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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 No. IPR2024-00617
U.S. Patent No. 11,151,142

DECLARATION OF HOSSEIN ARDEHALI, M.D., PH.D.

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I, Hossein Ardehali, M.D., Ph.D., declare as follows:

I. INTRODUCTION

1. I have been retained as a technical expert on behalf of Patent Owner Data Health Partners, Inc. (“Data Health”) for the above-captioned inter-partes review (“IPR”). I have been asked to provide my opinions on the technology disclosed in U.S. Patent No. 11,151,142 (“the ’142 Patent”) (Ex. 1001) and on the unpatentability arguments presented in Teladoc Health, Inc.’s (“Teladoc”) Petition (“Pet.”) alleging that claims 1-7, 9-14, 16-18, and 20 of the ’142 Patent (the “Challenged Claims”) are invalid under 35 U.S.C. § 103.

2. I make this declaration based on my personal knowledge, consideration of the materials I discuss herein, and my expert opinion.

3. I am being paid for my work on this matter on an hourly basis at \$500/hour. My compensation is not contingent on reaching any particular findings or conclusions, or on any particular outcome in this matter. I have no financial interest in the outcome of this matter.

4. In preparing this Declaration, I have reviewed the ’142 patent, its prosecution history, and considered each of the documents cited herein. I have also read and considered the IPR Petition concerning the ’142 patent and the exhibits and evidence cited therein as grounds for invalidity, including but not limited to

Exhibits 1001–18, the Patent Owner’s Preliminary Response, Exhibits 2001–04, and the Board’s Decision Granting Institution of this IPR.

5. In formulating my opinions, I have also relied upon my experience, education, knowledge and expertise in the area of healthcare, cardiovascular disease, computer science, health information technology, and computer-based systems for recording, tracking, and analyzing patient health information. In reviewing the material relevant to these proceedings, I have considered the viewpoint of a person of ordinary skill in the art in the March 2013 timeframe.

II. BACKGROUND AND QUALIFICATIONS

6. The following sections recite the most relevant aspects of my educational, professional, and technical background. A copy of my curriculum vitae, which describes my qualifications in more detail, is attached to this report as Exhibit 2008.

7. In summary, I am currently the Thomas D. Spies Professor of Cardiac Metabolism, Professor of Medicine - Cardiology and Pharmacology at Northwestern University in Chicago, IL. I hold board certification in the field of Cardiovascular Medicine. I am a Fellow of the American College of Cardiology (ACC), American Heart Association (AHA), and the International Society for Heart Research (ISHR). I am also an honorary fellow of the Association of Physicians of Great Britain and Ireland (AoP GB&I).

8. I attended the University of Utah in Salt Lake City, UT for my undergraduate studies. I graduated *cum laude* in 1990 with a Bachelor's degree in Computer Science.

9. During my undergraduate studies, I focused on computer programming with emphasis on computer graphics. I took a number of courses in the Department of Computer Science at the University of Utah and served as a teaching assistant for a number of computer science courses.

10. I then attended Vanderbilt University as a Medical Scientist Training Program (MSTP) student and received both MD and PhD degrees in 1998. My PhD was conducted in the laboratory of Dr. Daryl Granner and was focused on the structure and functional organization of hexokinase-2 gene.

11. During my PhD, I applied my background knowledge in computer science to my PhD project, setting up the website for our laboratory as well as to perform global analysis of hexokinase-2 and assess the interaction between the two halves of the protein.

12. After graduating from Vanderbilt, I completed an internship and residency in Internal Medicine at the Johns Hopkins Hospital in Baltimore, MD from 1998 to 2001.

13. After completion of my Internal Medicine residency, I continued my training at the Johns Hopkins Hospital as a cardiology fellow from 2001 to 2004.

During this time, I conducted research in the laboratory of Dr. Eduardo Marban, then Chief of Cardiology at Johns Hopkins. My research focused on the molecular structure of the mitochondrial ATP-sensitive potassium channel.

14. During my fellowship in cardiology, I received several prestigious awards, including the AHA Basic Cardiovascular Sciences (BCVS) Young Investigator Award (2003); first place prize in AstraZeneca Young Investigator Award Competition (2003); the GlaxoSmithKline International Competitive Grant Awards for Young Investigators (2004); and the Johns Hopkins Clinician Scientist Award (2004).

15. In 2004, I became an instructor at Johns Hopkins and served in that position for 6 months before I was recruited to Northwestern University.

16. In January of 2005, I joined the faculty of Northwestern University as an Assistant Professor of Medicine and Molecular Pharmacology and Biological Chemistry, and as an Investigator in the Feinberg Cardiovascular Research Institute.

17. Throughout my career at Northwestern University, my responsibilities included approximately 65% research, 10-25% clinical work, and 10-25% administrative work. My clinical work has been in the cardiac care unit (CCU) or on the general cardiology and consult service. On the general cardiology and consult service, I lead a team of residents, interns and students, and diagnose and

treat patients with various acute and chronic cardiovascular disorders, including coronary artery disease (CAD), heart failure, and atrial fibrillation, among other cardiovascular diseases and disorders.

18. During my fellowship and while I was junior faculty at Northwestern, I worked on a patient database to study the role of endomyocardial biopsy in diagnosing the case of dilated cardiomyopathy. These studies led to a number of publications.

19. I also have an outpatient clinical practice where I evaluate and manage patients with CAD, atrial fibrillation, heart failure, peripheral vascular disease and other common cardiovascular disorders. Additionally, many patients with rare cardiovascular disorders are referred to me by other internists and cardiologists.

20. I have served as one of the co-chairs of the AHA Educational Program, and part of my responsibility in this role was to give numerous lectures on various topics in the field of cardiovascular medicine, including the risk factors for atherosclerotic cardiovascular disease (ASCVD), the pathobiology of CAD, disorders of lipid metabolism and dyslipidemias, and blood pressure management. I have served on a number of leadership positions at the AHA, which are listed in my curriculum vitae. I have also served as a member of the Council Operations

Committee. In this role, I and other committee members oversaw the operational activities of the councils of the AHA.

21. Since moving to Northwestern University, I have won numerous prestigious awards. In summary, I won the Jeremiah Stamler Distinguished Young Investigator Award (2005); the Schweppe Foundation Research Award (2006); the Central Society for Clinical Research Early Career Development Award (2009); and the Most Valuable Player Award, AHA BCVS Council (2010). In 2009, I also won the Teaching Award given by the Northwestern medical students. In 2008 and 2009, I was twice nominated by the National Heart, Lung, Blood Institute (NHLBI) for the Presidential Early Career Award for Scientists and Engineers (PECAS), a highly prestigious award whose awardees are recognized by the President of the United States.

22. In 2011, I was inducted into the American Society for Clinical Investigation (ASCI), an honor society of physician-scientists. I served as the Secretary-Treasurer of ASCI, and as the President of the Society from 2021-2022.

23. Additionally, in 2018, I was inducted into the Association of American Physicians (AAP). The organization is defined on its website as: “[t]he Association is composed of members who are leading senior physician scientists and are competitively selected.”

24. In 2014, I was promoted to the academic rank of Professor of Medicine and Pharmacology at Northwestern University.

25. Since establishing myself at Northwestern University, my research has focused on the role of mitochondria and metabolism in heart failure. I have received extramural grant support of my research efforts from multiple sources, including the National Institutes of Health (NIH), the AHA, the Leducq Foundation, and the American Cancer Society (ACS).

26. I have trained several students, postdoctoral fellows, cardiology fellows, and technicians in my laboratory. Several of my graduate students have been MD/PhD candidates. My laboratory members have consistently been successful in obtaining independent extramural funding awards from various agencies, including those mentioned above.

27. I currently also serve as the Director of the Center for Molecular Cardiology.

28. I served as the Director of the Medical Scientist Training Program (also known as the MD/PhD Program) at Northwestern University from 2017 to 2023.

29. In 2019, I was also awarded an Endowed Chair as the Thomas D. Spies Professor of Cardiac Metabolism.

III. APPLICABLE LEGAL STANDARDS

A. Ordinary Skill in the Art

30. My opinions in this declaration are based on the understandings of a person of ordinary skill in the art—sometimes referred to as an “ordinary artisan” or by the acronyms “POSA” or “POSITA”—as of the time of the invention, which I understand to be the March 15, 2013 filing date of the earliest provisional applications leading to the ’142 patent. I understand that the person of ordinary skill in the art is a hypothetical person who is presumed to have known the art relevant to the Challenged Claims of the ’142 patent at the time of the invention.

31. I understand that, in assessing the level of skill of a person of ordinary skill in the art, one should consider the type of problems encountered in the art, the prior solutions to those problems found in the prior art references, the rapidity with which innovations are made, the sophistication of the technology, the level of education of active workers in the field, and one's own experience working with those of skill in the art at the time of the invention.

