

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 IPR2026-00390
Patent 11,675,791 B2

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

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PETITIONER'S EXHIBIT LIST

Exhibit	Shorthand	Description
1001	'791 Patent	U.S. Patent No. 11,675,791 B2
1002	Douglas	Pub. No. WO 1999/003045 A1
1003		Omitted
1004	Chitiveli	Pub. No. US 2013/0179450 A1
1005		Omitted
1006		Omitted
1007		Omitted
1008	ArchiveDec	Declaration of Nathaniel E Frank-White
1009	Koh	Hian Chye Koh & Gerald Tan, <u>Data Mining Applications in Healthcare</u> , 19 J. Healthcare Information Management 64 (2005)
1010	KohArchive	Printout of: https://web.archive.org/web/20050418095732/http://www.himss.org/ASP/publications_jhim_issue.asp?issue=3/30/2005 , evidencing 2005 public availability of Koh
1011	Hall-Ellis	Declaration of Sylvia D. Hall-Ellis, Ph.D.
1012	Bergeron	Declaration of Bryan Bergeron, M.D.
1013	BergeronCV	Curriculum Vitae of Bryan Bergeron, M.D.
1014	Microsoft	<u>Microsoft Computer Dictionary</u> (5th ed. 2002)
1015		Omitted
1016		Omitted
1017		Omitted
1018	NetSuite	Printout of https://web.archive.org/web/20111102042326/https://www.netsuite.co.uk/portal/uk/resource/articles/cloud-computing.shtml
1019		Omitted
1020		Omitted
1021		Omitted
1022	Virginia	<u>Autism Spectrum Disorders and the Transition to Adulthood</u> , VA Dep't of Educ. (2010)
1023	VirginiaArchive	Printout of https://web.archive.org/web/20111208001834/http://www.doe.virginia.gov/special_ed/disabilities/

Exhibit	Shorthand	Description
		autism/index.shtml, evidencing 2011 public availability of Virginia
1024	Khanuja	Pub. No. US 2004/0102683 A1
1025	'616FWD	Final Written Decision in IPR2024-00616 for U.S. Patent No. 11,144,554 B2
1026	'617FWD	Final Written Decision in IPR2024-00617 for U.S. Patent No. 11,151,142 B2

Claim Listing

Claim	Limitation No.	Limitation
1	1[p]	A method for tracking progression toward a customized goal, comprising:
	1[a]	receiving input establishing accounts for clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;
	1[b]	assigning each of the clients to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least a communications device;
	1[c]	establishing customized goals for each of the clients based on treatment or assistance required;
	1[d]	receiving data associated with each of the clients from a biometric device via the communication device;
	1[e]	compiling data associated with each of the clients;
	1[f]	determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and
	1[g]	automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.
2	2	The method of claim 1, wherein the one or more providers further include individuals available to treat or assist the clients.

Claim	Limitation No.	Limitation
3	3	The method of claim 1, further comprising: intervening in response to communicating the alerts to at least the one or more providers or caregivers associated with the one or more of the clients.
4	4	The method of claim 3, wherein the one or more providers physically intervene to treat or assist the one or more of the clients.
5	5	The method of claim 1, wherein the customized goals, data, compiled data, thresholds, and alerts are saved in the server.
6	6	The method of claim 1, wherein the one or more providers include biometric sensors worn by or proximate to the clients.
7	7	The method of claim 1, wherein the compiled data indicates the behavior of the clients, and wherein the one or more thresholds include a range.
8	8	The method of claim 1, wherein the server is accessed through a cloud network, and wherein a client management program is executed by communications devices utilized by the one or more providers to input the data.
9	9	The method of claim 1, further comprising: establishing the customized goals in response to input from each of the clients and the one or more providers associated with each of the clients.
10	10[a]	The method according to claim 1, further comprising: data mining the compiled data to determine best practices; and
	10[b]	recommending the best practices in response to the best practices being associated with one of the clients.
11	11[p]	A system for tracking progression toward a customized goal, the system comprising:

Claim	Limitation No.	Limitation
	11[a]	a server communicates with communications devices through a transceiver utilizing one or more networks, the server includes a processor that executes a client management program to:
	11[b]	receive input establishing an account for a client, wherein the client is an individual receiving treatment or assistance, and wherein the accounts are stored in a server available through the one or more networks;
	11[c]	assign the client to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least one of the communications devices;
	11[d]	establish customized goals for the client based on treatment or assistance required;
	11[e]	receive data associated with the client from a biometric device via the communications device;
	11[f]	compile the data associated with the client received from the communications devices in communication with the server;
	11[g]	determine whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for the client; and
	11[h]	automatically communicate alerts to at least perform a review of the treatment and assistance in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the client; and
	11[i]	a database in communication with the server configured to store the data, customized goals, compiled data, and thresholds associated with the client in the account.

Claim	Limitation No.	Limitation
12	12	The system of claim 11, wherein the one or more providers further include individuals available to treat or assist the client.
13	13	The system of claim 11, wherein the threshold is a customized range established for the client.
14	14	The system of claim 11, wherein the one or more providers or caregivers associated with the client physically intervene in response to the alerts.
15	15	The system of claim 11, wherein the database is a relational database management system performing data mining to analyze the data to automatically associate best practices with the client.
16	16[p]	A server comprising:
	16[a]	a processor for executing a set of instructions; and
	16[b]	a memory for storing the set of instructions, wherein the set of instructions are executed by the processor to:
	16[c]	receive input establishing accounts for clients, wherein the clients are individuals receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks;
	16[d]	assign each of the clients to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least a communications device;
	16[e]	establish customized goals for each of the clients based on treatment or assistance required;
	16[f]	compile data associated with each of the clients received from a biometric device via the communications device;

Claim	Limitation No.	Limitation
	16[g]	determine whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and
	16[h]	automatically communicate alerts to at least the one or more providers to at least perform a review of the goals, treatment, and assistance for the one or more of the clients in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.
17	17	The server of claim 16, wherein the one or more providers include individuals available to treat or assist the clients and the one or more providers include biometric sensors worn by or proximate to the clients.
18	18	The server of claim 16, wherein the one or more providers physically intervene with the one or more clients in response to the alerts.
19	19	The server of claim 16, wherein the compiled data indicates the behavior of the clients.
20	20	The server of claim 16, wherein the set of instructions are further executed to: recommend best practices in response to historic success with one or more of the clients.

I. INTRODUCTION

The '791 Patent is directed to a system for tracking a client's progress toward goals. In particular, the system establishes customized goals for a client, receives data from a biometric device, compiles data associated with the client to determine whether the client is progressing toward the goals, and alerts the client's provider based on the progress. The '791 Patent asserts that, because it implements this system using communication devices and a server, it constitutes an improvement over pre-existing paper- or local-computer-based goal-tracking systems.

Such a system, however, was known as early as 1999. For example, Douglas discloses an internet-accessible system implemented on a server that likewise establishes customized goals for a client, collects data from a biometric device to determine the client's progress toward the goals, and alerts the client's provider accordingly.

In fact, Douglas formed the basis of two prior IPRs with final written decisions for patents that are in the same family as the '791 Patent and have claims similar to those at issue here. The Board found that nearly all of the challenged claims in those family members were invalid based on Douglas alone or Douglas in combination with other prior art. The same situation applies here, where Douglas alone or Douglas in combination with other prior art invalidates all claims of the '791 Patent.

II. MANDATORY NOTICES

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

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

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

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

1. U.S. Patent No. 11,151,142 B2 (the “’142 Patent”), of which the ’791 Patent is a continuation;
2. U.S. Patent No. 10,061,812 B2 (the “’812 Patent”), of which the ’142 Patent is a continuation;
3. U.S. Patent No. 11,144,554 B2 (the “’554 Patent”), which is a continuation in-part of the ’142 Patent;
4. U.S. Patent No. 11,809,431 B2 (the “’431 Patent”), which is a continuation of the ’554 Patent;
5. Pending U.S. Patent App. No. 17/499,725, which is a continuation of the ’554 Patent;
6. Pending U.S. Patent App. No. 18/502,813, which is a continuation of the ’554 Patent;
7. *Data Health Partners, Inc. v. Teladoc Health, Inc.*, 1-23-cv-00160-JCG (D. Del.), in which the ’554, ’142, ’791, and ’431 Patents are asserted;

8. IPR2024-00616 for U.S. Patent No. 11,144,554 B2 (the “’616 IPR”);
and
9. IPR2024-00617 for U.S. Patent No. 11,151,142 B2 (the “’617 IPR”).

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

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D. Service Information (37 C.F.R. § 42.8(b)(4))

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

III. GROUNDS FOR STANDING

Petitioner certifies that the ’791 Patent is available for IPR, and Petitioner is not barred or estopped from requesting an IPR on the grounds identified herein. The ’791 Patent has not been subject to a previous FWD in an estoppel-based AIA proceeding.

IV. STATEMENT OF PRECISE RELIEF REQUESTED

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

Petitioner requests review and cancellation of Claims 1-20 (the “Challenged Claims”) of the ’791 Patent.

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

Ground	Basis	Reference(s)	Challenged Claims
1	§ 103	Douglas	1-7, 9, 11-14, and 16-19
2	§ 103	Douglas and Khanuja	1-7, 9, 11-14, and 16-19
3	§ 103	Douglas and Virginia	1-7, 9, 11-14, and 16-19
4	§ 103	Douglas and Chitiveli	8
5	§ 103	Douglas, Khanuja, and Chitiveli	8
6	§ 103	Douglas, Virginia, and Chitiveli	8
7	§ 103	Douglas and Koh	10, 15, and 20
8	§ 103	Douglas, Khanuja, and Koh	10, 15, and 20
9	§ 103	Douglas, Virginia, and Koh	10, 15, and 20

Published on January 21, 1999, Douglas (Ex. 1002) is prior art under § 102(b). In the ’616 IPR and ’617 IPR, Patent Owner did not challenge that Douglas is prior art to the ’554 and ’142 Patents.

Published on May 27, 2004, Khanuja (Ex. 1024) is prior art under § 102(b).

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

Published in October 2010, Virginia (Ex. 1022) is prior art under § 102(b). Virginia's 2010 publication is first evidenced by its "2010" copyright date. Virginia at 74. Further, Virginia was archived by the Internet Archive in 2011. ArchiveDec at ¶1, 5-6. Additionally, a Virginia Department of Education webpage archived by the Internet Archive in 2011 includes a hyperlink in the form of a picture of the front page and the title of Virginia. VirginiaArchive; ArchiveDec at ¶1, 5-6. In the '617 IPR, Patent Owner did not challenge that Virginia is prior art to the '142 Patent.

Filed on January 11, 2012, Chitiveli (Ex. 1004) is prior art under § 102(e). In the '616 IPR and '617 IPR, Patent Owner did not challenge that Chitiveli is prior art.²

Published in 2005, Koh (Ex. 1009) is prior art under § 102(b). Koh's 2005 publication is evidenced by Dr. Hall-Ellis's testimony that Koh was publicly available on or shortly after April 30, 2005. Hall-Ellis at ¶¶45-52. That testimony is based on: (1) Koh's MARC record from the Albin O. Kuhn Library & Gallery

² Patent Owner did assert that Chitiveli is not available as prior art under 35 U.S.C. § 311(b) in both the '616 IPR and '617 IPR, but the Board "agree[d] with Petitioner that Patent Owner's argument is foreclosed by our reviewing court's decision in *Lynk Labs, Inc. v. Samsung Elecs. Co.*, 125 F.4th 1120[, 1132] (Fed. Cir. 2025)." '616FWD at FN6.

indicating that the Library has received Koh's journal since 1998 and that Koh's journal was descriptively catalogued (*id.* at ¶¶46-48, 19, Attachments 2A-2C and 1D); and (2) Koh's MARC record from the Library of Congress that was created on April 22, 1977, indicating that the journal is a quarterly publication with subject matter descriptively classified and is currently available from 30 libraries (*id.* at ¶¶49-52, Attachments 2B-2E and 1D).

Koh's 2005 publication is further evidenced by KohArchive, which is a 2005-archived version of a Healthcare Information and Management Systems Society webpage (ArchiveDec at 1, 18) that includes the contents of the Journal of Healthcare Information Management (KohArchive at 1) in which Koh was published and lists Koh along with its authors and a truncated abstract. *Compare* Koh at cover with KohArchive at 1-2. In the '616 IPR and '617 IPR, Patent Owner did not challenge that Koh is prior art.

V. LEVEL OF ORDINARY SKILL IN THE ART

A POSITA as of March 15, 2013³—the '791 Patent's earliest claimed priority date—would have had at least a bachelor's degree in a healthcare field as well as 1-

³ All statements in this Petition about the knowledge and skills of, and what would have been obvious to, a POSITA are offered from this perspective as of this date. Bergeron at ¶37.

2 years of experience with health information technology, including specific experience with computer-based systems for recording, tracking, and analyzing patient health information. Bergeron at ¶36. In the '616 IPR and the '617 IPR, this definition of a POSITA was not challenged by Patent Owner and was adopted by the Board. '616FWD at 7-8; '617FWD at 7.

