

UNITED STATES PATENT AND TRADEMARK OFFICE

BEFORE THE PATENT TRIAL AND APPEAL BOARD

TELADOC HEALTH, INC.,
Petitioner,

v.

DATA HEALTH PARTNERS, INC.,
Patent Owner.

Case IPR2024-00617
Patent 11,151,142 B2

PETITION FOR *INTER PARTES* REVIEW UNDER 35 U.S.C. § 312

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PETITIONER'S EXHIBIT LIST

Exhibit	Shorthand	Description
1001	'142 Patent	U.S. Patent No. 11,151,142 B2
1002	Douglas	Pub. No. WO 1999/003045 A1
1003	Wager	Pub. No. US 2006/0149589 A1
1004	Chitiveli	Pub. No. US 2013/0179450 A1
1005		Omitted
1006		Omitted
1007		Omitted
1008	ArchiveDec	Declaration of Nathaniel E Frank-White
1009	Koh	Hian Chye Koh & Gerald Tan, <u>Data Mining Applications in Healthcare</u> , 19 J. Healthcare Information Management 64 (2005)
1010	KohArchive	Printout of: https://web.archive.org/web/20050418095732/http://www.himss.org/ASP/publications_jhim_issue.asp?issue=3/30/2005 , evidencing 2005 public availability of Koh
1011	Hall-Ellis	Declaration of Sylvia D. Hall-Ellis, Ph.D.
1012	Bergeron	Declaration of Bryan Bergeron, M.D.
1013	BergeronCV	Curriculum Vitae of Bryan Bergeron, M.D.
1014	Microsoft	<u>Microsoft Computer Dictionary</u> (5th ed. 2002)
1015	ADAA	Printout of https://web.archive.org/web/20100116093130/https://adaa.org/supportgroups
1016		Omitted
1017		Omitted
1018	NetSuite	Printout of https://web.archive.org/web/20111102042326/https://www.netsuite.co.uk/portal/uk/resource/articles/cloud-computing.shtml
1019	Wright	U.S. Patent No. 10,471,588 B2
1020	Prgomet	Prgomet et al., <u>The Impact of Mobile Handheld Technology on Hospital Physicians' Work Practices and Patient Care: A Systematic Review</u> , 16 J. Am. Med. Inform. Assoc. 792 (2009)

Exhibit	Shorthand	Description
1021	InfoGrasp	Printout of https://web.archive.org/web/20100812105813/https://infograsp.com/technology/benefits-of-web-applications/
1022	Virginia	<u>Autism Spectrum Disorders and the Transition to Adulthood</u> , VA Dep't of Educ. (2010)
1023	VirginiaArchive	Printout of https://web.archive.org/web/20111208001834/http://www.doe.virginia.gov/special_ed/disabilities/autism/index.shtml , evidencing 2011 public availability of Virginia

Claim Listing

Claim	Limitation No.	Limitation
1	1[p]	A method for tracking goal progression, the method comprising:
	1[a]	receiving input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;
	1[b]	creating fields required for compiling data associated with the treatment or assistance of each of the clients from the providers;
	1[c]	assigning each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;
	1[d]	establishing desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;
	1[e]	compiling data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;
	1[f]	automatically determining whether 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and
	1[g]	automatically communicating alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.

Claim	Limitation No.	Limitation
2	2	The method according to claim 1, wherein the server is accessed through a cloud network, and wherein a client management program is executed by the computing or communications devices is utilized to receive the data and track progress of the desired outcomes.
3	3	The method according to claim 1, further comprising: establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application.
4	4	The method according to claim 3, wherein the wizard application receives at least a main heading, a start date, a projected closure date, and a desired outcome description.
5	5[a]	The method according to claim 1, further comprising: data mining the compiled data to determine best practices; and
	5[b]	recommending the best practices to the providers in response to the best practices being associated with a client assigned to the providers.
6	6	The method according to claim 1, wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.
7	7[a]	The method according to claim 1, further comprising: determining whether the data required is received from each of the providers; and
	7[b]	sending an alert to one or more providers in response to determining there is missing data for one or more clients associated with the one or more providers.
9	9[a]	The method according to claim 1, further comprising: tracking a time and occurrence of number of client actions in response to input from the providers; and

Claim	Limitation No.	Limitation
	9[b]	indicating progress based on rules toward desired outcomes for the clients, wherein the rules compare data against a minimum growth line.
10	10	The method according to claim 1, further comprising: prompting the providers to provide data associated with assigned clients.
11	11[p]	A system for tracking goal progression, the system comprising:
	11[a]	a server that communicates with communications devices through a transceiver utilizing one or more networks, the server includes a processor that executes a client management program to;
	11[b]	receive input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;
	11[c]	create fields required for compiling data associated with the treatment or assistance of each of the clients from the providers;
	11[d]	assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;
	11[e]	establish desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;
	11[f]	compile data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;

Claim	Limitation No.	Limitation
	11[g]	automatically determine whether 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and
	11[h]	automatically communicate alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients;
	11[i]	a database in communication with the server configured to store the data and information associated with the clients and the providers.
12	12	The system according to claim 11, wherein the database is a relational database management system performing data mining to analyze the data from the providers to associate best practices with each of the clients.
13	13	The system according to claim 11, wherein the server is configured to recommend one or more best practices to the plurality of providers in response to the data of the clients being associated with the best practices.
14	14	The system according to claim 11, wherein the server further establishes the desired outcomes for the client utilizing a wizard application including at least a main heading, a start date, a projected closure date, and a desired outcomes description.
16	16[p]	A controller comprising:
	16[a]	a processor for executing a set of instructions; and
	16[b]	a memory for storing the set of instructions, wherein the set of instructions are executed by the processor to:
	16[c]	receive input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and

Claim	Limitation No.	Limitation
		wherein the accounts are stored in a server available through one or more networks;
	16[d]	create fields required for compiling data associated with the treatment or assistance of each of the clients from the providers;
	16[e]	assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;
	16[f]	establish desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;
	16[g]	compile data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;
	16[h]	automatically determine whether 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and
	16[i]	automatically communicate alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.
17	17	The server according to claim 16, wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.
18	18	The server according to claim 16, wherein the set of instructions are further executed to: recommend best practices to the providers in response to historic success with the clients.

Claim	Limitation No.	Limitation
20	20	The controller according to claim 16, wherein the controller is accessible by a plurality of mobile devices, a plurality of computing devices, and a web interface.

I. INTRODUCTION

The '142 Patent is directed to a system for tracking a client's progress toward goals. In particular, the system establishes desired outcomes (goals) for a client (such as those relating to healthcare), compiles data to determine whether the client is progressing toward the outcomes, and communicates alerts based on the progress. The '142 Patent asserts that, because it implements this system using communication devices and a server, it constitutes an improvement over pre-existing systems.

Such a system, however, was known as early as 1999. For example, Douglas discloses a server-implemented system that likewise establishes healthcare-related goals for a client, collects data to determine the client's progress toward the goals, and notifies the client's provider accordingly.

II. MANDATORY NOTICES

A. Real Party in Interest (37 C.F.R. § 42.8(b)(1))

The real party-in-interest is Petitioner, Teladoc Health, Inc.

B. Related Matters (37 C.F.R. § 42.8(b)(2))

The following matters could affect, or be affected by, a decision in this proceeding:

1. U.S. Patent No. 11,675,791 B2, which is a continuation of the '142 Patent;
2. U.S. Patent No. 11,144,554 B2 (the "'554 Patent"), which is a continuation in-part of the '142 Patent;

3. U.S. Patent No. 10,061,812 B2 (the “’812 Patent”), of which the ’142 Patent is a continuation;
4. Pending U.S. Patent App. No. 17/499,725, which is a continuation of the ’554 Patent;
5. U.S. Patent No. 11,809,431, which is a continuation of the ’554 Patent;
6. Pending U.S. Patent App. No. 18/502,813, which is a continuation of the ’554 Patent; and
7. *Data Health Partners, Inc. v. Teladoc Health, Inc.*, 1-23-cv-00160-JCG (D. Del.), in which the ’554, ’142, and ’812 Patents are asserted.

C. Lead and Back-Up Counsel (37 C.F.R. § 42.8(b)(3))

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Petitioner consents to electronic service at the above e-mail addresses.

III. GROUNDS FOR STANDING

Petitioner certifies that the '142 Patent is available for IPR, and Petitioner is not barred or estopped from requesting an IPR on the grounds identified herein. The '142 Patent has not been subject to a previous FWD in an estoppel-based AIA proceeding.

IV. STATEMENT OF PRECISE RELIEF REQUESTED

A. Claims for Which Review Is Requested (37 C.F.R. § 42.104(b)(1))

Petitioner requests review and cancellation of Claims 1-7, 9-14, 16-18, and 20 (the "Challenged Claims") of the '142 Patent.

B. Statutory Grounds of Challenge (37 C.F.R. § 42.104(b)(2))¹

Ground	Basis	Reference(s)	Challenged Claims
1	§ 103	Douglas	1, 3, 4, 6, 7, 10, 11, 14, 16, and 17
2	§ 103	Douglas and Wager	1, 3, 4, 6, 7, 10, 11, 14, 16, and 17
3	§ 103	Douglas and Chitiveli	2 and 20
4	§ 103	Douglas, Wager, and Chitiveli	2 and 20
5	§ 103	Douglas and Koh	5, 12, 13, and 18
6	§ 103	Douglas, Wager, and Koh	5, 12, 13, and 18
7	§ 103	Douglas and Virginia	9
8	§ 103	Douglas, Wager, and Virginia	9

Published on January 21, 1999, Douglas (Ex. 1002) is prior art under § 102(b).

Published on July 6, 2006, Wager (Ex. 1003) is prior art under § 102(b).

Filed on January 11, 2012, Chitiveli (Ex. 1004) is prior art under § 102(e).

Published in 2005, Koh (Ex. 1009) is prior art under § 102(b). Koh's 2005 publication is evidenced by Dr. Hall-Ellis's testimony that Koh was publicly available on or shortly after April 30, 2005. Hall-Ellis at ¶¶ 45-52. That testimony is based on: (1) Koh's MARC record from the Albin O. Kuhn Library & Gallery indicating that the Library has received Koh's journal since 1998 and that Koh's journal was descriptively catalogued (*id.* at ¶¶ 46-48, 19, Attachments 2A-2C and

¹ All Grounds are supported by a POSITA's general knowledge. *Koninklijke Philips N.V. v. Google LLC*, 948 F.3d 1330, 1337-38 (Fed. Cir. 2020).

1D); and (2) Koh's MARC record from the Library of Congress that was created on April 22, 1977, indicating that the journal is a quarterly publication with subject matter descriptively classified and is currently available from 30 libraries (*id.* at ¶¶ 49-52, Attachments 2B-2E and 1D).

Koh's 2005 publication is further evidenced by KohArchive, which is a 2005-archived version of a Healthcare Information and Management Systems Society webpage (ArchiveDec at 1, 18) that includes the contents of the Journal of Healthcare Information Management (KohArchive at 1) in which Koh was published and lists Koh along with its authors and a truncated abstract. *Compare* Koh at cover with KohArchive at 1-2.

Published in October 2010, Virginia (Ex. 1022) is prior art under § 102(b). Virginia's 2010 publication is first evidenced by its "2010" copyright date. Virginia at 74. Further, Virginia was archived by the Internet Archive in 2011. ArchiveDec at ¶ 1, 5-6. Additionally, a Virginia Department of Education webpage archived by the Internet Archive in 2011 includes a hyperlink in the form of a picture of the front page and the title of Virginia. VirginiaArchive; ArchiveDec at ¶ 1, 5-6.

V. LEVEL OF ORDINARY SKILL IN THE ART

A POSITA as of March 15, 2013²—the ’142 Patent’s earliest claimed priority date—would have had at least a bachelor’s degree in a healthcare field as well as 1-2 years of experience with health information technology, including specific experience with computer-based systems for recording, tracking, and analyzing patient health information. Bergeron at ¶ 36. The prior art and the ’142 Patent also evidence this level of ordinary skill. *See Okajima v. Bourdeau*, 261 F.3d 1350, 1355 (Fed. Cir. 2001).

VI. THE ’142 PATENT

As the ’142 Patent explains, “[t]he ability of organizations, hospitals, schools, businesses, individuals, and others to meet goals is ... a significant challenge,” so “it is important to recognize and treat problems and issues that prevent goals ... from being achieved.” ’142 Patent at 1:12-16. The ’142 Patent recognizes that “organizations and institutions ... have improved their processes in recent years.” *Id.* at 1:16-23.

² All statements in this Petition about the knowledge and skills of, and what would have been obvious to, a POSITA are offered from this perspective as of this date. Bergeron at ¶ 37.

The problem, per the '142 Patent, is that “electronic systems, equipment, software, and processes for tracking, treating, and recording results ... have not improved as significantly.” *Id.* at 1:27-30. “For example, some organizations still use paper documents and charts to track individuals’ information or a single computing system ... to enter and review data.” *Id.* at 1:30-33. With such systems, “viewing, updating, managing, and sharing[] relevant information may be more difficult than it should be.” *Id.* at 1:33-35.

To address this problem, the '142 Patent presents a platform that is used to create outcomes for a client, compile client data to determine whether the client is progressing toward their outcomes, and communicate alerts regarding the client’s progress. *Id.* at 4:6-12; claims 1, 11, and 16.

VII. CLAIM CONSTRUCTION

None of the claim terms of the Challenged Claims require an explicit construction to resolve the current grounds.

VIII. REASONS FOR THE RELIEF REQUESTED UNDER 37 C.F.R. §§ 42.22(A)(2) AND 42.104(B)(4)

A. Ground 1 – Douglas Renders Obvious Claims 1, 3, 4, 6, 7, 10, 11, 14, 16, and 17

1. Douglas Overview

Douglas is directed to “[a] therapeutic behavior modification program, compliance monitoring and feedback system” that “enables development of a

therapeutic behavior modification program having a series of milestones for an individual to achieve lifestyle changes.” Douglas at Abstract; Bergeron at ¶ 39.

A network administrator provides input into Douglas’s system to “subscribe” a physician to the system, thereby creating a physician account. Douglas at 25:17-19, 19:27-30, 25:5-9; Bergeron at ¶ 40. A case administrator creates a patient account “based on information contained in the patient prescription form” (*id.* at 6:33-7:20, FIG. 60), which is filled out and signed by the physician (*id.* at FIG. 2). Bergeron at ¶ 41. The patient can range from one having “coronary artery disease” to one “who simply want[s] to maintain their health.” Douglas at 6:6-14; Bergeron at ¶ 41.

“Once the ... administrator enters the patient into the system, ... the system ... recommends a default set of goals based on the patient’s needs and existing medical protocols that may be modified.” Douglas at 7:17-8:13; Bergeron at ¶ 42. Exemplary goals set by Douglas’s system include everything from “intake of calories from fat” to “Seatbelt Use.” Douglas at 8:1-13, FIG. 6. Bergeron at ¶ 42.