32. I understand that Petitioner submits that a POSITA at the time of the ’412 patent “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.” (Petition at 6.) I understand that Patent

Owner has not offered a different understanding of a POSITA, and the PTAB accepted Petitioner's submission. I accept and use Petitioner's and the PTAB's definition of a POSITA.

B. Claim Construction

33. I understand that the Challenged Claims of the '142 patent in this IPR are generally interpreted according to their ordinary and customary meaning taking into consideration the so-called "intrinsic evidence" of the patent consisting of (1) the claim language; (2) the specification; and (3) the prosecution history.

34. I understand that claim terms may be explicitly defined in the patent specification or they may be implicitly defined through consistent usage in the specification. I also understand that the scope of claim terms may be limited by statements in the specification or prosecution history where the applicant clearly disavows or disclaims subject matter.

35. I understand that claim construction is a matter of law.

C. Anticipation

36. I have been informed that a claim is invalid as anticipated under 35 U.S.C. § 102 if a prior art reference discloses, either expressly or inherently, all limitations of a claim as those limitations are arranged in the claim.

37. I have been informed that a limitation is disclosed inherently in a reference if it is necessarily present in the process or product described in the prior

art reference. I understand that probabilities or possibilities are insufficient to show that a prior art reference inherently discloses something beyond what it discloses explicitly.

D. Obviousness

38. Counsel has informed me, and I understand, that an issued patent claim is invalid as obvious if it can be shown that the differences between the patented subject matter and the prior art are such that the subject matter as a whole would have been obvious, at the time the invention was made, to a person having ordinary skill in the art. Relevant considerations include the level of ordinary skill in the art; the scope and content of the prior art; differences between the prior art and the claims at issue; and the objective indicia, or secondary considerations, of nonobviousness.

39. In this regard, I am informed and I understand that the secondary considerations of nonobviousness could include factors such as commercial success, long felt but unresolved needs, the failure of others, skepticism by experts, praise by others, award and accolades, and copying.

40. Counsel has informed me, and I understand, that in order to evaluate the obviousness of any claim of the '142 patent over a given prior art combination, I should analyze whether the prior art references, included collectively in the combination, disclose each and every element of the allegedly invalid claim as

those references are read by the person of ordinary skill in the art at the time of the invention.

41. Counsel has informed me, and I understand, that even where all of the claim limitations are expressly disclosed in the prior art references, there must be some showing that a person of ordinary skill in the art would have been motivated to combine such prior art references, and explanation of how the combination would be achieved, and that there would have been a reasonable expectation of successfully achieving the claimed invention from such combination.

42. Counsel has informed me, and I understand, that absent some additional reasoning, mere routine optimization for a person of ordinary skill in the art to arrive at the claimed invention through combination of prior art references is insufficient to support a conclusion of obviousness.

43. Counsel has informed me, and I understand, that to rely on a reference it must be analogous prior art. Counsel has informed me and I understand that a reference is considered analogous prior art: (1) if the reference is from the same field of endeavor as the claimed subject matter, or (2) if the reference “is reasonably pertinent to the particular problem with which the inventor is involved,” even though the reference is not within the field of the inventor’s endeavor.

44. Counsel has informed me, and I understand, in considering the obviousness of a claimed invention, one should not view the invention and the prior art with the benefit of hindsight. In an obviousness analysis, one must be aware of the distortion caused by hindsight bias and must be cautious of arguments reliant upon ex post reasoning. Counsel has instructed me and I understand that when considering obviousness, I should not consider what is known today or what was learned from the asserted patents. Instead, obviousness is assessed by the person of ordinary skill in the art at the time the invention was made.

45. In this regard, I am informed and I understand that the '142 patent may not be used as a guide to select and understand the prior art, because such an approach, at a minimum, discounts the value of combining various existing features or principles in a new way so as to achieve a new result.

46. Counsel has informed me, and I understand, that obviousness cannot be predicated on what was unknown at the time of the invention, even if the inherency of a certain feature is later established. Counsel has also informed me, and I understand, that unknown properties of the prior art may not be relied upon to provide the rationale for modifying or combining the prior art to reach the claimed subject matter.

47. Counsel has informed me, and I understand, that a reference may be said to teach away when a person of ordinary skill, upon reading the reference,

would be discouraged from following the path set out in the reference, or would be led in a direction divergent from the path that was taken by the applicant of the '142 patent.

E. Separate Elements

48. Counsel has informed me, and I understand, that where a claim lists elements separately, there is a presumption that those components are distinct.

49. I have applied the following principles in formulating the opinions contained herein.

IV. CHALLENGED CLAIMS

50. Petitioner challenges claims 1-7, 9-14, 16-18, and 20 of the '142 patent, of which claims 1, 11, and 16 are independent.

V. CLAIM CONSTRUCTION

51. I have been informed by counsel that the Challenged Claims of the '142 patent are to be construed in accordance with the ordinary and customary meaning of such claim as understood by one of ordinary skill in the art and the prosecution history pertaining to the patent. In forming my opinions set forth below, I have therefore applied the ordinary and customary meaning of the claim terms unless indicated below.

52. I note, however, that I disagree that the Petitioner has not asked the court to construe any claim term.

53. The Petition presumes a construction of the term “wizard application,” which Petitioner argues means “[a]n interactive help utility within an application that guides the user through each step of a particular task.” (Pet., 31.) Data Health disagrees that this proposed construction is supported by or consistent with the specification, and Petitioner has not attempted to establish that it is. (*See id.*)

54. Petitioner’s proposed construction also does not reflect the plain and ordinary meaning of the term. As noted *infra*, a “wizard application” cannot be an interactive help utility “within an application”; it must *be* the application. (*See infra* Section VIII.C.)

55. Additionally, the ’142 patent describes an embodiment of the wizard functionality:

In one embodiment, by choosing a heading, the service providers 216 may be presented with information for specific goals and objectives 226. For example, in a behavioral health field, the goals and objectives 226 may include areas, such as coping skills, fine motor skills, and physical aggression. The user may utilize a goal wizard or management function to be able to enter headings as well as detailed descriptions or narratives associated with each heading in a hierarchical format. For example, each of the goals and objectives 236 may include a main heading, a start date, a projected closure date, a goal description, a goal narrative, a lead service provider, a data collection method, email notifications (e.g., for individual users associated with the specific client or information for the client), function, and options. Goals may

be opened and closed out at any time and may be viewed in separate files, such as active and archived.

(Ex. 1001 at 12:30-49.)

56. The “wizard application” disclosed in the ’142 Patent is consistent with the plain and ordinary meaning of the term “wizard” and would require active facilitation of input through sequential or hierarchical prompts.

VI. OVERVIEW OF THE ’142 INVENTION

57. The ’142 patent is entitled “Platform for Optimizing Goal Progression” and was filed on August 2, 2018, claiming priority to U.S. Provisional Application No. 61/791,218 filed on March 15, 2013. The ’142 patent claims methods, systems, and controllers for tracking goal progression:

Input establishing accounts for providers serving clients is received. Each of the clients is assigned to one or more of the providers in response to selections from an administrator. Goals are established for each of the clients in response to treatments and assistance required. Data associated with each of the clients received from the providers is compiled. A determination is made whether the goals are being met in response to rules based on the compiled data. Alerts are automatically communicated in response to the compiled data varying from a threshold to become significant for one or more of the clients.

(Ex. 1001 at abstract.)

58. The claimed technology offers several advantages over prior art. (*See* Ex. 1001 at 27:39-40.) Specifically, the technology disclosed in the ’142 patent

allows a provider to define and automate a process for assessment that “drives goals, services, and interventions.” (*Id.* at 27:40-42.) It also improves goal management functionality by “allow[ing] goals to be defined, created, tracked, and analyzed using data.” (*Id.* at 27:42-44.)

59. For example, claim 1 of the '142 patent generally discloses (1) receiving input for establishing accounts for providers serving clients, (2) creating fields to compile client data, (3) assigning a client to a provider in response to selections from an administrator, (4) establishing desired outcomes with thresholds that indicate whether the desired outcomes are met, (5) compiling data associated with performance of the desired outcomes, (6) automatically determining whether the desired outcomes are being met and whether the data varies from any threshold, and (8) communicating alerts where the data significantly varies from any threshold. (*Id.* at claim 1.)

VII. ARGUMENT

A. All Grounds: Petitioner fails to provide evidence that any reference discloses or suggests “assign[/ing] the client to one or more of providers in response to selections from the administrator, wherein the one or more providers include at least individuals available to treat or assist the client” (all claims)

60. All Challenged Claims require assignment of the client “to one or more of providers in response to selections from the administrator, wherein the one or more providers include at least individuals available to treat or assist the client.”

(Ex. 1001 at claims 1-20.) The claims expressly require that the assignment of the physician to a client be done “*in response to selections from the administrator.*” (*Id.* (emphasis added).)