VI. THE '791 PATENT

As the '791 Patent explains, “[t]he ability of organizations, hospitals, schools, businesses, individuals, and others to meet goals is, and always will be, a significant challenge,” so “it is important to recognize and treat problems and issues that prevent goals and other objectives from being achieved.” '791 Patent at 1:15-19. With respect to helping individuals meet their goals, the '791 Patent recognizes that “organizations and institutions ... have improved their processes in recent years.” *Id.* at 1:19-26. Such “[i]mproved assessment, medications, training, treatment processes, and education[] have provided solutions for addressing the concerns of individuals with special needs.” *Id.* at 1:26-29.

The problem, per the '791 Patent, is that “electronic systems, equipment, software, and processes for tracking, treating, and recording results ... have not improved as significantly.” *Id.* at 1:30-33. “For example, some organizations still use paper documents and charts to track individuals’ information or a single computing system available from only one location to enter and review data.” *Id.* at

1:33-36. With such systems, “viewing, updating, managing, and sharing[] relevant information may be more difficult than it should be.” *Id.* at 1:36-38.

To address this problem, the ’791 Patent discloses a method, system, and server to create customized goals for a client, receive data from a biometric device, compile data associated with the client to determine whether the customized goals are being met, and alert the client’s provider to review the goals in response to consecutive data points of the compiled data varying from one or more thresholds to become significant. *Id.* at 8:38-52; claims 1, 11, and 16.

VII. CLAIM CONSTRUCTION

In the ’616FWD and ’617FWD, the Board construed the term “assigning . . . in response to selections” which also appears in the ’791 Patent as follows:

’616FWD Claim Term	’617FWD Claim Term	’791 Patent
1[b] “assigning the client to one or more of providers in response to selections from the administrator”	1[c] “assigning each of the clients to one or more of the providers in response to selections from an administrator”	1[b] “assigning each of the clients to one or more of providers in response to selections from an administrator”

Specifically, the Board construed “‘selection’ as including inputs to a user interface, thereby ‘assigning’ a client to a provider within the system” and “that assigning and selection must be distinct elements, because they are separately listed, and assigning happens in response to selection(s).” ’616FWD at 11-12; ’617FWD at 8-10.

These constructions from the '616FWD and '617FWD will be discussed below. Beyond this term in the '791 Patent, none of the claim terms of the Challenged Claims require an explicit construction to resolve the current grounds.

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

A. Ground 1 – Douglas Renders Obvious Claims 1-7, 9, 11-14, and 16-19

1. *Douglas Overview*

Douglas is directed to “[a] therapeutic behavior modification program, compliance monitoring and feedback system” that “enables development of a therapeutic behavior modification program having a series of milestones for an individual to achieve lifestyle changes necessary to maintain his or her health.” Douglas at Abstract, 1:8-10, 2:5-9; Bergeron at ¶39.

In Douglas’s system, a patient—ranging from one having “coronary artery disease” to one “who simply want[s] to maintain their health”—is subscribed to the system. Douglas at 6:6-14; Bergeron at ¶40. The patient’s subscription can be performed by an administrator, who “enter[s]” “baseline vital factors” “based on information contained in the patient prescription form” (Douglas at 6:33-7:20, FIG. 60), which is filled out and signed by the patient’s physician (*id.* at FIG. 2). Bergeron at ¶40. An account is created as part of that process into which the patient can “log in” to “view their levels of compliance and achievement of goals” (Douglas at 8:29-31, 12:3-7), and the patient’s physician updates the account as the patient progresses

through the system, both in terms of the goals and the patient data used to assess achievement of those goals (*id.* at 3:13-14, 11:1-5, 11:26-28). Bergeron at ¶40.

“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 by the physician.” Douglas at 7:17-8:13; Bergeron at ¶41. Exemplary goals set by Douglas’s system include everything from “intake of calories from fat” to “Seatbelt Use.” Douglas at 8:1-13, FIG. 6; Bergeron at ¶41. Those goals also include interim steps—“one month goals 61”—toward the “final goals 62.” Douglas at 8:10-13; FIG. 6; Bergeron at ¶41.

Douglas’s system then periodically receives updated patient data, including from a biometric device (Douglas at 11:1-5, FIG. 60), to determine the “patient’s progress and compliance with the program” (*id.* at 11:26-28). Bergeron at ¶42. For example, Douglas’s “system might also prompt the patient to input his or her vital signs 102, such as blood pressure and heart rate... .” *Id.* at 10:10-19, 2:32-36; FIG. 13. “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.” *Id.* If the updated patient data shows that the patient is not meeting their goals, the system “notif[ies] the physician,” who “may contact the patient in order to support and to further motivate” the patient or “recommend that

the program be modified to suit the patient's condition.” Douglas at 11:18-25; Bergeron at ¶42.

Douglas's system is implemented on a “network server 508” including “relational databases 522 ... that contain all the health plan data” and, more generally, “[a]ll the information needed by a user of the system.” Douglas at 24:12-34, FIG. 59; Bergeron at ¶43. The system is accessible by “patients, physicians,” and other users, for example, “via the Internet 518” and using “a PC 500.” Douglas at 24:3-26, FIG. 59; Bergeron at ¶43.

2. Claim 1

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

The preamble of claim 1 merely recites an intended use and is therefore not entitled to patentable weight. To the extent the preamble is found limiting, Douglas discloses a method for tracking progression toward a customized goal. For example, “a physician prescribes ... goals for a [sic] such a therapeutic behavior modification program to help a patient recover from an ailment or surgical procedure... The system ... helps monitor compliance with the program... .” Douglas at 2:25-32; Bergeron at ¶44; *see also* Douglas at Abstract, 6:24-32, 8:1-9, 11:7-10, 11:18-12:2, 20:14-19, 20:29-30, FIG. 7.

In the '616FWD and '617FWD, the Board found that Douglas discloses “[a] method for tracking goal progression.” '616FWD at 14; '617FWD at 13.

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

Douglas discloses receiving input establishing accounts for clients. In Douglas's method, "the case administrator sets up a new patient based on information contained in the patient prescription form" (Douglas at 6:36-7:20), which involves the administrator "enter[ing] the patient into the system" (*id.*) and entering patient information online (*id.* at FIG. 60), each of which constitutes input. Bergeron at ¶45. The patient prescription form is illustrated in Douglas FIG. 2 (reproduced below):

Fig 2

22 ~ **HeartLand Prescription Form**

23

Patient Name	Patient ID	Date	Physician Name	Physician ID

1. Fill in diagnosis:

Patient Diagnosis	Co-morbid Diagnosis

2. Circle a diagnostic category:

24 ~

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

3. Please circle as appropriate:

30 ~

Does the patient need smoking cessation?	Yes	No
Have you prescribed nicotine patch or gum?	Yes	No
Does the patient need weight reduction?	Yes	No

If yes, target weight: _____

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

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

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

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

Physician's Signature: _____ Telephone: _____

FAX THIS FORM TO SALUS MEDIA: (805) 969-3601

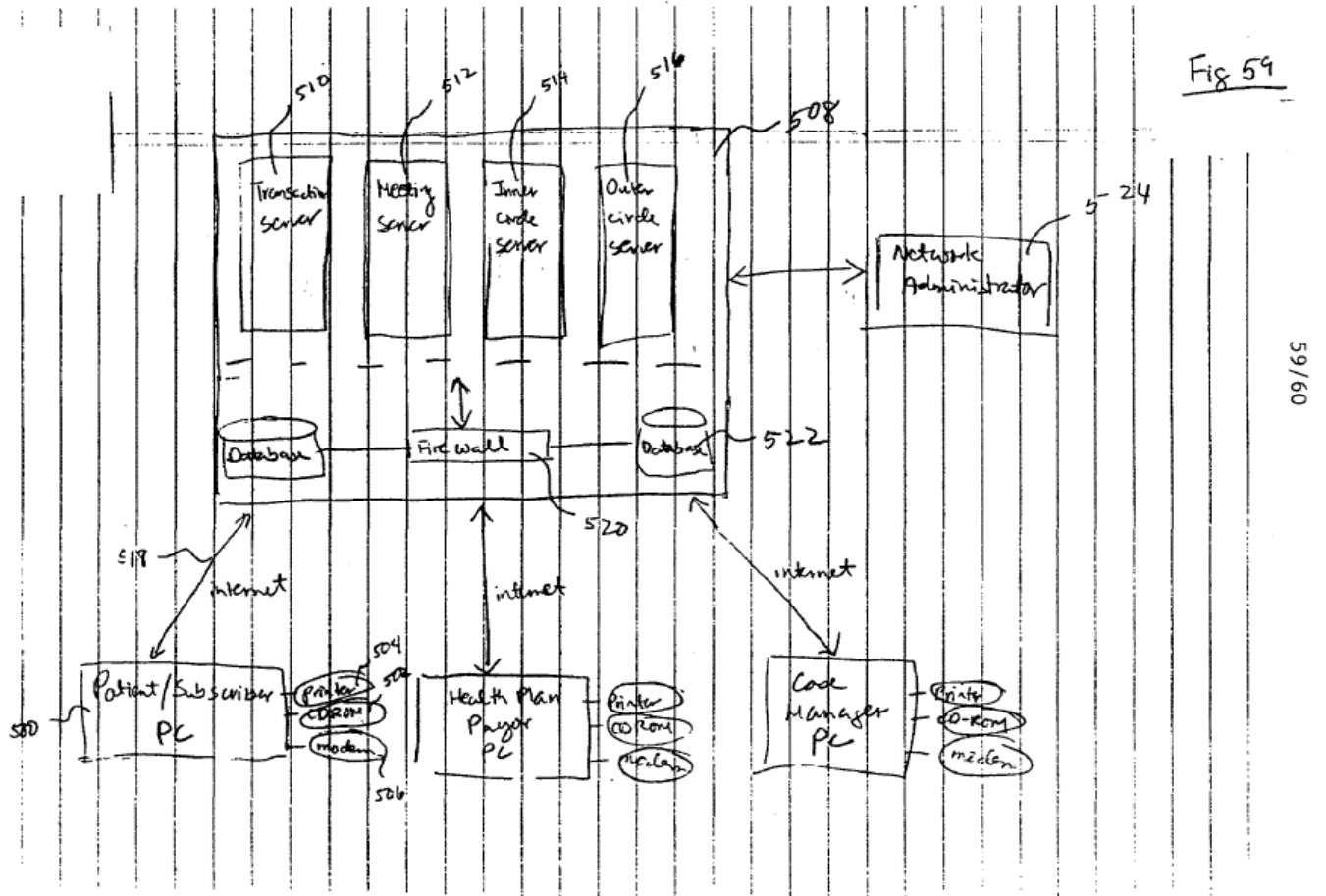
You will receive Fax confirmation within 24 Hours. For Assistance please call: (805) 969-2234

Douglas FIG. 2

Douglas discloses that such input is for establishing an account for a client, as Douglas explains that “[o]nce the patient is set up on the system, it assists him or her

in complying with his or her behavior modification program,” and “[t]o use the program, the patient logs into the system network” (Douglas at 8:28-31) using a “user id and password” (*id.* at 25:5-10, FIG. 36)—i.e., the patient logs into an account established for the patient. Bergeron at ¶46. Douglas’s patient is the claimed client. *See* ’791 Patent at 5:5-7 (“Individuals being cared for may be referred to as clients [or] patients”); Bergeron at ¶46.

Douglas further discloses that such accounts are stored in a server, as this patient account—like other patient accounts in Douglas’s system—is stored in Douglas’s network server 508, as shown in Douglas’s FIG. 59 (reproduced below):



Douglas FIG. 59

Server 508 stores the patient’s account, as it includes, and has access to, relational databases 522 that contain “[a]ll the information needed by a user of the system,” including the patient. Douglas at 24:28-37; Bergeron at ¶47-48. Douglas discloses that server 508 is available through one or more networks, as Douglas discloses that “each PC 500 is electronically linked to network server 508 via the Internet 518.” Douglas at 24:12-13, FIG. 29; Bergeron at ¶48; *see also* Douglas at 8:28-31.

Finally, Douglas’s patient is an individual receiving treatment or assistance from their physician, as, prior to being set up on the system, the physician “diagnoses

[the patient] with an ailment ... [and] recommend[s] a health care maintenance or recovery program which requires the patient to” take certain medications and actions. Douglas at 6:24-35; Bergeron at ¶49.

In the ’616FWD, the Board found that Douglas discloses “receiving input, by an administrator, for establishing an account for a client, wherein the client is an individual receiving treatment or assistance, and wherein the accounts are stored in a server available through one or more networks.” ’616FWD at 14-15.

