

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 IPR2026-00391
Patent 11,809,431 B2

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

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PETITIONER'S EXHIBIT LIST

Exhibit	Shorthand	Description
1001	'431 Patent	U.S. Patent No. 11,809,431 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		Omitted
1010		Omitted
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/autism/index.shtml , evidencing 2011 public availability of Virginia
1024		Omitted
1025	'616FWD	Final Written Decision in IPR 2024-00616 for U.S. Patent No. 11,144,554 B2
1026	'617FWD	Final Written Decision in IPR 2024-00617 for U.S. Patent No. 11,151,142 B2

Exhibit	Shorthand	Description
1027	Sweeney	Pub. No. US 2012/0203092 A1
1028	'431 PH	Prosecution History of the '431 Patent
1029	'583 Application	U.S. Provisional Patent App. No. 61/440,583

Claim Listing

Claim	Limitation No.	Limitation
1	1[p]	A method for tracking progression toward goals, the method comprising:
	1[a]	receiving input establishing one or more clients, wherein the one or more clients are individuals receiving treatment or assistance;
	1[b]	assigning the one or more clients to one or more providers, wherein the one or more providers include at least one or more individuals available to treat or assist the one or more clients;
	1[c]	creating a baseline associated with the one or more clients;
	1[d]	setting one or more goals for each of the one or more clients;
	1[e]	compiling data associated with the one or more clients over time, wherein the data includes at least one of weight data and provider data;
	1[f]	storing the compiled data associated with the one or more clients in a server available through one or more networks;
	1[g]	determining, for each goal of the one or more goals, a series of thresholds that represents progress towards the goal;
	1[h]	determining whether progress towards each goals is being achieved by comparing the series of thresholds that represents progress towards the goal against the compiled data and the baseline for the compiled data; and
	1[i]	automatically communicating alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for one of the one or more clients.
2	2	The method of claim 1, wherein the baseline is established utilizing at least one of weight data, provider data, and client data.

Claim	Limitation No.	Limitation
3	3	The method of claim 1, wherein the input is utilized to establish accounts associated with the one or more clients.
4	4	The method of claim 1, further comprising: intervening with one of the one or more clients in response to the alerts.
5	5	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 receive the data and track progress of the goals.
6	6	The method of claim 1, further comprising: performing an assessment of the one or more clients to determine the baseline associated with the one or more clients.
7	7	The method of claim 1, wherein each goal is associated with a plan of action for achieving the goal.
8	8	The method of claim 1, further comprising: recommending the one or more goals to the one or more clients and the one or more providers in response to receiving the input.
9	9	The method of claim 1, further comprising: modifying the one or more goals in response to the compiled data.
10	10	The method of claim 8, wherein modifications are determined to be required if the one of the one or more clients are unable to achieve the one or more goals associated with the one or more clients.
11	11[p]	A system for tracking progression toward goals, the system comprising:
	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:

Claim	Limitation No.	Limitation
	11[b]	receive input establishing an account associated with a client stored in the server, wherein the client is an individual receiving treatment or assistance;
	11[c]	assign the client to one or more providers, wherein the one or more providers include at least one or more individuals available to treat or assist the client;
	11[d]	create a baseline associated with the client based on data from at least the client and the one or more providers;
	11[e]	set one or more goals for the client;
	11[f]	compile data associated with the client received from the one or more providers or sensors over time, wherein the data includes at least one of weight data and provider data;
	11[g]	store the compiled data associated with the client in the server;
	11[h]	determine a series of thresholds representing progress towards each goal of the one or more goals;
	11[i]	determine whether progress towards each goal is being achieved by comparing the series of thresholds against the compiled data and the baseline for the compiled data; and
	11[j]	automatically communicate alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for the client; and
	11[k]	a database in communication with the server configured to store at least the data, the one or more goals, and the series of thresholds associated with the client and the one or more providers.
12	12	The system according to claim 11, wherein the baseline further performs an assessment of the clients to determine the baseline associated with the client.