61. For this limitation, Petitioner points to Douglas’s Figure 47 (showing the “Responsible Physician” for patient “Fred Smith”), column 15:8-9 (patients “keep in constant contact with their physician.”), claims 11, 25 (“alerting the individual’s physician”), Figure 2 (associating the patient, “Patient Name[/]ID,” with a physician, “Physician Name[/]ID”), and Figure 7 (“Dear Doctor Cavello: This is a status report on your patient”). (Petition at 18-23.)

62. Douglas discloses that “[a] case administrator creates a patient account based on information contained in the patient prescription form . . . *which is filled out and signed by the physician.* . . . 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.” (Petition at 8 (emphasis added and internal citations and quotations omitted).)

63. Douglas discloses two mechanisms for subscribing a patient to Douglas’s behavior modification program. First, after a physician diagnoses an individual with an ailment, the physician may recommend a health care maintenance or recovery program, measure baseline factors (e.g., blood pressure, heart rate, height), and then input such factors into the system directly via the

physician's personal computer. (Douglas at 6:28-35.) Alternatively, the physician can fill out a prescription form and send the information to a "case advisor," who then sets the patient up on the system. (*Id.*)

64. The Challenged Claims require that any "assign[ment]" of a provider to a client be done "in response to selections from an administrator." (Ex. 1001 at cl. 1.) The Petition identifies Douglas's disclosure that "the case administrator sets up each of the patients on Douglas's system by entering the information contained in the patient prescription form . . . where such information includes information associating the patient with a physician." (Petition at 19-20 (citing Douglas at 6:33-7:13, Fig. 2).)

65. Petitioner does not identify any selection made by Douglas's administrator which may result in assignment of a provider. *See id.* Petitioner identifies Douglas's disclosure that the case administrator enters information already contained in a patient prescription form into Douglas's system, stating that "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." *See id.* Petitioner does not identify how such entry constitutes "selections from an administrator." *See id.* Entering information (which a physician had already provided on the prescription

form) into Douglas's system cannot fairly be found to be "selections from an administrator" under a plain and ordinary meaning of the term.

66. The plain and ordinary meaning of the term "selections" envisions a deliberate and active choice by an administrator, which is confirmed by the specification's discussion of administrators as playing an active role in the assignment process, generally. (*See* Ex. 1001 at 11:13-18 ("Provider administrators 214 may manage their team of service providers 216 who work directly with clients 224 to administer information and data, such as goals and objectives 236. The provider administrators 214 may have complete access to the service providers 216 and the clients 224 to assign the clients 224 to individual service providers 216 through the user interface 210.").)

67. It is my opinion that Douglas does not disclose any such selection. Douglas's administrator merely inputs pre-determined information from the prescription form. (Douglas at 6:33-7:13, Fig. 2.)

68. Additionally, such information could only be found to have been "select[ed]" by the physician, not the administrator. Douglas discloses that "the physician may fill out a prescription form and send the information to a case advisor, who then . . . sets up a new patient based on information contained in the patient prescription form or accesses the records or existing patients through patient files 40." (Douglas at 6:33-7:16.) Thus, any such information, if entry of it

could be found to be “selection,” would be selected by the physician, not the administrator.

69. Douglas does not teach that any “assigning” of a provider is done “in response to” that data entry as required by the claims because the information entered by the case advisor was provided by the physician. (Douglas at 6:33-7:16.)

70. The administrator’s entry of prescription information—including identifying the prescribing physician—is also what Petitioner points to as “assign[ment] . . . to one or more of the providers in response to selections from an administrator.” (Petition at 19-20.) I understand that Petitioner’s expert confirmed in his deposition that “the selection of the physician is the assignment of the physician.” (Ex. 2006 at 32:1-6.)

71. I understand from counsel that there is a presumption that claim elements that are listed separately are distinct. I understand from counsel that Petitioner has not addressed this presumption.

72. It is my opinion that a person of ordinary skill in the art in March 2013 would not read Douglas as disclosing the process that the ’142 Patent teaches for assignment of a provider—namely that a provider is assigned to a client in response to selections made by an administrator. (Ex. 1001 at cl. 1.)

73. Petitioner also argues that it would have been obvious for the case administrator to assign the patient to the physician because “such assignment had

to be created to achieve the functionality of Douglas's system." (Petition at 20.) A significant distinction between the '142 patent and Douglas is that Douglas presumes a physician has already been assigned to the patient; the '142 patent does not. Douglas discloses that the physician diagnoses an individual with an ailment, then recommends a health care maintenance or recovery program, and then places the patient on the system to help the patient make lifestyle and behavior modifications. (Douglas at 2:25-35.) Douglas's system does not disclose or require the assignment of patients to physicians through any functionality within its platform.

74. The '142 patent discloses that clients are assigned to providers via the system in response to selections from an administrator, goals are established, and then the client proceeds through the system for goal progression in accordance with the particular claim requirements. (Ex. 1001 at 1:41-56.) The assignment process is fundamental to the '142 system and precedes the establishment of desired outcomes and subsequent progress tracking. The ability to assign clients to providers through the system facilitates centralized management and data integration, which are absent in Douglas's teachings.

75. Petitioner also states that "Douglas also renders obvious the assignment by the administrator of the patient to the physician through selections of graphical user interface ('GUI') components." (Petition at 20.) Pointing to

certain GUI components disclosed in Douglas (e.g., check boxes, drop-down menus), Petitioner states that it would have been obvious for an administrator to use Douglas's GUI components to assign the patient to the physician. (*Id.* at 20-23.)

76. It is my opinion that a person of ordinary skill in the art would not find that the case advisor's selection of the treating physician's name in the system (using GUI components or otherwise) to be an "assignment" to a "provider" under a plain and ordinary meaning of that term done "in response" to any "selection[]" from the administrator." In that scenario, any purported "assignment" of the physician would still also be the claimed "selection," and I understand that this precludes the assignment from being performed "in response" to the selection.

77. It is my opinion that a person of ordinary skill in the art would not find Douglas's inclusion of well-known GUI components such as check boxes, buttons, and drop-down menus to establish the requisite motivation to fundamentally alter the operation of Douglas's system. Therefore, a person of ordinary skill in the art would not find that Douglas renders this claim limitation obvious.

B. All Grounds: Petitioner fails to provide evidence that any reference discloses or suggests “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” (all claims)

78. All Challenged Claims require “automatically communicat[e/ing] 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.” (Ex. 1001 at cls. 1, 11, 16.)

79. For this claim limitation, Petitioner identifies Douglas’s “alarm” option (block 1040, Figure 60), which compares patient data with the system’s goals and notifies the physician or case advisor via email, fax, or pager if a health risk is present, or otherwise notifies the physician or case advisor if goals are not being met. (Petition at 31 (citing Douglas at 11:11-17).)

80. The “alarm” identified by Petitioner is expressly referred to by Douglas as an “option.” (Douglas at 11:11-17.) Specifically, Douglas states that “[a]s part of the feedback process, the system provides an ‘alarm’ *option* (block 1040, FIG. 60).” (*Id.* (emphasis added).) The claim requires that there be an “automatic[] communicat[ion]” of an alert in response to the compiled data varying from a threshold to become significant. (Ex. 1001 at cl. 1.) If the alarm must be enabled, activated, or configured by a user before it can be utilized, it cannot reasonably be found to be “automatic” and therefore does not satisfy the claims. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose

or render obvious “automatically communicat[e/ing] 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.”

C. Grounds 1 and 2: Petitioner fails to provide evidence that any reference discloses or suggests “establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application” (claim 3)

81. Claim 3 depends from claim 1 and requires “establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application.”

82. For this claim, Petitioner contends that Douglas discloses “establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application.” (Petition at 31-32.) To satisfy this claim limitation, Petitioner states that Douglas’s system establishes desired outcomes for the client “utilizing a wizard application.” *Id.* In doing so, Petitioner relies on a proposed claim construction for the term “wizard application.” *Id.* Specifically, Petitioner states that a “wizard application” is “[a]n interactive help utility within an application that guides the user through each step of a particular task.” *Id.*

83. I disagree that Petitioner’s proposed construction reflects the plain and ordinary meaning of “wizard application.” Critically, Petitioner’s proposed definition strips out the meaning of the word “application”: Petitioner proposes that a “wizard application” is a utility “within an application.” (Petition at 31.) But the

purported wizard functionality cannot be *within* an application to satisfy the claim; it must *be* the application. (Ex. 1001 at cl. 3.) Therefore, Petitioner has not alleged or established that the “discrete steps” it points to as disclosure of this claim limitation constitute any “application” at all, nor do they constitute an “application” under a plain and ordinary meaning of the word. (See Petition at 31-32.)