Douglas’s system periodically receives updated patient data, including data entered by the physician (Douglas at 11:1-5, FIG. 60), to determine the “patient’s progress and compliance with the program” (*id.* at 11:26-28). Bergeron at ¶ 43. If the updated patient data shows that the patient is not meeting their goals, the system

“notif[ies] the physician,” who may “recommend that the program be modified to suit the patient’s condition.” Douglas at 11:18-25; Bergeron at ¶ 43.

Douglas’s system is implemented on a “network server 508” including “relational databases 522 ... that contain all the health plan data.” Douglas at 24:12-34, FIG. 59; Bergeron at ¶ 44. Being so-implemented, the system is accessible by “patients, physicians,” and other users “via the Internet 518” and using “a PC 500.” Douglas at 24:3-26, FIG. 59; Bergeron at ¶ 44.

2. Claim 1

(a) *Limitation 1[p]: A method for tracking goal progression, the method comprising:*

The preamble of claim 1 merely recites an intended use and is not entitled to patentable weight. To the extent the preamble is found limiting, Douglas discloses a method for tracking goal progression: “the system recommends modifications and updates to both physician and patient by correlating the patient’s progress with previously established goals.” Douglas at 2:36-3:2; Bergeron at ¶ 45; *see also* Douglas at Abstract, 8:1-8, 11:7-10, 11:18-12:2, 20:14-19, 20:29-30, FIG. 7.

(b) *Limitation 1[a]: receiving input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;*

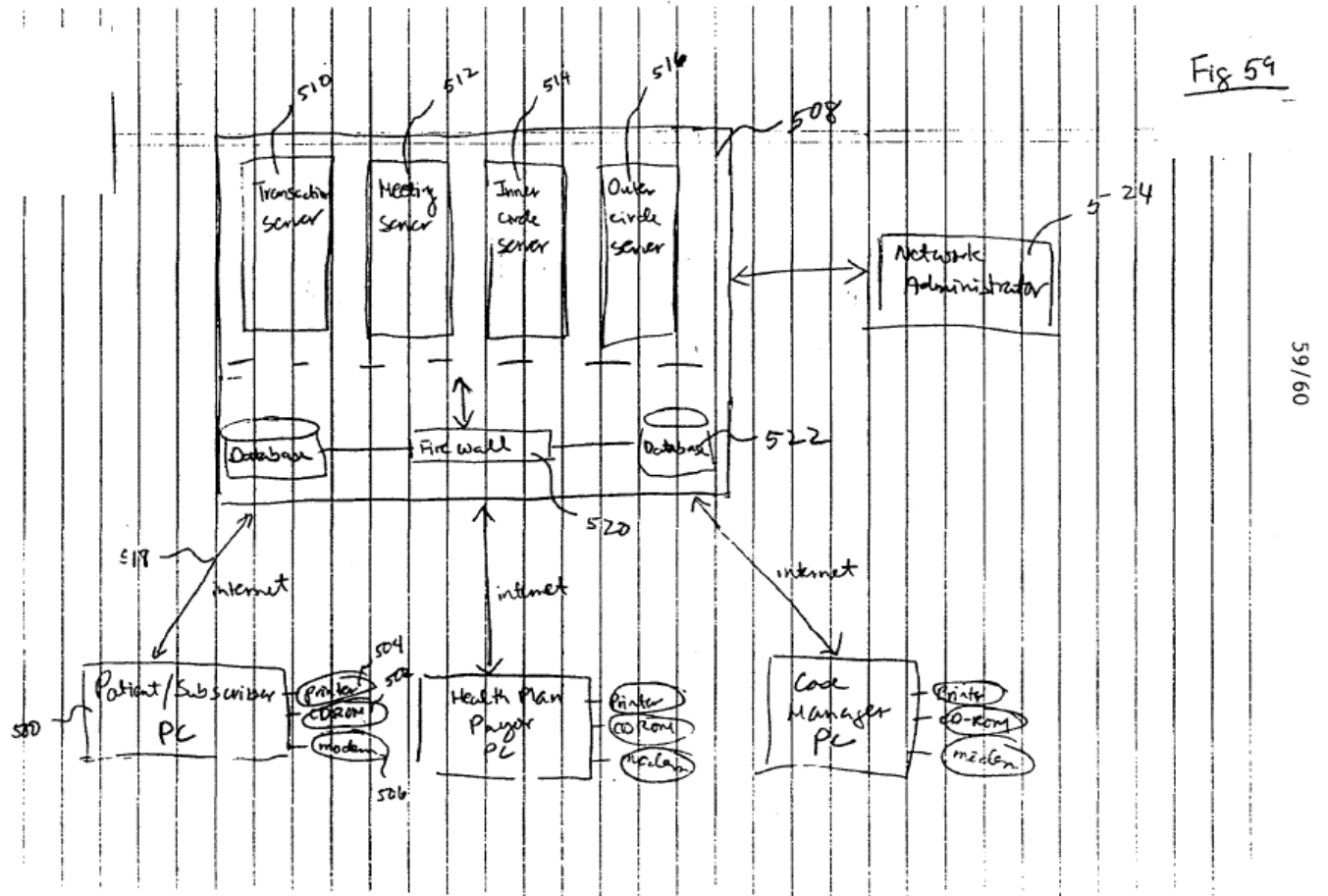
Douglas discloses receiving input establishing accounts for providers serving clients. As Douglas explains, “[a] network administrator 524, who may be the case

administrator ... subscribes all users to the system except for clinical or wellness group participants.” Douglas at 25:17-19; Bergeron at ¶ 46. Given that physicians are users of Douglas’s system (Douglas at 19:27-30, 25:5-9) and not clinical or wellness group participants, which are instead patients (*id.* at 6:6-14), the network administrator, per Douglas, subscribes physicians to the system. Bergeron at ¶ 46. This act of subscription constitutes input. Bergeron at ¶ 46. And that input establishes accounts for providers, as once so-subscribed, a physician “log[s]-on” “to gain access to the system” (Douglas at 19:27-30, FIG. 38; *see also id.* at 25:5-11, FIG. 36) using a created account. Bergeron at ¶ 46.

Douglas’s system includes multiple subscribed physicians (the claimed providers) (Douglas at FIG. 57), each serving multiple patients (the claimed clients) (*id.* at FIG. 57, 21:14-15), meaning the received input is for establishing accounts for providers serving clients. ’142 Patent at 4:17-25, 37-40; Bergeron at ¶ 48.

Douglas’s patients are each an individual receiving treatment or assistance from their physician, as, prior to being set up on the system, the patient’s physician “diagnoses [the patient] with an ailment ... [and] recommend[s] a health care maintenance or recovery program which requires the patient” to take various actions. Douglas at 6:24-35; Bergeron at ¶ 49.

Douglas further discloses that the provider accounts are stored in a server—Douglas’s network server 508, shown in Douglas’s FIG. 59 (reproduced below):



Douglas FIG. 59

Douglas’s server 508 includes servers 510-516 (Douglas at 24:12-16), which “have access to one or more relational databases 522 (such as SQL) that contain all the health plan data” along with “[a]ll the information needed by a user of the system” (*id.* at 24:28-37). Those databases are also part of server 508 (*id.* at FIG. 59). Bergeron at ¶ 50-51. Server 508 thus stores the accounts, as it contains “[a]ll the information needed by a user of the system,” including the physicians. Douglas at 24:28-37; Bergeron at ¶ 51.

Server 508 is available through one or more networks, as “each PC 500 is electronically linked to network server 508 via the Internet 518.” Douglas at 24:12-13, FIG. 29; Bergeron at ¶ 52; *see also* Douglas at 8:28-31.

(c) ***Limitation 1[b]: creating fields required for compiling data associated with the treatment or assistance of each of the clients from the providers***

Mapping 1: Shown in the patient record of Douglas’s FIG. 4, reproduced below, “[t]he first column 44 of the [patient’s] record sets forth fields for pertinent patient information, including the patient’s vital signs ... [and] other baseline characteristics.” *Id.* at 7:22-26.

HeartLand 68 Fig 4

Administration — HeartLand Provider/Case Advisor

HeartLand Health Assessment Review

SCREEN 1 OF 3

PATIENT STATUS & GOALS: DETAILS		Now 2/10/98	1 month Goal	GOALS
Name / D.O.B.	Fred Smith 2-5-49			
Starting Date	2/1/98			
Heartland I.D.	23-642			
Height / Sex	5'9" Male			
Weight	193	182		
BMI	28.28	26.28		
Smoke	.5 Packs/Day	.5		
Physical Activity	0 / 0 / 0 minutes / x-week / RPE	20 / 3 / 3		
Alcohol	2 Average Drinks per Day	2		
Eating Habits	40 %Fiber/Cmplx Carb Intake	60		
	40 %Fatty Food Intake	20		
	40 %Fatty Dairy Intake	20		
Calories	3,600	3,300		
Fat Calories & %	45%	1,500		
Cholesterol - LDL	142	140 mg/dl		
Cholesterol - HDL	35	37 mg/dl		
Cholesterol	246 ml/dl	225		
Resting Pulse Rate	88 Beats Per Minute	68		
Stress	8.5 Scale of 1 to 10 (10 being high stress)	7.0		
Depression	Scale of 1 to 10 (10 being greatest)	10		
Blood Pressure	140/100 systolic/diastolic	140/100		
Seatbelt Use	30 percent of time	60		
Back Pain	Incidents per month	3		
Pharmaceuticals				
- aspirin	325 mg	325 mg/da		
- hydrochlorothz.d.	12.5 mg	12.6 mg/da		
- Lovastatin	20 mg	20 mg/da		

EDIT DESIGN 50

Douglas FIG. 4

Douglas at 7:21-26; Bergeron at ¶ 53. The fields in the first column include fields for the patient's baseline data in second column 46, and, in the fields of "the third column 48, the record may be updated on an ongoing basis by taking data from... subsequent office visits." Douglas at 7:26-29, FIG. 4; Bergeron at ¶ 53.

Douglas's fields are required for compiling data associated with the treatment or assistance of the patient from the physician. Bergeron at ¶ 54. This is because those fields indicate the vital signs and characteristics of the patient that must be

entered by the physician and compiled over time (*see* Section VIII.A.2(f) (Limitation 1[e])) so that Douglas’s “system [can] periodically correlate[] the updated patient health information with the program goals” (*id.* at 11:26-28). Bergeron at ¶ 54. To the extent PO contends that the claimed fields must allow for the data to be entered, these fields do—they “tak[e] data ... from subsequent office visits” in column 48. Douglas at 7:26-29; Bergeron at ¶ 54.

Mapping 2: To the extent PO argues that the claimed fields themselves must allow for data entry and Douglas’s fields do not, Douglas discloses “accept[ing] updated patient data ... through data entered by the physician during office visits,” and using fields to allow the physician to enter the data would have been obvious. Douglas at 11:1-5, FIG. 60; Bergeron at ¶ 56; *see also* Section VIII.A.2(f) (Limitation 1[e]).

To begin, Douglas makes frequent use of fields for data entry. *Id.* For instance, Douglas’s FIG. 46 (reproduced below) includes fields for recommending an exercise regimen, a blood pressure warning threshold, daily calorie intake, as well as attendance at group support sessions. Douglas at FIG. 46; Bergeron at ¶ 57.

HeartLand 74 fig 46

HeartLand Recommendations

HEARTLAND PATIENT: Fred Smith PATIENT NUMBER: 23-642

DATE: 3/10/98 TOTAL AVERAGE DAILY CALORIES: 3,100

INCREASE EXERCISE TO: 45 minutes TOTAL DAILY CALORIES FROM FAT: 465 (15%)

INCREASE RPE TO: Level 5
see the Village Gym for suggestions and preferences

FREQUENCY AND DURATION OF STRESS REDUCTION EXERCISES: 45 minutes per sessions at least 5x/week

INDICATE TO PHYSICIAN BLOOD PRESSURE IN YELLOW ZONE AT: 146/92

ATTEND GROUP SUPPORT SESSIONS: 4 times/week

CHOOSE REWARD FROM: Village Mall
For 60 Smoke Free Days

CASE ADVISORY REVIEW: ☒ 4x/mo. ☐ 2x/mo. ☐ 1x/mo.

Good support group attendance

NEXT PHYSICIAN VISIT DUE: 5/25/97

OTHER: Diet Exercise Stress Support

Accepting Editing Communications

- Remain cigarette free!
- Remember to use your seatbelt!
- Remember back and flexibility exercises!

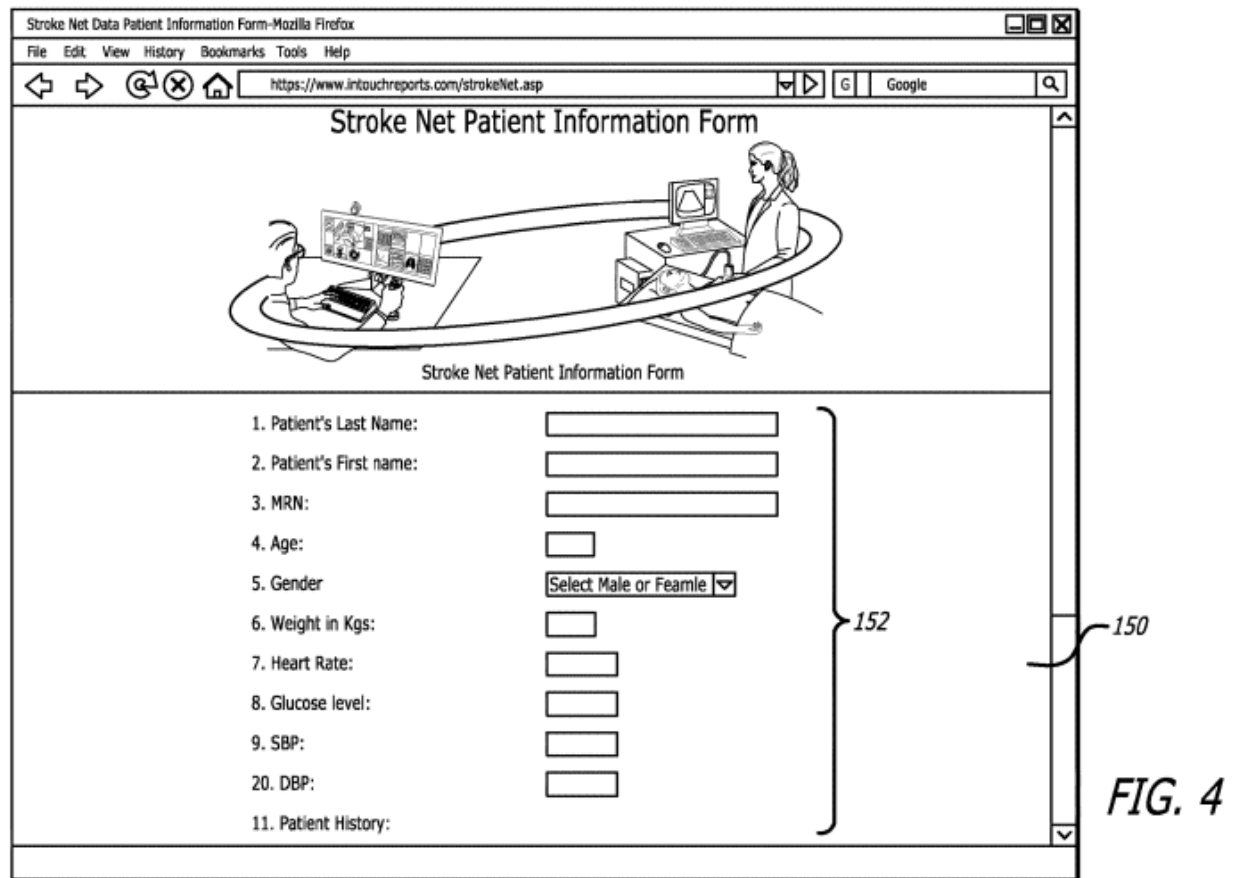
Douglas FIG. 46

Each of these fields allows the entry of data, as Douglas explicitly discloses that “[t]he physician reading the report can ... modify 332 the recommendations.” Douglas at 21:4-13. Douglas at FIG. 46; Bergeron at ¶ 57.