(c) *Limitation 1[b]: assigning each of the clients to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least a communications device;*

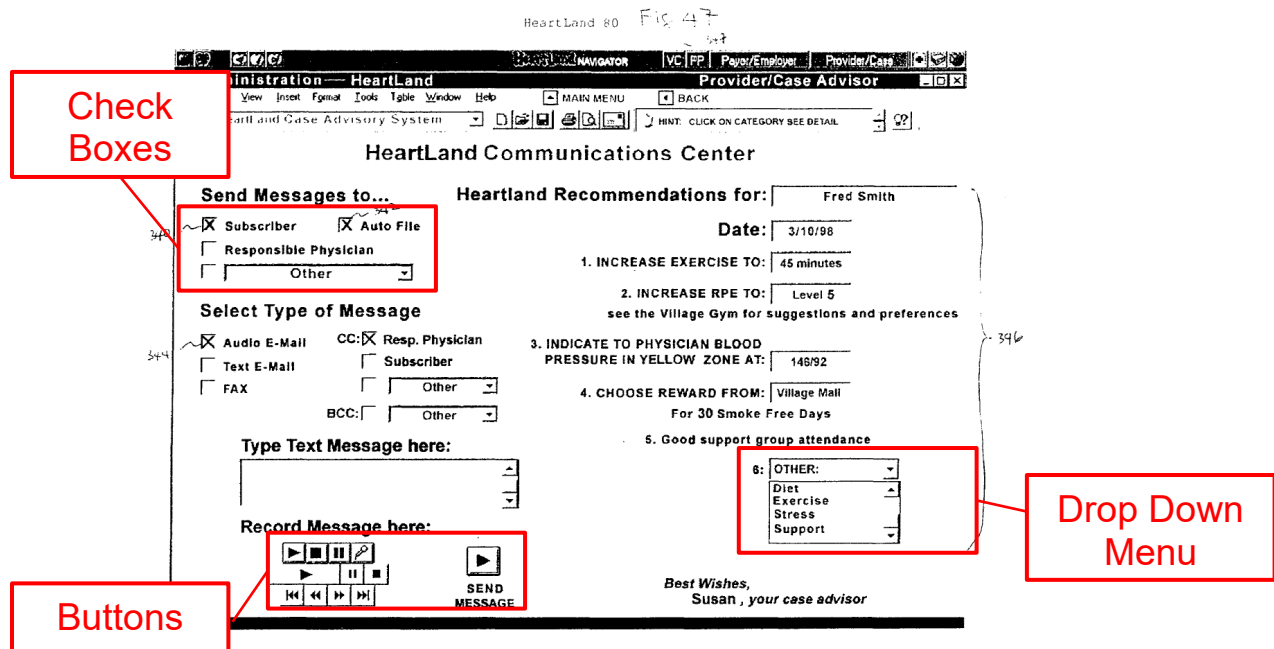
As noted above, in the ’616FWD and the ’617FWD, the Board construed “‘selection’ as including inputs to a user interface, thereby ‘assigning’ a client to a provider within the system” and “that assigning and selection must be distinct elements, because they are separately listed, and assigning happens in response to selection(s).” ’616FWD at 11-12; ’617FWD at 8-10. Applying these constructions, Douglas discloses assigning each of the clients to one or more providers in response to selections from an administrator. ’616FWD at 16-21; ’617FWD at 15-20.

In Douglas’s system, the patient is assigned to their physician, who provides treatment or assistance to the patient (*see* Section VIII.A.2(b) (Limitation 1[a])). Douglas at 21:24-28, FIG. 47 (showing the “Responsible Physician” for patient

“Fred Smith”), 15:8-9, claims 11, 25, FIG. 2; Bergeron at ¶51. Douglas’s physician is the claimed provider. *See* ’791 Patent at 6:7-14 (“a provider is ... [a] caregiver” who “care[s] for ... patients.”); Bergeron at ¶51.

Douglas further discloses that the case administrator sets up the patient on Douglas’s system by entering the information contained in the patient prescription form, as discussed above for Limitation 1[a], where such information includes information associating the patient with a physician. Douglas at FIG. 2 (“Physician” name, ID, and signature); Bergeron at ¶52. A POSITA would have understood the state of the patient being assigned to the physician to have resulted from such selections by the administrator. *Id.*

Furthermore, as found by the Board for similar limitations in the ’616FWD and the ’617FWD, Douglas also renders obvious assigning clients to providers in response to selections by the administrator, e.g., by using graphical user interface (“GUI”) components. Bergeron at ¶53. Douglas discloses several GUI components, including check boxes, drop-down menus, and buttons, which are shown in, for example, Douglas’s FIG. 47 (reproduced below):



Annotated Version of Douglas FIG. 47

Bergeron at ¶54; *see also e.g.*, Douglas at FIGS. 5, 6, 38, 39, 46, 49-52, 58.

It would have been obvious to use Douglas's GUI components to receive selections from an administrator to assign the patient to the physician in each of the following ways:

- (1) by receiving a selection of a check box associated with the physician in a list of physicians and receiving a selection of a button to assign the patient to the physician; and
- (2) by receiving a selection of the physician from a list of physicians in a drop-down menu and receiving a selection of a button to assign the patient to the physician. Bergeron at ¶55.

First, each of these options represents an obvious “combination of familiar elements according to known methods ... [that] does no more than yield predictable results.” *KSR Int’l Co. v. Teleflex Inc.*, 550 U.S. 398, 401 (2007); Bergeron at ¶56. In both options (1) and (2), the check boxes and drop-down menu, respectively, would perform the same choosing-from-a-list function they do in Douglas’s FIG. 47, but for a list of physicians. Bergeron at ¶57. And the button would, like in FIG. 47, act upon the choices—here, to create the patient-to-physician assignment. *Id.* at ¶57. Thus, in options (1) and (2), the functions of the GUI components remain unchanged. *Id.* at ¶57. Each of the options would also lead to the predictable result of the administrator assigning the chosen physician to the patient. *Id.* at ¶57.

Second, any of these options would have accomplished the necessary patient-to-physician assignment in Douglas’s system (*supra*) in a way that furthered Douglas’s desire for that system to be GUI-based and using the GUI components it already leverages. Douglas at 2:16-24 (“The present invention [] provides for [a] ... system ... through an integrated system of interactive graphical interfaces.”); Bergeron at ¶58; *see also* Douglas at 3:24-5:21, FIGS. 3-6 and 8-58.

Finally, Douglas discloses the limitation “wherein the one or more providers communicate with the client via at least a communications device.” Douglas discloses that “[t]he communications feature of the system ... allows user to keep in constant contact with their physician,” including “via e-mail ... instant messaging,

conference calls, and/or video conferencing as alternate means of communication.”

Douglas at 15:8-13; FIGS. 47, 48. Bergeron at ¶59. Such communications are accomplished via the “PC,” i.e., the “computer,” of the patient and the “PC”/“computer” of the physician. Douglas at 24:3-25:9, 15:28-29, 21:24-38, FIGS 59, 46-48, 20. Bergeron at ¶59.

(d) *Limitation 1[c]: establishing customized goals for each of the clients based on treatment or assistance required;*

Douglas discloses establishing customized goals for each of the clients. “[T]he physician ... can design a new program ... for [a] patient by selecting the system’s Design option 50.” Douglas at 7:29-32, FIG. 4. “[T]he system [then] prompts the physician ... to assign intensity levels 51 corresponding to the patient’s diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements,” as shown in FIG. 5 (reproduced below):

HeartLand 69 *Fig 5*

Administration — HeartLand
Provider/Case Advisor

File Edit View Insert Format Tools Table Window Help
MAIN MENU BACK PREVIEW PRINT PATIENT PROGRAM

HeartLand Health Assessment Review
HINT: CLICK BOX TO DESIGN PROGRAM

SCREEN 2 OF 3

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

INITIAL SCALE

	LOW	INTENSITY			HIGH
DIET	☐ 1	☐ 2	☒ 3	☐ 4	☐ 5
EXERCISE	☐ 1	☐ 2	☐ 3	☒ 4	☐ 5
STRESS MANAGEMENT	☐ 1	☒ 2	☐ 3	☐ 4	☐ 5
GROUP SUPPORT	☐ 1	☐ 2	☒ 3	☐ 4	☐ 5
DRUGS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
COMPLIANCE	☐ 1	☐ 2	☐ 3	☒ 4	☐ 5

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

Diet	15%	Calories From Fat
Exercise	3/4 4	hr days per week
Stress Management	1/2 7	hr days per week
Group Support	1/2 5	hr days per week
Compliance Mgt. Freq.	4	times per Month
Smoking		Cessation
Drug	-aspirin -hydrochlorothzid. -Lovastatin	325 12.5 20 mg/da

Program Detail

Douglas at 7:33-37; Bergeron at ¶60. “Based on the input information,” which includes the intensity levels as well as patient characteristics “such as age, sex, weight and information,” “the system ... generates a set of goals 52” for the patient as part of “a therapeutic program” for the patient. Douglas at 8:1-9, FIG. 5; Bergeron at ¶61. “The physician or case advisor may view details as to how the suggested goals may be implemented by selecting the system’s Program Detail option 54,” which shows “recommended one month goals 61 and final goals 62,” as shown in FIG. 6 (reproduced below):

HeartLand 70 Fig 6

Administration — HeartLand
Provider/Case Advisor

SCREEN 3 OF 3

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

PATIENT STATUS & GOALS: DETAILS		Now 2/10/98	1 month Goal	GOALS
Name / D.O.B.	Fred Smith 2-5-49			
Starting Date	2/1/98			
Heartland I.D.	23-642			
Height / Sex	6'9" Male			
Weight	193	182	175	170
BMI	28.28	26.28	25.64	25.00
Smoke	.5 Packs/Day	.5	0	0
Physical Activity	0 / 0 / 0 minutes / x-week / RPE	20 / 3 / 3	25 / 5 / 4	4 / 6 / 8
Alcohol	2 Average Drinks per Day	2	1	1
Eating Habits	40 %Fiber/Complex Carb Intake	60	70	80
	40 %Fatty Food Intake	20	20	15
	40 %Fatty Dairy Intake	20	10	5
Calories	3,600	3,300	3,100	2,800
Fat Calories & %	45%	45%	20%	15%
Cholesterol - LDL	142	140 mg/dl	125 mg/dl	100 mg/dl
Cholesterol - HDL	36	37 mg/dl	39 mg/dl	45 mg/dl
Cholesterol	246 mg/dl	225	210	190
Resting Pulse Rate	68 Beats Per Minute	68	65	79
Stress	8.5 Scale of 1 to 10 (10 being high stress)	7.0	6.0	3.5
Depression	Scale of 1 to 10 (10 being greatest)	10	6	0
Blood Pressure	140/100 systolic/diastolic	140/100	130/90	130/80
Seatbelt Use	30 percent of time	60	75	100
Back Pain	Incidents per month	3	2	0
Pharmaceuticals	aspirin 325 mg	325 mg/ds	325 mg/ds	325 mg/ds
	hydrochlorothz. 12.5 mg	12.5 mg/ds	12.5 mg/ds	0 mg/ds
	Lovastatin 20 mg	20 mg/ds	20 mg/ds	0 mg/ds

CONFIRM
EDIT
OPTIONS...

Douglas at 8:8-11; Bergeron at ¶61. “The physician ... may confirm 63 or edit 64 the suggested program to modify the goals by making appropriate selections.”
Douglas at 8:11-13; Bergeron at ¶61.

Douglas’s “goals 52” and “final goals 62” correspond to the claimed goals.
Douglas at 8:1-13, FIGS. 5 and 6; Bergeron at ¶62. These goals are “customized” to the patient as they result from data specific to the patient, such as the “intensity levels 51 corresponding to the patient’s diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements,” and the “patient characteristics “such as age, sex, weight and information.” Bergeron at ¶62.

Douglas's disclosure of "[t]he physician or case advisor confirm[ing] 63 or edit[ing] 64 the suggested program to modify the goals" is disclosure of establishing the customized goals based on treatment and assistance required. Douglas at 8:12-13; Bergeron at ¶63. Indeed, Douglas's program provides "goals 52" and "final goals 62" for weight loss, smoking cessation, reduction of alcohol consumption, and dietary improvements. Douglas at 8:1-13, FIGs. 5, 6; Bergeron at ¶63. Douglas's disclosure of the physician or case advisor "assign[ing] intensity levels 51 corresponding to the patient's diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements" (Douglas at 7:33-37, FIG. 5) is also disclosure of determining treatment and assistance for the client. Bergeron at ¶63. Treatments needed are further indicated by the intensity levels and confirmed or edited goals relating to the patient's use of pharmaceuticals (Douglas at FIG. 5 and 6), and assistance needed is further indicated by the provider-received intensity levels and confirmed or edited goals relating to the patient's participation in group support (Douglas at FIGs. 5 and 6). Bergeron at ¶¶63-64.

In the '616FWD, the Board held that "Douglas teaches 'determining, by the one or more providers, treatment and assistance for the client, which is used for establishing goals...'" '616FWD at 25.

(e) *Limitation 1[d]: receiving data associated with each of the clients from a biometric device via the communication device;*

Douglas discloses receiving data associated with each of the clients from a biometric device via the communication device⁴. Douglas states that “the system might also prompt the patient to input his or her vital signs 102, such as blood pressure and heart rate ... For example, devices can be hooked into the computer’s serial port for automatic input of blood pressure and heart rate into the system.” Douglas 10:12-19; Bergeron at ¶65. “This information is stored in the system’s database.” Douglas 10:18-19; Bergeron at ¶65. A POSITA would have understood

⁴ The claim term “the communication device” lacks antecedent basis, as there is no “a communication device” earlier in the claim. It is assumed that “the communication device” is referring to “a communications device” earlier in the claim in Limitation 1[b]. In any event, Douglas discloses “the communication device” in the context of Limitation 1[d] both if “the communication device” refers to the same “a communications device” in Limitation 1[b] or if “the communication device” can potentially cover a device different than the “a communications device” in Limitation 1[b]. For example, as discussed in this Section, in Douglas, data associated with patients is received from biometric devices both via the patient’s computer and via the physician’s computer.

that such devices for blood pressure or heart rate monitoring are biometric devices. Bergeron at ¶65. The patient's computer, which is a communication device to which the devices can be hooked, receives the biometric data associated with each of the clients. Bergeron at ¶65.

