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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. IPR2024-00618
U.S. Patent No. 10,061,812

**PATENT OWNER'S PRELIMINARY RESPONSE
UNDER 35 U.S.C. § 313 AND 37 C.F.R. § 42.107**

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I. INTRODUCTION

U.S. Patent No. 10,061,812 (“the ’812 patent”) claims important advances in the field of behavioral science. The ’812 patent culminated from years of hands-on experimentation and research at a private not-for-profit behavioral health organization that provides a continuum of services to individuals with intellectual, developmental, and behavioral needs. Executives at the Grafton School developed a novel patient-care approach involving a patient-specific iterative process of goal creation, multimodal data collection, data analysis, and multimodal intervention. The Grafton approach resulted in far greater adherence to goal regimens and better patient outcomes. The inventors then built a platform for applying their new process to other settings, both within and outside of healthcare settings, where actors sought to improve measurable outcomes through behavioral changes. And they patented that technology in the ’812 and other patents.

On March 1, 2024, Petitioner submitted a Petition to institute *inter partes* review (“IPR”) of U.S. Patent No. 10,061,812 (“the ’812 patent”) (Ex. 1001), challenging claims 1-7, 9-14, 16-18, and 20 (the “Challenged Claims”). Data Health Partners, Inc. (“Patent Owner”) requests that the Board decline to institute IPR because, for all Challenged Claims and Grounds: (1) Petitioner fails to allege that the compiled data is “without input from the clients” as each of the Challenged Claims recites; (2) Petitioner improperly equates the recited “rules for determining

progress of the clients” with the separately-recited “goals;” (3) Petitioner fails to provide evidence that any reference automatically communicates to the providers an alert including the compiled data and the status from the server; and (4) Petitioner cannot show that Douglas discloses “assigning the client to one or more of providers in response to selections from the administrator,” or that a POSA would have been motivated to make this assignment via the proposed Douglas-Wager combination.

Accordingly, Patent Owner requests that the Board deny institution on all Challenged Claims of the ’812 patent.

II. LEVEL OF ORDINARY SKILL

For purposes of this Preliminary Response only, Patent Owner does not dispute the Petitioner’s definition of a person of ordinary skill in the art, other than Petitioner’s indication that the relevant date is “October March 15, 2013,” which is not an actual date. (Petition, 6-7.)

III. BACKGROUND TECHNOLOGY

Traditional healthcare approaches recognize the importance of increasing patient adherence to goals and regimens prescribed by doctors or other professionals in improving overall outcomes. But achieving adherence to such goals is difficult. Behavioral science has long struggled with the problem of how to induce individuals to follow prescribed advice.

Grafton is a private not-for-profit behavioral health organization that provides a continuum of services to individuals with intellectual, developmental, and behavioral needs. Patient treatment at Grafton relied historically on behavioral strategies, but the traditional aversive safety measures of seclusion and restraint regularly resulted in physical incidents between staff and patients. There was limited tracking and monitoring of patient progress in improving skills and reducing problematic behavior.

In 2002, James Gaynor became the CEO of Grafton. In the face of rising costs from dangerous injury-prone physical interventions, Mr. Gaynor and other executives at Grafton began developing and refining a formal, systematic, data-management approach that tracked individualized goal outcomes in order to reduce trauma and costs associated with injuries to staff and patients. Eventually, Grafton's efforts paid off. Its approach centered on a cyclical process of collecting data on patients from multiple sources, assessing the various factors and influences that affected patient development, setting individualized goals for the patients, implementing strategies to reach those goals, tracking and continually evaluating patient attainment of their goals, and intervening to improve goal attainment based on that evaluation. For example, Grafton used a concept of "goal mastery" to assess individualized patient progress in attainment of the patient's assigned goals and to understand when the patient was falling short, automatically alerting staff

and enabling them to respond appropriately. And as patients met their specifically assigned goals, their reactive aggressive behavior decreased, leading to a reduced need for crisis intervention strategies and a lower rate of physical incidents between patients and staff.

Grafton's methods eventually led to savings of millions of dollars in decreased costs associated with interventions, while increasing goal attainment rates among the patient population from 35% to over 80%. Grafton's methods also improved overall goals related to patients' ability to engage productively and safely in learning, daily living activities, and social interactions.

Seeing the success of their program, Mr. Gaynor and Lisa Marshall, Ph.D., Grafton's Director of Clinical Services, sought to develop a generalized approach to patient care based on their experience at Grafton. They worked with software developers, including the founder and employees of Data Health, to combine their learned experience in tracking and improving goal outcomes with technology that would enable input of data by users, automatically develop goals and progress-tracking methodologies, and continually monitor collected data to both generate reports on patient progress and provide automated interventions and alerts to users.

In May 2013, AudioEye, Inc., the software company working with Grafton, issued a press release announcing that it had been hired by Grafton "to design, patent, and fully develop a new mobile behavioral health care technology

platform.” (Ex. 2001, 1.) The result was the REBOOT (Reliable Evidence-Based Outcomes Optimization Technologies) software-as-a-service product, which enabled a wide variety of organizations seeking to improve goal outcomes for targeted individuals and stakeholders to take advantage of the methods that had been proven to improve goal mastery at Grafton.

The '812 patent is based on the REBOOT technology, and claims methods, systems, and servers that improve outcomes associated with goal-tracking through a specific structure (of data collection, data assessment, and automated alerts and notifications) that has enabled organizations to better attain client adherence to prescribed regimens and improve clients' baseline conditions.

IV. OVERVIEW OF THE '812 INVENTION

The '812 patent is entitled “Platform for Optimizing Data Driven Outcomes” and was filed on March 14, 2014, claiming priority to U.S. Provisional Patent Application No. 61/791,218 filed on March 15, 2013. The '812 patent claims methods, systems, and servers that improve outcomes associated with goal-tracking through a specific structure (e.g., data collection, data compilation and analysis, and alerting the providers to intervene with the client, as needed, in response to the data analysis) that has enabled organizations to better attain client adherence to prescribed regimens and improve clients' baseline conditions.

The '812 patent offers several advantages over prior art. (See Ex. 1001, 27:25-26.) The technology disclosed in the '812 patent allows a provider to define and automate a process for assessment that “drives goals, services, and interventions.” (*Id.*, 27:25-28.) It also improves goal management functionality by “allow[ing]ng goals to be defined, created, tracked, and analyzed using data.” (*Id.*, 27:28-30.)

For example, claim 1 of the '812 patent generally discloses (1) receiving input for establishing accounts for providers servicing clients, (2) assigning the client to a provider in response to selections from the administrator, (3) prompting providers to provide data associated with the clients, (4) compiling client data/progress, (5) analyzing the compiled data to determine whether it significantly varies from a threshold, and (6) automatically alerting the provider if the compiled data significantly varies from a threshold. (*Id.*, Claim 1.)

V. CHALLENGED CLAIMS

Petitioner challenges claims 1-7, 9-14, 16-18, and 20 of the '812 Patent, of which claims 1, 11, and 16 are independent. Claim terms specifically discussed in this POPR are highlighted below.