84. The '142 patent describes an embodiment of the wizard functionality:

In one embodiment, by choosing a heading, the service providers **216** may be presented with information for specific goals and objectives **226**. For example, in a behavioral health field, the goals and objectives **226** may include areas, such as coping skills, fine motor skills, and physical aggression. The user may utilize a goal wizard or management function to be able to enter headings as well as detailed descriptions or narratives associated with each heading in a hierarchical format. For example, each of the goals and objectives **236** may include a main heading, a start date, a projected closure date, a goal description, a goal narrative, a lead service provider, a data collection method, email notifications (e.g., for individual users associated with the specific client or information for the client), function, and options. Goals may be opened and closed out at any time and may be viewed in separate files, such as active and archived.

(Ex. 1001 at 12:30-49.)

85. The “wizard application” disclosed in the '142 Patent is consistent with the plain and ordinary meaning of the term “wizard” and would require active facilitation of input through sequential or hierarchical prompts.

86. The series of interfaces depicted in Douglas's Figures 4-6 are not reflective of the kind of wizard application envisioned by the '142 patent or the

plain and ordinary meaning of the term. Douglas describes that “FIG. 4 is a graphical representation of an exemplary patient file taken from among those represented in FIG. 3.” (Douglas at 3:33-34.) Figures 5 and 6 are “graphical representation[s]” corresponding to the program design and program detail options, respectively. *Id.* Douglas describes that “[t]he 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.” (Douglas at 8:8-9.)

87. Douglas’s interface assumes user familiarity with its features and does not actively facilitate input through sequential prompts; it merely allows users to navigate freely between goal management features for entry of data.

88. What Douglas presents in Figures 4-6 is not a wizard application as a POSITA would understand the term, but ordinary data entry. This does not satisfy the requirements of claim 3. (*See* Ex. 2006 at 37:14-38:1 (“I don’t believe it covers simply entering data.”).)

89. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “establishing desired outcomes for the client associated with treatment or assistance utilizing a wizard application.”

D. Grounds 1 and 2: Petitioner fails to provide evidence that any reference discloses or suggests “wherein the wizard application receives at least a main heading, a start date, a projected closure date, and a desired outcome description” (claims 4 and 14)

90. Claim 4 depends from claim 3 and requires that “the wizard application receives at least a main heading, a start date, a projected closure date, and a desired outcome description.” (Ex. 1001 at cl. 4.)

91. For this claim, Petitioner points to various fields within Figure 6 to attempt to identify each of the components identified in the claim. (Petition at 33.)

92. Douglas lacks disclosure of receipt by any “wizard application” of at least a “projected closure date.” Petitioner does not propose a construction for this term, but the word “closure” necessarily requires some kind of end or finality. The ’142 patent confirms the plain and ordinary meaning of the word applies, describing that “[a] projected closure date is the date at which the goal will end.” (Ex. 1001 at 6:30-31.) The projected closure date is “utilized to keep users and clients focused on reaching a designated goal in a reasonable time period. For example, depending upon procedural and regulatory parameters, a projected closure date may be pre-determined (e.g., one year) or may be set by user or agent specification of timeline (e.g., organizational key performance indicators may be set annually).” (*Id.*, 6:31-37.)

93. For this limitation, Petitioner identifies the words “1 month” in the heading of Douglas’s one month goals 61 in Figure 6. (Petition at 33.) I disagree that Douglas’s one month goals 61 constitute a “projected closure date.”

94. Douglas’s Figure 6 presents recommended “one month goals 61 and final goals 62.” (Douglas at 8:10-13.) Figure 6 confirms that Douglas’s one month goals 61 are intermediate goals and that final goals 62 represent the ultimate desired result for a particular metric. Petitioner’s expert agreed in his deposition. (Ex. 2006 at 49:1-6 (“Q. The goals identified in Column 61 do not represent the final goals, correct? A. That’s correct. Q. The goals identified in Column 61 represent intermediate one month goals, correct? A. Correct.”).)

95. For example, looking specifically at “physical activity” identified by Petitioner, the patient’s physical activity level as of 2/10/98 is “20/3/3” (minutes/x times per week/RPE), the one month goal activity level is 25/6/4, and the final goal activity level is 4/6/6.¹ (See Douglas at Fig. 6.) The projected closure date for this goal—the date at which the goal will end—would be the date at which it is projected that the patient will achieve the final goal activity level of 4/6/6. (See *id.*)

¹ The number “4” in “4/6/6” appears to be a typographical error given that the final goals for all other categories represent an incremental progression over time. For example, for “weight,” the current weight is 182, the one-month goal weight is 175, and the final goal weight is 170. Similarly for “BMI,” the current BMI is 28.28, the one-month goal BMI is 26.64, and the final goal BMI is 25.00.

There is no projected or target date for completion of that final activity level goal disclosed in Douglas.

96. Instead, Petitioner points to what is an intermediate goal of 25 minutes / 6 times per week / 4 RPE within one month. (Petition at 33.) I disagree that the date at which the “physical activity” goal will end is one month from the then-current date of February 10, 1998 or the “projected closure date.” Indeed, the program expressly contemplates that the goal will continue past that date, at least until the final goal activity level is achieved. (See Douglas at Fig. 6.) Petitioner’s expert confirmed this in his deposition. (Ex. 2006 at 49: 7-21 (“[Y]ou would agree that the program in Figure 6 envisions Douglas’s plan continuing past one month, correct? A. Correct.”).)

97. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “the wizard application receives at least a main heading, a start date, a projected closure date, and a desired outcome description.”

E. Grounds 1 and 2: Petitioner fails to provide evidence that any reference discloses or suggests “wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes” (claim 6)

98. Claim 6 depends from claim 1 and requires “wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.”

99. To be clear, “the data” referred to in claim 6 must be (1) “associated with at least performance of the desired outcomes by each of the clients”; (2) “compiled”; (3) “received from the providers utilizing computing or communication devices in communication with the server” in accordance with claim 1. (Ex. 1001 at cl. 1.) Claim 6 additionally requires that such data also “includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.” (Ex. 1001 at cl. 6.)

100. For this claim, Petitioner argues that Douglas’s “data” includes “intervention plans,” pointing to “points for good participation in the program, “exercise and stress management programs,” and notifications sent to physicians when goals are not being met and when a health risk is present. (Petition at 34.) There is no indication in Douglas that any of those aspects of Douglas’s system—assuming they could be fairly interpreted as “intervention plans”—are received from providers utilizing computing/communication devices. Petitioner acknowledges claim 1’s requirements for “the data,” arguing that such information is “compiled.” (Petition at 35-36.)

101. But Petitioner ignores the requirement that such data must be received “from providers utilizing computing or communication devices in communication with the server.” Because none of any of Petitioner’s purported “intervention plans” are, Douglas does not satisfy this claim limitation.

102. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “wherein the data includes at least intervention plans, desired outcomes and objectives, recorded activities, and general notes.”

F. Grounds 1 and 2: Petitioner fails to provide evidence that any reference discloses or suggests “determining whether the data required is received from each of the providers” or “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” (claim 7)

103. Claim 7 depends from claim 1 and requires “determining whether the data required is received from each of the providers” and “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.” (Ex. 1001 at cl. 7.)

104. For this claim, Petitioner refers back to its analysis of Limitations 1[f]-1[g] and identifies Douglas’s notification and alarm at 11:11-19. (Petition at 36.) Petitioner argues that “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” because “doing so would have encouraged the provider to enter the missing data . . . thereby allowing Douglas’s system to identify (and potentially uncover) a threatening or potentially dangerous situation indicated by the data.” (Petition at 36 (citing Bergeron Decl., ¶101).) I disagree.

105. The Petition does not address the claim’s requirement that there be a determination of whether “the data required is received *from each of the*

providers” or attempt to establish that Douglas or any other reference teaches it.²

(Petition at 36 (emphasis added).) And Douglas does not teach such a determination.

106. Douglas does disclose that the system can accept updated patient data *from the patient directly* via email or other forms of communication and that it “correlates the patient’s input with the physician’s to check for accuracy” and “provides the physician with reports of patient progress.” (Douglas at 11:1-10 (emphasis added).) However, there is no determination of whether data associated with performance of the desired outcomes is received “*from each of the providers*” and Petitioner did not argue otherwise. (Petition at 36; Ex. 2006 at 55:22-56:9 (“I agree that it doesn’t explicitly point out missing data.”).)