Douglas also discloses receiving data from the one or more providers as “the system accepts ... data entered by the physician during office visits.” Douglas at 11:1-5, FIG. 60; *see also* claim 14, FIG. 41 (“Physician reported” blood pressure); Bergeron at ¶66. A POSITA would have understood that the physician “enter[ing]” such data from a biometric device is disclosure of the data being entered via the physician's computer, i.e., a communication device. Bergeron at ¶66.

(f) *Limitation 1[e]: compiling data associated with each of the clients;*

Douglas discloses compiling data associated with each of the clients. Data associated with each of the clients, such as the data received from the biometric device as discussed for Limitation 1[d], is collected over time—i.e., compiled—to determine progress of the patient toward achieving the goals. Bergeron at ¶67. For example, Douglas discloses that “[t]he system generates reports on patient progress based on the data shown in FIGS. 40-45,” which depict various aspects of patient data collected over time, namely, blood pressure, smoking activity, physical activity, pulse, weight, stress level, medication intake, caloric intake, cholesterol level, and attitude toward change, charted against respective patient goals. Douglas at 20:3-

37, FIGS. 40-45; *see also* Douglas at 20:14-19 (discussing FIGS. 41-44); Bergeron at ¶67.

In the '616FWD, the Board held that “Douglas teaches compiling client data received from the provider utilizing communication devices communicating with the server to determine progress of the client towards achieving the goals.” '616FWD at 27; *see also* '617FWD at 23.

- (g) *Limitation 1[f]: determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and*

Douglas discloses determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients. First, as noted above, Douglas discloses customized goals such as goals 52 and final goals 62. *See* VIII.A.2(d). Further, Douglas’s “one month goals 61” correspond to the claimed thresholds representing certain points of progress toward the customized goals. Douglas at 8:1-13, FIGS. 5 and 6; Bergeron at ¶68. In the '616FWD, the Board held that “Douglas’s goals 52 and final goals 62 ... correspond to the claimed goals, Douglas’s one-month goals 61 ... correspond to the claimed thresholds.” '616FWD at 25.

Douglas's system records the patient's data for these various medical parameters in consecutive data points, as shown, for example, in the patient health record of FIG. 40:

HeartLand 72 Fig 40

Administration — HeartLand **Provider/Case Advisor**

File Edit View Insert Format Tools Table Window Help MAIN MENU BACK BEHAVIOR RECOMMEND

Heartland Case Management Review HINT: CLICK ON CATEGORY SEE DETAIL

Chosen case for review: Fred Smith Date: 3/10/98

Heartland I.D. #: 23-642 Social Security #: 213-48-3947

Subscriber since: 1/20/98 Total weeks on Heartland program: 24

Fred Smith, 48 years, anterior M.I. 1/6/98 Risk Factors: Hypertension, smoker, lack of exercise, elevated LDL cholesterol

	2/10/98	2/17/98	2/24/98	3/2/98	3/9/98	
BASFI INF (1/20/98)						GOALS
HBP (160/90 mmHG)	156/96	166/92	148/90	148/90	146/92	B.P. < 140/90 mmHG
Cigarettes/day (20)	15	10	0	0	0	Complete Smoking Cessation
Physical Activity minutes/x-week/RPE	0 / 0 / 0	20 / 3 / 3	30 / 4 / 3	35 / 4 / 3.5	35 / 4 / 4	45 mins walking / 7 days week / 6
Resting H.R.	88	79	68	69	67	
Weight baseline (180 lbs.)	179 lbs.	178 lbs.	176 lbs.	176 lbs.	172 lbs.	WEIGHT: 170 BMI: 25.00
Stress level (8) (weekly average)	7.0	7.2	6.9	6.1	6.9	3.5 (10=MAX)
Aspirin 325 mg/day (missed dose/wk)	1	2	1	1	1	Compliant use of Medications
Hydrochlorothiazide 12.5 mg. daily (missed dose/wk)	1	1	0	0	0	
Lovastatin 20 mg/day (missed dose/wk)	1	1	0	0	0	
Calories avg / day	3,600		3,300		3,100	2,800 cal / day
Fat Calories %	45%		45%		20%	15% fat calories
Cholesterol - LDL	142 mg/dl		140 mg/dl		125 mg/dl	100 mg/dl
Cholesterol - HDL	35 mg/dl		37 mg/dl		39 mg/dl	45 mg/dl
Cholesterol	246		225		210	190

In this health record, “[c]olumn 258 shows the patient’s vital signs and other health-related factors, such as blood pressure 250.” Douglas at 20:5-7; Bergeron at ¶69. These factors “may be monitored and reported on a weekly basis, as shown in columns 260-268” or “on a bi-weekly basis, as shown in columns 260, 264, and 268. The ultimate goal to be achieved in each of the specified areas is given in column 272.” Douglas at 20:7-11; Bergeron at ¶69. For example, for blood pressure 250,

there are weekly consecutive measurements during the months of 2/98 and 3/98, including at dates of 2/10/98, 2/17/98, 2/24/98, 3/2/98 and 3/9/98. Douglas at FIG. 40; Bergeron at ¶69.

Further, Douglas discloses determining whether the customized goals, such as goals 52 and final goals 62, are being met in response to the compiled data, including the consecutive data points described above, passing one or more thresholds, such as one month goals 61, to become significant for one or more of the clients. Douglas's "system periodically correlates the updated patient health information with program goals to determine the patient's progress and compliance with the program," including one-month goals 61 (i.e., the claimed threshold). Douglas at 11:26-12:2, FIGS. 60 (block 1050), 5, 6; Bergeron at ¶70. A POSITA would have understood Douglas's periodic comparison of the consecutive points of patient data to the goals, including the one-month goals 61, as disclosure of determining whether the compiled data passes one or more thresholds. Douglas at 11:18-12:2, 11:12-13 ("The system compares actual data about the patient with the goals and parameters residing in the system's database"); Bergeron at ¶70. Douglas also discloses determining that the difference between the patient data and the one-month goals is significant in a number of ways, including at least by Douglas's indication that the determined difference causes "the physician [to] then determine[] whether to modify the patient's therapeutic program, provide the patient with additional support, or

remove the patient from the system.” Douglas at 11:28-12:2, 11:18-24 (the difference between the data and goals “must ... be addressed by the physician or case advisor,”); Bergeron at ¶70.

Douglas also discloses reviewing program activity at various different review periods. For example, Douglas discloses that “[t]he system generates reports on patient progress based on the data shown in FIGS. 40-45, as frequently as the physician desires,” and “depend[ing] on the needs of the particular patient.” Douglas at 20:33-37; Bergeron at ¶72. Douglas also indicates exemplary “case advisory review” periods of “4x/mo.,” “2x/mo.,” and “1x/mo.” Douglas at FIG. 46; Bergeron at ¶71. Douglas therefore discloses, at least for periodic review periods of 2x/mo and 1x/mo, and for data collected on a weekly basis, evaluating two to four new consecutive data points when performing a review. Bergeron at ¶¶71-72. Thus, Douglas’s determination of whether customized goals are being met will be in response to consecutive data points passing the one month thresholds to become significant, such as when at least two of the new consecutive data points pass the one month threshold during a review. *Id.*

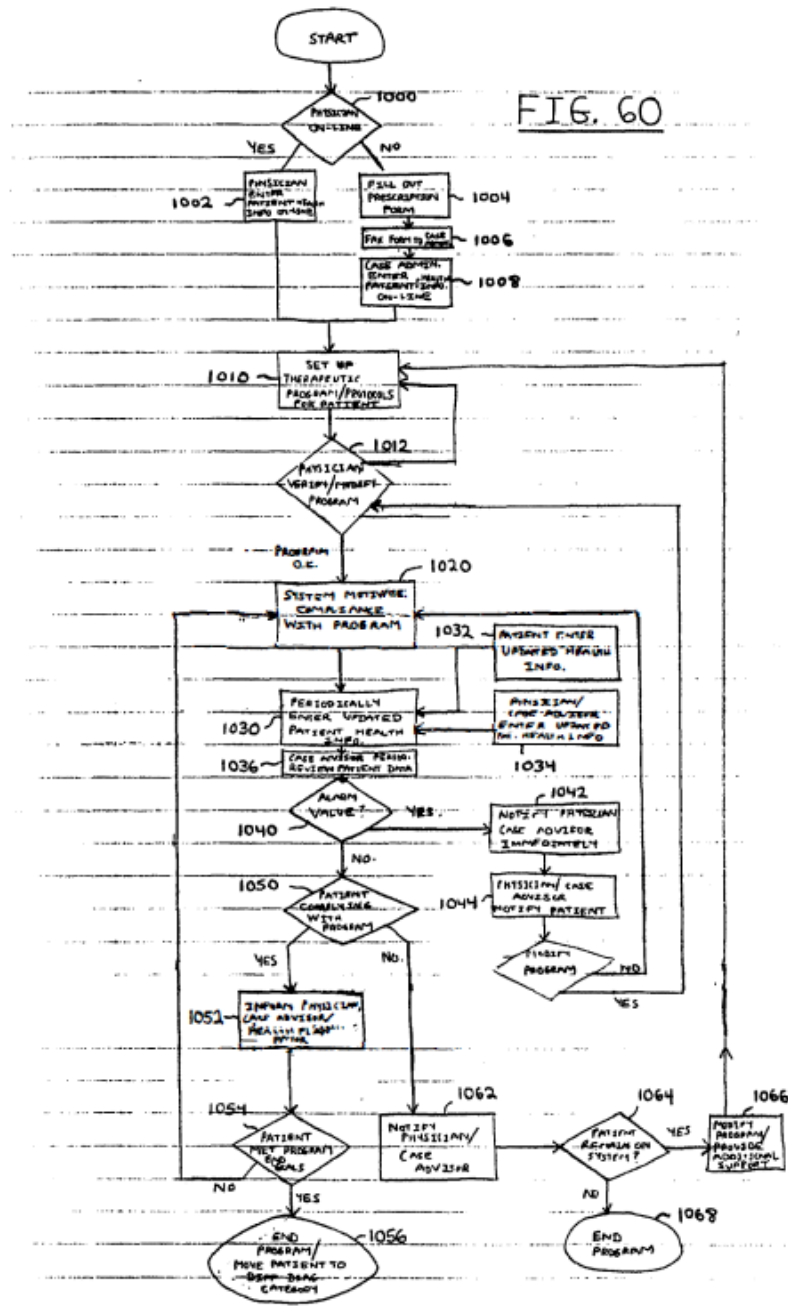
In the ’617FWD, the Board held that “Douglas teaches or suggests” “the compiled data varies from one or more thresholds to become significant for one or more of the clients.” ’617FWD at 24-25.

- (h) *Limitation 1[g]: automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.*

Douglas's system provides multiple mechanisms to automatically communicate alerts to the providers to perform a review of the goals of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant. As noted above for Limitation 1[f], Douglas's system determines whether the customized goals 52, 62 are being met in response to consecutive data points of the complied data passing one or more of the one month goals 61—i.e., thresholds—to become significant for a client. The Douglas system then automatically communicates alerts to a provider to perform a review of the goals when this happens. Bergeron at ¶73.

For example, FIG. 60 and the related description in Douglas disclose a compliance feedback look beginning at block 1020:

60/60



As part of Douglas's periodic review process at block 1050 discussed above for Limitation 1[f], Douglas discloses that "If the patient is progressing in accordance

with his or her program, the system informs the physician and/or case advisor (block 1052, FIG. 60).” Douglas at 11:28-30; Bergeron at ¶75. “The system also notifies the physician or case advisor if the patient is not progressing toward program goals or is not using the system (block 1060, FIG. 60).” Douglas at 11:35-36, *see also* Douglas at 11:12-15 (“automatically notifies the physician or case advisor, if a health risk is present (block 1042, FIG. 60)”), 11:18-21 (“[i]f the difference between current data and goals does not represent a threatening situation, the system will notify the physician ... that these goals are not being met.”); Bergeron at ¶75. A POSITA would have understood Douglas’s “inform[ing]” and “notify[ing]” the physician to disclose generating an alert. Bergeron at ¶75. A POSITA also would have understood Douglas’s indication that “the system” informs and notifies the physician as disclosure of the system automatically doing so. *Id.*

Further, Douglas’s system providing notifications to the physician causes the physician to review the goals for the patient, as “[i]f the patient is progressing in accordance with his or her program,” the “physician can [] determine whether to modify the program by altering the goals,” and “if the patient is not progressing the physician can again “determine[] whether to modify the patient’s therapeutic program,” as indicated in blocks 1046, 1052, 1056, and 1066. Douglas at 11:28-12:2, *see also* Douglas at 11:21-25 (“the physician or case advisor may recommend that the program be modified to suit the patient’s condition”); Bergeron at ¶76. Such

modification of the program discloses the claimed review of the goals of the client in response to consecutive data points of the compiled data varying from the thresholds to become significant for a client. Bergeron at ¶76.

In the '617FWD, the Board held that “Douglas teaches or suggests” “automatically communicating alerts in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.” '617FWD at 24-25.

3. *Claim 2: The method of claim 1, wherein the one or more providers further include individuals available to treat or assist the clients.*

In Douglas's system, one or more of the physicians includes individuals available to treat or assist the client. Douglas at 21:24-28, FIG. 47 (showing the “Responsible Physician” for patient “Fred Smith”), 15:8-9, claims 11, 25 (“alerting the individual's physician”), FIG. 2; Bergeron at ¶77.