Claim 1 recites:

A method for tracking outcome specific data, the method comprising:
receiving input establishing accounts for providers serving
clients in a client management program, wherein the clients are

individuals receiving treatment or assistance, wherein the input includes rules for determining progress of the clients, wherein the accounts are stored in a database of a server, and wherein the input is received from an administrator utilizing one of a plurality of communications devices in communication with the server by one or more networks;

assigning each of the clients to one or more of the providers in response to selections from the administrator utilizing one of the plurality of communications devices, wherein the one or more providers are individuals available to treat or assist the clients;

prompting the providers to provide data associated with each of the clients that is required and not already received through the client management program, wherein the one or more providers periodically provide/update the data, and wherein the data relates to the well-being of the clients;

compiling the data associated with each of the clients received from the providers without input from the clients for the client management program to generate a score utilizing the rules, wherein the score is associated with progress toward mastery of one or more goals;

analyzing the compiled data and the score to automatically determine a status of the clients within the client management program, wherein the score is compared with previous compiled data to determine whether a plurality of measurements of the compiled data vary from a threshold to become significant; and

automatically communicating an alert including the compiled data and the status from the server executing the client management

program to the plurality of communications devices associated with the providers assigned to one of the clients that is utilized by the administrator or one or more of the providers to intervene with the client in response to the plurality of measurements of the compiled data varying from the threshold to become significant for one of the clients.

(Ex. 1001 31:9-51.)

Claim 11 recites:

A system for tracking goal achievement of individuals, the system comprising:

a server is a computing device that communicates with communications devices through a transceiver utilizing one or more networks, the server includes a processor that executes a client management program stored in a memory to receive input establishing accounts for providers serving the individuals and rules for determining progress of individuals, assign each of the individuals to one or more of the providers in response to selections from an administrator, prompt the providers to provide data associated with each of the individuals that is required and not already received through the client management program, compile data associated with each of the individuals received from the providers without input from the individuals to generate a score utilizing the rules, analyze the compiled data and the score to automatically determine a status of the individuals, the score is compared with previous compiled data to determine whether a plurality of measurements of the compiled data vary from a threshold to become significant, and automatically

communicate an alert to the administrator or the one or more providers to intervene with the assigned individuals, the alert including the compiled data and the status from the server to the communications devices associated with the providers in response to the compiled data becoming significant, the clients are individuals receiving treatment or assistance, the one or more providers are individuals available to treat or assist the clients, the providers periodically provide/update the data, and the data relates to the well-being of the clients; and

a database in communication with the server that manages the data, the database configured to store the accounts, assignments of the individuals to the one or more providers, and the compiled data.

(Ex. 1001 32:32-67.)

Claim 16 recites:

A server comprising:

a processor for executing a set of instructions or client management; and

a memory for storing the set of instructions for client management, wherein the set of instructions are executed by the processor to:

receive input establishing user accounts for providers serving clients, wherein the input includes rules for determining the progress of clients, wherein the clients are individuals receiving treatment or assistance;

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 are individuals available to treat or assist the clients;

prompt the providers to provide data associated with each of the clients that is required and not already received through the client management program, wherein the providers periodically provide/update the data, and wherein the data relates to the well-being of the clients;

compile data associated with each of the clients received from the providers utilizing communications devices in communication with the server without input from the clients to generate a score utilizing the rules, wherein the score is associated with progress toward mastery of one or more goals;

analyze the compiled data and the score to automatically determine a status of the clients, wherein the score is compared with previous compiled data to determine whether a plurality of measurements of the compiled data vary from a threshold to become significant; and

automatically communicate an alert from the server to the communications devices associated with the providers assigned to one of the clients in response to the plurality of measurements of the compiled data varying from the threshold to become significant for one of the clients, wherein the administrator or one of the providers intervenes with the one of the clients based on the alert; and

communicate the compiled data to specified parties in response to a request from the providers or administrator.

(Ex. 1001 33:27-34:22.)

VI. CLAIM CONSTRUCTION

The Challenged Claims of the '812 patent are construed “using the same claim construction standard that would be used to construe the claim in a civil action under 35 U.S.C. § 282(b).” 37 C.F.R. § 42.100(b) (Nov. 13, 2018). The '812 patent claim terms are therefore 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.” *Id.*

Data Health agrees with Petitioner that, for purposes of this Preliminary Response only, all terms of the '812 patent have their plain and ordinary meaning.

VII. STANDARD FOR GRANTING *INTER PARTES* REVIEW

A petition for IPR may only be granted when “the information presented in the petition...shows that there is a reasonable likelihood that the petitioner would prevail with respect to at least 1 of the claims challenged in the petition.” 35 U.S.C. § 314(a); *see also* 37 C.F.R. § 42.108(c). Petitioner has the burden of proof to show that the statutory threshold is satisfied. (*See* Office Patent Trial Practice Guide, 77 Fed. Reg. 48756 (Aug. 14, 2012).)

IPR institution is discretionary. *See SAS Inst. v. Iancu*, 138 S. Ct. 1348, 1356 (2018) (“[Section] 314(a) invests the Director with discretion on the question whether to institute review ...”) (emphasis omitted). “In exercising that discretion, [the Board is] guided by the statutory requirement, in promulgating regulations for

inter partes review, to consider the effect of any regulations on ‘the efficient administration of the Office [and] the ability of the Office to timely complete proceedings,’ 35 U.S.C. § 316(b), as well as the requirement to construe the PTAB’s rules to ‘secure the just, speedy, and inexpensive resolution of every proceeding,’ 37 C.F.R. § 42.1(b).”

For example, “the Board may consider the number of claims and grounds that meet the reasonable likelihood standard when deciding whether to institute *inter partes* review under 35 U.S.C. § 314(a).” *Deeper, UAB v. Vexilar, Inc.*, IPR2018-01310, slip op. at 42 (PTAB Jan. 24, 2019) (Paper 7) (Informative).

VIII. IPR SHOULD NOT BE INSTITUTED

- 1. Petitioner fails to allege that compiling data associated with each of the clients received from the providers is “without input from the clients” as each of the Challenged Claims recites.**

Claim 1 (and claims 2-10 that depend from claim 1) recites “compiling the data associated with each of the clients received from the providers *without input from the clients* ...” (Claim 1 (emphasis added).) Similarly, claim 11 (and claims 12-15 that depend from claim 11) recites “compile data associated with each of the individuals received from the providers *without input from the clients* ...” (Claim 11 (emphasis added).) Likewise, claim 16 (and claims 17-20 that depend from claim 16) recites “compile data associated with each of the clients received from