Further, the use of fields for entering data—specifically, patient data—was within a POSITA’s general knowledge, as reflected by Wright, and such general knowledge can be mapped to the claimed fields. *Koninklijke Philips N.V. v. Google LLC*, 948 F.3d at 1337; Bergeron at ¶ 58. Wright, for example, discloses a “graphical

user interface 150 [that] includes a plurality of data fields 152 that can be filled by the user” to enter “medical data such as heart rate, glucose level and blood pressure.”

Wright at 4:53-59, FIG. 4 (reproduced below); Bergeron at ¶ 58.



Wright FIG. 4

Using such fields, whether Douglas's or those from a POSITA's general knowledge, to allow the physician to enter patient data during office visits (Douglas at 11:1-5, FIG. 60) represents an obvious “combination of familiar elements according to known methods ... [that] does no more than yield predictable results.”

KSR Int'l Co. v. Teleflex Inc., 550 U.S. 398, 401 (2007); Bergeron at ¶ 59. Indeed,

these fields would perform the same data-entry function that they were known to perform and would lead to the predictable result of the physician entering patient data into Douglas's system. Bergeron at ¶ 59.

Additionally, Douglas's system must somehow "accept[] updated patient data ... through data entered by the physician during office visits." Douglas at 11:1-5, FIG. 60, *see also id.* at 6:32-33; Bergeron at ¶ 60. Using fields as described above would have enabled the entry of updated patient health data and allowed Douglas's system to perform its goal-tracking purpose. Douglas at 11:26-28; Bergeron at ¶ 60.

These obvious-to-implement fields would have been the vehicle for Douglas's system to accept the physician-entered patient data that Douglas compiles over time (*see* Section VIII.A.2(f) (Limitation 1[e])), meaning they would be required for compiling data. Bergeron at ¶ 61.

Mappings 1 and 2: The data recorded in Douglas's disclosed or obvious fields is associated with the treatment or assistance of the patient, given that "the system periodically correlates the updated patient health information with program goals to determine the patient's progress and compliance with the program," including its goals 52, 61, and 62, each of which are related to the treatment or assistance of the patient. Douglas at 11:6-12:2, FIGs. 60, 5, 6; Bergeron at ¶ 62.

Such fields were (Mapping 1) or would have been (Mapping 2) created for each of Douglas's multiple patients (*see* Section VIII.A.2(b) (Limitation 1[a])) so

that each patient's physician was able to enter the patient's health data for compilation. Bergeron at ¶ 63.

- (d) ***Limitation 1[c]: assigning each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;***

Douglas discloses that each of the clients (i.e., patients) are assigned to one or more of the providers (i.e., physicians), who are individuals available to treat or assist their patients (*see* Section VIII.A.2(b) (Limitation 1[a])). Douglas at 21:24-28, FIG. 47 (showing the "Responsible Physician" for patient "Fred Smith"), 15:8-9 (patients "keep in constant contact with their physician"), claims 11, 25, FIG. 2 (associating the patient, "Patient Name[/]ID," with a physician, "Physician Name[/]ID"), FIG. 7; Bergeron at ¶ 64. Indeed, such patient-to-physician assignment is required for Douglas's system to "provide[] the physician with reports of patient progress," "send an alarm to the physician," or otherwise "notify the physician" regarding the patient's progress. Douglas at 11:6-12:2; Bergeron at ¶ 65.

Douglas further discloses that the assignment of clients to providers is in response to selections from an administrator, as the case administrator sets up each of the patients on Douglas's system by entering the information contained in the patient prescription form (Douglas at 6:33-7:13, FIG. 2), where such information

includes information associating the patient with a physician (*id.* at FIG. 2);

Bergeron at ¶ 66. Douglas's FIG. 2 is reproduced below:

Fig. 2

22 ~ **HeartLand Prescription Form**

Patient Name	Patient ID	Date	Physician Name	Physician ID
--------------	------------	------	----------------	--------------

1. Fill in diagnosis:

Patient Diagnosis	Co-morbid Diagnosis
-------------------	---------------------

2. Circle a diagnostic category:

Category	Diagnosis	Level 1 (mos.)	Level 2 (mos.)	Level 3 (mos.)	Health and Wellness
I	Current year MI survivor	3	3	6	Contin.>12th month
II	Current year alt. to PTCA or CABG	3	3	6	Contin.>12th month
III	Current year diagnosed CAD	3	3	6	Contin.>12th month
IV	All diagnosed Angina	3	3	6	Contin.>12th month
V	Prior years' post MI/surgical--High Risk	3	3	6	Contin.>12th month
VI	Prior years' post MI/surgical--Low Risk	1	1	10	Contin.>12th month
VII	2 or more Risk factors	0	2	4	Contin.>6th month
VIII	Health and Wellness	0	0	0	Continuous

3. Please circle as appropriate:

Does the patient need smoking cessation?	Yes	No	
Have you prescribed nicotine patch or gum?	Yes	No	
Does the patient need weight reduction?	Yes	No	If yes, target weight: _____

4. What are patient's current and prescribed medications?

Medication	Standard Dosage	Comments/Changes
HCTZ	25 mg	
Atenolol	50 mg	
Lisinopril	20 mg	
Atorvastatin	20 mg	
Lovastatin	20 mg	
Antioxidant: Vitamin E	400 IU	
Antioxidant: Vitamin C	500 mg	
Other:		
Other:		
Other:		
Other:		

5. Circle or fill in desired 3-month targets:

	1200	1500	2000	2500	3000
Daily calories					
Sat Fat Grams	<15	15	18	20	25
Pet Fat Cal	10%	15%	20%	25%	30%
Exercise (Freq/wk/RPE)	20/5x/3	30/5x/4	45/5x/5	50/5x/6	60/5x/7
Max Heart Rate					
Stress Reduction Needs	Low Need	Some	Definite	High	Very High
Lipid Level Target					
Total Cholesterol	140	150	175	200	<225
LDL	60	70	80	<100	<125
HDL	35	37	39	41	>42

Physician's Signature: _____ Telephone: _____

FAX THIS FORM TO SALUS MEDIA: (805) 969-3601
 You will receive Fax confirmation within 24 Hours. For Assistance please call: (805) 969-2234

Douglas FIG. 2

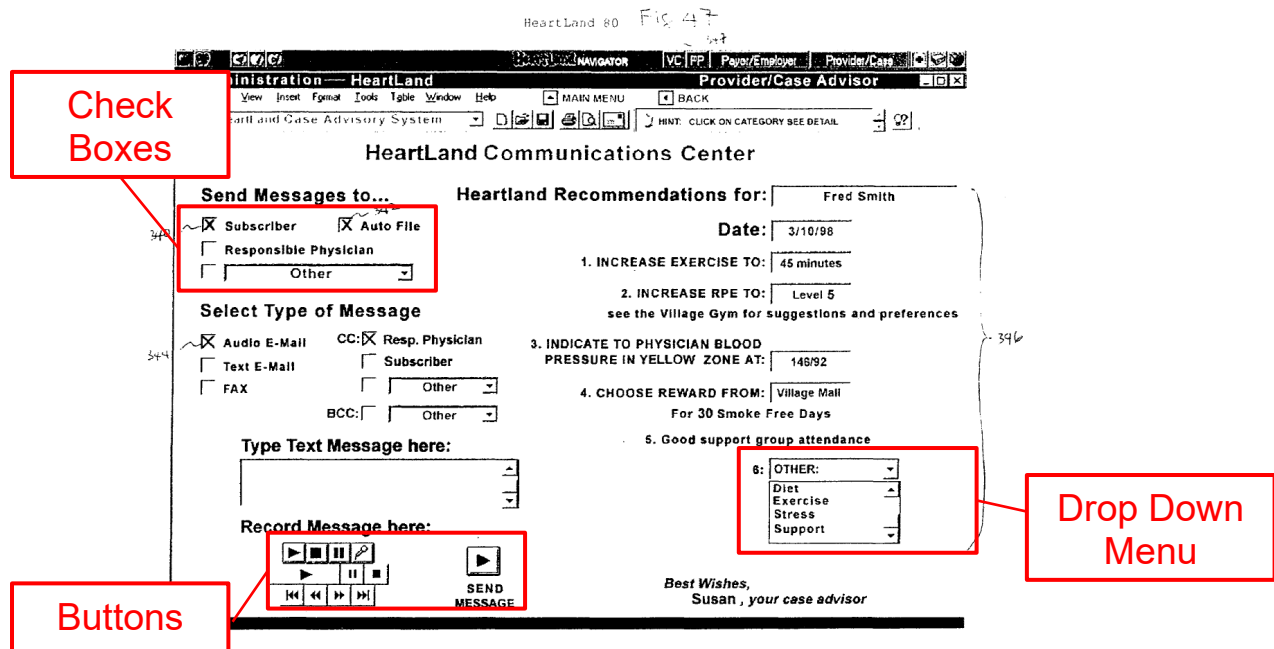
A POSITA would have understood Douglas's disclosure of the administrator entering this patient-physician information from the patient prescription form to be

disclosure of the administrator's assignment of the patient to the physician within Douglas's system. Bergeron at ¶ 66.

It also would have been obvious for the case administrator to assign the patients to their physicians. Bergeron at ¶ 67. As explained above, such assignments had to be created to achieve the functionality of Douglas's system, and the administrator was a logical and therefore obvious option for creating it, particularly in view of Douglas's disclosure that it is the administrator who "sets up a new patient based on information contained in the prescription form" (Douglas at 6:33-7:20), and the prescription form identifies the patient's physician (*supra*). Bergeron at ¶ 67.

Additionally, by entering the patient prescription form, the case administrator's assignments of the patients to the physicians constitute the administrator's selections of each of the patients and of the physician to be assigned to that patient. Bergeron at ¶ 68.

Should Patent Owner argue that something more is required to meet the claimed selections, Douglas also renders obvious the assignments by the administrator of the patients to their physicians through selections of graphical user interface ("GUI") components. Bergeron at ¶ 69. Douglas discloses several GUI components, including checkboxes, drop-down menus, and buttons, which are shown in, for example, Douglas's FIG. 47 (reproduced below):



Annotated Version of Douglas FIG. 47

Bergeron at ¶ 70; *see also e.g.*, Douglas at FIGs. 5, 6, 38, 39.

It would have been obvious to use Douglas's GUI components to assign each of the patients to their physician in each of the following ways:

- (1) by selecting a check box associated with the physician in a list of physicians and selecting a button to assign the patient to the physician; and
- (2) by selecting the physician from a list of physicians in a drop-down menu and selecting a button to assign the patient to the physician.

Bergeron at ¶ 71.

First, each of these options represents an obvious “combination of familiar elements according to known methods ... [that] does no more than yield predictable results.” *KSR Int’l Co.*, 550 U.S. at 401; Bergeron at ¶ 72. Douglas discloses the use of selectable checkboxes and drop-down menus to choose items from lists. Douglas at FIG. 47; Bergeron at ¶ 72. FIG. 47 also evidences Douglas’s use of a selectable button to act upon those choices. Bergeron at ¶ 72.

In both options (1) and (2), the checkboxes and drop-down menu would perform the same choosing-from-a-list function they do in Douglas’s FIG. 47, but for a list of physicians. Bergeron at ¶ 73. And the button would, like in FIG. 47, act upon the choices—here, to create the patient-to-physician assignment. *Id.* at ¶ 73. Thus, in options (1) and (2), the functions of the GUI components remain unchanged. *Id.* at ¶ 73. Each of the options would also lead to the predictable result of the patient being assigned to the chosen physician by the administrator. *Id.* at ¶ 74.

Second, any of these options would have accomplished the necessary patient-to-physician assignments in Douglas’s system in a way that furthered Douglas’s desire for that system to be GUI-based and using the GUI components it already leverages. Douglas at 2:16-24; Bergeron at ¶ 75; *see also* Douglas at 3:24-5:20 (FIGs. 3-6 and 8-58 are “graphical representation[s]”). Indeed, as a POSITA would have understood, option (1)’s checkboxes, option (2)’s drop-down menu, and both options’ buttons were basic building blocks of a GUI. Bergeron at ¶ 75.

Although the claim states “assigning each of the clients to one or more of the providers,” should PO argue that the claim requires multiple providers to be assigned to a patient, this would have been obvious. Bergeron at ¶ 76. Douglas’s system is used to treat patients with a variety of diagnoses, including those with multiple diagnoses. Douglas at FIGs. 2, 7; Bergeron at ¶ 76. Such patients would have benefited from having assigned physicians specialized in addressing those conditions, such as a cardiologist for a patient’s heart conditions (*see* Douglas at FIG. 2 (Diagnostic Categories I-VII)), a psychiatrist for the patient’s mental conditions (*see id.* at FIGs. 4 and 6 (“Depression”)), and a general practitioner to address the patient’s general needs, such as diet and exercise (*see id.* at FIG. 6). Bergeron at ¶ 76.