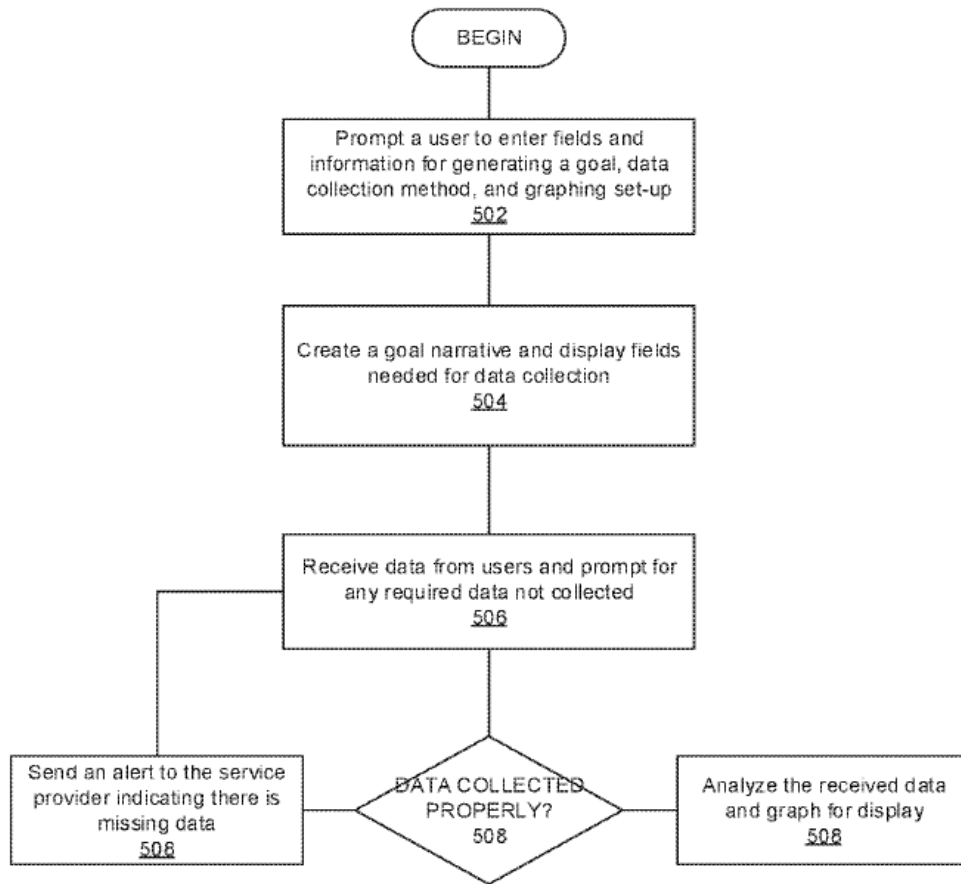
107. Regarding the claim’s requirement that an alert be sent in response to a determination that there is missing data, Petitioner agrees that Douglas does not actually disclose this limitation and states that it would have been obvious to “send an alert to the provider associated with the client” if client data was missing.

² Petitioner merely (conclusorily) argued that it would have been obvious for Douglas’s system to determine whether client data was missing. (Petition at 36.) But that ignores the claim’s requirement that the data be “received from each of the providers.”

(Petition at 36.) Petitioner states “it would have encouraged the provider to enter the missing data.” (*Id.*) However, Douglas teaches that updated patient data “*may*” be input by the physician or directly from the patient. (Douglas at 11:1-5 (emphasis added).) It is not required.

108. Douglas assumes a certain level of patient engagement in the system and focuses on encouraging patients to meet behavioral milestones rather than managing provider data entry. (See Douglas at 8:28-31 (“Once the patient is set up on the system, it assists him or her in complying with his or her behavior modification program (block 1020, FIG. 60). To use the program, the patient logs into 30 the system network via telephone line, cable modem, cellular connection, satellite link or other communication method that allows for a connection into a network server.”).)

109. This stands in contrast to the disclosure in the ’142 patent, which expressly describes the process for alerting physicians as to missing patient data:



(Ex. 1001 at Fig. 5.)

110. Bergeron’s declaration does not bridge the gap. Detecting missing data requires implementing rules or logic to define what constitutes “required” data and determining when its absence is significant enough to trigger an alert.

Petitioner does not identify a specific motivation or benefit to adding missing data alerts to Douglas’s system beyond its assertion that it would “have encouraged the provider to enter the missing data.” (Petition at 36.) But Douglas does not provide any framework or logic for handling missing data as an actionable condition. The

existing alert mechanisms are designed to support compliance monitoring and risk mitigation without addressing data completeness. (Douglas at 11:11-16.)

Implementing this functionality would require significant modifications to the system's architecture and operational logic without any motivating basis for doing so.

111. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “determining whether the data required is received from each of the providers” or “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.”

G. Grounds 1 and 2: Petitioner fails to provide evidence that any reference discloses or suggests “prompting the providers to provide data associated with assigned clients” (claim 10)

112. Claim 10 depends from claim 1 and further requires “prompting the providers to provide data associated with assigned clients.” (Ex. 1001 at cl. 10.)

113. For this claim, Petitioner states that Douglas’s “disclosed or obvious fields for entering patient data . . . 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.” (Petition at 31 (citing Douglas at Figs. 4 and 46).) In other words, Petitioner argues the mere presentation of a field for data entry satisfies the requirement that the provider be “prompt[ed]” to provide patient data. (*See id.*)

114. Petitioner’s argument strips the plain and ordinary meaning of the word “prompt” from the claims. The specification confirms that “prompt[ing]” in the context of the ’142 patent requires “guid[ing] the user through completing fields” via, e.g., “a series of probes or questions”:

In one embodiment, *the process may begin by prompting a user to enter fields and information for generating a goal*, data collection method, and graphing set-up (step 502). For example, *a series of probes or questions may guide the user through completing fields* that may generate the goal/objective narrative, data collection method set up, and graphing setup schedule. Step 502 may help ensure all elements are included in the goal/objective narrative to make specific, objective, and measurable goals. *The process may also ensure information is entered* to define how the process facilitates data collection, graph set-up, graph scheduling, and alert/notifications associated with these processes.

(Ex. 1001 at 23:11-23 (emphasis added).)

115. Additionally, claim 1 already requires there be creation of “fields required for compiling data associated with the treatment or assistance of each of the clients from the providers.” (Ex. 1001 at cl. 1.) If Petitioner’s interpretation of this limitation is correct and “prompting” merely requires presentation of fields for compiling data, claims 1 and 10 are identical in scope. I understand from counsel that there is a presumption that they are different in scope which is strengthened by the dependency of claim 10 on claim 1. Petitioner has not addressed this presumption.

116. It is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “prompting the providers to provide data associated with assigned clients.”

H. Grounds 1 and 2: Petitioner fails to provide evidence that Douglas discloses “a database in communication with the server configured to store the data and information associated with the clients and the providers” (claim 11)

117. Claim 11 (and claims 12-15 that depend from claim 13) requires “database in communication with the server configured to store the data and information associated with the clients and the providers.” (Ex. 1001 at cl. 11.)

118. For this claim, Petitioner state “that network server 508 includes ‘one or more relational databases 522,’ but does not allege that network server 508’s inclusion of relational database 522 requires that database 522 is “in communication” with server 508 as claim 11 recites. (Petition at 41 (citing Bergeron at ¶ 110).) Indeed, the phrase “in communication” never appears in the Petition’s analysis of claim 11 outside of the section headings reciting the claim language. (Petition at 37-44.)

119. Based on the Petition, it is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “a database in communication with the server configured to store the data and information associated with the clients and the providers.”

I. Grounds 1 and 2: Petitioner fails to provide evidence that Douglas discloses “a processor for executing a set of instructions” (claims 16-20)

120. Claim 16 (and claims 17-20 that depend from claim 16) recites “a processor for executing a set of instructions.” (Ex. 1001 at cl. 16.)

121. For this claim, Petitioner and its expert rely solely on Douglas and state that “Douglas discloses or renders obvious a processor within network server 508 for executing a set of instructions, specifically those for implementing Douglas’s system.” (Petition at 45 (citing Section VIII.A.8(b) (Limitation 11[a]).)

122. While Petitioner does refer back to its analysis of Limitation 11[a], neither claim 11—nor Petitioner’s analysis of claim 11—discusses or even contains the word “instructions.”

123. Based on the Petition, it is my opinion as a person of ordinary skill in the art that Douglas does not disclose or render obvious “a processor for executing a set of instructions.”

J. Ground 2: Petitioner fails to provide evidence that any reference discloses or suggests “assigning each of the clients to one or more of the providers in response to selections from an administrator” (all claims)

124. In Ground 2, Petitioner states that a POSITA would have been motivated to combine Douglas with Wager, a system for managing clinical workforces. (Petition at 47-53.) Specifically, Petitioner proposes that a POSITA would have been motivated to modify Douglas to include Wager’s interface to

allow an administrator to assign a patient to a physician. (*Id.*, 50.) In the Douglas-Wager System, Petitioner asserts, a case administrator would have assigned to each patient a physician, and the assignment would have 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.” (*Id.*, 52 (citing Wager at ¶ [0021])).)