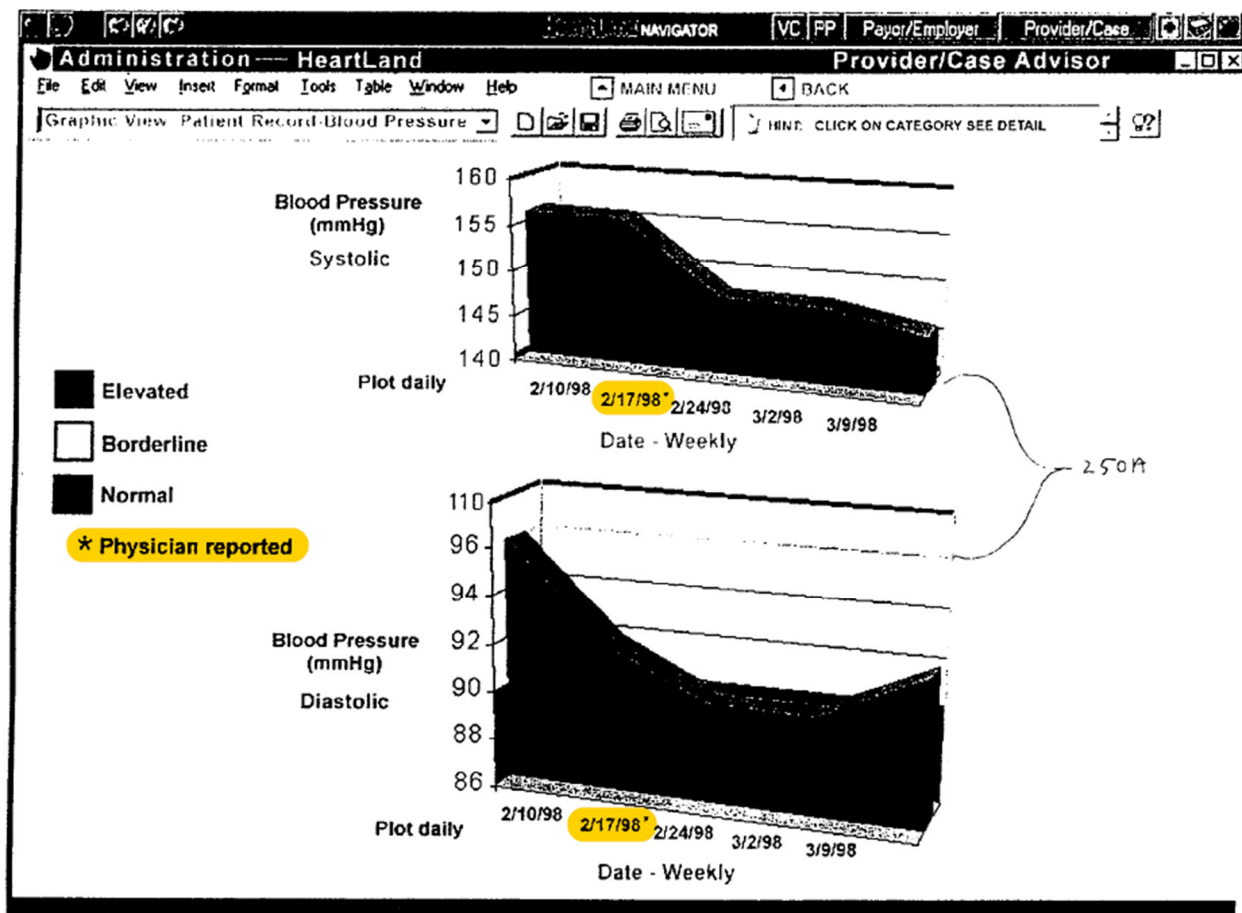
the providers utilizing communications devices in communication with the server ***without input from the clients*** ...” (Claim 16 (emphasis added).)

Despite the fact that every claim of the ’812 patent requires compiling the data associated with each of the clients received from the providers “***without input from the clients***,” this phrase never even appears in Petitioner’s allegations or analysis for claim 1, or for claim 11, which merely relies on the claim 1 analysis. (See Petition, 31-32, 46-49.) This alone is fatal to Petitioner’s challenge. See *Intelligent Bio-Sys., Inc. v. Illumina Cambridge Ltd.*, 821 F.3d 1359, 1369 (Fed. Cir. 2016) (emphasizing the “*utmost importance*” of petitioners introducing “*with particularity*” the rationale and evidence to “make their case *in their petition* to institute” (emphases added) (quoting 35 U.S.C. § 312(a)(3)).

Instead, for these claims (all Grounds), Petitioner alleges that “Douglas discloses compiling data associated with the patients received from the providers, as updated patient data is collected over time—i.e., compiled—to determine progress of a patient toward achieving the goals.” (Petition, 31.) However, compiling data received from the providers does not exclude also compiling data with input from the clients, and such exclusion is what the Challenged Claims require. Indeed, the explicit inclusion of data with input from the clients is what Douglas discloses, even in Petitioner’s own citations. (See Petition at 31-32.) Specifically, Petitioner alleges that the claimed “patient data compilation 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, charted against respective goals.” (Petition, 31-32.)

In addition to the Petition’s failure to allege that Douglas discloses an explicit claim element, Petitioner’s citation is additionally fatal to its challenge to all Challenged Claims for all Grounds (as Petitioner only relies on Douglas for this claim element). Specifically, in Douglas’s Figure 41, shown below, only 1 of the five weekly blood pressure readings is labeled as being “Physician reported,” meaning that the other four out of the five readings are made *with* input from the clients—such that the compiled data—which Petitioner alleges includes the data from Figure 41—is *not* “without input from the clients” as all Challenged Claims recite.



(Douglas, Figure 41 (annotated).)

Indeed, each of Douglas's Figures 40-45 contains information for which Douglas explicitly collects client input—physical activity/exercise (Figures 40 and 42), blood pressure (Figures 40-41), heart rate (Figure 40), weight (Figures 40 and 43), cholesterol (Figure 44), behavioral intention (Figure 45), self-efficacy (Figure 45), and social support (Figure 45). And presumably all of the other information in Figures 40-45, such as cigarettes/day calories/day, and stress level are also client-reported, as the client, not the physician, would be the only one with knowledge of

that information on such a frequent basis (particularly when Douglas teaches against accomplishing its goals in an in-person setting like the one to which Wager is directed. (*See Douglas, 1:29-35; Section VIII.4.e., infra.*) Specifically, Douglas explains:

Referring again to FIG. 9, the system also enables the user to access an integrated patient journal 94 from the village's inner core and self-report on their progress and describe their feelings.

...

FIG. 13 exemplifies the type of information which may be contained in the journal. For instance, a heart patient belonging to a clinical group may need to monitor his or her emotions 100 as well as the **exercises** he or she has been doing 104 by means of the journal.

Depending on the patient's program, the system might also prompt the patient to input his or her vital signs 102, such as **blood pressure** and **heart rate**, in the journal. This can be done manually or automatically. For example, devices can be hooked into the computer's serial port for automatic input of blood pressure and heart rate into the system. Depending on the particular program, patients might be required to **weigh themselves** on a weekly basis and/or measure their **cholesterol level** with a home cholesterol kit on a relatively less frequent basis.

...

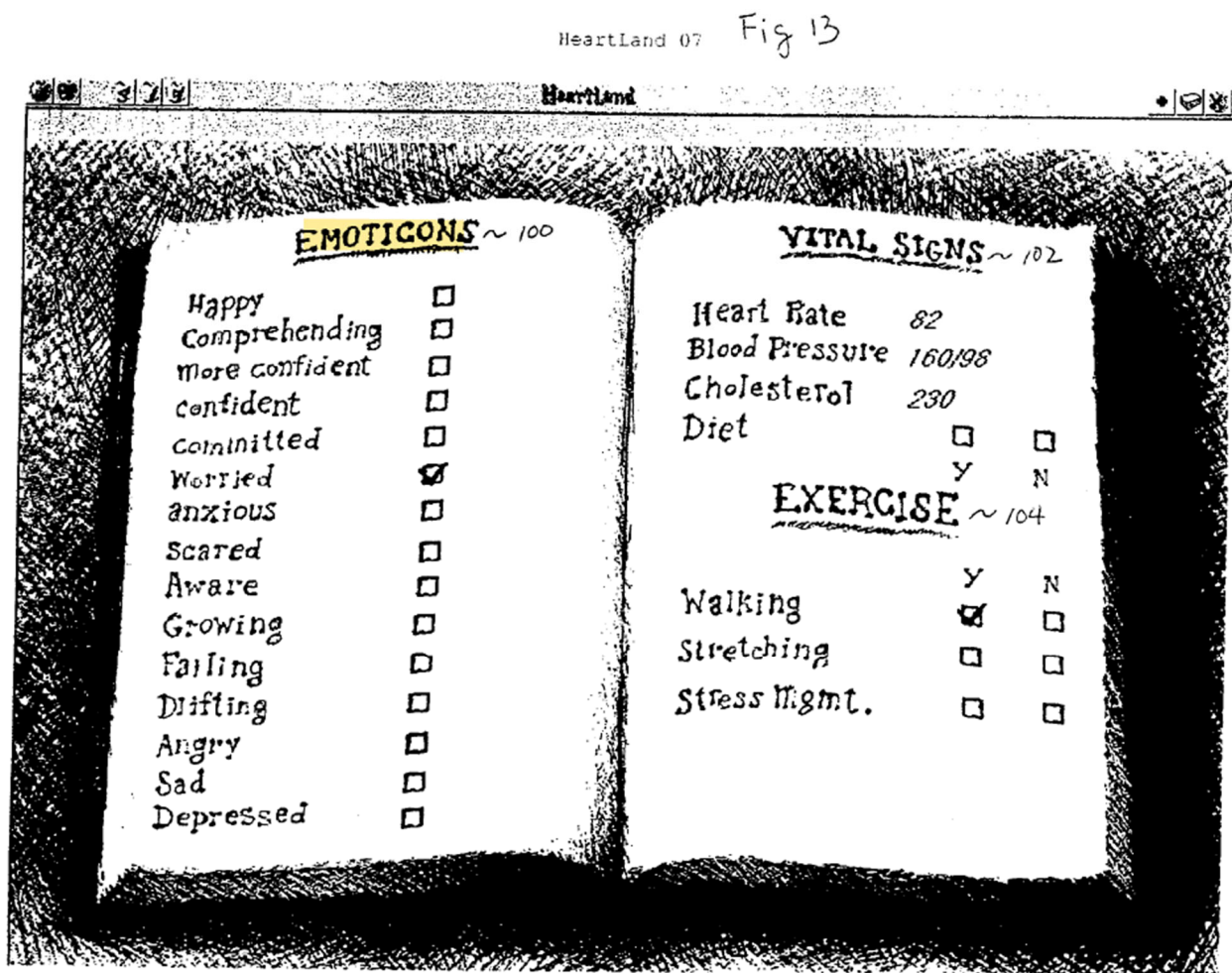
[T]he system provides a behavioral change assessment form 305 like the one shown in FIG. 45. This form 305 is used to determine how included the selected patient is toward complying with the