Claim	Limitation No.	Limitation
13	13	The system according to claim 11, wherein the alerts indicate that the one or more providers are to intervene with the client.
14	14	The system according to claim 11, wherein the one or more goals are associated with a plan of action for achieving the one or more goals.
15	15	The system according to claim 11, wherein the one or more goals are established by the client and the one or more providers.
16	16	The system according to claim 11, wherein the client management program is further executed to: recommend one of the one or more goals to the client and the one or more providers in response to receiving the input.
17	17[p]	A server comprising:
	17[a]	a processor for executing a set of instructions; and
	17[b]	a memory for storing the set of instructions, wherein the set of instructions are executed by the processor to:
	17[c]	receive input establishing clients receiving assistance, wherein the clients are individuals receiving treatment or assistance;
	17[d]	assign the clients to one or more providers in response to selections from an administrator, wherein the one or more providers include at least one or more individuals available to treat or assist the clients;
	17[e]	create a baseline associated with the clients;
	17[f]	set one or more goals for the clients;
	17[g]	compile data in the memory, the compiled data is associated with the clients received from the one or more providers or sensors over time, wherein the data includes at least one of weight data and provider data;
	17[h]	determine, for each goal of the one or more goals, a series of thresholds that represent progress towards the goal;

Claim	Limitation No.	Limitation
	17[i]	determining whether progress towards each goal is being achieved by comparing the series of thresholds that represents progress towards the goal against the compiled data and the baseline for the compiled data; and
	17[j]	automatically communicate alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for one of the one or more clients.
18	18	The server according to claim 17, wherein the set of instructions are further executed to: physically intervene with the one or more of the clients in response to the alerts, wherein the physical intervention is performed by the one or more providers.
19	19	The server according to claim 17, wherein the one or more goals is associated with a plan of action for achieving the one or more goals, and wherein the one or more goals are established by the client and the one or more providers utilizing the baseline.
20	20	The server according to claim 17, wherein the set of instructions are further executed to: recommend the one or more goals to the clients and the one or more providers in response to receiving the input.

I. INTRODUCTION

The '431 Patent is directed to a system for tracking a client's progress toward goals. In particular, the system creates a baseline and a goal for a client, compiles data associated with a client over time, determines whether the client is progressing toward the goal based on a series of thresholds, and communicates alerts based on the progress. The '431 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 significantly before the earliest claimed priority date for the '431 Patent. For example, the Douglas-Virginia and Douglas-Sweeney combinations disclose an internet-accessible system implemented on a server that likewise establishes a baseline and a goal for a client, collects data to determine the client's progress toward the goals based on a series of thresholds, and communicates alerts accordingly.

In fact, Douglas alone and the Douglas-Virginia combination formed the basis of two prior IPRs with final written decisions for patents that are in the same family as the '431 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 in combination with other prior art invalidates all claims of the '431 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 '431 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. 11,675,791 B2 (the "'791 Patent"), which is a continuation of the '142 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. IPR 2026-00616 for U.S. Patent No. 11,144,554 B2 (the "'616 IPR"); and
9. IPR 2024-00617 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 '431 Patent is available for IPR, and Petitioner is not barred or estopped from requesting an IPR on the grounds identified herein. The '431 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 ’431 Patent.

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

Ground	Basis	Reference(s)	Challenged Claims
1	§ 103	Douglas and Virginia	1-4, 6-20
2	§ 103	Douglas and Sweeney	1-4, 6-20
3	§ 103	Douglas, Virginia, and Chitiveli	5
4	§ 103	Douglas, Sweeney, and Chitiveli	5

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 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

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).

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 on August 9, 2012, filed on February 6, 2012, and with priority claimed to U.S. provisional application No. 61/440,583 (“’583 Application” (Ex. 1029)) filed on February 8, 2011, Sweeney (Ex. 1027) is prior art under §§ 102(a) and (e). With respect to § 102(e), Sweeney has a prior art date as of its February 8, 2011 priority date, as the subject matter of Sweeney relied upon in Grounds 2 and 4 herein is supported by the ’583 Application, *compare* Ex. 1027 at [0037]-[0039], [0040], [0045], [0048], [0053], [0056], [0062], [0064]-[0065], FIG. 6B *with* Ex. 1029 at 7:17-9:3, 9:4-23, 11:3-29, 12:23-13:11, 15:4-14, 16:12-22, 18:24-19:4, 19:18-20:12, FIG. 6B, and at least claim 1 of Sweeney is supported by the ’583

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).” ’616 FWD at FN6.