4. *Claim 3: The method of claim 1, further comprising: intervening in response to communicating the alerts to at least the one or more providers or caregivers associated with the one or more of the clients.*

As discussed above in Section VIII.A.2(h) (Limitation 1[g]), in response to the alerts, the physician can modify the patient's program, including “by altering the goals.” Douglas at 11:24-25, 31-34, 36-12:2; Bergeron at ¶78. Such modification discloses the claimed intervening in response to communicating the alerts to at least the one or more providers or caregivers associated with the one or more of the clients. Bergeron at ¶78.

5. Claim 4: The method of claim 3, wherein the one or more providers physically intervene to treat or assist the one or more of the clients.

Douglas discloses that if the patient's data presents a health risk, the physician is required to take immediate action. Douglas at 11:18-21 ("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."); Bergeron at ¶79. A POSITA would have understood that such immediate action includes physical intervention. Bergeron at ¶79.

Additionally, as discussed above in Section VIII.A.2(h) (Limitation 1[g]), Douglas discloses that a physician may contact the patient or provide the patient with additional support if the patient data shows the patient is not on track to meet the goals or even if the patient is on track. Douglas at 11:18-25; Bergeron at ¶80. A POSITA would have understood that both of these actions can include a physical intervention. *Id.*

6. Claim 5: The method of claim 1, wherein the customized goals, data, compiled data, thresholds, and alerts are saved in the server.

Douglas discloses that the customized goals, data, compiled data, thresholds, and alerts are saved in the server. As discussed above in Section VIII.A.2(b) (Limitation 1[a]), Douglas discloses that network server 508 includes "one or more relational databases 522 (such as SQL) that contain all the health plan data" as well as "[a]ll the information needed by a user of the system." Douglas at 24:28-37;

Bergeron at ¶81. Such data and information includes Douglas’s disclosure of the customized goals, data, compiled data, one month goals (thresholds), and alerts given that: (1) they are needed by users—patients and physicians—of Douglas’s system (Douglas at 12:3-7 (“users may view their levels of compliance and achievement of goals”), 8:11-13 (“The physician ... may edit 64 the suggested program to modify the goals....”); and (2) they reflect confidential health plan data that a POSITA would have therefore understood resided behind firewall 520 that “protects confidentiality of health plan data” (Douglas at 25:14-16, Douglas at FIG. 59). Bergeron at ¶81.

7. *Claim 6: The method of claim 1, wherein the one or more providers include biometric sensors worn by or proximate to the clients.*

As discussed above in Section VIII.A.1 and VIII.A.2(e) (Limitation 1[d]), Douglas discloses receiving data from a biometric device, including blood pressure and heart rate data provided by the patient or physician using a device connected to a computer. Douglas 10:12-19; 11:1-5, FIG. 60; *see also* claim 14, FIG. 41; Bergeron at ¶82. A POSITA would have understood that such devices include biometric sensors worn by or proximate to the clients. Bergeron at ¶82. Douglas also renders obvious that the device used by the patient may be provided by, and thus included in, the one or more providers, as it was known for physicians to supply such devices as a part of the treatment and assistance. Bergeron at ¶82. A POSITA

also would have understood that a device used by the physician is also included in the one or more of the providers. Bergeron at ¶82.

8. *Claim 7: The method of claim 1, wherein the compiled data indicates the behavior of the clients, and wherein the one or more thresholds include a range.*

As discussed above in Section VIII.A.1, Douglas discloses a therapeutic behavior modification program based on a review of health data, including data that indicates the behavior of the clients. Douglas at Abstract, 1:8-10, 3:13-14, 11:1-5, 11:26-28; FIGS. 5-7, 40; Bergeron at ¶83. In addition, as discussed above in Section VIII.A.2(g) (Limitation 1[f]), Douglas discloses one month goals (thresholds) that include a range, e.g., blood pressure range. Douglas FIGS. 5-7, 7; Bergeron at ¶83.

9. *Claim 9: The method of claim 1, further comprising: establishing the customized goals in response to input from each of the clients and the one or more providers associated with each of the clients.*

As discussed in Sections VIII.A.2(a) (Limitation 1[p]) and VIII.A.2(d) (Limitation 1[c]), the customized goals are created in response to input from a provider associated with a client. In addition, the customized goals result from data specific to the patient, which must come at least in part as a result of input from the patient. Douglas at 7:17-19; Bergeron at ¶84. FIG. 4 provides “an exemplary patient record” based on input from the patient that serves as a basis for establishing the customized goals:

HeartLand 68 *Fig 4*

SCREEN 1 OF 3

PATIENT STATUS & GOALS: DETAILS		Now 2/10/98	1 month Goal	GOALS
Name / D.O.B.	Fred Smith 25-49			
Starting Date	2/1/98			
Heartland I.D.	23-642			
Height / Sex	5'9" Male			
Weight	193	182		
BMI	28.28	28.28		
Smoke	5 Packs/Day	5		
Physical Activity	0 / 0 / 0 minutes / x-week / RPE	20 / 3 / 3		
Alcohol	2 Average Drinks per Day	2		
Eating Habits	40 % Fiber/Complex Carb Intake	80		
	40 % Fatty Food Intake	20		
	40 % Fatty Dairy Intake	20		
Calories	3,600	3,300		
Fat Calories & %	45%	1,500		
Cholesterol - LDL	142	140 mg/dl		
Cholesterol - HDL	35	37 mg/dl		
Cholesterol	246 m/dl	225		
Resting Pulse Rate	88 Beats Per Minute	68		
Stress	8.5 Scale of 1 to 10 (10 being high stress)	7.0		
Depression	Scale of 1 to 10 (10 being greatest)	10		
Blood Pressure	140/100 systolic/diastolic	140/100		
Seatbelt Use	30 percent of time	50		
Back Pain	Incidents per month	3		
Pharmaceuticals				
- aspirin	325 mg	325 mg/da		
- hydrochlorothz.	12.5 mg	12.5 mg/da		
- Lovastatin	20 mg	20 mg/da		

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Douglas at 7:20-28; Bergeron at ¶84. “The second column 46 of the record sets forth the baseline values corresponding to the vital signs and patient characteristics at the beginning of his or her participation in the program.” Douglas at 7:26-28; Bergeron at ¶84. Thus, the customized goals disclosed in Douglas are, in part, in response to input from each of the clients.

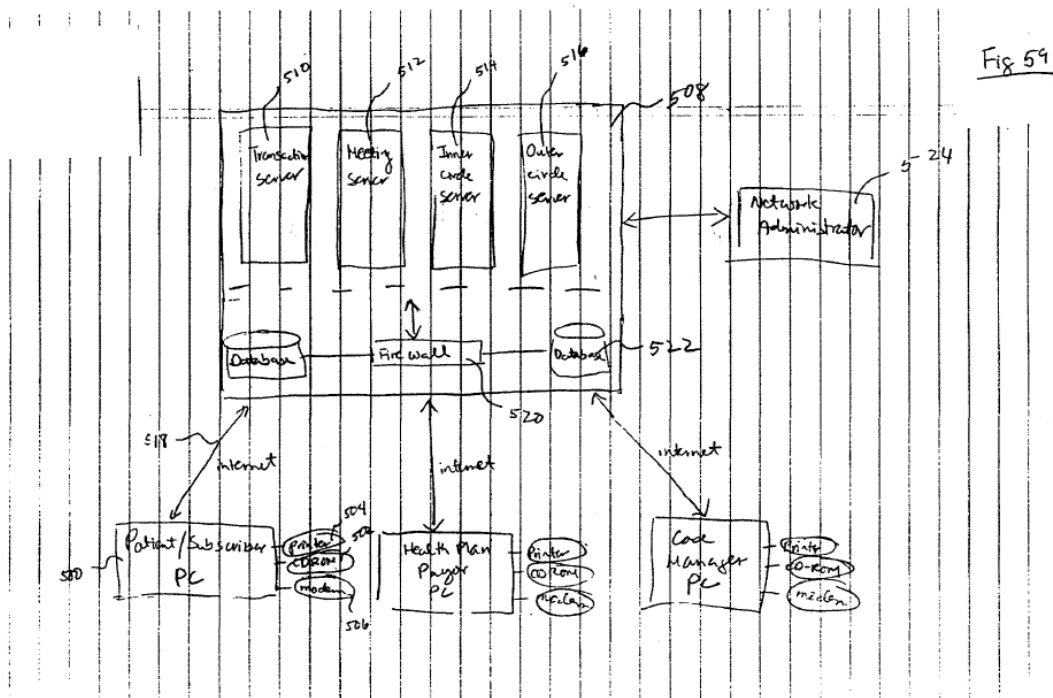
10. Claim 11

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

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

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

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



Douglas FIG. 59

Douglas at 24:12-34; Bergeron at ¶86. Such PCs include those for “patients, physicians, case advisors, and health plan payors.” Douglas at 24:3-6; Bergeron at ¶86. These PCs are communications devices, as they communicate with the server. Douglas at 24:22-27-34; Bergeron at ¶86.

The communications between PCs 500 and network server 508 were also through a transceiver, which a POSITA would have understood to be “[a] device that can both transmit and receive signals.” Microsoft at 527; Bergeron at ¶87. Indeed, Douglas discloses that PCs 500 transmit signals that are received by network server 508, and the network server transmits signals that are received by the PCs, indicating the presence of a transceiver at each of the PCs and the network server for transmitting and receiving the communications. Douglas at 24:22-34; Bergeron at ¶87.

Douglas further discloses a client management program, specifically, Douglas’s “therapeutic behavior modification program’s compliance monitoring and feedback system.” Douglas at 5:22-25, FIGS. 59 and 60; Bergeron at ¶88. Douglas’s system is software and therefore a processor executes the system. Douglas at 25:22-26, 3:10-13, 2:25-27; Bergeron at ¶89. A POSITA would have understood that Douglas’s compliance monitoring and feedback system resided on Douglas’s network server 508 and so did the processor that executed it, and thus Douglas discloses the server including the processor. Bergeron at ¶¶89-93.

In the ’616FWD and ’617FWD, the Board found that Douglas teaches or suggest “a server [‘that’ in the ’617FWD] communicates with communications devices through a transceiver utilizing one or more networks, the server includes a

processor that executes a client management program.” ’616FWD at 29-31;
’617FWD at 26-28.

- (c) ***Limitation 11[b]: receive input establishing an account for a client, wherein the client is an individual receiving treatment or assistance, and wherein the accounts are stored in a server available through the one or more networks;***

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

- (d) ***Limitation 11[c]: assign the client to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least one of the communications devices;***

See Section VIII.A.2(c) (Limitation 1[b]).

- (e) ***Limitation 11[d]: establish customized goals for the client based on treatment or assistance required;***

See Section VIII.A.2(d) (Limitation 1[c]).

- (f) ***Limitation 11[e]: receive data associated with the client from a biometric device via the communications device;***

See Section VIII.A.2(e) (Limitation 1[d]).

- (g) ***Limitation 11[f]: compile the data associated with the client received from the communications devices in communication with the server;***

See Section VIII.A.2(f) (Limitation 1[e]).

- (h) ***Limitation 11[g]: determine whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for the client; and***

See Section VIII.A.2(g) (Limitation 1[f]).

- (i) ***Limitation 11[h]: automatically communicate alerts to at least perform a review of the treatment and assistance in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the client; and***

See Section VIII.A.2(h) (Limitation 1[g]). Douglas's notifications to the physician cause the physician to review the treatment and assistance for the patient, as "determine[ing] whether to modify the program," "moving the patient into a different diagnostic category," and "remov[ing] the patient from the system" each disclose at least reviewing the treatment received by the patient, and "provid[ing] the patient with additional support" discloses at least reviewing the assistance received by the patient. Douglas at 11:26-12:2, Fig. 60; Bergeron at ¶101.

- (j) ***Limitation 11[i]: a database in communication with the server configured to store the data, customized goals, compiled data, and thresholds associated with the client in the account.***

See Sections VIII.A.2(b) (Limitation 1[a]) and VIII.A.6 (Claim 5). Douglas further discloses a database in communication with the server, as Douglas discloses that network server 508 includes "servers 510-516" that "have access to one or more relational databases 522," as discussed in Section VIII.A.2(b). Douglas at 24:12-16, 28-30; Bergeron at ¶103. A POSITA would have understood that the components

of the network server 508 having access to the database 522 discloses that the network server 508 is in communication with the database 522. Bergeron at ¶103. Further, as discussed in Section VIII.A.6, Douglas discloses that this database 522 includes Douglas's disclosure of the received data, customized goals, compiled data, and one month goals (thresholds). *Id.*

In the '616FWD, the Board held that Douglas teaches or suggests "a database in communication with the server configured to store the data, goals, plan of action, compiled data, and thresholds with the account associated with the client and the one or more providers." '616FWD at 31-34; *see also* '617FWD at 28-30.

11. Claim 12: The system of claim 11, wherein the one or more providers further include individuals available to treat or assist the client.

See Section VIII.A.3 (Claim 2).

12. Claim 13: The system of claim 11, wherein the threshold is a customized range established for the client.

See Sections VIII.A.2(g) (Limitation 1[f]) and VIII.A.8 (Claim 7). Douglas discloses one month goals (thresholds) that include a customized range, e.g., blood pressure range, established for the client. Douglas FIGS. 5-7; Bergeron at ¶106.