recommended program. In the preferred embodiment, on-line questionnaires are submitted to the patients, asking them to rate their **behavioral intention** 300, **self-efficacy** 302, and **social support** 304.

(Douglas, 9:32-34, 10:10-19, 20:20-25 (emphasis added).)

Further, Douglas confirms that “[i]n addition to allowing the patient to electronically enter his or her updated health information, the journal also provides the physician or case advisor with a means of getting feedback on the patient’s progress.” (Douglas, 10:31-33.) Thus, not only did Petitioner fail to allege that Douglas discloses compiling the data associated with each of the clients received from the providers “*without input from the clients*,” Douglas affirmatively discloses that such compilations are done **with** input from the clients, as confirmed by Petitioner’s own citations.

Indeed, Douglas’s patient input journal, which includes client-input emoticons, as shown below, is strikingly similar to a reference that was distinguished during prosecution as not teaching compiling data associated with each of the clients received from the providers *without input from the clients* because it, too, received emoticons from the user being monitored.



(Douglas, Figure 13 (annotated).)

Specifically, during prosecution, in response to an Office Action, Applicants specifically amended the claims to include the limitation specifying that the compiled data received from the providers is “without input from the clients to generate a score utilizing the rules,” (Ex. 2005, 183-184.) Based on these amendments, Applicants argued that the prior art reference, Metzler, “**teaches that emoticons and other response to interactive content are received from the user being monitored,**” and so “does not teach compiling data associated with each

of the clients received from the providers without input from the clients.” (Ex. 2005, 193 (emphasis added).) In response, the Examiner “agree[s] that Metzler does not fully disclose the claim limitation. Metzler does teach that users can set their status and that data can be obtained from the user. As explained above, Metzler also teaches that user interactions can be used to determine the status of a user. However, user interactions are still data that is input from the user, and therefore Metzler does not teach a specific embodiment where data is obtained or a status determined without any user input.” (Ex. 2005, 204; *see also id.* at 209 (“Although Metzler discloses that data can be retrieved based on user interactions, Metzler does not specifically teach that data can be received without input from the users.”), 297 (“Examiner does agree that one substantial difference with Metzler is that Metzler generally teaches that data is received from the user, either explicitly or implicitly.”). Thus, for each of the above reasons, Petitioner’s challenge to claims 1 and 11, and each of their dependent claims, must fail.

For claim 16 and its dependent claims, Petitioner again relied on its failed analysis for claim 1. (Petition, 51 (citing analysis of limitation 11[d], which in turn merely cited the analysis of limitation 1[d] at Petition, 49).) However, for claim 16, Petitioner for the first time gives a nod to the “without input from the clients” claim element, and so alleges that “data entry, being input by the physicians, is without input from the patients.” (Petition, 51.) However, the element in claim 16

does not require data entry without input from the patients. Instead, as discussed, claim 16 recites that “instructions are executed by the processor to: ... **compile data** associated with each of the clients received from the providers utilizing communications devices in communication with the server **without input from the clients** ...” (Claim 16 (emphasis added).) So, while Petitioner’s additional claim 16 allegations show that physician-entered data exists, Petitioner makes no allegations for claim 16 about data compilation, and indeed does not mention any permutation of the word “compile” in its analysis. (*See* Petition, 51.)

Thus, for the data compilation element of the claim, Petitioner relies only on its citation to its claim 11[d] analysis, which relies only upon its claim 1[d] analysis—which, as discussed, not only fails to allege compiling data “without input from the clients,” but also affirmatively relies on compilations of data that Douglas explicitly indicates contain input from the clients. Petitioner’s challenge to claim 16 and its dependent claims therefore fails for the same reasons as its challenges to claims 1 and 11, discussed above.

For each of the above reasons, Petitioner’s challenge must fail as to all Challenged Claims—as all Challenged Claims require compiling data “without input from the clients”—and for all Grounds, since Petitioner relies only on Douglas for this claim element.

2. **Petitioner improperly equates the recited “rules for determining progress of the clients” with the separately-recited “goals,” improperly rendering the phrase “wherein the score is associated with progress toward mastery of one or more goals” meaningless.**

Claims 1 and 16 recite “receiving/receiv[ing] input establishing accounts for providers ..., wherein the input includes **rules for determining progress of the clients**” and further “generat[ing] a score **utilizing the rules**, wherein the **score is associated with** progress toward mastery of **one or more goals**.” (Claims 1, 16 (emphasis added).) Similarly, claim 11 recites “a system for tracking **goal** achievement of individuals, the system comprising: “receiv[ing] input establishing accounts for providers ... and **rules for determining progress of individuals**” and further “generat[ing] a score **utilizing the rules**.” (Claim 11 (emphasis added).)

For all Challenged Claims and all Grounds, Petitioner relies only on Douglas for the “rules” and “goals” claim elements. (Petition, 23-24, 49-51.) Specifically, Petitioner alleges that “Douglas’s goals are rules for determining progress of the clients.” (Petition, 24; *see also* Petition, 32 (alleging that “Douglas does not, however, explicitly disclose generating a score utilizing these **goals—i.e., rules**” (emphasis added)).) Petitioner’s claims 1 and 16 analysis fails for two reasons.