Application. Ex. 1029 at 7:17-8:24, 9:4-10:7, 11:3-12:9, 15:4-17:15, 18:24-21:14, claim 1, Figs. 1, 2A-2B, 3, 4, 6A-6B. In addition, Sweeney is also available as prior art under § 102(e) as of its February 6, 2012 filing date.

V. LEVEL OF ORDINARY SKILL IN THE ART

A POSITA as of March 15, 2013³—the '431 Patent's earliest claimed priority date—would have had at least a bachelor's degree in a healthcare field as well as 1-2 years of experience with health information technology, including specific experience with computer-based systems for recording, tracking, and analyzing patient health information. Bergeron at ¶36. 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 '431 PATENT

As the '431 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.” Ex. 1001 at 1:18-22. With respect

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.

to helping individuals meet their goals, the '431 Patent recognizes that “organizations and institutions ... have improved their processes in recent years.” *Id.* at 1:22-25. Such “[i]mproved assessment, medications, training, treatment processes, and education[] have provided solutions for addressing the concerns of individuals with special needs.” *Id.* at 1:29-32.

The problem, per the '431 Patent, is that “electronic systems, equipment, software, and processes for tracking, treating, and recording results ... have not improved as significantly.” *Id.* at 1:33-36. “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 1:36-39. With such systems, “viewing, updating, managing, and sharing[] relevant information may be more difficult than it should be.” *Id.* at 1:39-41.

To address this problem, the '431 Patent discloses a method, system, and server for creating a baseline and a goal for a client, compiling data associated with a client over time, determining whether the client is progressing toward the goals based on a series of thresholds, and communicating alerts based on the progress. *Id.* at 7:33-56; claims 1, 11, and 17. In this connection, the '431 Patent states that “a baseline may be initial data obtained when the identified goal is first implemented.” With respect to a series of thresholds, the '431 Patent utilizes a “minimum growth line that runs from the baseline data and score ... to the mastery level on the date

that starts the final mastery window.” *Id.* at 7:57-60. The minimum growth line serves as “a reference point against which ongoing data ratings are compared to assess status and level of progress”—that is, the client data collected at a plurality of times are compared to the values of the minimum growth line at those times. *Id.* at 7:63-65.

The ’431 Patent further contemplates that determining progress towards goals takes into consideration the results of the comparison for previous data points. *Id.* at 8:5-7. For example, “a client may be deemed to be progressing if when reviewing three of the most recent data points at least two of the three are better than the minimum growth line (e.g., higher than the upward-sloping minimum growth line ..., lower than the downward slanting minimum growth line, etc.).” *Id.* at 8:7-13. On the other hand, “[a] client's goal may be determined to not be on track if two of the three most recent data points are worse than the minimum growth line.” *Id.* at 8:16-18.

VII. CLAIM CONSTRUCTION

In the ’616FWD and ’617FWD, the Board construed the term “assigning . . . in response to selections” which also appears in the ’431 Patent as follows:

’616FWD Claim Term	’617FWD Claim Term	’431 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”	17[d] “assign the clients to one or more 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 are discussed below. Beyond this term in the ’431 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 and Virginia Render Obvious Claims 1-4 and 6-20

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 (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. The data can be from a provider or the patient. Douglas at 10:10-19, 11:1-5; Bergeron at ¶42. For example, the "system also accepts additional patient data obtained during office visits or directly from the patient... ." Douglas at 11:1-5; Bergeron at ¶42. Douglas's "system might also prompt the patient to input his or her vital signs 102, such as blood pressure and