125. All Challenged Claims require that the assignment of clients to one or more providers be done “in response to selections from an administrator.” (Ex. 1001 at cl. 1.) Petitioner does not identify what particular selections would have been made by an administrator in the Douglas-Wager modified system to which a provider would have been assigned in response. To the extent Petitioner intended to identify “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” as the claimed “selections,” Petitioner has also pointed to such selecting/highlighting as the claimed “assigning.” I understand that, for the reasons described in Sections IV and VII.E, this is presumptively improper. I further understand that Petitioner has not addressed this presumption.

126. It is my opinion as a person of ordinary skill in the art that Petitioner’s proposed combination of Douglas and Wager does not disclose or render obvious

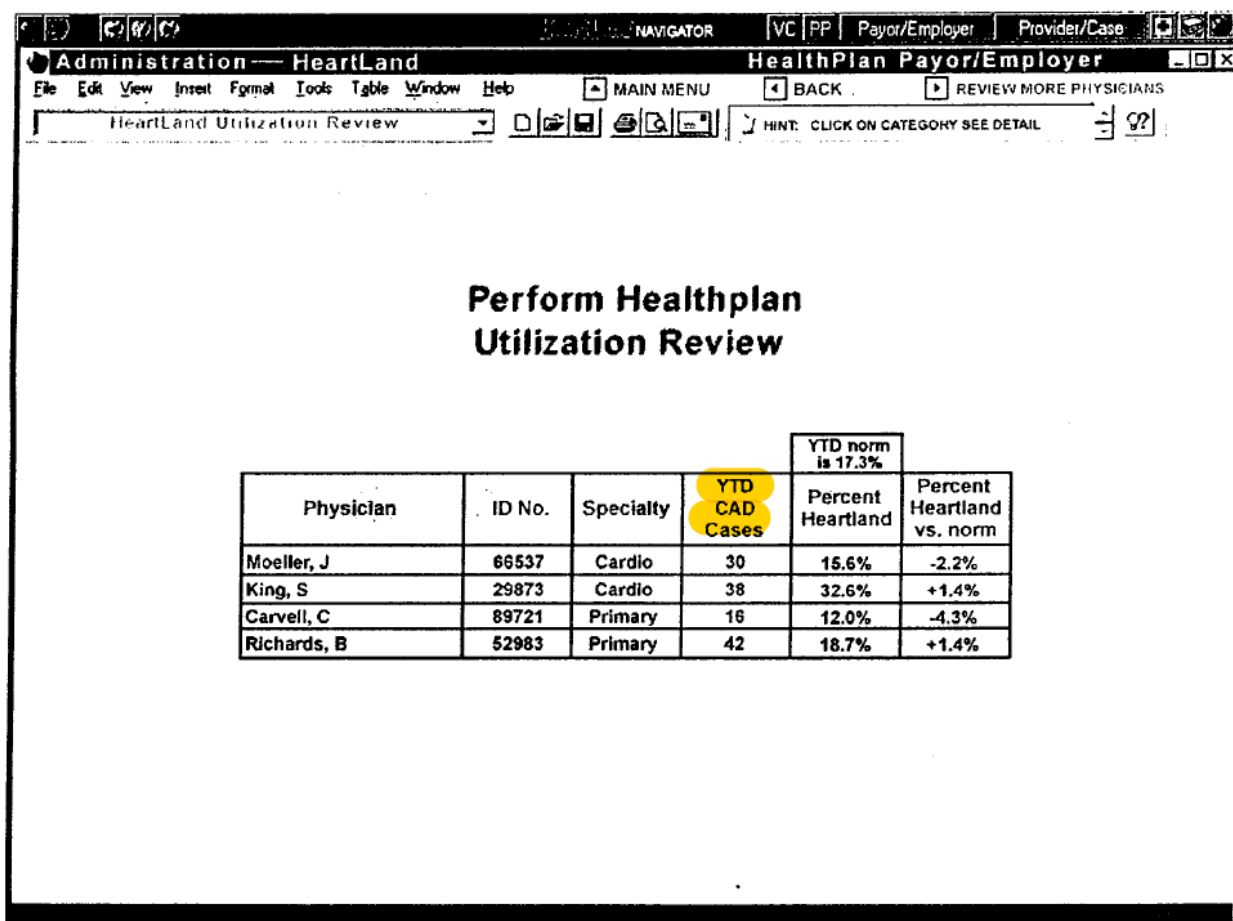
“assigning each of the clients to one or more of the providers in response to selections from an administrator.”

K. Grounds 2, 4, 6, and 8: A POSITA would not have been motivated to combine Douglas with Wager (all claims)

127. Petitioner relies on a proposed combination of Douglas and Wager for Grounds 2, 4, 6, and 8. It is my opinion that a person of ordinary skill in the art would not have been motivated to combine Douglas with Wager.

128. Petitioner alleges that “it would have been obvious to modify Douglas’s system to include an interface like Wager’s that provide the administrator with ‘an intuitive, visual interface for generating patient-to-care provider assignments, including capacity computation, skill set matching, [and] ratio management’ through which the administrator assigned a patient to a physician.” (Petition at 50.) I disagree.

129. Petitioner points to Douglas’s Figure 57 (copied below) as evidence that the patients in Douglas “were not evenly distributed amongst physicians,” implying that Wager could provide a benefit by redistributing the patients among the physicians listed in Figure 57. (Petition at 51.)



(Douglas at Fig. 57 (annotated).)

130. However, I understand that at deposition, Petitioner's expert acknowledged that Douglas's Figure 57 does not discuss whether patients were evenly distributed amongst physicians. Rather, as Petitioner's expert testified, Figure 57 merely lists the number of year-to-date coronary artery disease cases (whether open or closed) each physician had treated, without regard to each physician's total patient caseload (or current patient caseload):

Q: So based on Figure 57, you would – of Douglas at you would not be able to tell the current case load of any of the listed physicians, correct?

A: Current case load. The current case load it could be – current case load is not on this list on any of these columns. It would depend how you – how you define, usually, cases. So a case would be either – either define cases as in process or completed. And so – so I’m not sure why but – so again, for each of these cases – so in this list, Mueller or Moeller had 30 cases this year to date; King had 38; Carvell had 16 and Richards had 42.

Q: And those numbers you just listed are the year to date coronary artery disease cases for each of those patients – or each of those physicians, correct?

A: Correct.

Q: But there’s no indication on how many non-coronary artery disease year to date cases any of these physicians listed in Figure 57 have, correct?

A: Correct.

(Ex. 2006, 63:14-64:11.) Thus, Petitioner has provided no evidence that a POSITA would have seen a need in Douglas for balancing patient ratios among physicians, contrary to the Petition’s allegations.

131. A POSITA viewing Douglas’s system would not look to Wager’s system of “generating patient-to-care provider assignments” as Petitioner states because in Douglas at patients are subscribed to the system only after they have

selected and seen their own physician. (*See* Douglas at 6:28-35; Petition at 50.)

Thus, a POSITA would understand that Wager's system is redundant of this aspect of Douglas, in which patients are only subscribed to the system because they are already assigned to a physician.

132. A POSITA would further understand that because in Douglas, patients are subscribed to the system only after they have selected and seen their own physician, the patients in Douglas would be harmed, rather than benefitted, by utilization of Wager's system. Specifically, a POSITA would recognize the importance of continuity of care to accomplishing the very goals of Douglas—"adherence to their physician's medical recommendations." (Ex. 2007 at 10-11 ("Results for our sample show a significant association between the patient-physician relationship and patients' adherence to their physician's medical recommendations and healthy eating behavior.").)

133. Petitioner's expert acknowledged that he did not "consider the impact of a patient's relationship continuity with their physician" when rendering his opinions in this case. (Ex. 2006 at 65:21-66:1.)

134. A POSITA would recognize that this continuity of care is important to patients as well, such that the threat of being reassigned to a new physician would deter their willingness to be enrolled in the proposed Douglas-Wager system. (*See, e.g.,* Ex. 2007 at 10 ("The vulnerability and dependency inherent in being ill and at

a knowledge disadvantage, the necessity of revealing personal information, and the sheer importance of the service make finding—and keeping—a ‘good doctor’ a consumer priority.”); Ex. 2003 at 11-12 (“There is a lot of evidence that a good relationship with a freely chosen primary care doctor, preferably over several years, is associated with better, more appropriate care, better health and much lower healthcare costs. These advantages come from the trust that builds up through relationship continuity.”).)

135. Douglas is specifically directed to “an ongoing support program . . . for patients who have undergone surgery and must make subsequent lifestyle changes . . .” (Douglas at 1:29-31). A POSITA would readily recognize that a patient who has undergone surgery would not want to, and should not, change post-surgery care providers just because the proposed Douglas-Wager system found a provider with greater capacity. This is particularly the case where there is no evidence that having a patient subscribed to Douglas’s system takes up much of the physician’s time, as most of the patient’s interactions with Douglas’s system are done without requiring action on the part of the physician. (*See* Douglas at 9:21-10:32, explaining that patients can enter their own data updates into Douglas’s system, including that “a user may then sign up for the meeting that best fits his or her schedule. Other factors, such as the city in which the other members are located 108 may also influence the user’s choice . . . The journal also provides

a diary used to make a daily record of information pertinent to accomplishing the user's goals. The journal 94A provides an important tool that lets the patient express his or her feelings and fears in a context other than that of a support group. . . . The user may also record his or her personal comments in the journal. . . . The user may, for example, input information as to his or her exercise schedule (such as 30 minutes walking on Tuesdays, Thursdays, and Saturdays) or meditation schedule into the journal. . . . In addition to allowing the patient to electronically enter his or her updated health information . . .”).)