First, claims 1 and 16 each recite both “rules for determining progress of individuals” and “one or more goals.” (Claims 1, 16.) But the Federal Circuit has repeatedly held that “[w]here a claim lists elements separately, as done here, there is ‘a presumption that those components are distinct.’” *Barrday, Inc. v. Lincoln*

Fabrics Inc., No. 2022-1903, 2023 WL 7871688, at *4 (Fed. Cir. Nov. 16, 2023) (quoting *Kyocera Senco Indus. Tools Inc. v. Int’l Trade Comm’n*, 22 F.4th 1369, 1382 (Fed. Cir. 2022)); see *Becton, Dickinson & Co. v. Tyco Healthcare Grp., LP*, 616 F.3d 1249, 1254 (Fed. Cir. 2010) (“Where a claim lists elements separately, ‘the clear implication of the claim language’ is that those elements are ‘distinct component[s]’ of the patented invention.”) (quoting *Gaus v. Conair Corp.*, 363 F.3d 1284, 1288 (Fed. Cir. 2004)). Thus, in contrast to the Petition’s allegations, “Douglas’s goals” cannot be the claimed “rules for determining progress of the clients” because claims 1 and 16 list “goals” and “rules for determining progress of the clients” separately. (Claims 1, 16; see Petition, 24, 32.)

Petitioner has not even addressed this presumption, much less rebutted it, and it is too late to make this argument now. See *Live Power Intelligence Co. NA, LLC v. Genscape Intangible Holding, Inc.*, IPR2019-00169, Paper 7 at 13-14 (PTAB June 7, 2019) (“Our role is not to remedy the deficiencies in Petitions that fall short.”) (citing *Sirona Dental Sys. GmbH v. Institut Straumann AG*, 892 F.3d 1349, 1356 (Fed. Cir. 2018) (because “the petitioner’s contentions, not the Director’s discretion, define the scope, it would thus not be proper for the Board to deviate from the grounds in the petition and raise its own obviousness theory instituting a different inter partes review” (quoting *SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1356–57 (2018) (cleaned up)); *In re Magnum Oil Tools Int’l, Ltd.*, 829

F.3d 1364, 1381 (Fed. Cir. 2016) (IPRs are “a system that is predicated on a petition followed by a trial in which the petitioner bears the burden of proof. Given that framework, we find no support for the PTO’s position that the Board is free to adopt arguments on behalf of petitioners that could have been, but were not, raised by the petitioner during an IPR.”). For this reason, Petitioner has failed to meet its burden of demonstrating that Douglas discloses or suggests “rules for determining progress of the clients” as claims 1 and 16 (and their dependent claims) recite.

Second, Petitioner’s assertion that “Douglas’s goals are rules for determining progress of the clients” is additionally incorrect because it renders a claim term meaningless, violating the Federal Circuit’s repeated pronouncement that “[i]t is highly disfavored to construe terms in a way that renders them void, meaningless, or superfluous.” *Wasica Fin. GmbH v. Continental Auto. Sys., Inc.*, 853 F.3d 1272, 1288 n.10 (Fed. Cir. 2017); *see Bicon, Inc. v. Straumann Co.*, 441 F.3d 945, 950-51 (Fed. Cir. 2006) (refusing to construe claim terms in a way that made other limitations meaningless); *In re Power Integrations, Inc.*, 884 F.3d 1370, 1376 (Fed. Cir. 2018) (reversing “board’s claim construction [because] it renders claim language meaningless.”).

Specifically, claims 1 and 16 recite “generat[ing] a score utilizing the rules, wherein the score is associated with progress toward mastery of one or more goals. (Claims 1, 16.) When the antecedent basis of “the rules” (“rules for determining

progress of the clients”) is inserted into the claim language, and “goals” is substituted for these rules, the second clause of the claims becomes a superfluous tautology:

- generat[ing] a score utilizing the goals for determining progress of the clients, wherein the score is associated with progress toward mastery of one or more goals.”

As shown in the above modified claim language, if “Douglas’s goals are rules for determining progress of the clients” as Petitioner alleges, then the clause “wherein the score is associated with progress toward mastery of one or more goals” is superfluous because if the score is generated utilizing the goals for determining progress of the clients then the score must always be associated with progress toward mastery of one more goals. (Petition, 24.) Put another way, a score generated utilizing progress goals must by definition be associated with those progress goals, rendering the recitation of this association superfluous.

Finally, claim 11 recites “goals” in its preamble and contains the same limitation reciting “**rules for determining progress of individuals**” and further “generat[ing] a score **utilizing the rules**” as in claims 1 and 16 (Claim 11 (emphasis added).) Likewise, Petitioner relies on its claim 1 analysis for this claim element, which again alleges that “Douglas’s goals are rules for determining progress of the clients.” (Petition, 49.) But “because ‘claim terms are normally

used consistently throughout the patent,’ other claims of the patent, both asserted and unasserted, can provide insight into the meaning of a claim term.” *Evolusion Concepts, Inc. v. HOC Events, Inc.*, 22 F.4th 1361, 1365 (Fed. Cir. 2022) (quoting *Phillips v. AWH Corp.*, 415 F.3d 1303, 1314 (Fed. Cir. 2005).) As such, because Douglas’s goals cannot be “rules for determining progress of the clients” in claims 1 and 16, Douglas’s goals also cannot be “rules for determining progress of the clients” as recited in claim 11.

For each of the above reasons, Petitioner’s challenge must fail as to all Challenged Claims—as all Challenged Claims require “rules for determining progress of the clients—and for all Grounds, since Petitioner relies only on Douglas for this claim element.

3. Petitioner fails to provide evidence that any reference automatically communicates to the providers an alert including the compiled data and the status from the server.

Claim limitation 1 recites “**automatically communicating an alert including the compiled data and the status** ... in response to the plurality of measurements of the compiled data varying from the threshold to become significant for one of the clients....” (Claim 1 (emphasis added).) Claim limitation 11 similarly recites “**automatically communicate an alert..., the alert including the compiled data and the status...**in response to the compiled data becoming significant....” (Claim 11 (emphasis added).) The remaining independent Claim

16, at limitation [h], recites “**automatically communicate an alert ... in response to the plurality of measurements of the compiled data varying from the threshold to become significant for one of the clients....**” (Claim 16 (emphasis added).)

Accordingly, each of the above limitations in independent claims 1, 11, and 16 require an alert to be at least (i) automatic in response to compiled data becoming significant or varying from a threshold, and either (ii) have the alert itself include the compiled data and status (as in claims 1 and 11), or (iii) be in response to measurements of compiled data (as in claim 16). Yet Petitioner’s discussion of these limitations with respect to its cited references confirms the absence to these specific elements from such references. (Petition, 36-38, 49, 52.) Petitioner’s analyses regarding these limitations for claims 1, 11, and 16 accordingly fail for the following reasons.

a. Douglas discloses sending an alert automatically only when there is an imminent health risk.

Petitioner cites only to Douglas **automatically** sending an alarm or notification under the condition of a health risk being present—not when the patient’s goals are not being met. (Petition, 36 citing Douglas, 11:11-15.) Douglas only provides a single instance of a health risk prompting an automatic alarm—namely one involving high blood pressure: “For instance, **if a patient’s current blood pressure is potentially dangerous**, the system will automatically send an

alarm to the physician or case advisor and require his or her immediate action.”

(Douglas, 11:15-17 (emphasis added).) In contrast, in the next paragraph of Douglas—when no health risk is at issue and a patient is simply not reaching their weight goals—neither Petitioner nor Douglas makes any mention of any notification or alarm being automatic (i.e., rather than specifically automatically notify, it will “simply” notify):

If the difference between current data and goals does not present a threatening situation, the system will **simply notify** the physician or case advisor that these goals are not being met. For 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, 11:18-21 (emphasis added); *see also* Petition, 36-38.) Recognizing this, Petitioner attempts to expand, in contradiction to the cited references, what can constitute a “health risk.” Douglas directly contrasts “a health risk” such as “a patient’s current blood pressure” that “is potentially dangerous,” with its next paragraph where it explicitly describes a scenario in which a patient’s “goals are not being met”—such as when “a patient has lost 5 pounds instead of 10”—as “not life-threatening.” (*Compare* Douglas, 11:11-17 *with* Douglas, 11:19-22.) Petitioner not only ignores, but contradicts Douglas’s explicit contrast between a “health risk” and “goals not being met” when Petitioner asserts, without citation, that

“health risk can include both ‘threatening situation[s]’ and lesser concerns that ‘goals are not being met.’” (Petition, 36.)