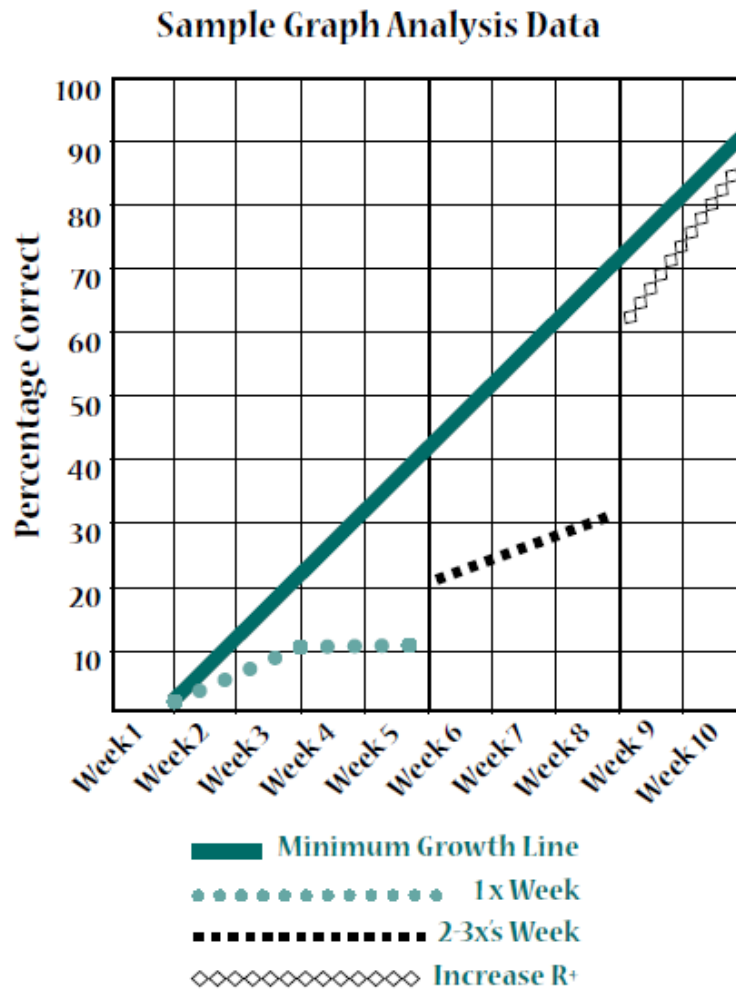
heart rate... .” *Id.* at 10:10-19, 2:32-36; FIG. 13; Bergeron at ¶42. “This can be done manually or automatically. For example, devices can be hooked into the computer's serial port for automatic input of blood pressure and heart rate into the system.” *Id.* If the updated patient data shows that the 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. 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 ¶44. Specifically, Virginia utilizes a minimum growth line (“MGL”)-based approach. Virginia at 27; Bergeron at ¶44. In this approach, a teacher measures a “baseline” performance of a student “[a]t the beginning of the teaching period,” and establishes a “goal [that] stipulates a mastery criterion ... [to be achieved] by the end of the

teaching period.” Virginia at 27-28; Bergeron at ¶44. A line is then drawn on a graph “between the baseline ... and the goal criterion,” which “is called the *minimum growth line*.” Virginia at 27; Bergeron at ¶44. Virginia’s FIG. 4, reproduced below, shows a sample MGL:



Virginia FIG. 4

Virginia at 27; Bergeron at ¶44.

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 ¶45. 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 ¶45. 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 ¶45.

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 ’431 Patent, which is directed to tracking goal progression (*see, e.g.*, ’431 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 ¶46. It is also reasonably related to a problem faced by the inventors of the ’431 Patent: how to assess an individual’s progress toward a goal. *See, e.g.*, ’431 Patent at Abstract, 1:15-19, 30-38, 6:26-37; Bergeron at ¶46. Virginia is therefore analogous prior art to the ’431 Patent.