- (e) ***Limitation 1[d]: establishing desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;***

Douglas discloses establishing desired outcomes for each of the clients. Bergeron at ¶ 77. “[T]he physician or case advisor can design a new program ... for [a] patient by selecting the system’s Design option 50.” Douglas at 7:29-32, FIG. 4. “[T]he system [then] prompts the physician or case advisor to assign intensity levels 51 corresponding to the patient’s” needs, as shown in FIG. 5 (reproduced below):

HeartLand 69 Fig 5

SCREEN 2 OF 3

Design a new program for: Date:
Heartland I.D. #: Social Security #:

INITIAL SCALE

	LOW	INTENSITY	HIGH
DIET	☐	☐	☒
EXERCISE	☐	☐	☒
STRESS MANAGEMENT	☐	☒	☐
GROUP SUPPORT	☐	☐	☒
DRUGS	☐	☐	☐
COMPLIANCE	☐	☐	☒

Based on your input, Heartland suggests the following program and goals for:

Diet	15%	Calories From Fat
Exercise	3/4	hr days per week
Stress Management	1/2	hr days per week
Group Support	1/2	hr days per week
Compliance Mgt. Freq.	4	times per Month
Smoking		Cessation
Drug -aspirin	325	
-hydrochlorothz.	12.5	mg/da
-Lovastatin	20	

Program Detail ~ 54

Douglas FIG. 5

Douglas at 7:33-37; Bergeron at ¶ 77. “Based on the input information,” which includes the intensity levels as well as patient characteristics, “the system, case advisor, or physician generates a set of goals 52” as part of “a therapeutic program” for the patient. Douglas at 8:1-9, FIG. 5; Bergeron at ¶ 77. “The physician or case advisor may view details as to how the suggested goals may be implemented by selecting the system’s Program Detail option 54,” which shows “recommended one month goals 61 and final goals 62,” as shown in FIG. 6 (reproduced below):

HeartLand 70 *Fig 6*

Administration — HeartLand
File Edit View Insert Format Tools Table Window Help MAIN MENU BACK
HeartLand Health Assessment Review HINT: CLICK ON CATEGORY SEE DETAIL

SCREEN 3 OF 3
Based on your input, here is HeartLand's recommended program for: Fred Smith
Use the buttons to confirm or edit this program.

PATIENT STATUS & GOALS: DETAILS		Now 2/10/98	1 month Goal	GOALS
Name / D.O.B.	Fred Smith 2-5-49			
Starting Date	2/1/98			
Heartland I.D.	23-642			
Height / Sex	6'9" Male			
Weight	193	182	175	170
BMI	28.28	28.28	26.64	25.00
Smoke	.5 Packs/Day	.5	0	0
Physical Activity	0 / 0 / 0 minutes / x-week / RPE	20 / 3 / 3	25 / 5 / 4	4 / 6 / 8
Alcohol	2 Average Drinks per Day	2	1	1
Eating Habits	40 %Fiber/Complex Carb Intake	60	70	80
	40 %Fatty Food Intake	20	20	15
	40 %Fatty Dairy Intake	20	10	5
Calories	3,600	3,300	3,100	2,800
Fat Calories & %	45%	45%	20%	15%
Cholesterol - LDL	142	140 mg/dl	125 mg/dl	100 mg/dl
Cholesterol - HDL	35	37 mg/dl	39 mg/dl	45 mg/dl
Cholesterol	246 m/dl	225	210	190
Resting Pulse Rate	88 Beats Per Minute	68	65	79
Stress	8.5 Scale of 1 to 10 (10 being high stress)	7.0	6.0	3.5
Depression	Scale of 1 to 10 (10 being greatest)	10	6	0
Blood Pressure	140/100 systolic/diastolic	140/100	130/90	130/90
Seatbelt Use	30 percent of time	50	75	100
Back Pain	Incidents per month	3	2	0
Pharmaceuticals				
- aspirin	325 mg	325 mg/da	325 mg/da	325 mg/da
- hydrochlorothz.d.	12.5 mg	12.5 mg/da	12.5 mg/da	0 mg/da
- Lovastatin	20 mg	20 mg/da	20 mg/da	0 mg/da

CONFIRM
EDIT
OPTIONS...

Douglas FIG. 6

Douglas at 8:8-11; Bergeron at ¶ 77. “The physician or case advisor may confirm 63 or edit 64 the suggested program to modify the goals by making appropriate selections.” Douglas at 8:11-13; Bergeron at ¶ 77.

Douglas’s goals 51, 61, 62 are each a desired outcome. Bergeron at ¶ 78. And Douglas’s system assesses whether those desired outcomes are met by comparing data relating to the patient to respective thresholds of the desired outcomes, also shown in Douglas’s FIG. 6, such as the patient’s blood pressure being below 130/90

and the patient's weight being below 175. Douglas at FIG. 6; *see also id.* at 11:18-28; Bergeron at ¶ 78.

Douglas's disclosure of "[t]he physician or case advisor confirm[ing] 63 or edit[ing] 64 the suggested program to modify the goals" is disclosure of establishing these desired outcomes based on treatment and assistance required to meet them, whether the physician or case advisor confirms the goals as consistent with such treatment and assistance or edits them to be so. Douglas at 8:12-13; Bergeron at ¶ 79. Indeed, Douglas's program provides "goals 52," "one month goals 61," and "final goals 62" for weight loss, smoking cessation, reduction of alcohol consumption, and dietary improvements. Douglas at 8:1-13, FIGs. 5, 6; Bergeron at ¶ 79. The presence of these goals in the program is evidence that they are aspects for which the patient needs treatment and assistance to meet. Bergeron at ¶ 79.

Douglas's disclosure of the physician or case advisor "assign[ing] intensity levels 51 corresponding to the patient's diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements" (Douglas at 7:33-37, FIG. 5) is also disclosure of determining treatment and assistance for the client to meet the desired outcomes. Bergeron at ¶ 80. Such intensity levels form the basis for Douglas's goals as, "[b]ased on the input information," including the intensity levels, "the system ... generates a set of goals 52 ... for the patient," along

with more-detailed “one month goals and final goals 62.” Douglas at 81-13, FIGs. 5 and 6; Bergeron at ¶ 80.

To the extent required, treatments needed are further indicated by the intensity levels and confirmed or edited goals relating to the patient’s use of pharmaceuticals (Douglas at FIG. 5 and 6), and assistance needed is further indicated by the provider-received intensity levels and confirmed or edited goals relating to the patient’s participation in group support (Douglas at FIGs. 5 and 6; Bergeron at ¶ 81.

Beyond that, the therapeutic program’s pharmaceutical treatments, taking “aspirin,” “hydrochlorothzdzd,” and “Lovastatin” (Douglas at FIG. 6), are also, as a POSITA would have recognized, linked to other desired outcomes, reflecting a determination that such treatments are needed to meet those outcomes. Bergeron at ¶ 82. Indeed, aspirin reduces “Back Pain,” hydrochlorothiazide reduces “Blood Pressure,” and Lovastatin reduces “Cholesterol,” each of which is a desired outcome. Douglas at FIG. 6; Bergeron ¶ 82. Similarly, a POSITA would have recognized that the therapeutic program’s recommended assistance—attending “Group Support”—is linked to, e.g., desired outcomes of reducing “Alcohol” consumption, “Stress,” and “Depression,” reflecting a determination that such assistance is needed to meet those outcomes. Douglas at FIG. 6; Bergeron at ¶ 82.

- (f) *Limitation 1[e]: compiling data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;*

Douglas discloses receiving data associated with each patient from the providers, as “the system accepts updated patient data ... through data entered by the physician during office visits.” Douglas at 11:1-5, FIG. 60; *see also* claim 14, FIG. 41; Bergeron at ¶ 83.

Douglas discloses that this data received from providers is associated with at least performance of the desired outcomes, as Douglas explains that the system leverages that data to determine whether a patient is meeting their goals. *See* Douglas at 11:1-12:2; Bergeron at ¶ 84.

Being collected over time, the received data is compiled. Bergeron at ¶ 85. This is evidenced by “[t]he system generating reports on patient progress based on the data shown in FIGs. 40-45,” which depict various aspects of patient data collected over time, including, e.g., blood pressure, smoking activity, and physical activity, charted against respective patient goals. Douglas at 20:3-37, FIGs. 40-45; *see also id.* at 20:14-19; Bergeron at ¶ 85.

Douglas discloses that the data is received from a provider utilizing computing or communications devices in communication with the server, as the patient data is entered by the provider using a “PC 500” that “is electronically linked to network

server 508 via the Internet 518” using “a high-speed modem 506 connected to the PC 500.” Douglas at 24:3-26, FIG. 59; Bergeron at ¶ 86. Indeed, the physician “ENTER[S] UPDATED PAT. HEALTH INFO ONLINE” (Douglas at FIG. 60), and Douglas explains that the entry of such patient health info is achieved “via [the physician’s] personal computer.” See Douglas at 6:31-33; see also *id.* at 24:28-36, 11:3-5; Bergeron at ¶ 86.

As explained in Section VIII.A.2(b) (Limitation 1[a]), Douglas’s system treats multiple patients, each having one or more physicians, meaning provider-received data is compiled for each of those patients, and whether for a patient having multiple physicians or across multiple patients, that data is received from multiple physicians. Bergeron at ¶ 87.

- (g) ***Limitation 1[f]: automatically determining whether 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and***

Douglas discloses automatically determining whether the desired outcomes are being met, as Douglas’s “system compares actual data about the patient with the goals and parameters residing in the system’s database” and will “notify the physician or case advisor [if] these goals are not being met.” Douglas at 11:18-12:2; Bergeron at ¶ 88. Such goals—i.e., desired outcomes—include Douglas’s goals 52, one-month goals 61, and final goals 62. See Section VIII.A.2(e) (Limitation 1[d]).

Douglas further discloses that this determination is in response to rules governing data analysis that are utilized based on the compiled data, given that “the system periodically correlates the updated patient health information [(i.e., compiled data)] with program goals to determine the patient’s progress and compliance with the program,” including its goals 52, 61, and 62. Douglas at 11:6-12:2, FIGs. 60, 5, 6; Bergeron at ¶ 89. As a specific examples of such rules, Douglas discloses comparing thresholds of the goals (*see* Section VIII.A.2(e) (Limitation 1[d])) to updated patient data to determine whether the patient has met the goals; “[f]or example, if the current data states that the patient has lost 5 pounds instead of 10, the system will notify the physician or case advisor of this fact.” Douglas at 11:18-24; Bergeron at ¶ 89.

Douglas also discloses automatically determining whether the compiled data varies from one or more thresholds to become significant for one or more of the clients. For instance, Douglas discloses that “[t]he system compares actual data about the patient with the goals and parameters residing in the system’s database and automatically notifies the physician or case advisor ... if a health risk is present.” Douglas at 11:11-15, FIG. 60. Bergeron at ¶ 90. More specifically, Douglas discloses the identification of such a health risk—“a threatening situation”—based on “the difference between current data and goals.” Douglas at 11:18-19; Bergeron at ¶ 90. As explained above, Douglas arrives at this difference by assessing the

variation between patient data and thresholds associated with the goals. Bergeron at ¶ 90.

- (h) *Limitation 1[g]: automatically communicating alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.*

As explained in Section VIII.A.2(g) (Limitation 1[f]), Douglas’s system identifies when a health risk is present for a patient based on the compiled data varying from the goals’ corresponding thresholds. And if it so-identifies a health risk, it—via an “alarm” option—automatically communicates an alert. Douglas at 11:11-17; Bergeron at ¶ 91.

3. *Claim 3: The method according to claim 1, further comprising: establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application.*

As described above in Section VIII.A.2(e) (Limitation 1[d]), Douglas’s system establishes desired outcomes—in the form of goals 52, 61, and 62—for the client associated with treatment or assistance needed by the client. And Douglas’s system does so utilizing a wizard application. Bergeron at ¶ 92. As a POSITA would have understood, a wizard application is “[a]n interactive help utility within an application that guides the user through each step of a particular task.” Microsoft at 573; Bergeron at ¶ 92. In Douglas, the task is establishing goals for the patient, and Douglas breaks this task down into discrete steps to guide a user therethrough. See Douglas at FIGs. 4-6.

Douglas's wizard application first accepts "baseline values corresponding to the vital signs and patient characteristics at the beginning of ... the program." Douglas at 7:17-26, FIG. 4; Bergeron at ¶ 93. The wizard application then provides the user with a "Design option 50" through which the user "can design a new program ... for the patient." Douglas at 7:29-32, FIG. 4; Bergeron at ¶ 93. Under that design option, Douglas's wizard application "prompts the [user] ... to assign intensity levels 51" for various aspects of the program. Douglas at 7:33-37, FIG. 5; Bergeron at ¶ 93. With this information, "the system generates a set of goals 52 ... for the patient." Douglas at 8:1-9, FIG. 5; Bergeron at ¶ 93.

Douglas's wizard application also presents the user with a "Program Detail option 54," which allows the user to "view details as to how the suggested goals may be implemented," by showing "recommended one month goals 61 and final goals 62." Douglas at 8:1-9, FIG. 6; Bergeron at ¶ 94. Finally, the wizard application allows the user to "edit 64 the suggested program." Douglas at 8:10-13, FIG. 6; Bergeron at ¶ 94.

4. *Claim 4: The method according to claim 3, wherein the wizard application receives at least a main heading, a start date, a projected closure date, and a desired outcome description.*

As explained in Section VIII.A.3 (Claim 3), Douglas discloses a wizard application that establishes goals for a client as part of a suggested program. Douglas's FIG. 6, annotated and reproduced below, depicts the suggested program:

HeartLand 70 Fig 6

Administration

Provider/Case Advisor

SCREEN 3 OF 3

Based on your Input, here is HeartLand's recommended program for: [Fred Smith]
Use the buttons to confirm or edit this program.

Projected Closure Date

Start Date

Main Heading

Desired Outcomes Description

PATIENT STATUS & GOALS: DETAILS		Now	2/10/98	1 month	Goal
Name / D.O.B.	Fred Smith 2-5-49				
Starting Date	2/1/98				
Heartland I.D.	23-642				
Height / Sex	5'9" Male				
Weight	193	182	175	170	
BMI	28.28	26.28	25.64	25.00	
Smoke	.5 Packs/Day	.5	0	0	
Physical Activity	0 / 0 / 0 minutes / x-week / RPE	20 / 3 / 3	25 / 6 / 4	4 / 6 / 6	
Alcohol	2 Average Drinks per Day	2	1	1	
Eating Habits	40 %Fiber/Complex Carb Intake	60	70	80	
	40 %Fatty Food Intake	20	20	15	
	40 %Fatty Dairy Intake	20	10	5	
Calories	3,600	3,300	3,100	2,800	
Fat Calories & %	45%	45%	20%	15%	
Cholesterol - LDL	142	140 mg/dl	125 mg/dl	100 mg/dl	
Cholesterol - HDL	35	37 mg/dl	39 mg/dl	45 mg/dl	
Cholesterol	246 mg/dl	225	210	190	
Resting Pulse Rate	88 Beats Per Minute	68	65	79	
Stress	8.5 Scale of 1 to 10 (10 being high stress)	7.0	6.0	3.5	
Depression	Scale of 1 to 10 (10 being greatest)	10	6	0	
Blood Pressure	140/100 systolic/diastolic	140/100	130/90	130/90	
Seatbelt Use	30 percent of time	60	75	100	
Back Pain	Incidents per month	3	2	0	
Pharmaceuticals					
- aspirin	325 mg	325 mg/da	325 mg/da	325 mg/da	
- hydrochlorothiazide	12.5 mg	12.5 mg/da	12.5 mg/da	0 mg/da	
- Lovastatin	20 mg	20 mg/da	20 mg/da	0 mg/da	

CONFIRM ~ 63

EDIT ~ 64

OPTIONS...