136. A POSITA would recognize that the reason the combined Douglas-Wager system would harm, rather than benefitting patients, is because Wager envisions its invention being used to coordinate staffing in a clinical setting such as a hospital—where each patient does need a medical professional inside the facility to be assigned to them. (Wager at [0004] (invention directed to “clinical workforce management” and “the task of promulgating shift-by-shift patient assignments”), [0005] (invention to assist “[c]harge nurses or other unit or other managers [who] thus must frequently rely on manual notes, memory and intuition to assemble a staff schedule . . . Staff managers may moreover have little time to generate such a floor schedule for the next shift . . . Other problems in clinical workforce management exist.”), [0011] “The staff manager may access the workforce management interface 106 before, during or after a work shift for a unit 110 such

as an emergency room, acute care unit, post-operative unit or other section, division, department, floor or other organizational unit of a hospital or other clinical care facility.”), [0013] (“For instance, the assignment bar 120 may indicate that for an eight-hour shift from 11 p.m. to 7 a.m. or other period, the patient is covered by assignment of a primary care nurse, or other personnel. Conversely, if a patient does not have a designated care provider for that or other period, the assignment bar 120 may display a gap 122 . . . ”).) I understand that Petitioner’s expert agrees with this characterization of Wager. (Ex. 2006 at 66:6-19.)

137. By contrast, a POSITA would recognize that Douglas teaches against accomplishing its goals in an in-person setting like the one to which Wager is directed. (Douglas at 1:29-35 (“Participation in an ongoing support program is often effective for patients who have undergone surgery and must make subsequent lifestyle changes, but *currently available in-person programs involve costly medical staff and facilities. It can also be inconvenient for the patient to travel to such programs on a regular basis. Because of their cost and the potential for inconvenience, many support programs last for only a limited time, which is often insufficient for the patient to modify behavior thoroughly and effectively.*”) (emphasis added).) Instead, Douglas expresses that its invention is designed for use remotely—where there is no need for an in-facility medical professional to be assigned to the patient. (Douglas at 2:5-7 (“The development of a therapeutic

program that could effectively motivate patients to modify their behavior and change their lifestyles to prevent or recover from ailments, and could be delivered to them electronically at home, work, or while traveling, would be highly desirable.”). I understand that Petitioner’s expert agrees with this characterization of Douglas. (Ex. 2006 at 67:16-68:2.)

138. While Douglas teaches that its system “also accepts additional patient data obtained during office visits,” a POSITA would recognize that, for the reasons I have described above, it would be in the patient’s best interest to maintain the patient’s continuity of care by allowing the patient to have these office visits with their original physician who subscribed them to Douglas’s system, instead of utilizing the proposed Douglas-Wager system to reassign the patient to a new physician. (Ex. 2007 at 10-11 (“Results for our sample show a significant association between the patient-physician relationship and patients’ adherence to their physician’s medical recommendations and healthy eating behavior.”).)

139. For each of these reasons, a POSITA would not have been motivated to combine Douglas and Wager in the manner that the Petition alleges.

L. Grounds 5 and 6: A POSITA would not have been motivated to combine Douglas and Koh (claims 5, 12, 13, and 18)

140. Petitioner asserts that Douglas and Koh can be combined to render claims 5, 12, 13, and 18 of the ’142 patent obvious, arguing that Koh’s data mining techniques would enhance the compliance monitoring system in Douglas. (Petition

at 61-64.) It is my opinion that a person of ordinary skill in the art would not have been motivated to combine Douglas and Koh.

141. Petitioner argues that combining Douglas and Koh would have benefited Douglas's healthcare providers and patients by identifying "effective treatments and best practices." (Petition at 64.) Douglas addresses individualized compliance tracking with user-specific interactions, while Koh's focus on applications for aggregated organizational data lacks any disclosed capability for individualized feedback or integration into a compliance system. (*See* Ex. 1009, 7 ("To aid healthcare management, data mining applications *can be developed* to better identify and track chronic disease states and high-risk patients, design appropriate interventions, and reduce the number of hospital admissions and claims") (emphasis added).) The distinct and unrelated problem-solution frameworks of these references provide no reasonable basis for their combination.

142. Douglas is directed to a therapeutic behavior modification program that utilizes compliance monitoring and feedback to assist individuals in making lifestyle changes for medical or wellness purposes. (Douglas at 2:16-24.) It focuses on compliance, monitoring, and feedback, which supports the design of customized therapeutic behavior and lifestyle modification programs. (*Id.*, 2:25-3:20.) Conversely, Koh describes the application of data mining techniques in healthcare, particularly focusing on identifying patterns in vast datasets for predictive insights

and operational improvements. (Ex. 1009, 11 (“[I]t is critical that the healthcare industry consider how data can be better captured, stored, prepared, and mined. Possible directions include the standardization of clinical vocabulary and the sharing of data across organizations to enhance the benefits of healthcare data mining applications.”.) These distinct objectives address entirely different problems: patient engagement and compliance versus applications for organizational data analysis. There is no logical nexus between these two systems to suggest that a POSITA would combine their teachings.

143. Petitioner also cannot establish that Douglas and Koh would be interoperable. Douglas’s system centers on user-specific, interactive compliance tracking, where individual patients actively engage with a prescribed program. (Douglas at 6:1-14 (“The system provides at least two separate benefits: it helps the patient comply with the program through an electronically-implemented support mechanism; and further assists in monitoring such compliance.”).)

144. Petitioner’s suggestion that Koh’s data mining capabilities could be adapted for patient-specific recommendations lacks any basis in Koh’s disclosure, which centers on broad data aggregation and trend analysis at an organizational level. (Ex. 1009 at 7 (“As another example, Blue Cross has been implementing data mining initiatives to improve outcomes and reduce expenditures through better disease management.”).)

145. Integrating these systems would require substantial technical modifications to align their functionalities. Petitioner fails to show how such integration could be achieved without undue experimentation or how the combined system would improve upon the prior art.

146. It is my opinion that a person of ordinary skill in the art would not have been motivated to combine Douglas and Koh.

147. Even assuming that a POSITA would have been motivated to combine Douglas and Koh, the resulting combination would not satisfy the limitations of the '142 patent claims. Petitioner's reliance on Koh's data mining capabilities fails to address the specific requirements for individualized best practices and recommendations outlined in the claims, as described below.

1. Petitioner's Douglas-Koh system does not render claims 5, 12, or 13 obvious

148. Claim 5 requires a system capable of "data mining the compiled data to determine best practices" and "recommending the best practices to providers in response to the best practices being associated with a client assigned to the providers." (Ex. 1001 at cl. 5.)

149. Douglas lacks any disclosure of data mining techniques; its functionality is limited to compliance monitoring and milestone tracking for individual users. (Douglas at 6:1-14.)

150. Koh, while discussing data mining, is focused on organizational-level analysis rather than deriving actionable insights specific to individual clients, as required by the claim. (Ex. 1009, 7 (“To aid healthcare management, data mining applications can be developed to better identify and track chronic disease states and high-risk patients, design appropriate interventions, and reduce the number of hospital admissions and claims.”).)

151. Combining these references does not bridge this gap, as neither inherently teaches or suggests this claim element. Petitioner does not allege that it does. For example, the claim requires “recommending the best practices to the providers *in response to the best practices being associated with a client assigned to the providers.*” (Ex. 1001 at cl. 5.) Petitioner generally alleges that Koh’s analysis of data mining would have motivated a POSITA to implement data mining practices into Douglas’s system, but Petitioner does not allege that, in doing so, any “best practice” would be “associated with a client assigned to the providers” such that “best practices” could be recommended to the providers in response. (Petition at 62-65.) Neither Koh nor Douglas discloses such association or responsive recommendation.

152. Because there is no showing that Koh and Douglas can be combined to disclose “associat[ing] best practices” with any particular client, this failure also extends to claims 12 and 13, which require such association.

153. It is my opinion as a person of ordinary skill in the art that the proposed combination of Douglas and Koh does not disclose or render obvious claims 5, 12, or 13.

2. Petitioner’s Douglas-Koh system does not render claim 18 obvious

154. Claim 18 requires “[t]he 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.” (Ex. 1001 at cl. 18.) Petitioner states that “it would have been obvious for the processor executing Douglas’s system . . . to also execute data mining of that compiled data to protect the confidentiality of the compiled data” and “that therapeutic program and modifications to the same reflected best practices determined to be historically successful through data mining.” (Petition at 67.)