Petitioner then further attempts to improperly, and without basis, expand Douglas’s example of a “health risk” by speculating on the use of MGR analysis. Specifically, Petitioner alleges that at least in certain scenarios, a deviation from an MGR line could potentially lead to a change or revision in a program, and any cause for a change or revision in a program should be considered a “health risk.” (Petition, 37-38.) Not only is this unsupported speculation, but it directly contradicts Douglas, which specifically teaches that even “[i]f the difference between current data and goals not does present a threatening situation ... the physician or case advisor may recommend that the program be modified to suit the patient’s condition.” (Douglas, 11:18-25.) As an example of such a scenario, Douglas cites a situation in which “the current data states that the patient has lost 5 pounds instead of 10.” (*Id.*)

Accordingly, with Douglas teaching limiting automatic alarms and notifications only to “health risks,” Douglas does not disclose the required automatic limitation in response to compiled data more generally becoming significant or varying from a threshold, and so Petitioner’s Challenge fails as to all Claims and for all Grounds.

b. Douglas only discloses alerts relating to current/single data points rather than compiled data.

As discussed above, each of the limitations in claims 1, 11, and 16 require an alert to be based on **compiled data**. Petitioner relies exclusively on Douglas for this limitation. (Petition, 36-37). Yet Douglas reflects only two specific instances of alarms or notifications based on data, and those, as previously discussed, relate to (1) an instance wherein a “patient’s current blood pressure is potentially dangerous,” and (2) “if the current data states that the patient has lost 5 pounds instead of 10.” (Douglas, 11:15-21.) Neither the “current blood pressure” nor the “current data” that a patient has lost 5 rather than 10 pounds constitutes “compiled data” as required in each of the recited claim limitations. For this additional reason, Petitioner’s arguments with respect to these limitations must fail as to all Challenged Claims and Grounds.

c. Claims 1 and 11 specifically require that the alert itself include the compiled data.

As recited above, claims 1 and 11 require that the alert itself contain the compiled data and status that prompted the alert. Petitioner again relies on Douglas to support this limitation, but nothing in Douglas provides such support. Specifically, Petitioner relies on the naked statement in Douglas, that: “For 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, 11:20-21; *see also* Petition, 36-37.) Petitioner’s position fails for at least two reasons.

First, as indicated in the prior section, none of the information cited in these instances constitutes “compiled data.” **Second**, even if it did, Petitioner cites to no disclosure in Douglas teaching that the compiled data itself is sent along with any alarm or notification. (*See* Petition, 36-38.) Douglas’s reference to “the fact” that a patient lost 5 rather than 10 pounds can hardly constitute evidence that specific compiled data accompanied any such alarm or notification. Petitioner cites to the Bergeron declaration, but such declaration should be provided little, if any weight, because it merely restates—without additional support—the Petition’s arguments. (*See*, Petition, 36-38 (citing Bergeron, ¶¶99-103.) *See Xerox Corp. v. Bytemark, Inc.*, IPR2022-00624, Paper 9 at 15 (PTAB Aug. 24, 2022) (Precedential) (denying institution where the expert’s declaration “merely repeats, verbatim, the conclusory assertion for which it is offered to support” and “does not cite to any additional supporting evidence or provide any technical reasoning to support his statement. Thus, the cited declaration testimony is conclusory and unsupported, adds little to the conclusory assertion for which it is offered to support, and is entitled to little weight.”).

For each of the above reasons, Petitioner’s challenge must fail as to all Challenged Claims and for all Grounds.

4. **Petitioner fails to provide evidence that any reference discloses or suggests “assigning 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.”**

The Petition suffers from an additional facial deficiency that cuts across all asserted Grounds: Petitioner cannot show that Douglas discloses “assigning the client to one or more of providers in response to selections from the administrator.” Indeed, Douglas expressly contemplates that a patient has already been seen by his or her physician prior to entry into Douglas’s behavior modification program; there is no assignment of any provider to any patient. For this reason alone, institution should be denied.

- a. **Douglas discloses that patients are subscribed to the disclosed system only *after* they have selected and seen their own physician.**

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, 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).)

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, 26-30.) But none of the portions of Douglas cited by Petitioner show that Douglas discloses that a physician is “assigned” to any client, let alone that such assignment is made “in response to selections from an administrator.”

Indeed, Douglas’s behavior modification program does not teach that a physician or provider is “assigned” to any patient as part of the program. As described by Petitioner, “[a] case administrator subscribes a patient to Douglas’s system based on information contained in the patient prescription form . . . ***which is filled out and signed by the physician.*** . . . An account is created into which the patient can ‘log[] in’ to ‘view their levels of compliance and achievement of goals.’ The patient’s physician then updates that account as the patient progresses through the system, both in terms of the goals and the patient data used to assess goal-achievement.” (Petition, 8 (emphasis added and internal citations and quotations omitted).) Thus, even as characterized by Petitioner, the patient’s subscription into Douglas’s system is done ***after*** the patient has already seen a physician and the physician has filled out a patient prescription form. (*Id.*)

This deficiency in proof is confirmed by a review of Douglas, itself, which 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, 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.*)

In either scenario, the patient has already seen a specific doctor, who is either directly or indirectly responsible for subscribing the patient to Douglas’s program. (Douglas, 6:28-35.) Douglas therefore does not teach “assigning” the client to one or more providers as is required by the Challenged Claims; selection of the physician by the patient happens outside the context of the claimed system. (*See id.*)

b. Douglas’s “case advisor” does not make any “selections” that bear on assignment of a physician to a patient.

Additionally, the “assignment” Petitioner alleges that Douglas discloses could not be done “in response to selections from the administrator” as the Challenged Claims recite (Ex. 1001, claims 1, 11, 16.) This is because Douglas discloses that, *after* a physician performs a diagnosis, recommends treatment, and

chooses to subscribe a patient into the claimed system, the physician fills out a prescription form and sends to the “case advisor,” who then “sets the patient up on the system.” (Douglas, 6:28-35.) The case advisor does this “based on information contained in the patient prescription form or accesses the records of existing patients through patient files 40.” (*Id.*, 7:11-16.)

“Once the physician or case administrator enters the patient into the system, either the system or case advisor recommends a default set of goals based on the patient’s needs and existing medical protocols that may be modified by the physician.” (*Id.*, 7:17-20.) The case advisor can also generate a set of goals or milestones for the patient “based on the input information.” (*Id.*, 8:1-9.) Douglas also discloses various aspects of monitoring and information access that are made available to the case advisor (and physician) via the claimed system. (*See id.*, 9:9-11:10 (describing various tools to monitor patient compliance accessible to the physician and case advisor).)

However, none of Douglas’s disclosures relating to the case advisor satisfy the claims’ requirement that an “assign[ment]” to one or more providers be done “in response to selections from the administrator.” (Ex. 1001, claim 1.) Any “selections” made by Douglas’s case advisor relate to a treatment plan, not assignment to any provider under a plain and ordinary meaning of the claim. (Douglas, 7:11-16.)

In an attempt to shoehorn the disclosures of Douglas into the confines of the claim language, Petitioner argues that “Douglas further discloses that such assigning of clients to providers is in response to selections from the administrator utilizing a communications device, as the case/network administrator sets up a patient on Douglas’s system using a PC, where the entered information from the patient prescription form includes associating the patient with a physician.”