Douglas FIG. 6 (Annotated)

Bergeron at ¶ 95. The suggested program's goals include a main heading (e.g., "Physical Activity"), a start date ("Starting Date 2/1/98"), a projected closure date ("1 month"), and a desired outcome description (e.g., "25/6/4" "minutes / x-week / RPE" of exercise). Douglas's wizard application receives these items to display them as shown in FIG. 6. Bergeron at ¶ 95.

Douglas's wizard application also allows "[t]he physician or case advisor ... [to] edit 64 the suggested program to modify the goals." Douglas at 8:10-13; *see also* Section VIII.A.3 (Claim 3). Such goal-modification would have at least obviously included the user's ability to edit the goals' main heading, start date, projected closure date, and desired outcome description, with such edited aspects

thereby being received by the wizard application. Bergeron at ¶ 96. This ability would have furthered Douglas's objective of creating "customized ... modification programs" for patients (Douglas at 2:16-19, 2:37-38, 6:1-2). Bergeron at ¶ 96.

5. *Claim 6: The method according to claim 1, wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.*

Douglas's data contains intervention plans, including positive interventions, in which "[u]sers may earn points for good participation in the program and by reaching certain milestones." Douglas at 16:15-25; Bergeron at ¶ 97. Those intervention plans also include "[e]xercise and stress management programs ... designed ... to lie within the individual patient's ability range." Douglas at 16:32-35; Bergeron at ¶ 97. Such intervention plans further include negative interventions, such as "notify[ing] the physician ... that ... goals are not being met," which "must ... be addressed by the physician." Douglas at 11:18-12:2; Bergeron at ¶ 97. And "if a health risk is present ... the system will automatically send an alarm to the physician ... and require his or her immediate action." Douglas at 11:11-17; Bergeron at ¶ 97. Being triggered or based on updated patient health data in Douglas's system, such intervention plans are part of the system and thus also constitute data. Bergeron at ¶ 97. Further, such would be "information needed by a user of the system," all of which "is located in the databases 522." Douglas at 24:35-37; Bergeron at ¶ 97.

Douglas's data further includes desired outcomes and objectives, in the form of Douglas's goals 51, 61, and 62. *See* Section VIII.A.2(e) (Limitation 1[d]). Recorded activities, too, are included in Douglas's data, such as the number of packs of cigarettes the patient smokes per day, the patient's physical activity, the percentages of certain types of food consumed by the patient, and the patient's seatbelt use. Douglas at FIG. 4; Bergeron at ¶ 98.

Finally, Douglas's data also includes general notes, as Douglas's prescription form allows the physician to note the patient's "current and prescribed medications," including "Comments/Changes" (Douglas at FIG. 2), which are general notes. Bergeron at ¶ 99. Considering "the case administrator sets up a new patient based on information contained in the patient prescription form," these general notes are entered into Douglas's system as data. Douglas at 7:11-12; *see also id.* at FIG. 60 (blocks 1004-1008); Bergeron at ¶ 99. Correspondingly, Douglas's FIG. 4 includes values for aspirin, hydrochlorothiazide, and Lovastatin intake, but not other drugs such as Atenolol or Lisinopril, each of which is notable by the physician on FIG. 2's prescription form, indicating the case administrator's entry of the physician's general notes as data. *Compare* FIG. 4 *with* FIG. 2; Bergeron at ¶ 99.

To the extent PO argues that all of the above data are not "compiled," first, they are, in at least that Douglas's system handles multiple patients, each with their own intervention plans, desired outcomes and objectives, recorded activities, and

general notes (Douglas at 21:14-15, FIG. 57 (showing physicians with multiple patients)), which is therefore compiled in Douglas's databases 522 (Douglas at 24:35-37). Bergeron at ¶ 100. And second, the claims only require compiling data "associated with at least performance of the desired outcomes" (Limitation 1[e]), which Douglas's system does (*see* Section VIII.A.2(f)). Bergeron at ¶ 100.

6. Claim 7:

- (a) *The method according to claim 1, further comprising: determining whether the data required is received from each of the providers; and***
- (b) *sending an alert to one or more providers in response to determining there is missing data for one or more clients associated with the one or more providers.***

Douglas discloses sending an "alert" to a client's provider should the client's data indicate a "threatening" situation. *See* Sections VIII.A.2(g)-VIII.A.2(h) (Limitations 1[f]-1[g]); Bergeron at ¶ 101. Given that client data may indicate a "threatening" or "potentially dangerous" situation (Douglas at 11:11-19), it would have been obvious for Douglas's system to determine whether client data was missing and, if so, send an alert to the provider associated with the client. Bergeron at ¶ 101. Doing so would have encouraged the provider to enter the missing data (*see* Section VIII.A.2(f) (Limitation 1[e])), thereby allowing Douglas's system to identify (and potentially uncover) a threatening or potentially dangerous situation indicated by the data. Bergeron at ¶ 101.

7. ***Claim 10: The method according to claim 1, further comprising: prompting the providers to provide data associated with assigned clients.***

Douglas's disclosed or obvious fields for entering patient data (*see* Section VIII.A.2(c) (Limitation 1[b])) prompt the providers to provide data associated with the clients by providing a space for entering data labeled with the type of data that is to be entered (*see* Douglas at FIG. 4 (fields 46 and 48 for receiving, e.g., "Blood Pressure" data)), Douglas at FIG. 46 (space for entering, e.g., "TOTAL ... CALORIES"), Wright at FIG. 4 (space for entering, e.g., "Heart Rate")). Bergeron at ¶ 102.

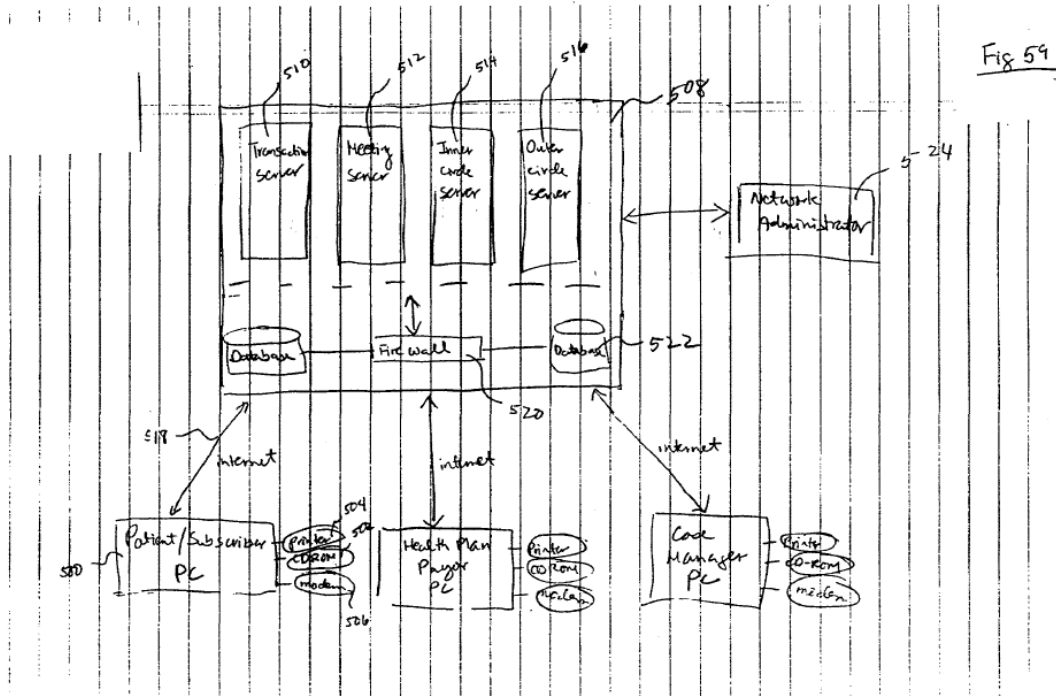
8. ***Claim 11***

- (a) ***Limitation 11[p]: A system for tracking goal progression, the system comprising:***

See Section VIII.A.2(a) (Limitation 1[p]).

- (b) ***Limitation 11[a]: a server that communicates with communications devices through a transceiver utilizing one or more networks, the server includes a processor that executes a client management program to:***

Douglas discloses that its system includes a server that communicates with communications devices utilizing one or more networks, as Douglas discusses "PC[s] 500 electronically linked to network server 508 via the Internet 518," shown in Douglas's FIG. 59 (reproduced below):



Douglas FIG. 59

Douglas at 24:12-34; Bergeron at ¶ 104. Such PCs are for “patients, physicians, case advisors, and health plan payors” and are communications devices, as they communicate with the server. Douglas at 24:3-6, 22-34; Bergeron at ¶ 104.

The communications between PCs 500 and network server 508 are also through a transceiver, which a POSITA would have understood to be “[a] device that can both transmit and receive signals.” Microsoft at 527; Bergeron at ¶ 105. Douglas discloses that PCs 500 transmit signals that are received by network server 508, and the network server transmits signals that are received by the PCs, indicating the presence of a transceiver at each of the PCs and the network server. Douglas at 24:27-34; Bergeron at ¶ 105. Specific transceivers that Douglas discloses include

“high-speed modem 506 connected to the PC 500” (Douglas at 24:22-24) and transceivers for establishing a “cellular connection [or] satellite link ... [with the] network server” (Douglas at 8:28-31). Bergeron at ¶ 105.

Douglas further discloses a client management program, specifically, Douglas’s “compliance monitoring and feedback system.” Douglas at 5:22-25, FIGs. 59 and 60; Bergeron at ¶ 106. That system manages a patient in that it:

- provides for the creation of a patient account (Douglas at 6:33-35, FIG. 60);
- “recommends a default set of goals based on the patient’s needs and existing medical protocols” (*id.* at 7:17-20, FIG. 60);
- “assists [the patient] in complying with ... [the] program” (*id.* at 8:28-29, FIG. 60);
- “periodically correlates ... updated patient health information with the program goals to determine the patient’s progress” (*id.* at 11:26-28, FIG. 60); and
- “informs the physician” regarding the patient’s progress, who then “determines whether to modify the patient’s therapeutic program” (*id.* at 11:28-12:2, FIG. 60). Bergeron at ¶ 106.

Douglas’s system is software and therefore a processor executes the system. Douglas at 25:22-26, 3:10-13, 2:25-27; Bergeron at ¶ 106.

A POSITA would have understood that Douglas's system resided on Douglas's network server 508 and so did the processor that executed it. Bergeron at ¶ 107. First, as Douglas explains, network server 508 includes an “inner circle” server 515” that “is dedicated to handle sensitive data, such as medical records.” Douglas at 24:13-19, FIG. 59; Bergeron at ¶ 108. Such handling of sensitive medical records includes:

- Setting up secure provider accounts that have access to patient data (Limitations 11[b], 11[d]);
- Compiling patient data (Limitations 11[c], 11[f]);
- Establishing goals and assessing the patient's compliance therewith based on patient data (Limitations 11[e], 11[g], 11[h], Claim 14).

Bergeron at ¶ 108.

A POSITA would have understood that these relied-on portions of Douglas's system are implemented by “inner circle” server 515 of network server 508. Bergeron at ¶ 108.

Second, as Douglas explains, patients and physicians must log into the system to use or access it, further indicating its implementation on network server 508. Douglas at 8:29-31, 19:27-30, 25:5-11, FIG. 59; Bergeron at ¶ 109.

It also would have been obvious for the processor implementing Douglas's system to reside in network server 508. To begin, network server 508 includes “one

or more relational databases 522 ... that contain all the health plan data” and “all the information needed by a user of the system.” Douglas at 24:28-25:4; *see also id.* at FIG. 59; Bergeron at ¶ 110. Given that a patient on Douglas’s system and their physician need access to the patient’s health data (*see* Douglas at FIGs. 41-44 (charts of a patient’s data that are provided to the patient and physician (*id.* at 20:14-19, 12:3-7))), a POSITA would have understood that such health data was stored in databases 522. Bergeron at ¶ 110; *see also* Douglas at 24:32-33. And Douglas’s system makes periodic use of that health data. *See, e.g.,* Douglas at 11:26-28, FIG. 60; Bergeron at ¶ 110.

Therefore, a POSITA would have understood that locating the processor implementing Douglas’s system in the server containing the health data upon which that system operated—databases 522 of network server 508—would have achieved Douglas’s goal of “protect[ing the] confidentiality of health plan data.” Douglas at 25:14-16; *see also id.* at 10:7-9, 19:29-30, 22:12-14, 24:18-19, 25:5-9; Bergeron at ¶ 111. In this arrangement, the health data could remain behind firewall 520 that “protects confidentiality of health plan data” (Douglas at 25:14-16, Douglas at 59), while it was “correlate[d] ... with the program goals” (Douglas at 11:26-28). Bergeron at ¶ 111.

- (c) ***Limitation 11[b]: receive input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;***

See Sections VIII.A.2(b) (Limitation 1[a]) and VIII.A.8(b) (Limitation 11[a]).

- (d) ***Limitation 11[c]: create fields required for compiling data associated with the treatment or assistance of each of the clients from the providers;***

See Sections VIII.A.2(c) (Limitation 1[b]) and VIII.A.8(b) (Limitation 11[a]).

- (e) ***Limitation 11[d]: assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;***

See Sections VIII.A.2(d) (Limitation 1[c]) and VIII.A.8(b) (Limitation 11[a]).

- (f) ***Limitation 11[e]: establish desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;***

See Sections VIII.A.2(e) (Limitation 1[d]) and VIII.A.8(b) (Limitation 11[a]).

- (g) ***Limitation 11[f]: compile data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;***

See Sections VIII.A.2(f) (Limitation 1[e]) and VIII.A.8(b) (Limitation 11[a]).

- (h) ***Limitation 11[g]: automatically determine whether 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and***

See Sections VIII.A.2(g) (Limitation 1[f]) and VIII.A.8(b) (Limitation 11[a]).

- (i) ***Limitation 11[h]: automatically communicate alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients;***

See Sections VIII.A.2(h) (Limitation 1[g]) and VIII.A.8(b) (Limitation 11[a]).

- (j) ***Limitation 11[i]: a database in communication with the server configured to store the data and information associated with the clients and the providers.***

Douglas discloses that network server 508 includes “one or more relational databases 522 (such as SQL) that contain all the health plan data” as well as “[a]ll the information needed by a user of the system.” Douglas at 24:28-37; Bergeron at ¶ 119. Such databases include the patient data. *See* Section VIII.A.8(b) (Limitation 11[a]).