3. *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 combined Douglas-Virginia System. Virginia at 27-28; Bergeron at ¶47. In such a

combined System, Douglas is modified so that a minimum growth line as in Virginia is created for each goal, running from a baseline value at a corresponding starting time to a mastery, or goal, value at a corresponding ending time. Virginia at 27-28; Bergeron at ¶47. For a given goal, the baseline starting value for the minimum growth line is set to “the baseline value[] corresponding to the vital signals and patient characteristics at the beginning of his or her participation in the program” relevant to that goal, such as a baseline weight for a goal focused on weight loss or gain. Douglas at 7:22-28, FIGS. 6, 40, Virginia at 27; Bergeron at ¶47. Similarly, the mastery, or goal, value is set by the physician, such as, *e.g.*, a goal weight for a goal focused on weight loss or gain, at a corresponding end time set to align with the “period” for which the program is desired to run. Douglas at 7:20-29, 8:10-11, 20:10-11, FIGS. 6, 40; Virginia at 27; Bergeron at ¶47. Once the minimum growth line is created, a representation of it can be stored in the network server of Douglas, where “a]ll the information needed by a user of the system” is stored. Douglas at 24:27-37; Bergeron at ¶47.

To perform the evaluation of “the patient’s progress and compliance with the program” in Douglas, the patient’s data for a particular goal “can [be] compare[d] ... against that line” as in Virginia. Virginia at 27-28; Douglas at 11:26-28; Bergeron at ¶48. That is, at each of a plurality of times during the program, when it is desired to check progress of the patient toward achieving the goal, the value of the patient

data is compared against the value of the minimum growth line at that time. Douglas at 11:26-28; Virginia at 27-28; Bergeron at ¶48. At each point of comparison, if the patient data value “is on or above the line [value]” for an upward trending goal, e.g., for a weight gain goal, or on or below the line value for a downward trending goal, e.g., a weight loss goal, then the patient “is on track to master the goal” by the end of the program, as discussed in Virginia. Virginia at 27-28; Bergeron at ¶48. By contrast, for each point of comparison, if the patient data “demonstrates performance below [or above, depending on the direction of the goal,] that line for three data points,” then the patient is not on track to meet the goal, and the lack of progress is sufficiently large that the program may be “revise[d],” as discussed in Virginia. Virginia at 27-28; Bergeron at ¶48.

The physician is then notified of the result of each comparison, as in Douglas. Douglas at 11:26-12:2; Bergeron at ¶49. For example, if the result is that the patient is on track to master the goal, “[t]he physician ... may then provide positive reinforcement to the patient,” but if the result is that the patient demonstrates performance not meeting the minimum growth line for three data points, “the physician then determines whether to modify the patient’s therapeutic program” or “provide the patient with additional support.” Douglas at 11:26-12:2; Bergeron at ¶49.

4. *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 ¶50. That is, Douglas discusses program goals for completion in “certain period[s],” and an interim “one month goal,” but does not specify in detail how to evaluate at other times 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 ¶50. But Virginia teaches that the MGL approach enables an evaluation at any time during a program 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 ¶50.

Second, a POSITA would have been motivated to use such a combined 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 ¶51. 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 ¶51. 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 ¶52.

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. v. Teleflex Inc.*, 550 U.S. 398, 401 (2007); Douglas at 7:20-29, 8:10-11, 20:5-11, FIGS. 4, 6; Virginia at 27-28; Bergeron at ¶52.

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 ’431 Patent. *Id.* at 69.

5. Claim 1

(a) Limitation 1[p]: A method for tracking progression toward goals, the method 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, the Douglas-Virginia System discloses a method for tracking progression toward goals.

For example, in Douglas, “a physician prescribes ... goals for ... a therapeutic behavior modification program to help a patient recover from an ailment or surgical procedure,” and “[t]he system ... helps monitor compliance with the program.” Douglas at 2:25-32; Bergeron at ¶53; *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 one or more clients, wherein the one or more clients are individuals receiving treatment or assistance;*

The Douglas-Virginia System discloses receiving input establishing one or more clients. In Douglas, “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 ¶54. 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
	26

2 Circle a diagnostic category:

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

24 ~

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:

Daily calories	1200	1500	2000	2500	3000
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 a client in the system, 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 ¶55. Douglas’s patient is the claimed client. *See* ’431 Patent at 5:5-7 (“Individuals being cared for may be referred to as clients [or] patients”); Bergeron at ¶55.