13. Claim 14: The system of claim 11, wherein the one or more providers or caregivers associated with the client physically intervene in response to the alerts.

See Sections VIII.A.4 (Claim 3) and VIII.A.5 (Claim 4).

14. Claim 16

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

See Section VIII.A.10(b) (Limitation 11[a]) (network server 508).

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

Douglas discloses or renders obvious a processor within network server 508 for executing a set of instructions for implementing Douglas's system. For example, as discussed in Section VIII.A.10(b) (Limitation 11[a]), Douglas discloses or renders obvious that its network server 508 includes a processor to execute its "therapeutic behavior modification program's compliance monitoring and feedback system," which is software. Douglas at 5:22-25, FIGS. 59 and 60; Bergeron at ¶109. Further, Douglas also discloses that this software system includes a set of instructions, as it "is constructed using the C++ programming language in conjunction with SQL 6.5, Cold Fusion, ... Visual Basic, ... and HTML," as well as "Active X and Java components," which a POSITA would understand are all programming languages or tools used to produce program instructions. Douglas at 25:22-26; Bergeron at ¶109. In the '616FWD and '617FWD, the Board found that Douglas teaches or suggest "a processor for executing a set of instructions." '616FWD at 34-37; '617FWD at 31-33.

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

Douglas discloses a memory in network server 508 for storing the set of instructions that the server's processor executes to implement Douglas's system. See Section VIII.A.10(b) (Limitation 11[a]); Bergeron at ¶110. A POSITA would have known that a processor required a memory—at a minimum, RAM—to store the instructions that the processor executed. Bergeron at ¶¶110-111.

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

See Sections VIII.A.2(b) and VIII.A.10(c) (Limitations 1[a] and 11[b]).

- (e) ***Limitation 16[d]: assign each of the clients to one or more of providers in response to selections from an administrator, wherein the one or more providers communicate with the client via at least a communications device;***

See Sections VIII.A.2(c) and VIII.A.10(d) (Limitations 1[b] and 11[c]).

- (f) ***Limitation 16[e]: establish customized goals for each of the clients based on treatment or assistance required;***

See Sections VIII.A.2(d) and VIII.A.10(e) (Limitations 1[c] and 11[d]).

- (g) *Limitation 16[f]: compile data associated with each of the clients received from a biometric device via the communications device;*

See Sections VIII.A.2(e)-VIII.A.2(f) and VIII.A.10(f)-VIII.A.10(g) (Limitations 1[d]-1[e] and 11[e]-11[f]).

- (h) *Limitation 16[g]: determine whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and*

See Sections VIII.A.2(g) and VIII.A.10(h) and (Limitations 1[f] and 11[g]).

- (i) *Limitation 16[h]: automatically communicate alerts to at least the one or more providers to at least perform a review of the goals, treatment, and assistance for the one or more of the clients in response to the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.*

See Sections VIII.A.2(h) and VIII.A.10(i) (Limitations 1[g] and 11[h]).

15. *Claim 17: The server of claim 16, wherein the one or more providers include individuals available to treat or assist the clients and the one or more providers include biometric sensors worn by or proximate to the clients.*

See Sections VIII.A.3 (Claim 2) and VIII.A.7 (Claim 6).

16. *Claim 18: The server of claim 16, wherein the one or more providers physically intervene with the one or more clients in response to the alerts.*

See Sections VIII.A.4 (Claim 3) and VIII.A.5 (Claim 4).

17. Claim 19: The server of claim 16, wherein the compiled data indicates the behavior of the clients.

See Section VIII.A.8 (Claim 7).

B. Ground 2 – Douglas and Khanuja Render Obvious Claims 1-7, 9, 11-14, and 16-19

1. Khanuja Overview

Khanuja discloses “a patient monitoring system for monitoring various physiological characteristic data of a patient, such as blood pressure, pulse rate, blood glucose, weight and others.” Khanuja at [0004]. “The system includes a portable physiological transducer or patient monitoring device that can be worn by a patient.” *Id.* at [0029], [0036]. “The data from the patient monitoring device is wirelessly transmitted to a local hub, which, in turn, is configured to automatically transfer the data to a remote server” *Id.* at [0010].

“[T]he remote server is configured as a web portal which selectively allows access to patient data by selected third party users, such as physicians, clinicians, patients, and/or relatives,” and “automatically generate[s] communications with the patient or other third parties . . . when predetermined thresholds for selected physiological characteristics are exceeded.” *Id.* at [0004].

A user, including a physician, “sets up an alert by choosing the condition that they would like to be alerted to and by providing the parameters (e.g. threshold value for the reading) for alert generation.” *Id.* at [0119]. “Each alert thus set up has an

interval associated with it,” such as “the number of data points or a time duration ... depending on the type of reading for which this alert is being set up.” *Id.* at [0120]. “The values of readings lying within the interval specified by the user must all either positively or negatively exceed the Specified threshold for the alert to be generated” *Id.* at [0121]. For example, “[t]he user may choose certain parameters of the triggering events e.g. if their blood pressure is above X for Y days, then trigger an alert, where X and Y are chosen by the user.” *Id.* at [0250]. In another example, as show in FIG. 21, an alert may be set for blood pressure by indicating a threshold and a number of readings that the data needs to be above the threshold to generate an alert. Additionally, “[t]he user chooses the destination where the alert may be sent,” such as to “the user's portal, e-mail, pager, voice-mail,” and/or to “third parties, such as the physician and/or relatives.” *Id.* at [0122], [0033]; Bergeron at ¶¶121-123.

2. *Modification of Douglas*

In a first mapping, it would have been obvious to modify the Douglas system to determine whether the customized goals are being met in Douglas in response to a selected number of consecutive readings for a particular medical parameter being above or below a threshold as in Khanuja, resulting in the Douglas-Khanuja System. Bergeron at ¶124.

In a second, alternative mapping, it would have been obvious to modify the Douglas system in view of Khanuja as in the first mapping, and to also use the patient

monitoring devices of Khanuja to measure and provide the patient's vital signs to the Douglas patient computer for transmission into the system. As discussed above, Douglas's system periodically receives updated patient data, including from a biometric device (Douglas at 11:1-5, FIG. 60), to determine the "patient's progress and compliance with the program" (*id.* at 11:26-28). Bergeron at ¶125. Douglas provides examples of biometric devices to measure blood pressure and heart rate (Douglas at 10:10-19; FIG. 13) "hooked into the computer's serial port for automatic input of blood pressure and heart rate into the system." *Id.* The Douglas-Khanuja System of this second mapping would implement a biometric device using the patient monitoring device 32 of Khanuja to monitor physiological characteristic data of a patient. Bergeron at ¶125. In such a Douglas-Khanuja system, instead of connecting to a hub, the patient monitoring device of Khanuja would connect to the patient computer of Douglas, which would then transmit the data to the network server. *Id.*

In a third, alternative mapping, it would have been obvious to modify the Douglas system in view of Khanuja as in the first and second mappings, and to also implement notifications to physicians in Douglas, such as in response to periodic reporting, using the alerts as in Khanuja. Bergeron at ¶126.

3. *Motivation to Combine*

For the first mapping, a POSITA would have been motivated to determine whether the customized goals are being met in Douglas in response to a selected number of consecutive readings for a particular medical parameter being above or below a threshold as in Khanuja because this would have provided an enhanced, more customizable evaluation framework for determining whether the goals were being met. Bergeron at ¶127. Douglas discusses comparing the patient data with the one month goals 61—i.e., thresholds—such as at certain periodic intervals, but does not otherwise indicate how to further customize the comparison as between different types of medical parameters, such as between blood pressure versus weight. *Id.* Khanuja teaches a need for “enhanced functionality and expanded access to the healthcare data,” and correspondingly provides functionality for users, such as both the provider and patient, to set the conditions for alerts in more detail, including by setting both a custom interval, or number of consecutive data points, and a custom threshold, as the conditions for the alert. Khanuja at [0009], [0117]-[0123]; Bergeron at ¶127. This would also allow the use of “[s]pecific preset alerts ... based on medically established conditions in the case of common reading types e.g. heart rate, weight, blood sugar etc.,” which could also be further modified. Khanuja at [0123]; Bergeron at ¶127.

Additionally for the first mapping, a POSITA would have understood that evaluating data against a threshold as done in Khanuja was known, and could be applied to evaluating whether the patient data indicated that goals were being met in a known behavioral modification program like that of the Douglas system, and that such an approach would work in Douglas's system in essentially the same way that it works in Khanuja, with the results of the combination being predictable. *KSR Int'l Co.*, 550 U.S. at 401; Bergeron at ¶128.

For the second mapping, in addition to the above motivations to combine for the first mapping, a POSITA would have been motivated to use the patient monitoring devices of Khanuja with the Douglas system in order to measure a wider variety of physiological characteristics for a patient. Bergeron at ¶129. Douglas discloses the use of certain types of biometric devices, including for blood pressure and heart rate, but Khanuja discloses other types of biometric devices, including also for blood pressure and heart rate, as well as for weight, temperature, blood oxygen, body fat, cholesterol, and exercise. Khanuja at [0036]; Bergeron at ¶129. A POSITA would have recognized that modifying the Douglas system to additionally use other types of biometric devices, such as those disclosed in Khanuja, would have improved the scope of devices a patient could use to measure biometric data, such as blood pressure, heart rate and other data types. Bergeron at ¶129.

Additionally for the second mapping, a POSITA would have understood that in the Douglas-Khanuja System, the patient monitoring devices of Khanuja were known, and could be used to monitor and transmit patient data in a known behavioral modification program like that of the Douglas system. Bergeron at ¶130. Such an approach would work in Douglas's system in essentially the same way that it works in Khanuja, with the results of the combination being predictable. *KSR Int'l Co.*, 550 U.S. at 401; Bergeron at ¶130.

For the third mapping, in addition to the above motivations to combine for the first and second mappings, a POSITA would have been motivated to use the alerts of Khanuja to implement the notifications in Douglas's system because this would have provided a more customizable framework for setting up and sending the notifications. Bergeron at ¶131. Douglas discloses sending notifications "via e-mail or facsimile []or pager," but Khanuja discloses additional ways of sending alerts, including to via the "portal, e-mail, pager, voice-mail or any combination of the above." A POSITA would have recognized that modifying the Douglas system to additionally use other types of alerts, such as those disclosed in Khanuja, would have improved the effectiveness and reach of the alerts. *Id.*

Additionally for the third mapping, a POSITA would have understood that the alerts of Khanuja could have been used to implement notifications in the Douglas-Khanuja System in essentially the same way that they work in Khanuja, with the

result of the combination being predictable. *KSR Int'l Co.*, 550 U.S. at 401; Bergeron at ¶132.

4. Claims 1-7, 9, 11-14, and 16-19

For claim elements or any part of claim elements not explicitly discussed below, the Douglas-Khanuja System renders obvious the limitations of claims 1-7, 9, 11-14, and 16-19 of the '791 Patent for the reasons discussed above for Ground 1 in Section VIII.A.

(a) Limitations 1[d], 11[e], and 16[f]: receiving data associated with each of the clients from a biometric device via the communication device (or similar);

For the first mapping, the Douglas-Khanuja System discloses these claim limitations for the same reasons discussed above in Sections VIII.A.2(e) (Limitation 1[d]), VIII.A.10(f) (Limitation 11[e]), and VIII.A.14(g) (Limitation 16[f]) based on Douglas's disclosure alone. Bergeron at ¶134. For the second and third mappings, the Douglas-Khanuja System also discloses these claim limitations for the same reasons discussed above in Sections VIII.A.2(e), VIII.A.10(f) and VIII.A.14(g), but with the combined System using the portable monitoring device of Khanuja connected to the patient computer in Douglas instead of the device of Douglas connected to the computer, as discussed in VIII.B.2. Bergeron at ¶134. Thus, the Douglas-Khanuja System receives data associated with each of the clients from Khanuja's portable monitoring device. *Id.*

- (b) ***Limitations 1[f], 11[g], and 16[g]: determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and***

For all three mappings, the Douglas-Khanuja System discloses these claim limitations for the same reasons discussed above in Sections VIII.A.2(g) (Limitation 1[f]), VIII.A.10(h) (Limitation 11[g]), and VIII.A.14(h) (Limitation 16[g]), but with the combined System performing the comparison of the patient data with the goals to determine whether the goals are being met by determining whether a selected number of consecutive readings of the data is above or below a selected threshold as in Khanuja as discussed in Section VIII.B.2. Khanuja at [0250], FIG. 21; Bergeron at ¶135.