The databases also include the patients’ “goals and parameters” (Douglas at 11:12-17) approved by their physicians (*see* Section VIII.A.2(e) (Limitation 1[d])), the patients’ journal entries accessible by their physicians (*id.* at 10:31-36, 24:31-33), recommendations to patients made by their physicians (*id.* at 21:25-28), and those physicians’ accounts (*see* Section VIII.A.2(b) (Limitation 1[a])), each of

which constitute “information associated with the clients and the providers.”

Bergeron at ¶ 120.

9. ***Claim 14: The system according to claim 11, wherein the server further establishes the desired outcomes for the client utilizing a wizard application including at least a main heading, a start date, a projected closure date, and a desired outcomes description.***

See Sections VIII.A.3-VIII.A.4 (Claims 3 and 4). Douglas’s wizard application is, or obviously would have been, implemented by network server 508 for the reasons explained in Section VIII.A.8(b) (Limitation 11[a]).

Further, as shown in Section VIII.A.4, that wizard application includes a main heading, a start date, a projected closure date, and a desired outcomes description.

Bergeron at ¶ 122.

10. Claim 16

(a) Limitation 16[p]: A controller comprising

Douglas discloses a controller, as it discusses a network server 508 that implements Douglas’s system. Douglas at 24:3-25:21, FIG. 59; Bergeron at ¶ 123. The ’142 Patent makes no relevant distinction between “controller” and “server.” ’142 Patent at 1:52-56; *compare id.* at 3:60-61 (“FIG. 2 is a block diagram of a controller”) *with* 8:62-63 (“FIG. 2 is a block diagram of a server 200”); Bergeron at ¶ 123. This is further evidenced by claims 17-19 referring to “[t]he server”—not the controller—“according to claim 16.” ’142 Patent at claims 17-19; Bergeron at ¶ 123.

(b) *Limitation 16[a]: a processor for executing a set of instructions; and*

Douglas discloses or renders obvious a processor within network server 508 for executing a set of instructions, specifically those for implementing Douglas's system. *See* Section VIII.A.8(b) (Limitation 11[a]).

(c) *Limitation 16[b]: a memory for storing the set of instructions, wherein the set of instructions are executed by the processor to:*

As a POSITA would have understood, Douglas discloses a memory in network server 508 for storing the set of instructions that the server's processor executes to implement Douglas's system. Bergeron at ¶ 125. A POSITA would have known that a processor required a memory—at a minimum, RAM—to store the instructions that the processor executed. Bergeron at ¶ 125.

Should PO disagree, the use of a memory to store software was within a POSITA's general knowledge. Bergeron at ¶ 126. Chitiveli, for instance, discloses that his server includes a “memory 230 including the content analytics tool” (Chitiveli at ¶¶ [0044]-[0046], FIG. 2), which—like Douglas's system—analyzes patient data (*id.* at ¶ [0019]). *See also infra* Section VIII.C.1; Bergeron at ¶ 126. This general knowledge, reflected by Chitiveli, is mappable to the claimed memory. *Koninklijke Philips N.V.*, 948 F.3d at 1337. And using such a memory to store Douglas's system amounts to nothing more than the obvious use of the memory to

perform its established, software-storing function. *KSR Int'l Co.*, 550 U.S. at 401; see Chitiveli at ¶¶ [0044]-[0046], FIG. 2; Bergeron at ¶ 126.

- (d) ***Limitation 16[c]: receive input establishing accounts for providers serving clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;***

See Section VIII.A.8(c) (Limitation 11[b]).

- (e) ***Limitation 16[d]: create fields required for compiling data associated with the treatment or assistance of each of the clients from the providers;***

See Section VIII.A.8(d) (Limitation 11[c]).

- (f) ***Limitation 16[e]: assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more providers include at least individuals available to treat or assist the client;***

See Section VIII.A.8(e) (Limitation 11[d]).

- (g) ***Limitation 16[f]: establish desired outcomes for each of the clients based on treatment and assistance required to meet the desired outcomes, wherein one or more thresholds indicates whether the desired outcomes are met;***

See Section VIII.A.8(f) (Limitation 11[e]).

- (h) ***Limitation 16[g]: compile data associated with at least performance of the desired outcomes by each of the clients received from the providers utilizing computing or communications devices in communication with the server;***

See Section VIII.A.8(g) (Limitation 11[f]).

- (i) *Limitation 16[h]: automatically determine 1) the desired outcomes are being met in response to rules governing data analysis that are utilized based on the compiled data, and 2) the compiled data varies from one or more thresholds to become significant for one or more of the clients; and*

See Section VIII.A.8(h) (Limitation 11[g]).

- (j) *Limitation 16[i]: automatically communicate alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.*

See Section VIII.A.8(i) (Limitation 11[h]).

- 11. *Claim 17: The server according to claim 16, wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.*

See Section VIII.A.5 (Claim 6).

B. Ground 2 – Douglas and Wager Render Obvious Claims 1, 3, 4, 6, 7, 10, 11, 14, 16, and 17

1. Wager Overview

Wager is directed to “an intuitive, visual interface for generating patient-to-care provider assignments, including capacity computation, skill set matching, [and] ratio management.” Wager at ¶ [0003]; *see also id.* at Title, Abstract; Bergeron at ¶ 135. An exemplary such “workforce management interface 106” is shown in Wager’s FIG. 2, reproduced below:

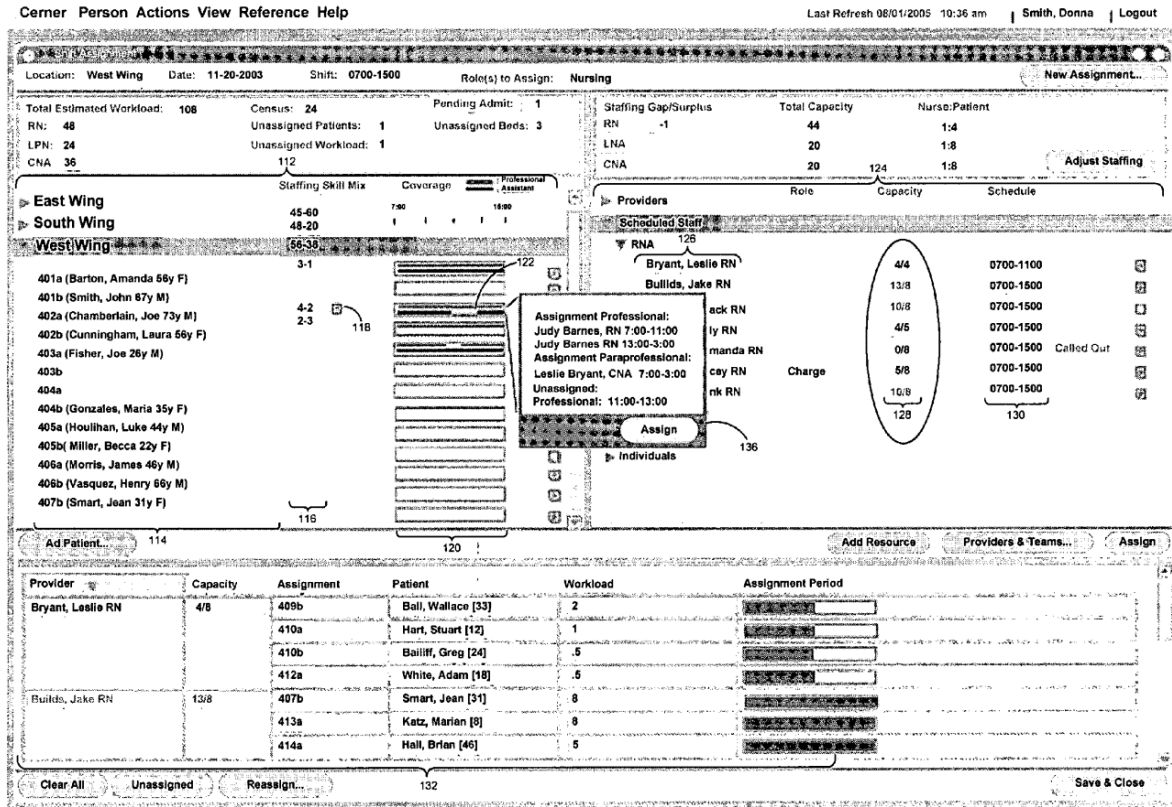


FIG. 2

Wager at ¶ [0011]; Bergeron at ¶ 135.

As Wager explains, a “staff manager” associated with “a hospital or other clinical care facility” can “operate the workforce management interface 106 to ... generate care provider-to-patient assignments,” where those providers include “nurses, therapists, technicians, physicians,” etc. Wager at ¶ [0011]; Bergeron at ¶ 136. Specifically, workforce management interface 106 includes a “patient population profile 112,” which includes “a patient list 114” associating individual patients with “a patient needs rating 116 indicating the rated amount of workload or work effort represented by a patient’s care” and “a set of skill criteria 118 ...

indicating that the care of a particular patient requires specialized training, certification or skills.” Wager at ¶ [0012]; Bergeron at ¶ 136. “[T]he workforce management interface 106 may likewise include ... a provider population profile 124 which may contain a provider list 126” associating individual providers with “provider capacity ratings 128 which may indicate a given ... [provider’s] capacity to undertake patient care” that “may include or incorporate a scaling or adjustment factor to take a given provider’s experience level, specialized training, patient continuity and other factors into account.” Wager at ¶ [0014]; Bergeron at ¶ 136. “Provider population profile 124 ... may further include a provider schedule” for each provider “indicating a provider’s availability ... for [certain] times or periods.” Wager at ¶ [0015]; Bergeron at ¶ 136.

Using Wager’s workforce management interface 106, “the ... staff manager may assess or determine the clinical care needs of patients,” including “specialized skills criteria 118,” and “assess and determine available care providers and their projected or estimated capacities, skill sets and other information or qualifications to service the patient population.” Wager at ¶¶ [0018]-[0021]; Bergeron at ¶ 137. Proper assignments of the care providers to the patients are facilitated by matching the patients’ time- and skill-needs to the care providers’ capacities and skill sets. Wager at ¶¶ [0018]-[0022]; Bergeron at ¶ 137. Those assignments can be accomplished by “the staff manager ... selecting or highlighting a nurse, therapist,

technician or other from provider list 126 and dragging that name or other object on top of a patient name in the patient list 114.” Wager at ¶ [0021]; Bergeron at ¶ 137.

2. Modification of Douglas

Douglas’s system is used to treat patients with a variety of needs, ranging from patients “who have suffered from a heart attack within the current year” to patients who “are on the plan simply to promote wellness.” Douglas at 6:36-7:4; *see also id.* at 6:6-14; Bergeron at ¶ 138. Consistently, Douglas’s physicians treating those patients have varied skill sets. *See* Douglas at FIG. 57 (showing “Specialty[s]” of “Cardio” and “Primary”); Bergeron at ¶ 138.

Should it be found that Douglas does not disclose or render obvious the case administrator’s assignment of the patient to a physician based on the administrator’s selections (*see* Section VIII.A.2(d) (Limitation 1[c])), it would have been obvious to modify Douglas’s system to include an interface like Wager’s that provided the administrator with “an intuitive, visual interface for generating patient-to-care provider assignments, including capacity computation, skill set matching, [and] ratio management” (Wager at ¶ [0003]) through which the administrator assigned the patient to a physician. Bergeron at ¶ 139. Such a modified system is hereinafter referred to as the Douglas-Wager System.

3. *Motivation to Combine*

Doing so would have helped ensure that the assigned physician was equipped, in terms of skill set, to treat the patient, particularly in view of Douglas's patients having varied needs and Douglas's physicians having varied skill sets (*supra* Section VIII.B.2). Bergeron at ¶ 140. Such is explicitly taught by Wager, whose "invention overcome[s] ... problems," including "the unit or other managers ...[needs to] rely on manual notes, memory and intuition to ... make appropriate provider-to-patient assignments," by the "staff manager [being] presented with a suite of provider assignment options and alternatives, to automatically organize and drive assignment ratios and other assignment parameters and options with compliance, capacity, best practice and other criteria taken into account." Wager at ¶¶ [0005]-[0007]; Bergeron at ¶ 140.

The Douglas-Wager System would have also helped ensure that the assigned physician had the capacity to effectively treat the patient. Bergeron at ¶ 141. Evidenced by Douglas's FIG. 51, there are many patients on Douglas's system. Douglas at FIG. 51 ("12,984" patients on the program); Bergeron at ¶ 141. And those patients were not evenly distributed amongst physicians. *See* Douglas at FIG. 57; Bergeron at ¶ 141. As a POSITA would have understood, a physician's capacity to tend to a patient decreases as the number of patients that the physician treats increases. Bergeron at ¶ 141. Through use of Wager's interface, such capacity

issues “may be more effectively managed against fluctuating clinical demands” (Wager at ¶ [0006]; *see also id.* at ¶¶ [0008], [0020]), ultimately increasing quality of care for the patient. Bergeron at ¶ 141.

4. Claims 1, 3, 4, 6, 7, 10, 11, 14, 16, and 17

The mappings to Claims 1, 3, 4, 6, 7, 10, 11, 14, 16, and 17 for Ground 2 are the same as for Ground 1 (*see* Section VIII.A), excepting Limitations 1[c], 11[d], 16[e], additions to which are addressed below. Bergeron at ¶ 142.

- (a) *Limitation 1[c]: assigning each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;***

In the Douglas-Wager System (*see* Sections VIII.B.2-VIII.B.3), the case administrator would have assigned to each patient a physician having a capacity and skill set that matched the patient’s time- and skill-needs.³ Bergeron at ¶ 143.

The Douglas-Wager System also discloses that such assignments would have been in response to selections from the administrator—i.e., of each of the patients

³ Or multiple physicians, should PO argue that such is required (*see* Section VIII.A.2(d) (Limitation 1[c])), at least to address a patient’s various needs. *See* Wager at ¶¶ [0018], [0020] (emphasizing that providers’ skill sets need to be matched to a patient’s needs); Bergeron at ¶ 143.

and the physician to be assigned to the patient. Bergeron at ¶ 144. These assignments would have each been performed by “selecting or highlighting a nurse, therapist, technician or other from provider list 126 and dragging that name or other object on top of a patient name in the patient list 114” (Wager at ¶ [0021]). Bergeron at ¶ 144.

- (b) *Limitation 11[d]: assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client,*

See Section VIII.B.4(a).

- (c) *Limitation 16[e]: assign each of the clients to one or more of the providers in response to selections from an administrator, wherein the one or more of the providers include at least individuals available to treat or assist the client;*

See Section VIII.B.4(a).