(Petition, 26.) But this ignores the claims’ express requirement that the “assignment” of the provider be done “*in response to* selections from the administrator.” Even if the case advisor’s entry of the treating physician’s name in the system could be fairly characterized as “assignment” to a “provider,” it is not done “in response” to any “selection[] from the administrator”—it merely reflects that a particular provider has already seen and begun treating the patient.

Petitioner’s proof fails.

c. Petitioner’s obviousness arguments are unavailing.

Petitioner also argues that it would have been obvious for the case administrator to assign the patients to the physicians because “such assignments had to be created to achieve the functionality of Douglas’s system.” (Petition, 27.) But this is false. Douglas’s system envisions that, before any patient is entered into the system—either manually by the physician or by the case advisor using a prescription form—such patient will have already selected and/or seen a particular

physician to begin receiving treatment. (Douglas, 6:28-35, 7:11-16.) For a case advisor to subsequently “assign” such patient to any physician would be nonsensical, unnecessary, and would frustrate the express purpose of “allow[ing] immediate patient access to the behavior modification program.” (*Id.*, 2:29-32.) *Plas-Pak Indus., Inc. v. Sulzer Mixpac AG*, 600 F. App’x 755, 758 (Fed. Cir. 2015) (“[C]ombinations that change the ‘basic principles under which the [prior art] was designed to operate’. . . or that render the prior art ‘inoperable for its intended purpose’. . . may fail to support a conclusion of obviousness.” (quoting *In re Ratti*, 46 CCPA 976, 270 F.2d 810, 813 (1959), *In re Gordon*, 733 F.2d 900, 902 (Fed. Cir. 1984))).

Petitioner alternatively argues that “Douglas also renders obvious the assignment by the administrator of the patients to the physicians through selections of graphical user interface (‘GUI’) components.” (Petition, 27.) Pointing to certain GUI components disclosed in Douglas (e.g., check boxes, drop-down menus), Petitioner contends that it would have been obvious for an administrator to use Douglas’s GUI components to assign the patient to the physician. (*Id.*, 28-30.)

First, and as noted above, even if the case advisor’s selection of the treating physician’s name in the system (using GUI components or otherwise) could constitute “assignment” to a “provider” under a plain and ordinary meaning of that term, it would not be done “in response” to any “selection[] from the

administrator.” *See supra*, Sections VIII.4.a. and VIII.4.b. Moreover, Douglas’s inclusion of well-known GUI components such as check boxes, buttons, and drop-down menus does not establish the requisite motivation to fundamentally alter the operation of Douglas’s system. Douglas does not identify any need or justification for a case advisor, which Douglas describes as a “nurse trained *in the protocols of the system’s software*,” to assign physicians to patients. (Douglas, 3:11-13 (emphasis added).)

Conversely, the ’812 patent expressly describes the administrator as someone with authority to “manage their team of service providers . . . who work directly with clients . . . to administer information and data, such as goals and objectives. . . The provider administrators . . . may have complete access to the service providers . . . and the clients . . . to assign the clients . . . to individual service providers . . . through the user interface.” (Ex. 1001, 10:58-64.) These are fundamentally distinct functions, and Petitioner cannot rely on the blueprint drawn by the inventor, beginning the analysis at the claimed invention and matching it to the prior art, to establish obviousness. *Interconnect Planning Corp. v. Feil*, 774 F.2d 1132, 1138 (Fed. Cir. 1985) (“The invention must be viewed not with the blueprint drawn by the inventor, but in the state of the art that existed at the time.”).

d. Petitioner cannot cure Douglas’s deficiencies via Wager.

For Ground 2, Petitioner alleges that it would have been obvious to a POSITA to modify Douglas’s system to reflect Wager’s interface, which Petitioner alleges discloses “an intuitive, visual interface for generating patient-to-care provider assignments, including capacity computation, skill set matching, [and] ratio management.” (Petition, 54-57.) For the reasons disclosed *infra*, a POSITA would not have been motivated to combine Douglas and Wager. Thus, Wager cannot fill Douglas’s gap, and institution should be denied.¹

e. A POSA would not have been motivated to combine Douglas with Wager.

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, 57.) Not so.

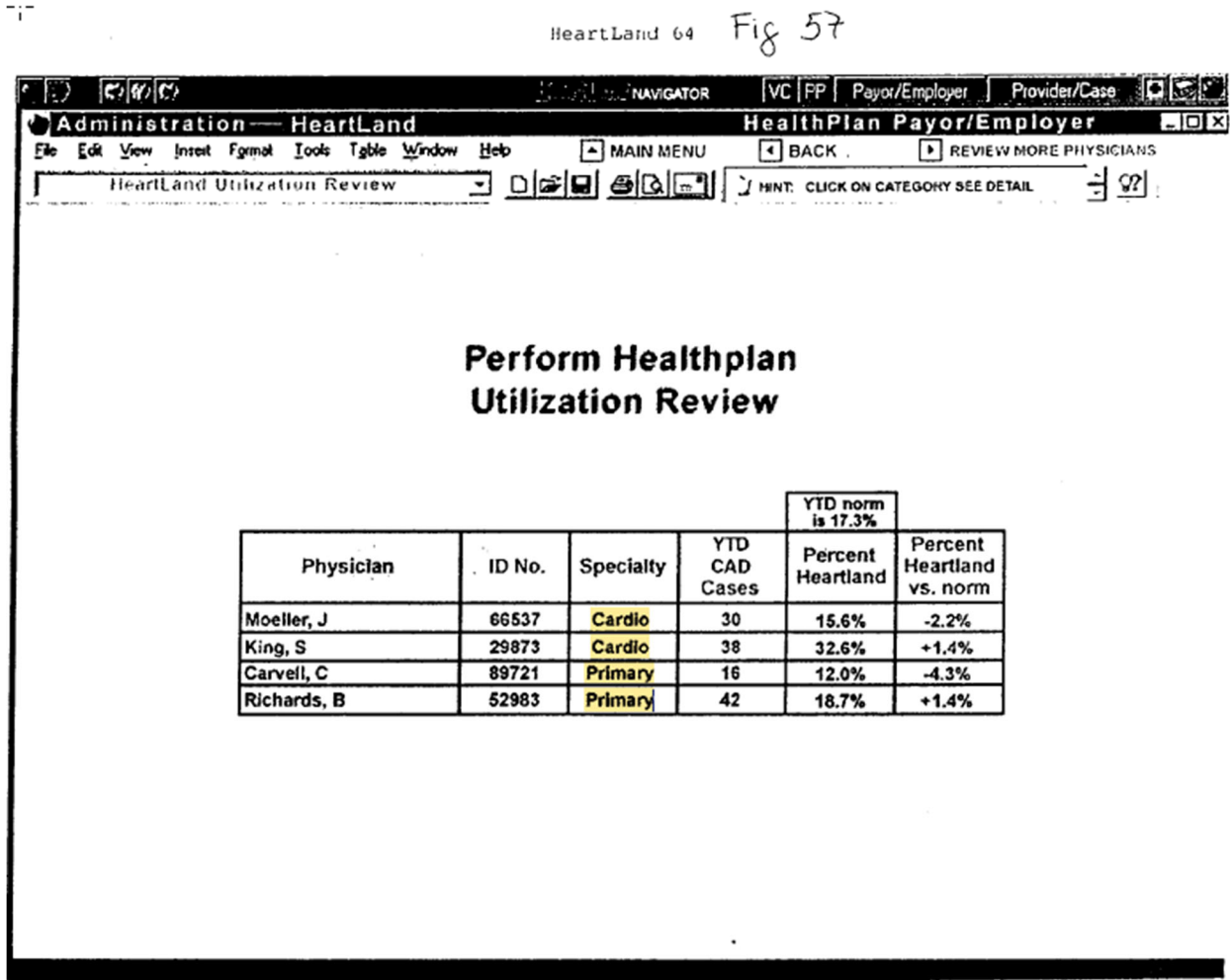
First, as discussed in Section VIII.4.a., above, Douglas’s system does not require Wager’s system “through which the administrator assigned a patient to a