- (c) ***Limitations 1[g], 11[h], and 16[h]: automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.***

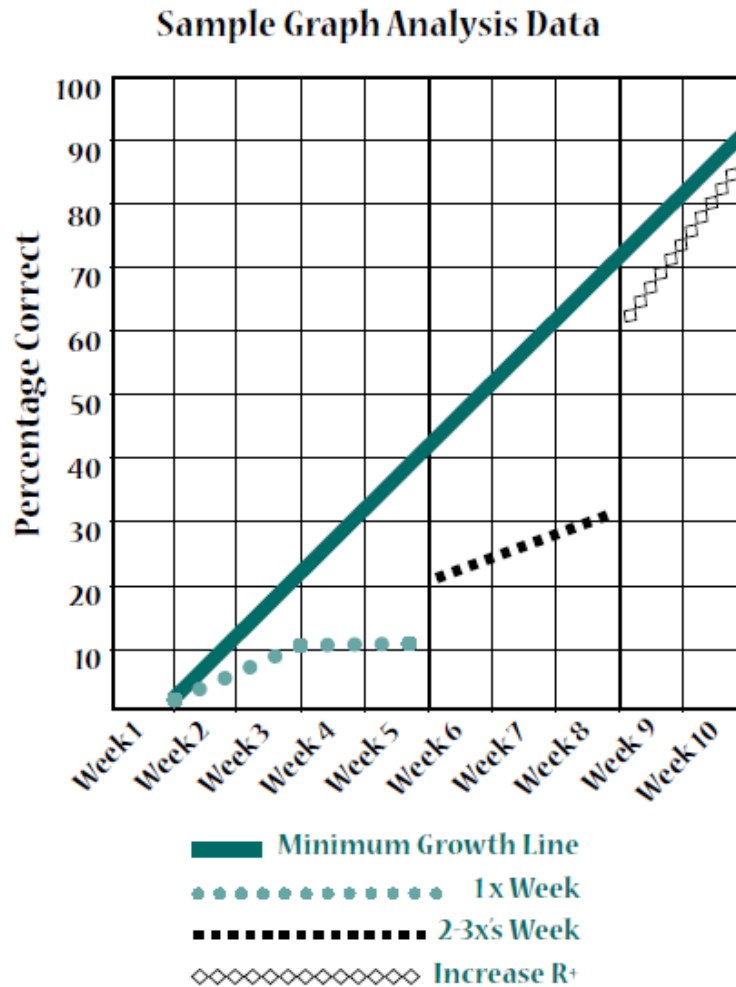
For all three mappings, the Douglas-Khanuja System discloses automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients as discussed in Sections VIII.A.2(h)

(Limitation 1[g]), VIII.A.10(i) (Limitation 11[h]), and VIII.A.14(i) (Limitation 16[h]), except the alerts are automatically communicated in response to a selected number of data points, such as for blood pressure, being above or below a selected threshold in the Douglas-Khanuja System as discussed in Section VIII.B.4(b). Bergeron at ¶136. Additionally for the third mapping, although the notifications in Douglas already disclose alerts, the Douglas-Khanuja System’s implementation of notifications using alerts as in Khanuja discloses the claimed alerts as well. *Id.*

C. Ground 3 – Douglas and Virginia Render Obvious Claims 1-7, 9, 11-14, and 16-19

1. Virginia Overview

Virginia “describe[s] how to help persons with autism” in “acquiring skills ... that will increase their success in adulthood.” Virginia at 5, 12; Bergeron at ¶137. Specifically, Virginia utilizes a minimum growth line (“MGL”)-based approach. Virginia at 27; Bergeron at ¶137. In this approach, a teacher establishes a “baseline” performance of a student as well as a “goal [that] stipulates a mastery criterion ... [to be achieved] by the end of [a] teaching period.” *Id.* A line is then drawn on a graph “between the baseline ... and the goal criterion,” which “is called the *minimum growth line*.” *Id.* Virginia’s FIG. 4, reproduced below, shows a sample MGL:



Virginia FIG. 4

Id.

To evaluate progress, the teacher also plots the student's performance data over time to "compare the student's performance against [the] line." Virginia at 27; Bergeron at ¶138. As shown in FIG. 4, there are consecutive data points that are measured and compared. If "the student demonstrates performance that is on or above the line, then the student is on track to master the goal." Virginia at 27-28; Bergeron at ¶138. But "[i]f the student demonstrates performance below that line

for three data points, then the teacher should revise their teaching strategy.” Virginia at 28; Bergeron at ¶138.

While Virginia applies its progress-monitoring method to an autistic student’s performance in learning skills and behavior to transition to adulthood (*see* Virginia at 5, 27-28), Virginia is in the same field of endeavor of the ’791 Patent, which is directed to tracking goal progression (*see, e.g.*, ’791 Patent at Abstract, 1:42-44, 6:4-6, 27-29), including of “individuals with ... autism” (*id.* at 1:22-29) and students generally (*id.* at 5:57-61) (“the subject may be a ... student”). Bergeron at ¶139. It is also reasonably related to a problem faced by the inventors of the ’791 Patent: how to assess an individual’s progress toward a goal. *See, e.g.*, ’791 Patent at Abstract, 1:15-19, 30-38, 6:26-37; Bergeron at ¶139. Virginia is therefore analogous prior art to the ’791 Patent.

2. *Modification of Douglas*

It would have been obvious to modify the Douglas system to perform the evaluation of compliance with the program in Douglas by analyzing the patient’s data using an MGL-based approach as discussed in Virginia, resulting in the Douglas-Virginia System. Virginia at 27-28; Bergeron at ¶140. In such a modified System, data related to the patient (such as the duration, frequency, and intensity of physical activity; weight; etc.) for corresponding goals (such as related to physical activity, weight, etc.) is evaluated “at the beginning” of the program to establish a

“baseline,” a program “goal stipulates a mastery criterion” value for the data to be achieved “by the end” of the program, and an MGL is extended from the baseline data to the goal. Douglas at 7:20-29, 8:10-11, 11:3-5, 26-28, FIGS. 4, 6; Virginia at 27; Bergeron at ¶140. As the patient progresses through the program, if the patient data “is on or above the line,” then the patient “is on track to master the goal,” and the physician is notified of such, but if the patient data is “below that line for three data points,” then the physician is again notified and the program is evaluated and may need to be “revise[d].” Virginia at 27-28; Bergeron at ¶140.

3. Motivation to Combine

First, a POSITA would have been motivated to use a MGL-based approach like in Virginia to evaluate progress toward meeting goals in the Douglas system to provide an “evidence based” evaluation of the sufficiency of the progress to meet the goals in a specified time period, as taught by Virginia. Virginia at 27-28; Bergeron at ¶141. That is, Douglas discusses program goals for completion in “certain period[s],” but does not specify in detail how to evaluate whether progress is sufficient to meet a goal by the specified time. Douglas at 7:5-7, 7:8-10, 8:10-11; Bergeron at ¶141. But Virginia teaches that the MGL approach enables an evaluation of whether an individual attempting to meet a goal is “on track to master the goal” by the “end” of a corresponding “period.” Virginia at 27-28; Bergeron at ¶141.

Second, a POSITA would have been motivated to use such a modified System to improve the chances of meeting goals of the program by a specified deadline, as taught by Virginia. Virginia at 27-28; Bergeron at ¶142. That is, Douglas discusses “determin[ing] whether to modify the patient's therapeutic program” “if the patient is not progressing toward program goals,” but does not discuss in detail the timing of when to make changes. Douglas at 11:35-12:2; Bergeron at ¶142. However, Virginia teaches iteratively evaluating whether the individual “demonstrates performance below [MGL] for three data points,” and, if so, revising the program to enable “mastering the skill at the targeted criterion,” where if an initial revision results in “performance [being] improved, but not enough to master the skill within the time left,” then further revisions are made to ensure compliance by the target date. Virginia at 28; Bergeron at ¶142.

Third, a POSITA would have understood that an MGL approach like that in Virginia was known, and could be applied to evaluating the timeliness of progress in a known behavioral modification program like that of the Douglas system, and that such an approach would work in Douglas's system in essentially the same way that it works in Virginia, with the results of the combination being predictable. *KSR Int'l Co.*, 550 U.S. at 401; Douglas at 7:20-29, 8:10-11, 20:5-11, FIGS. 4, 6; Virginia at 27-28; Bergeron at ¶143.

In the '617FWD, the Board found that “Virginia is within the field of endeavor of the '142 patent” and that “Virginia is reasonably pertinent to a problem to be solved by the '142 patent.” '617FWD at 66-70. Thus, “Virginia is analogous art” to the '142 Patent, the parent of the '791 Patent. *Id.* at 69.

4. Claims 1-7, 9, 11-14, and 16-19

For claim elements or any part of claim elements not explicitly discussed below, the Douglas-Virginia system renders obvious all of the limitations of claims 1-7, 9, 11-14, and 16-19 of the '791 Patent for the reasons discussed above for Ground 1 in Section VIII.A.

- (a) *Limitations 1[f], 11[g], and 16[g]: determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant for one or more of the clients; and***

As discussed in Section VIII.C.2, the Douglas-Virginia System discloses determining whether the customized goals are being met in response to consecutive data points of the compiled data passing one or more thresholds to become significant, as the combined System evaluates whether goals are being met in response to three consecutive data points passing the threshold of the minimum growth line. Douglas at 11:11-12:2; Virginia at 27-28 (“If the student demonstrates performance below that line for three data points, then the teacher should revise their teaching strategy”); Bergeron at ¶145.

- (b) *Limitations 1[g], 11[h], and 16[h]: automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients.*

The Douglas-Virginia System discloses automatically communicating alerts to at least the one or more providers to at least perform a review of the goals for the one or more of the clients in response to consecutive data points of the compiled data varying from the one or more thresholds to become significant for the one or more of the clients as discussed in Sections VIII.A.2(h), VIII.A.10(i) and VIII.A.14(i), except the alerts are automatically communicated in response to three consecutive data points passing the threshold of the minimum growth line in the Douglas-Virginia system as discussed in Section VIII.C.4(a). Bergeron at ¶146.

D. Grounds 4, 5, and 6 – Douglas and Chitiveli (Ground 4), Douglas, Khanuja, and Chitiveli (Ground 5), and Douglas, Virginia, and Chitiveli (Ground 6) Render Obvious Claim 8

1. Chitiveli Overview

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

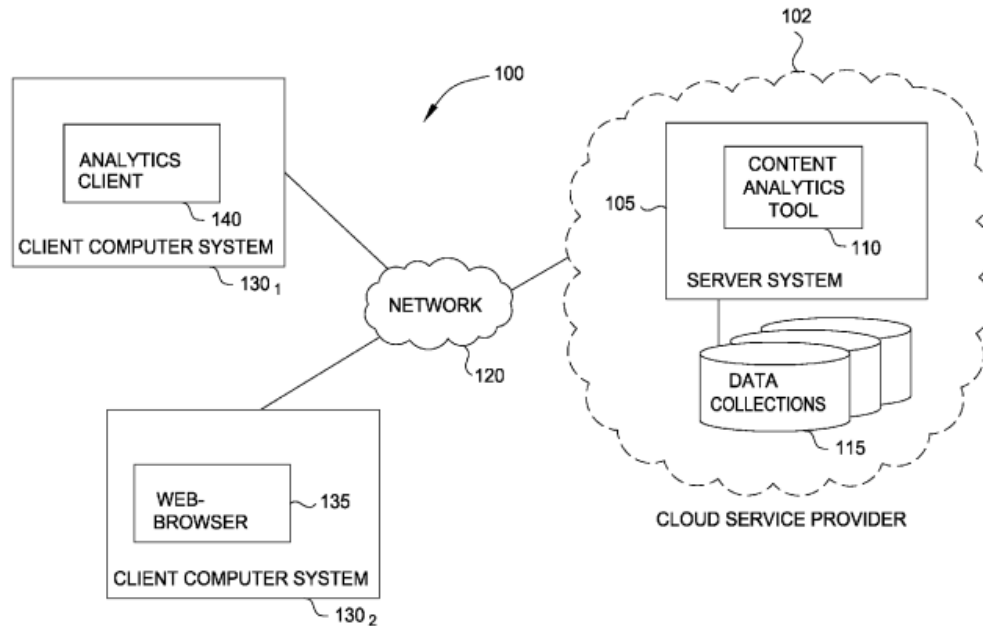


FIG. 1

Chitiveli at [0035]; Bergeron at ¶147. That computing infrastructure includes “a cloud based service provider 102 hosting a server system 105 and also includes computing client systems 130₁₋₂, all of which are connected to a communications network 120.” Chitiveli at [0035]; Bergeron at ¶148. Client computing system 130₁ “execute[s] an analytics client 140” and client computing system 130₂ “execute[s] a web browser 135” to “communicate with a content analytics tool 110 on the server system 105.” Chitiveli at [0036]; Bergeron at ¶148. Using the analytics client or the web browser, a user can “upload enterprise data associated with a given tenant as well as access the resulting data collections 115 hosted by the service provider 102.” Chitiveli at [0036]; Bergeron at ¶148. Content analytics tool 110 then performs “analytical processing” on the uploaded data to “generate periodic reports

... or dynamically generate insights as new data is provided to the content analytics tool 140.” Chitiveli at [0037]; Bergeron at ¶148.

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

2. *Modification of Douglas*

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

- resides on a server (Chitiveli at FIG. 1; *see* Section VIII.A.10(b) (Limitation 11[a]));
- receives data from client devices such as a “desktop or laptop computer systems” (Chitiveli at [0036]; *see* Section VIII.A.2(e) (Limitation 1[d])); and
- analyzes that data to “generate periodic reports on the analyzed data to monitor progress on identified issues” (Chitiveli at [0037]; *see* Sections VIII.A.2(f) and VIII.A.2(g) (Limitations 1[e] and 1[f])). Bergeron at ¶150.

