatment for opioid addiction on Medicaid expenditures and health services utilization rates in Vermont. *Journal of Substance Abuse Treatment*. 2016;67:9-14.

[32] Medication Assisted Treatment for Substance Use Disorders. Informational Bulletin. Center for Medicaid and CHIP Services, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism. July 11, 2014. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf.

[33] Vermont case study: Medication assisted treatment program for opioid addiction. The Association of State and Territorial Health Officials and the de Beaumont Foundation. May 2014. http://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/Case-Studies/Vermont-MAT-Program-for-Opioid-Addiction.

[34] Brooklyn JR and Sigmon SC. Vermont Hub-and-Spoke Model of Care for opioid use disorder: Development, implementation, and impact. *Journal of Addiction Medicine*. 2017;11(4):286-292.

[35] Dowell D, Haegerich TM, and Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. Atlanta, GA: Centers for Disease Control and Prevention, 2016. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[36] Dorr H and Townley C. Chronic pain management therapies in Medicaid: Policy considerations for non-pharmacological alternatives to opioids. National Academy for State Health Policy. August 2016. http://www.nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf.

[37] Davis R. Pilot: Acupuncture for chronic pain in the Vermont Medicaid population. Undated presentation. https://www.uvm.edu/sites/default/files/media/Medicaid_UVMMC.pdf.

[38] Quinn M. Amid opioid crisis, states start embracing alternative medicine. Governing Magazine. November 2017. http://www.governing.com/topics/health-human-services/gov-painkiller-alternatives-no-prescripition.html.

[39] Wachino V. Best practices for addressing prescription opioid overdoses, misuse, and addiction. Center for Medicaid and CHIP Services. CMCS Informational Bulletin. January 28, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf.

[40] Manasco AT, Griggs C, Leeds R, Langlois BK, Breaud AH, Mitchell PM, and Weiner SG. Characteristics of state prescription drug monitoring programs: a state-by-state survey. *Pharmacoepidemiology and Drug Safety*. 2016 Jul 1;25(7):847-51.

About IBM Watson Health

Each day, professionals throughout the health ecosystem make powerful progress toward a healthier future. At IBM Watson Health, we help them remove obstacles, optimize efforts and reveal new insights to support the people they serve. Working across the landscape, from payers and providers to governments and life sciences, we bring together deep health expertise; proven innovation; and the power of artificial intelligence to enable our customers to uncover, connect and act — as they work to solve health challenges for people everywhere.

For more information on IBM Watson Health, visit ibm.com/watsonhealth.

IBM Corporation
Software Group
Route 100
Somers, NY 10589

Produced in the United States of America
May 2018

WH 18901 0518

IBM Watson Health™