C. Grounds 3 and 4 – Douglas and Chitiveli (Ground 3), and Douglas, Wager, and Chitiveli (Ground 4) Render Obvious Claims 2 and 20

1. Chitiveli Overview

Chitiveli discloses “techniques for a software as a service (SaaS) provider to host a content analytics tool to evaluate data collections for multiple customers.” Chitiveli at ¶ [0014]. Chitiveli FIG. 1 (reproduced below) “illustrates an example computing infrastructure 100” embodying those techniques:

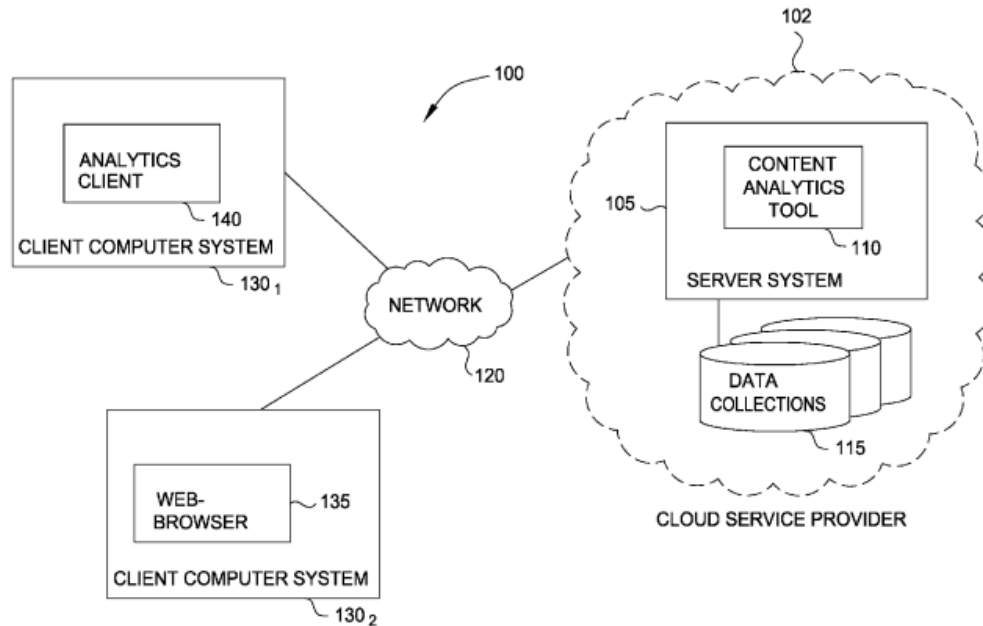


FIG. 1

Chitiveli at ¶ [0035]; Bergeron at ¶ 147. That computing infrastructure includes “a cloud based service provider 102 hosting a server system 105 and also includes [client computing] systems 130₁₋₂, all of which are connected to a communications network 120.” Chitiveli at ¶ [0035]; Bergeron at ¶ 147. Client computing systems 130₁₋₂ can be “desktop or laptop computer systems” as well as “mobile telephone devices [and] tablet computers.” Chitiveli at ¶ [0036]; Bergeron at ¶ 147.

Client computing system 130₁ “execute[s] an analytics client 140” and client computing system 130₂ “execute[s] a web browser 135” to “communicate with a content analytics tool 110 on the server system 105.” Chitiveli at ¶ [0036]; Bergeron at ¶ 148. Using the analytics client or the web browser, a user can “upload enterprise data associated with a given tenant as well as access the resulting data collections

115 hosted by the service provider 102.” Chitiveli at ¶ [0036]; Bergeron at ¶ 148. Content analytics tool 110 then performs “analytical processing” on the uploaded data to “generate periodic reports on the analyzed data to monitor progress on identified issues.” Chitiveli at ¶ [0037]; Bergeron at ¶ 148.

While Chitiveli’s computing infrastructure 100 is usable in many fields, Chitiveli expressly discloses its use in the medical field to analyze patient data. Chitiveli at ¶¶ [0019], [0020], [0034], [0042], [0048], [0054], [0063], FIG. 7; Bergeron at ¶ 149.

Like Chitiveli’s content analytics tool 110, Douglas’s compliance monitoring and feedback system:

- resides on a server (Chitiveli at FIG. 1; *see* Section VIII.A.8(b) (Limitation 11[a]));
- receives data from client/provider devices such as a “desktop or laptop computer system[]” (Chitiveli at ¶ [0036]; *see* Section VIII.A.2(f) (Limitation 1[e])); and
- analyzes that data to “generate periodic reports on the analyzed data to monitor progress on identified issues” (Chitiveli at ¶ [0037]; *see* Section VIII.A.2(f) (Limitation 1[e])). Bergeron at ¶ 149.

2. Claim 2

(a) Modification of Douglas

It would have been obvious to implement Douglas's system using a SaaS provider like Chitiveli discloses for his content analytics tool, with Douglas's network server 508 implemented on a cloud network (Chitiveli at ¶ [0035], FIG. 1), and Douglas's provider computing or communications devices executing client applications to upload patient data to that server for analysis using Douglas's system (*id.* at ¶¶ [0036]-[0037]). Bergeron at ¶ 151.

(b) Motivation to Combine

As a POSITA would have recognized, such modification would have provided several benefits. Bergeron at ¶ 152. First, it would have reduced overhead by eliminating the need to procure, maintain, and find space for the network server or to maintain Douglas's system. Chitiveli at ¶ [0031]; NetSuite at 1 ("Upgrades, maintenance and system administration take place in the cloud and are managed by the vendor"). Bergeron at ¶ 152. Second, it would have provided increased availability of Douglas's system. NetSuite at 1 ("Cloud software architectures ... frequently deliver better application-level availability."); Bergeron at ¶ 153. Third, using a cloud service provider would have resulted in increased security (NetSuite at 1 ("the level of security ... provided by a software-as-a-service provider far exceeds that which [a company] can provide themselves")), which is a focus of Douglas (Douglas at 25:5-9). Bergeron at ¶ 153. Fourth, it would have saved

costs—“eliminating the need for on-premise hardware, cloud computing reduces overall server room electric consumption as well.” NetSuite at 1; Bergeron at ¶ 153.

Should PO argue that an independent rationale is required to use a client application like Chitiveli’s analytics client 140 in the Douglas-Chitiveli system, such represents no more than the predictable use of a client application like Chitiveli’s to do the same thing that it does in Chitiveli. *KSR Int’l Co.*, 550 U.S. at 401; Bergeron at ¶ 154. In the combination, that client application would continue to perform its Chitiveli-disclosed functions of allowing a client to: (1) “upload enterprise data” in the form of Douglas’s updated patient data; (2) “access the resulting data collections” in the form of Douglas’s compiled patient data; and (3) receive “periodic reports on the analyzed data from” a “content analytics tool 110” in the form of periodic reports from Douglas’s system. Chitiveli at ¶¶ [0036]-[0037]; Bergeron at ¶ 154.

Further, Douglas’s network server 508 with its compliance monitoring and feedback system must be accessible by PCs 500 “via the Internet 518.” Douglas at 24:12-26; Bergeron at ¶ 155. As Chitiveli evidences, there were a finite number of predictable solutions for providing such access—“an analytics client 140” or “a web browser” (Chitiveli at ¶¶ [0035]-[0036])—rendering each an obvious option. *KSR Int’l Co.*, 550 U.S. at 402-03; Bergeron at ¶ 155.

- (c) ***Claim 2: The method according to claim 1, wherein the server is accessed through a cloud network, and wherein a client management program is executed by the computing or communications devices is utilized to receive the data and track progress of the goals.***

Ground 3: See Section VIII.A.2 (Claim 1).

Ground 4: See Section VIII.B.4 (Claim 1).

Grounds 3 and 4: See Section VIII.C.2. Douglas as modified by Chitiveli discloses that the server is accessed through a cloud network, since Douglas's network server 508 would have been implemented on, and thus accessed through, a cloud network, as in Chitiveli. Bergeron at ¶ 158. That modified system also discloses that a client management program is executed by the computing or communications devices and is utilized to receive the data and track progress of the goals, since, in the system, PCs 500 used by physicians to transmit patient data to the network server for tracking patients' progress toward their goals in Douglas (see Section VIII.A.2(f) (Limitation 1[e])) would have done so using a client application like Chitiveli's analytics client 140. Bergeron at ¶ 158. Such client applications are client management programs, and they are utilized so that Douglas's system can receive the data and track progress of the goals. Bergeron at ¶ 158.

3. Claim 20

(a) Modification of Douglas

It would have been obvious to modify Douglas such that network server 508 was accessible by—in addition to Douglas's plurality of computing devices

(Douglas at 24:3-13 and FIG. 59 (PCs 500))—a plurality of mobile devices and a web interface as taught by Chitiveli (Chitiveli at ¶ [0036]). Bergeron at ¶ 159.

(b) *Motivation to Combine*

As a POSITA would have understood, allowing access to Douglas’s network server 508 via a plurality of mobile devices, such “laptop computer systems,” “mobile telephone devices, and tablet computers” (Chitiveli at ¶ [0036]) would have been beneficial. Bergeron at ¶ 160. As a POSITA would have known, “[m]obility is a central feature of health care delivery.” Prgomet at 792; Bergeron at ¶ 161. This is because physicians—such as Douglas’s—must often “move between patients, wards, clinics, laboratories, operating theaters, and offices,” and they “require information systems which provide access to data [and] resources ... where and when they undertake work.” Prgomet at 792; Bergeron at ¶ 161. Mobile devices, via their mobility, meet this requirement by providing “for information access anywhere, anytime.” Prgomet at 792; Bergeron at ¶ 161. To illustrate, if Douglas’s physician was with a patient, with a mobile device, that physician would not be required to “search to find an accessible computer at a location away from the patient” (Prgomet at 792) to enter the patient’s updated health information. Douglas at 11:1-5; Bergeron at ¶ 161.

A POSITA further would have seen using a web interface like Chitiveli’s (Chitiveli at ¶ [0036]) to access Douglas’s network server 508 as beneficial.

Bergeron at ¶ 162. To begin, it was known to a POSITA that accessibility to Douglas’s network server 508 would have been enhanced via a web interface. *Id.* at ¶ . Indeed, “[w]herever an Internet ... enabled [device] is found” Douglas’s network server would have then been accessible, regardless of “what operating system” the device is running. InfoGrasp at 1; Bergeron at ¶ 162. Further, a POSITA would have understood that using a web interface to access Douglas’s network server 508 would have reduced the need for updates to or management of a client application on the devices used to access the server. InfoGrasp at 1; Bergeron at ¶ 162.

- (c) ***Claim 20: The controller according to claim 16, wherein the controller is accessible by a plurality of mobile devices, a plurality of computing devices, and a web interface.***

Ground 3: See Section VIII.A.10 (Claim 16).

Ground 4: See Section VIII.B.4 (Claim 16).

Grounds 3 and 4: Douglas’s network server 508—i.e., the claimed controller—is accessible by a plurality of computing devices, specifically, PCs 500 via the Internet 518. Douglas at 24:3-13, FIG. 59. And as explained in Section VIII.C.3, it would have been obvious to modify Douglas such that network server 508 was also accessible by a plurality of mobile devices and a web interface.

D. Grounds 5 and 6 – Douglas and Koh (Ground 5), and Douglas, Wager, and Koh (Ground 6) Render Obvious Claims 5, 12, 13, and 18

1. *Koh Overview*

Koh “explores data mining applications in healthcare,” including “in major areas such as the evaluation of treatment effectiveness.” Koh at 64; *see also id.* at 66; Bergeron at ¶ 167. Per Koh, data mining “aims to identify valid, novel, potentially useful, and understandable correlations and patterns in data by combing through copious data sets to sniff out patterns that are too subtle or complex.” Koh at 65; Bergeron at ¶ 167. Such copious data sets are “generated by healthcare transactions,” and they are “too complex and voluminous to be processed and analyzed by traditional methods.” Koh at 65; Bergeron at ¶ 167. For this reason, and because data mining can “identify[] effective treatments and best practices” from such a data set and thereby benefit “healthcare providers, such as hospitals, clinics and physicians, and patients,” data mining “is becoming increasingly popular if not essential” in the healthcare field. Koh at 65; Bergeron at ¶ 167.

Data mining is performed on a data set through, e.g., “online analytical processing; traditional statistical methods, such as cluster analysis, discriminant analysis and regression analysis; and non-traditional statistical analysis, such as neural networks, decisions trees, link analysis and association analysis.” Koh at 65; Bergeron at ¶ 168.

2. *Modification of Douglas*

Douglas’s system “recommends a default set of goals based on the patient’s needs and existing medical protocols that may be modified by the physician.” Douglas at 7:17-20; Bergeron at ¶ 169. “This is done by correlating patient information such as age, sex, [and] weight,” and “the patient’s medication and other health conditions” to “established medical protocols for that type of patient.” Douglas at 8:1-13; Bergeron at ¶ 169. Such recommendations are made by Douglas’s system not just at the outset of the patient’s treatment, but throughout the patient’s treatment. Douglas at 21:9-12; Bergeron at ¶ 169.

Douglas does not explicitly disclose—apart from “established medical protocols”—how those initial or subsequent recommendations are made. Bergeron at ¶ 170. But Douglas’s system contains a copious amount of patient health data; for instance, his FIG. 50 shows a total of 12,978 patients on Douglas’s system. Douglas at FIG. 50; Bergeron at ¶ 170. And Douglas’s patients include “those with chronic ailments,” those “who are recovering from medical procedures,” and those “who simply want to maintain their health.” Douglas at 6:6-14; Bergeron at ¶ 170. Being on Douglas’s system, each of these patients would have been associated with a therapeutic plan including goals (Douglas at 8:2-9) and compiled data (*see* Section VIII.A.2(f) (Limitation 1[e])). Douglas at FIG. 50; Bergeron at ¶ 170.

Douglas's system also tracks outcomes for these patients. For one, FIG. 50 breaks down its patients into "participating patients complying with the program 368, participating patients put on probation due to lack of compliance 372, and patients terminated 376." Douglas at 22:21-25; Bergeron at ¶ 171. Douglas's system further includes a "review outcomes 354 option," which Douglas broadly explains includes "information as to the various patient outcomes, based on various pre-determined categories." Douglas at 23:16-22; Bergeron at ¶ 171. Specific examples are shown in Douglas's FIG. 55, which include "information as to the percent of compliant subscribers who had an emergency room ("ER") visit 420" (Douglas at 23:16-22) as well as those who were re-hospitalized for angina, suffered a heart attack, underwent a coronary artery bypass graft or percutaneous transluminal coronary angioplasty, or passed away (*id.* at FIG. 55). Bergeron at ¶ 171.