It would have been obvious to implement Douglas’s system (Ground 4), the Douglas-Khanuja System (Ground 5, all three mappings), and the Douglas-Virginia

System (Ground 6) using a SaaS provider like Chitiveli discloses for his content analytics tool, with Douglas's network server 508 implemented on a cloud network (Chitiveli at [0035], FIG. 1), and Douglas's PCs 500 executing client applications to upload patent data to that server for analysis using Douglas's system (*id.* at [0036]-[0037]). Bergeron at ¶151. For Grounds 5 and 6, the modifications of Douglas by Khanuja and Virginia are not affected. The resulting systems are referred to as the Douglas-Chitiveli System (Ground 4), Douglas-Khanuja-Chitiveli System (Ground 5), and the Douglas-Virginia-Chitiveli System (Ground 6).

3. *Motivation to Combine*

As a POSITA would have recognized, such modification of Douglas by Chitiveli would have provided several benefits. Bergeron at ¶152. First, it would have reduced overhead by eliminating the need to procure, maintain, and find space for the network server or to maintain Douglas's system. Chitiveli at [0031]; NetSuite at 1. Bergeron at ¶153. Second, it would have provided increased availability of Douglas's system. NetSuite at 1; Bergeron at ¶154. Third, using a cloud service provider would have resulted in increased security (NetSuite at 1), which is a focus of Douglas (Douglas at 25:5-9). Bergeron at ¶155. Fourth, it would have saved costs—"eliminating the need for on-premise hardware, cloud computing reduces overall server room electric consumption as well." NetSuite at 1; Bergeron at ¶¶156-157.

In the '616 IPR and '617 IPR, Patent Owner did not challenge the motivation to combine Chitiveli with Douglas.

4. ***Claim 8: The method of claim 1, wherein the server is accessed through a cloud network, and wherein a client management program is executed by communications devices utilized by the one or more providers to input the data.***

Ground 4: See Section VIII.A.2 (Claim 1).

Ground 5: See Section VIII.B.4 (Claim 1).

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

Grounds 4, 5, and 6: See Sections VIII.D.2-VIII.D.3. The Douglas-Chitiveli System (Ground 4), the Douglas-Khanuja-Chitiveli System (Ground 5), and the Douglas-Virginia-Chitiveli System (Ground 6) each discloses that the server is accessed through a cloud network, since Douglas's network server 508 would have been implemented on, and thus accessed through, a cloud network, as in Chitiveli. Bergeron at ¶161. The combined Systems also each discloses that a client management program is executed by the computing or communications devices and is utilized by the providers to input the data and track progress of the goals, since, in the system, PCs 500 used by physicians to transmit patient data to the network server for tracking patients' progress toward their goals in Douglas (*see* Sections VIII.A.2(e)-VIII.A.2(g) (Limitations 1[d]-1[f])) would have done so using a client application like Chitiveli's analytics client 140. Bergeron at ¶161. Such client applications disclose the claimed client management program, and they are utilized

in the combination so that Douglas's system can input the data and track progress of the goals. *Id.*

In the '616 IPR and '617 IPR, the Board held that "the combination of Douglas and Chitiveli teaches a client management program executed by a computer device." '616FWD at 50-54; '617FWD at 50-54.

E. Grounds 7, 8, and 9 – Douglas and Koh (Ground 7), Douglas, Khanuja, and Koh (Ground 8), and Douglas, Virginia, and Koh (Ground 9) Render Obvious Claims 10, 15, and 20

1. Koh Overview

Koh "explores data mining applications in healthcare," including "in major areas such as the evaluation of treatment effectiveness." Koh at 64; *see also id.* at 66; Bergeron at ¶162. Per Koh, data mining "aims to identify valid, novel, potentially useful, and understandable correlations and patterns in data by combing through copious data sets to sniff out patterns that are too subtle or complex." Koh at 65; Bergeron at ¶162. Such copious data sets are "generated by healthcare transactions," and they are "too complex and voluminous to be processed and analyzed by traditional methods." Koh at 65; Bergeron at ¶162. For this reason, and because data mining can "identify[] effective treatments and best practices" from such a data set and thereby benefit "healthcare providers, such as hospitals, clinics and physicians, and patients," data mining "is becoming increasingly popular if not essential" in the healthcare field. Koh at 65; Bergeron at ¶162.

Data mining is performed on a data set through, e.g., “online analytical processing; traditional statistical methods, such as cluster analysis, discriminant analysis and regression analysis; and non-traditional statistical analysis, such as neural networks, decisions trees, link analysis and association analysis.” Koh at 65; Bergeron at ¶163.

2. *Modification of Douglas*

Douglas’s system “recommends a default set of goals based on the patient’s needs and existing medical protocols that may be modified by the physician.” Douglas at 7:17-20; Bergeron at ¶164. “This is done by correlating patient information such as age, sex, [and] weight,” and “the patient’s medication and other health conditions” to “established medical protocols for that type of patient.” Douglas at 8:1-13; Bergeron at ¶164. Such recommendations are made by Douglas’s system not just at the outset of the patient’s treatment, but throughout the patient’s treatment. Douglas at 21:9-12; Bergeron at ¶164.

Douglas does not explicitly disclose—apart from “established medical protocols”—how those initial or subsequent recommendations are made. Bergeron at ¶165. But Douglas’s system contains a copious amount of patient health data; for instance, his FIG. 50 shows a total of 12,978 patients on Douglas’s system. Douglas at FIG. 50; Bergeron at ¶165. And Douglas’s patients include “those with chronic ailments,” those “who are recovering from medical procedures,” and those “who

simply want to maintain their health.” Douglas at 6:6-14; Bergeron at ¶165. Being on Douglas’s system, each of these patients would have been associated with a therapeutic plan including goals (Douglas at 8:2-9) and compiled data (*see* Section VIII.A.2(f) (Limitation 1[e])). Douglas at FIG. 50; Bergeron at ¶165.

Douglas’s system also tracks outcomes for these patients. For one, FIG. 50 breaks down its patients into “participating patients complying with the program 368, participating patients put on probation due to lack of compliance 372, and patients terminated 376.” Douglas at 22:21-25; Bergeron at ¶166. Douglas’s system further includes a “review outcomes 354 option,” which Douglas broadly explains includes “information as to the various patient outcomes, based on various pre-determined categories.” Douglas at 23:16-22; Bergeron at ¶166.

It would have been obvious to modify the Douglas system (Ground 7), the Douglas-Khanuja System (Ground 8), and the Douglas-Virginia System (Ground 9) with Koh (hereinafter the “Douglas-Koh System”, the “Douglas-Khanuja-Koh System,” and the “Douglas-Virginia-Koh System,” respectively) such that Douglas’s compiled data was data mined to identify best practices for patients; specifically, the “therapeutic program including goals” that Douglas’s system recommends for those patients (Douglas at 8:1-9). Bergeron at ¶167. For Grounds 8 and 9, the modifications of Douglas by Khanuja and Virginia are not affected. In

the Douglas-Koh System, Douglas-Khanuja-Koh System, and the Douglas-Koh System, data mining would be used to identify:

- (1) a therapeutic plan for a patient based on therapeutic plans for similarly situated patients that were correlated with improvement in compiled data or other positive outcomes, such as compliance with the program or a lack of re-hospitalization, heart attack, or surgery; and/or
- (2) a trend in the patient's compiled data that, for similarly situated patients, was correlated with deterioration in compiled data or other negative outcomes, such as non-compliance with the program or re-hospitalization, heart attack, or surgery, to recommend changes to that therapeutic plan to avoid such negative outcomes. Bergeron at ¶167.

3. Motivation to Combine

Modifying Douglas's system to data mine its compiled data, as taught by Koh, would have "benefitted [Douglas's] healthcare providers ... and patients, for example, by identifying effective treatments and best practices." Koh at 65; Bergeron at ¶168. As to example (1), "[b]y comparing and contrasting ... courses of treatments" and "outcomes," like Douglas's therapeutic plans and outcomes (*see* Section VIII.E.2), "which treatments work best and are most cost-effective" would have been identified. Koh at 66; Bergeron at ¶168. And as to example (2), "data mining applications can be developed to better identify ... high-risk patients," like

those whose compiled data is trending toward a negative outcome (*see* Section VIII.E.2), and “design appropriate interventions” like modifications to Douglas’s therapeutic plans to “reduce the number of hospital admissions and claims,” which is a negative outcome that Douglas seeks to avoid (*see* Douglas at FIG. 55). Koh at 66; Bergeron at ¶168.

In the ’616FWD and ’617FWD, the Board held that “that one of ordinary skilled in the art would have had a reason to combine Douglas and Koh, and a reasonable expectation of success in doing so.” ’616FWD at 57-61; ’617FWD at 57-61.

4. Claim 10

- (a) ***Limitation 10a: The method according to claim 1, further comprising: data mining the compiled data to determine best practices; and***

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

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

Ground 9: *See* Section VIII.C.4 (Claim 1).

Grounds 7, 8, and 9: The Douglas-Koh System (Ground 7), the Douglas-Khanuja-Koh System (Ground 8), and the Douglas-Virginia-Koh System (Ground 9) (*see* Sections VIII.E.1 - VIII.E.3) would have included data mining the compiled data to determine best practices, as Douglas’s compiled data for his numerous patients would have been data mined to determine best practices for a specific

patient, particularly, a therapeutic program or a modification to the therapeutic program for that specific patient. Bergeron at ¶171.

In the '616FWD and '617FWD, the Board held that “by combining the two references [Douglas and Koh], one skilled in the art would have recommended Koh’s best practices to the provider by associating those best practices with specific patients when creating a patient-specific therapeutic program.” '616FWD at 61-63; '617FWD at 61-62.

(b) *Limitation 10b: recommending the best practices in response to the best practices being associated with one of the clients.*

Grounds 7, 8, and 9: The Douglas system, Douglas-Khanuja System, and Douglas-Virginia System each recommends the therapeutic program to the patient’s physician as well as modifications thereto. Douglas at 2:36-3-2, 7:17-20, 21:7-13; Bergeron at ¶172. In the Douglas-Koh System, Douglas-Khanuja-Koh System and Douglas-Virginia-Koh System, that therapeutic program, and modifications to the same reflected best practices associated with one of the clients as determined through data mining. *See* Section VIII.E.4(a) (Limitation 10[a]); Bergeron at ¶172.

In the '616FWD and '617FWD, the Board held that “by combining the two references [Douglas and Koh], one skilled in the art would have recommended Koh’s best practices to the provider by associating those best practices with specific

patients when creating a patient-specific therapeutic program.” ’616FWD at 61-63; ’617FWD at 61-62.

5. ***Claim 15: The system of claim 11, wherein the database is a relational database management system performing data mining to analyze the data to automatically associate best practices with the client.***

Ground 7: See Section VIII.A.10 (Claim 11).

Ground 8: See Section VIII.B.4 (Claim 11).

Ground 9: See Section VIII.C.4 (Claim 11).

Grounds 7, 8, and 9: See Section VIII.E.4 (Claim 10). The Douglas-Koh System, Douglas-Khanuja-Koh System, and Douglas-Virginia-Koh System each discloses that the database is a relational database management system, as Douglas’s databases are “relational databases 522” (Douglas at 24:28-30 (“SQL” is a language used by a database management system), 22:6-7) and that the Systems are used to perform data mining to analyze the data to automatically associate best practices with the clients. See Section VIII.E.2; Bergeron at ¶176.

In the ’617FWD, the Board held that the Douglas-Koh System teaches “wherein the database is a relational database management system performing data mining to analyze the data from the providers to associate best practices with each of the clients” of claim 12 of the ’142 Patent. ’617FWD at 61-62. In the ’616FWD, the Board held that the Douglas-Koh System teaches “wherein the database is a relational database management system performing data mining to analyze the data

from the providers to determine best practices, wherein the best practices are recommended for the client if relevant” of claim 14 of the ’554 Patent. ’616FWD at 61-63.

6. ***Claim 20: The server of claim 16, wherein the set of instructions are further executed to: recommend best practices in response to historic success with one or more of the clients.***

Ground 7: See Section VIII.A.14 (Claim 16).

Ground 8: See Section VIII.B.4 (Claim 16).

Ground 9: See Section VIII.C.4 (Claim 16).

Grounds 7, 8, and 9: See Section VIII.E.4 (Claim 16). In the Douglas-Koh System, Douglas-Khanuja-Koh System, and Douglas-Virginia-Koh System, the therapeutic program and modifications to the program reflected best practices determined to be historically successful through data mining. See Section VIII.E.4(a) (Limitation 10[a]); Bergeron at ¶180.

In the ’617FWD, the Board held that the Douglas-Koh System teaches “wherein the set of instructions are further executed to: recommend best practices to the providers in response to historic success with the clients” of claim 18 of the ’142 Patent. ’617FWD at 63.

IX. CONCLUSION

For the above reasons, the Challenged Claims are invalid, and institution is appropriate.

Dated: June 5, 2026

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CERTIFICATE OF WORD COUNT

Pursuant to 37 C.F.R. § 42.24(a)(i), the undersigned certifies that this Paper—exclusive of the table of contents, mandatory notices under § 42.8, certificate of service, and this certificate of word count—includes 13,945 words.

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

CERTIFICATE OF SERVICE

Pursuant to 37 C.F.R. § 42.6(e) and 37 C.F.R. § 42.105(a), the undersigned certifies that on June 5, 2026, a complete copy of this Petition for *Inter Partes* Review, Petitioner's power of attorney, and all exhibits were served on Patent Owner at the correspondence addresses of record listed below by USPS Priority Mail Express:

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