¹ Petitioner does not rely on references other than Douglas or Wager for this claim limitation. (Petition, 54-59.)

physician” because in Douglas, patients are subscribed to the system only after they have selected and seen their own physician. (See Douglas, 6:28-35; Petition, 8.) Thus, 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. See *BMW of North America, LLC v. Carrum Techs., LLC*, IPR2019-00904, Paper 10 at 14 (PTAB Oct. 18, 2019) (no motivation to combine because when “[one prior art reference] discloses methods for identifying when a vehicle has entered a curve..., it is not evident why [a POSA] would have looked to [a second prior art reference] to obtain additional methods of determining curve entry.”); *Winner Int’l Royalty Corp. v. Wang*, 202 F.3d 1340, 1349-50 (Fed. Cir. 2000) (affirming nonobviousness where “there was no apparent disadvantage” to the prior art mechanism); *Apple Inc. v. Uniloc Luxembourg S.A.*, IPR2017-02041, Paper 10 at 24-25 (PTAB Mar. 8, 2018) (declining to institute IPR because “Petitioner, however, fails to articulate or show sufficiently why achieving a Passwordable ID with uniqueness to a device and user would be necessary or helpful to Schull’s system. For instance, Petitioner does not address whether Schull’s existing methods of generating a Passwordable ID already attain such uniqueness.” (citation omitted)).

Second, Petitioner points to Douglas’s Figure 57 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, 58.) But this actually demonstrates why a POSA would *not* modify Douglas’s system with Wager’s interface, through which “such capacity issues ‘may be more effectively managed.’” (Petition, 58.)



(Douglas, Figure 57 (annotated).) Indeed, as shown in Douglas’s Figure 57, copied above, the four doctors listed consist of two cardiologists and two primary physicians. In order to make these patients “evenly distributed amongst physicians” as Petitioner argues would be the benefit of a combined Douglas-

Wager System, patients assigned to a cardiologist would have to be reassigned to a primary care physician. It should go without saying that this sort of redistribution is almost certain to be detrimental to the care of the patients who were under the care of a cardiologist—who subscribed them to Douglas’s system—and so should continue being seen by their cardiologist until that cardiologist—not an administrator attempting to “evenly distribute patients” believes that such care by a specialist is no longer necessary.

Third, even if Petitioner were to argue that redistribution would only be from physicians within the same specialty, it is safe to assume that patients would not agree to participate in Douglas’s system if doing so meant that they were going to be unassigned from their own primary care physician who subscribed them to Douglas’s system in the first place—and reassigned to the least popular primary care physician simply because that physician had the fewest numbers of patients subscribed to the system. (*See, e.g.*, Ex. 2002, 1 (“Relationship continuity (a sustained relationship with a specific GP) has been a core feature of primary care, is popular with patients and practitioners, and is associated with better patient outcomes.”) (citing Ex. 2003, 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.”).

Even worse, Douglas is specifically directed to “an ongoing support program ... for patients who have undergone surgery and must make subsequent lifestyle changes . . .” (Douglas, 1:29-31). It is absurd to think that a patient who has undergone surgery would want to change post-surgery care providers just because the proposed Douglas-Wager system found a provider with fewer patients. *See KSR Int’l Co. v. Teleflex Inc.*, 550 U.S. 398, 421 (2007) (“Rigid preventative rules that deny factfinders recourse to common sense, however, are neither necessary under our case law nor consistent with it.”). 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, 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...”).)

Fourth, because, as described above, it is a patient’s physician in Douglas who subscribes their patients to Douglas’s system, a POSA would certainly understand that a physician would be unlikely to assign their patients to the combined Douglas-Wager system if this meant that an administrator would then reassign their patient to another physician who had fewer patients. Indeed, common sense dictates that most professionals refer their patients and clients to others only when necessary, and not merely because the other professional has been less successful at acquiring their own patients through more traditional means. *See KSR*, 550 U.S. at 421.

Fifth, the reason that combining Wager’s system with Douglas results in the absurd scenarios above 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, [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 ...”).)

By contrast, Douglas teaches away from Wager by teaching against accomplishing its goals in an in-person setting like the one to which Wager is directed. (Douglas, 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, 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.*”) (emphasis added)). See *Depuy Spine, Inc. v. Medtronic Sofamor Danek, Inc.*, 567 F.3d 1314, 1327 (Fed. Cir. 2009) (“A reference may be said to teach away when a [POSA], 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.”) (quotation omitted) (affirming non-obviousness).

Finally, a POSA would understand that, if the proposed Douglas-Wager system were to assign the patient to a different physician than the one that subscribed the patient to the system, the patient’s continuity of care would likely suffer due to the fact that, in 2013, most electronic health records (EHR) were not interoperable. (Ex. 2004 at 28 (“Unfortunately, most EHRs, medical devices, and other IT systems are not interoperable—that is, they do not have the functional ability to ‘work with other systems or products without special effort on the part of

the customer.”).) Indeed, even by 2017, “fewer than one in three hospitals [was] able to electronically find, send, receive, and integrate patient information from another provider.” (*Id.*) Thus, “[w]hen patients experience a care transition such as discharges or referrals, most providers still rely on paper or fax to some extent when sending a care summary, potentially creating fragmentation in care coordination.” (*Id.*) In fact, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009’s “stage 2 Meaningful Use program, which began in 2014, required hospitals to send the care record summaries electronically to the subsequent provider for a minimum of 10 percent of care transitions” only. (*Id.*) Thus, requiring a care transition to a new physician, as Petitioner’s proposed Douglas-Wager combination envisions would not “increas[e] quality of care for the patient” as Petitioner alleges, but would likely decrease this quality of care through the inefficiencies caused by lack of interoperability of patient records and the loss of “trust that builds up through relationship continuity.” (Petition, 58; Ex. 2003, 12.)

For each of these reasons, a POSA would not have been motivated to combine Douglas and Wager in the manner that the Petition alleges, and so the Petition’s challenge additionally fails.

IX. CONCLUSION

For the reasons discussed above, Petitioner fails to meet its burden of demonstrating a reasonable likelihood that claims 1-7, 9-14, 16-18, and 20 are invalid. Therefore, Patent Owner respectfully requests the Board deny Petitioner's request for *Inter Partes* Review of U.S. Patent No. 10,061,812.

Dated: June 27, 2024

Respectfully Submitted,

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CERTIFICATE OF WORD COUNT

Under the provisions of 37 CFR § 42.24(d), the undersigned hereby certifies that the Microsoft Office word count for the foregoing Patent Owner's Preliminary Response Under 35 U.S.C. § 313 and 37 C.F.R. § 42.107, excluding the table of contents, table of authorities, certificate of word count, and certificate of service, totals 10,040 words, which is less than the 14,000 words allowed under 37 C.F.R. § 42.24(b)(1).

Dated: June 27, 2024

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CERTIFICATE OF SERVICE

Pursuant to 37 C.F.R. § 42.6(e), I certify that I caused to be served on the counsel for Petitioner a true and correct copy of the foregoing Patent Owner's Preliminary Response Under 35 U.S.C. § 313 and 37 C.F.R. § 42.107, by electronic means on June 27, 2024 at the following addresses of record:

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