It would have been obvious to modify Douglas with Koh (hereinafter the "Douglas-Koh System") such that Douglas's compiled data was data mined to identify best practices for patients; specifically, the "therapeutic program including goals" that Douglas's system recommends for those patients (Douglas at 8:1-9). Bergeron at ¶ 172. In the Douglas-Koh System, data mining would be used to identify:

- (1) a therapeutic plan for a patient based on therapeutic plans for similarly situated patients that were correlated with improvement in compiled

data or other positive outcomes, such as compliance with the program or a lack of re-hospitalization, heart attack, or surgery; and/or

- (2) a trend in the patient's compiled data that, for similarly situated patients, was correlated with deterioration in compiled data or other negative outcomes, such as non-compliance with the program or re-hospitalization, heart attack, or surgery, to recommend changes to that therapeutic plan to avoid such negative outcomes. Bergeron at ¶ 172.

3. *Motivation to Combine*

Modifying Douglas's system to data mine its compiled data, as taught by Koh, would have "benefitted [Douglas's] healthcare providers ... and patients, for example, by identifying effective treatments and best practices." Koh at 65; Bergeron at ¶ 173. As to example (1), "[b]y comparing and contrasting ... courses of treatments" and "outcomes," like Douglas's therapeutic plans and outcomes (*see* Section VIII.D.2), "which treatments work best and are most cost-effective" would have been identified. Koh at 66; Bergeron at ¶ 173. And as to example (2), "data mining applications can be developed to better identify ... high-risk patients," like those whose compiled data is trending toward a negative outcome (*see* Section VIII.D.2), and "design appropriate interventions" like modifications to Douglas's therapeutic plans to "reduce the number of hospital admissions and claims," which

is a negative outcome that Douglas seeks to avoid (*see* Douglas at FIG. 55). Koh at 66; Bergeron at ¶ 173.

4. Claim 5

- (a) ***Limitation 5a: The method according to claim 1, further comprising: data mining the compiled data to determine best practices; and***

Ground 5: *See* Section VIII.A.2 (Claim 1).

Ground 6: *See* Section VIII.B.4 (Claim 1).

Grounds 5 and 6: The Douglas-Koh System (*see* Sections VIII.D.2-VIII.D.3) would have included data mining the compiled data to determine best practices, as Douglas's compiled data for his numerous patients would have been data mined to determine best practices for a specific patient, particularly, a therapeutic program or a modification to the therapeutic program for that specific patient. Bergeron at ¶ 176.

- (b) ***Limitation 5b: recommending the best practices to the providers in response to the best practices being associated with a client assigned to the providers.***

Grounds 5 and 6: Douglas's system recommends the therapeutic program to the patient's physician as well as modifications thereto. Douglas at 2:36-3-2, 7:17-20, 21:7-13; Bergeron at ¶ 177. In the Douglas-Koh System, that therapeutic program and modifications to the same reflected best practices as determined through data mining. *See* Section VIII.D.4(a) (Limitation 5[a]); Bergeron at ¶ 178.

5. ***Claim 12: The system according to claim 11, wherein the database is a relational database management system performing data mining to analyze the data from the providers to associate best practices with each of the clients.***

Ground 5: See Section VIII.A.8 (Claim 11).

Ground 6: See Section VIII.B.4 (Claim 11).

Grounds 5 and 6: See Section VIII.D.4. The Douglas-Koh System discloses that the database is a relational database management system, as Douglas's databases are "relational databases 522" (Douglas at 24:28-30 ("SQL" is a language used by a database management system), 22:6-7) that, in the Douglas-Koh system, are used to perform data mining to analyze the data to determine best practices, wherein the best practices are recommended for the clients. See Section VIII.D.2; Bergeron at ¶ 181. Again, Douglas's compiled data is from the providers. See Section VIII.A.2(f) (Limitation 1[e]).

6. ***Claim 13: The system according to claim 11, wherein the server is configured to recommend one or more best practices to the plurality of providers in response to the data of the clients being associated with the best practices.***

Ground 5: See Section VIII.A.8 (Claim 11).

Ground 6: See Section VIII.B.4 (Claim 11).

Grounds 5 and 6: See Section VIII.D.4(b) (Limitation 5[b]).

7. ***Claim 18: The server according to claim 16, wherein the set of instructions are further executed to: recommend best practices to the providers in response to historic success with the clients.***

Ground 5: See Section VIII.A.10 (Claim 16).

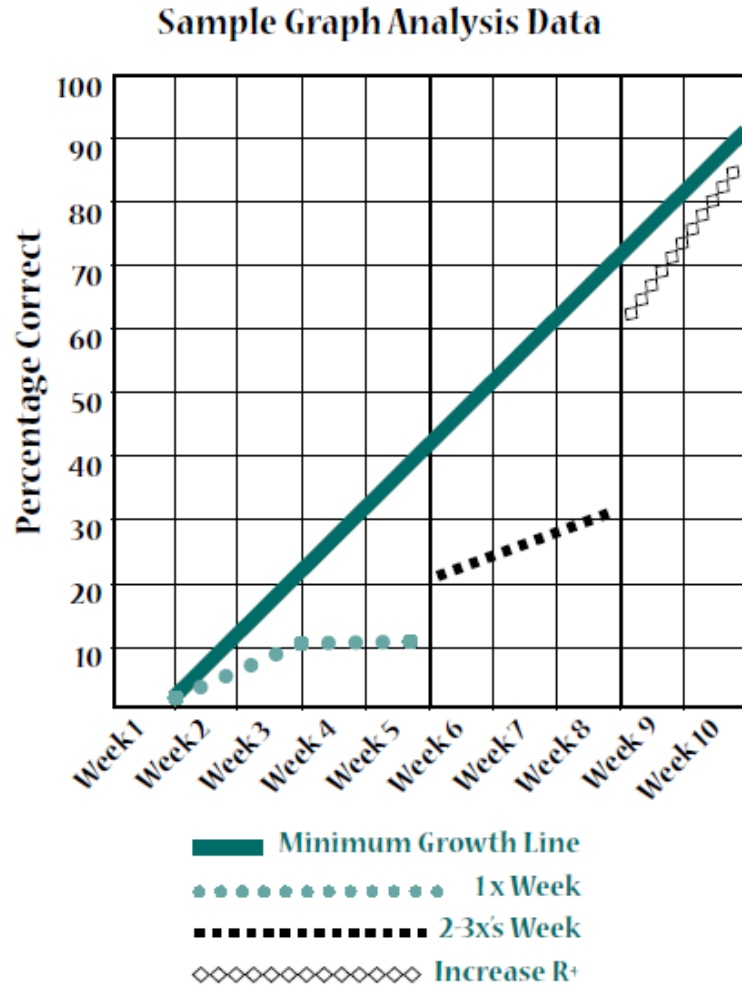
Ground 6: *See* Section VIII.B.4 (Claim 16).

Grounds 5 and 6: *See* Section VIII.D.4 (Claim 5). In the Douglas-Koh System, it would have been obvious for the processor executing Douglas’s system, which is in network server 508 alongside Douglas’s databases 522, to also execute data mining of that compiled data to protect the confidentiality of the compiled data as described in Section VIII.A.8(b) (Limitation 11[a]). Bergeron at ¶ 187. Further, in the Douglas-Koh System, that therapeutic program and modifications to the same reflected best practices determined to be historically successful through data mining. *See* Section VIII.D.4(a) (Limitation 5[a]); Bergeron at ¶ 187.

E. Grounds 7 and 8 – Douglas and Virginia (Ground 7), and Douglas, Wager, and Virginia (Ground 8) Render Obvious Claim 9

1. Virginia Overview

Virginia “describe[s] how to help persons with autism” in “acquiring skills ... that will increase their success in adulthood.” Virginia at 5, 12; Bergeron at ¶ 188. Specifically, Virginia utilizes a minimum growth line (“MGL”)-based approach. Virginia at 27; Bergeron at ¶ 188. In this approach, a teacher establishes a “baseline” performance of a student as well as a “goal [that] stipulates a mastery criterion ... [to be achieved] by the end of [a] teaching period.” Virginia at 27; Bergeron at ¶ 188. A line is then drawn on a graph “between the baseline ... and the goal criterion,” which “is called the *minimum growth line*.” Virginia at 27; Bergeron at ¶ 188. Virginia’s FIG. 4, reproduced below, shows a sample MGL:



Virginia FIG. 4

Virginia at 27; Bergeron at ¶ 188.

To evaluate progress, the teacher also plots the student's performance data over time to "compare the student's performance against [the] line." Virginia at 27; Bergeron at ¶ 189. If "the student demonstrates performance that is on or above the line, then the student is on track to master the goal." Virginia at 27-28; Bergeron at ¶ 189. But "[i]f the student demonstrates performance below that line for three data

points, then the teacher should revise their teaching strategy.” Virginia at 28; Bergeron at ¶ 189.

While Virginia applies its progress-monitoring method to an autistic student’s performance in learning skills and behavior to transition to adulthood (*see* Virginia at 5, 27-28), Virginia is in the same field of endeavor of the ’142 Patent, which is directed to tracking goal progression (*see, e.g.*, ’142 Patent at Abstract, 1:39-41, 4:34-36, 57-59), including of “individuals with ... autism” (*id.* at 1:19-23) and students generally (*id.* at 4:20-24) (“the subject may be a ... student”). Bergeron at ¶ 190. It is also reasonably related to a problem faced by the inventors of the ’142 Patent: how to assess an individual’s progress toward a goal. *See, e.g.*, ’142 Patent at Abstract, 1:12-16, 27-35, 4:56-69; Bergeron at ¶ 190. Virginia is therefore analogous prior art to the ’142 Patent.

2. *Modification of Douglas*

It would have been obvious to modify the Douglas system to evaluate compliance with the program by analyzing the patient’s updated data using an MGL-based approach as discussed in Virginia. Virginia at 27-28; Bergeron at ¶ 191. In such a modified system, updated data related to the patient (such as the duration, frequency, and intensity of physical activity; weight; etc.) for corresponding goals (such as related to physical activity, weight, etc.) is evaluated “at the beginning” of the program to establish a “baseline,” a program “goal stipulates a mastery criterion”

value for the data to be achieved “by the end” of the program, and an MGL is extended from the baseline data to the goal. Douglas at 7:20-29, 8:10-11, 11:3-5, 26-28, FIGS. 4, 6; Virginia at 27; Bergeron at ¶ 191. As the patient progresses through the program, if the updated data “is on or above the line,” then the patient “is on track to master the goal,” but if the updated data is “below that line for three data points,” then the program is evaluated and may need to be “revise[d].” Virginia at 27-28; Bergeron at ¶ 191. The modified Douglas system is referred to herein as the Douglas-Virginia system.

3. Motivation to Combine

First, a POSITA would have been motivated to use a MGL-based approach like in Virginia to evaluate progress toward meeting goals in the Douglas system to provide an “evidence based” evaluation of the sufficiency of the progress to meet the goals in a specified time period, as taught by Virginia. Virginia at 27-28; Bergeron at ¶ 192. That is, Douglas discusses program goals for completion in “certain period[s],” but does not specify in detail how to evaluate whether progress is sufficient to meet a goal by the specified time. Douglas at 7:5-7 (“cease smoking or ... lose a targeted amount of weight within a certain period”), 8-10 (“3-month targets”), 8:10-11 (“one month goals 61 and final goals 62”); Bergeron at ¶ 192. But Virginia teaches that the MGL approach enables an evaluation of whether an

individual attempting to meet a goal is “on track to master the goal” by the “end” of a corresponding “period.” Virginia at 27-28; Bergeron at ¶ 192.

Second, a POSITA would have been motivated to use such a modified system to improve the chances of meeting goals of the program by a specified deadline, as taught by Virginia. Virginia at 27-28; Bergeron at ¶ 193. That is, Douglas discusses “determin[ing] whether to modify the patient's therapeutic program” “if the patient is not progressing toward program goals,” but does not discuss in detail the timing of when to make changes. Douglas at 11:35-12:2; Bergeron at ¶ 193. However, Virginia teaches iteratively evaluating whether the individual “demonstrates performance below [MGL] for three data points,” and, if so, revising the program to enable “mastering the skill at the targeted criterion,” where if an initial revision results in “performance [being] improved, but not enough to master the skill within the time left,” then further revisions are made to ensure compliance by the target date. Virginia at 28; Bergeron at ¶ 193.

Third, a POSITA would have understood that an MGL approach like that in Virginia was known, and could be applied to evaluating the timeliness of progress in a known behavioral modification program like that of the Douglas system, and that such an approach would work Douglas's system in essentially the same way that it works in Virginia, with the results of the combination being predictable. *KSR Int'l*

Co., 550 U.S. at 401; Douglas at 7:20-29, 8:10-11, 20:5-11, FIGS. 4, 6; Virginia at 27-28; Bergeron at ¶ 194.

4. Claim 9

- (a) ***Limitation 9a: The method according to claim 1, further comprising: tracking a time and occurrence of number of client actions in response to input from the providers; and***

Ground 7: See Section VIII.A.2 (Claim 1).

Ground 8: See Section VIII.B.4 (Claim 1).

Grounds 7 and 8: Douglas discloses tracking a time and occurrence of client actions, as the Douglas “system accepts updated patient data,” where for goals related to cigarette smoking, physical activity, weight, etc., the data includes the number of packs of cigarettes smoked per day; the duration, frequency, and intensity of physical activity; weight; etc. Douglas at 7:20-29, 8:10-11, 11:3-5, 26-28, FIGS. 4, 6; Bergeron at ¶ 197. And, per Douglas, such tracking is responsive to input from providers, as the updated data includes “data entered by the physician during office visits.” Douglas at 11:3-5; Bergeron at ¶ 197.

- (b) ***Limitation 9b: indicating progress based on rules toward desired outcomes for the clients, wherein the rules compare data against a minimum growth line.***

Grounds 7 and 8: Douglas indicates progress toward desired outcomes for the clients, as it “generates reports on patient progress based on the data.” Douglas at 20:33-34; 11:26-12:2; Bergeron at ¶ 198. And, as discussed in Section VIII.E.2, the

Douglas-Virginia system determines such progress based on rules that compare data against an MGL. Virginia at 27-28; Bergeron at ¶ 198.

IX. CONCLUSION

The Challenged Claims are invalid, and institution is appropriate.

Dated: March 1, 2024

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CERTIFICATE OF WORD COUNT

Pursuant to 37 C.F.R. § 42.24(a)(i), the undersigned certifies that this Paper—exclusive of the table of contents, mandatory notices under § 42.8, certificate of service, and this certificate of word count—includes 13,989 words.

/Michael Solomita/
Michael Solomita (Reg. No. 53,940)

CERTIFICATE OF SERVICE

Pursuant to 37 C.F.R. § 42.6(e) and 37 C.F.R. § 42.105(a), the undersigned certifies that on March 1, 2024, a complete copy of this Petition for *Inter Partes* Review, Petitioner's power of attorney, and all exhibits were served on Patent Owner at the correspondence addresses of record listed below by USPS Priority Mail Express:

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