155. Petitioner asks the Board to find that Koh’s general disclosure of the use of data mining in healthcare applications renders obvious of a particular “set of instructions” that can be “executed to . . . recommend best practices to the providers in response to historic success with the clients.” (Petition at 67.) Petitioner does not identify these instructions or why it would have been obvious for a POSITA to rely on Koh’s discussion of data mining applications (which lacks any processor-level specifics) to alter any purported instructions executed by Douglas’s processor.

156. It is my opinion as a person of ordinary skill in the art that the proposed combination of Douglas and Koh does not disclose or render obvious claim 18.

M. Grounds 7 and 8: Virginia is not analogous art (all claims)

157. Virginia is entitled “Autism Spectrum Disorders and the Transition to Adulthood” and describes that, “[i]n this Guide, we discuss the issues, challenges, and strategies that are involved in helping young people like Dan fully participate in society. Our focus in this guide is about what young people with autism can do and how to design the supports to expand opportunity and potential. . . . The chapters in this Guide will describe how to help persons with autism move from adolescence to adulthood, and overcome the barriers that their disability presents.” (Ex. 1022 at 6.)

158. I understand that to determine whether art is analogous, courts consider (1) whether the art is from the same field of endeavor as the asserted patent, regardless of the problem addressed and, (2) if the reference is not within the field of the inventor’s endeavor, whether the reference still is reasonably pertinent to the particular problem with which the inventor is involved. I further understand that a reference is reasonably pertinent if, even though it may be in a different field from that of the inventor’s endeavor, it is one which, because of the matter with which it deals, logically would have commended itself to an inventor’s

attention in considering his problem. It is my opinion that Virginia does not qualify as analogous art under either the field of endeavor or the reasonably pertinent standards.

1. The Virginia reference is not in the same field of endeavor.

159. It is my opinion as a person of ordinary skill in the art that Virginia is not in the same field of endeavor as the '142 patent. The '142 patent addresses the field of technology-driven systems for optimizing behavioral goal progression. Specifically, it discloses a sophisticated software platform designed to systematically collect, analyze, and monitor goal-related data, complete with automated alerts and visual reporting tools. (*See, e.g.*, Ex. 1001 at 1:12-3:49, Fig. 5.) It is a solution tailored to enhance client outcomes in behavioral health and therapy settings through automation and data intelligence. (*See id.*)

160. The Virginia reference is a transition guide for students with Autism Spectrum Disorder (ASD). (Ex. 1022 at 1.) Authored by the Virginia Department of Education, it offers practical guidance for educational and vocational programs, life skills planning, and individualized education programs (IEPs) for special-needs students. The reference describes that “[t]he chapters in this Guide will describe how to help persons with autism move from adolescence to adulthood, and overcome the barriers that their disability presents.” (*Id.* at 6.) It is a programmatic and educational resource, generally devoid of technological systems, software

algorithms, or mechanisms for automated data tracking. (*See* Ex. 1022 at 33 (describing data collection methods as including review of records, interviews, review of incident reports and behavioral data, and observations of the person in their working and learning environments).)

161. Petitioner states that Virginia is “directed to tracking goal progression.” (Petition at 69.) I disagree. Virginia relies on educational foundations to “discuss the issues, challenges, and strategies that are involved in helping young people [with autism] fully participate in society. Our focus in this guide is about what young people with autism can do and how to design the supports to expand opportunity and potential.” (Ex. 1022 at 6.) The Virginia reference is centered on education and transition planning; the ’142 patent teaches technology-enabled goal tracking. These fields do not overlap.

2. The Virginia reference is not reasonably pertinent to the problem addressed by the ’142 patent.

162. Nor is the Virginia reference reasonably pertinent to the problem addressed by the ’142 patent. The ’142 patent addresses a highly specific technological problem: how to efficiently track, analyze, and manage goal progression to improve outcomes for clients in behavioral health settings. (*See, e.g.,* Ex. 1001 at 1:12-3:49, Fig. 5.)

163. The Virginia reference, however, concerns a fundamentally different issue: how to guide educational programs for transitioning students with ASD. (Ex.

1022, 6, 28-32.) It provides broad, generalized strategies for life and employment readiness, not a solution for technological goal tracking. (*See* Ex. 1022, 33 (describing data collection methods).) It is my opinion that there is no overlap in the problems being solved in the '142 patent and the Virginia reference.

164. The Virginia reference, centered on educational frameworks and legal requirements for transition planning, would not “logically” have drawn the attention of an inventor tasked with solving the technical challenges addressed by the '142 patent. Virginia does not disclose technological teachings applicable to goal optimization systems.

165. It is therefore my opinion as a person of ordinary skill in the art that the Virginia reference is neither in the same field of endeavor as the '142 patent nor reasonably pertinent to the problem the patent solves and is, therefore, not analogous art.

N. Grounds 4, 6, and 8: Petitioner has not identified its proposed combinations of Douglas, Wager, and Chitiveli (claims 2 and 20), Douglas, Wager, and Koh (claims 5, 12, 13, and 18), or Douglas, Wager, and Virginia (claim 9)

166. For Ground 4, Petitioner relies on a combination of Douglas, Wager, and Chitiveli. (Petition at 53-60.) As a person of ordinary skill in the art, I am unable to discern Petitioner’s proposed combination with specificity. While Petitioner discusses Wager in the context of its Ground 2 arguments, it does not mention Wager in its Ground 4 arguments except in the section heading. (*Id.*)

167. In Ground 2, Petitioner relies on Wager’s disclosure of “an intuitive, visual interface for generating patient-to-care provider assignments” and argues that it would have been obvious to modify Douglas’s system to include an interface like Wager’s.³ (Petition at 53.) Ground 4 is a proposed combination of Douglas, Wager, and Chitiveli, and Petitioner discusses a proposed modification of Douglas in view of Chitiveli “using a SaaS provider like Chitiveli discloses for his content analytics tool . . . to upload patient data.” (Petition at 56.) Chitiveli’s tool uses an “analytics client or a web browser” to upload data. (Petition at 54-55.)

168. Petitioner does not disclose any Douglas-Wager-Chitiveli combination. (*See id.*) Petitioner does not specify what aspects of Wager, if any, are to be incorporated into this combination. Specifically, it is unclear how Petitioner contends Wager’s visual interface would have been incorporated into a combination of Douglas with Chitiveli, particularly given that Chitiveli itself teaches upload of data “[u]sing the analytics client or the web browser.” (Petition at 54 (citing Chitiveli, ¶[0036]).) There is no discussion of how or whether Wager’s interface interacts with Chitiveli’s client/web browser, how it would be implemented alongside Chitiveli’s analytics tool, or whether the functionalities of Wager and Chitiveli can coexist without conflict or redundancy.

³ Petitioner refers to this modified system as the “Douglas-Wager” system.

169. I am unable to discern, as a person of ordinary skill in the art, what the proposed combination of Douglas, Wager, and Chitivel is for Ground 4.

170. Similarly, for Ground 6, Petitioner relies on a combination of Douglas, Wager, and Koh. (Petition at 61-67.) Again, Petitioner does not mention Wager in this Ground except in the heading. (*Id.*) In Ground 6, Petitioner proposes combining Douglas, Wager, and Koh, but fails to mention Wager or articulate how Wager's visual interface would interact with Koh's data mining methods in the context of Douglas's compliance monitoring system. (Petition at 61-65.) Again, there is no discussion of how Koh can be implemented into the proposed combination of Douglas and Wager or whether the functionalities of Wager and Koh can coexist without conflict or redundancy.

171. I am unable to discern, as a person of ordinary skill in the art, what the proposed combination of Douglas, Wager, and Koh is for Ground 6.

172. Similarly, for Ground 8, Petitioner relies on a combination of Douglas, Wager, and Virginia. (Petition at 67-73.) Again, Petitioner does not mention Wager in this Ground except in the heading. (*Id.*) In Ground 8, Petitioner discusses modification of Douglas to "evaluate compliance with the program by analyzing the patient's updated data using an MGL-based approach" but provides no specific explanation of how Virginia's disclosures regarding autism treatment frameworks would integrate with Wager's interface. (Petition at 69.)

173. I am unable to discern, as a person of ordinary skill in the art, what the proposed combination of Douglas, Wager, and Virginia is for Ground 8.

Under penalty of perjury, I declare the above statements as true and accurate to the best of my recollection. I further state that these statements are made with the knowledge that willful false statements and the like are punishable by fine or imprisonment, or both under Section 1001 of Title 18 of the U.S. Code.

Executed December 23, 2024, in Chicago, Illinois.

By: Ardehali
Hossein Ardehali, M.D., Ph.D.