Furthermore, 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 ¶56.

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 the one or more clients to one or more providers, wherein the one or more providers include at least one or more individuals available to treat or assist the one or more clients;*

In the Douglas-Virginia System, the patient is assigned to their physician, who provides treatment or assistance to the patient (*see* Section VIII.A.5(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 ¶57. Indeed, such patient-to-physician assignment is required for Douglas’s system to, *inter alia*, “provide[] the physician with reports of patient progress,” “send an alarm to the physician,” or otherwise “notify the physician” of the patient’s progress. Douglas at 11:6-12:2. Douglas’s physician is the claimed provider. *See* ’431 Patent at 4:64-5:7 (“a provider is ... [a] caregiver” who “care[s] for ... patients.”); Bergeron at ¶57.

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 ¶58.

In the ’616FWD and the ’617FWD, the Board found that Douglas discloses assigning the clients to one or more providers wherein the one or more providers include at least individuals available to treat or assist the client. ’616FWD at 16-21; ’617FWD at 15-20.

(d) *Limitation 1[c]: creating a baseline associated with the one or more clients;*

The Douglas-Virginia System discloses creating a baseline associated with the one or more clients. In Douglas, 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 ¶59. Douglas states that “[i]n order

to subscribe the patient to the system, his or her baseline vital factors are entered. Such factors may include blood pressure readings, heart rate, height, weight, and cholesterol levels.” Douglas at 6:29-31; Bergeron at ¶59. 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 ¶59. For example, in Fig. 4 of Douglas, 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. A POSITA would have understood that by entering the baseline, it is created within the system in Douglas. Bergeron at ¶59.

(e) *Limitation 1[d]: setting one or more goals for each of the one or more clients;*

The Douglas-Virginia System discloses setting one or more goals for each of the clients. In Douglas, “the 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: Fred Smith Date: 3/10/98
Heartland I.D. #: 23-642 Social Security #: 213-48-3947

INITIAL SCALE

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

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

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

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 ¶60. “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	88 Beats Per Minute	88	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/day	325 mg/day	325 mg/day
	hydrochlorothz. 12.5 mg	12.5 mg/day	12.5 mg/day	0 mg/day
	Lovastatin 20 mg	20 mg/day	20 mg/day	0 mg/day

CONFIRM
EDIT
OPTIONS...

Douglas at 8:8-11; Bergeron at ¶60. “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 ¶60. Douglas’s “goals 52” and “final goals 62” for the patient correspond to the claimed goals for the client. Douglas at 8:1-13, FIGS. 5 and 6; Bergeron at ¶60.

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.

(f) ***Limitation 1[e]: compiling data associated with the one or more clients over time, wherein the data includes at least one of weight data and provider data;***

The Douglas-Virginia System discloses compiling data, including weight data or provider data, associated with the clients over time. In Douglas, data associated with each of the clients is collected over time—i.e., compiled—to determine progress of the patient toward achieving the goals. Bergeron at ¶61. The data includes weight data and provider data. 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 ¶61. The data can be “obtained during office visits or directly from the patient” and thus includes provider data. Douglas at 10:10-19, 11:1-5, 2:32-36; FIG. 13; Bergeron at ¶61.

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]: storing the compiled data associated with the one or more clients in a server available through one or more networks;*

The Douglas-Virginia System discloses storing the compiled data associated with a client in a server available through a network. 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 ¶62. Server 508 is available through one or more networks, as Douglas discloses that the "each PC 500 [used by patients, physicians, etc.] is electronically linked to network server 508 via the Internet 518." Douglas at 24:3-26, FIG. 59; Bergeron at ¶62.

(h) *Limitation 1[g]: determining, for each goal of the one or more goals, a series of thresholds that represents progress towards the goal;*

The Douglas-Virginia System discloses determining, for each goal, a series of thresholds that represents progress towards the goal. As discussed in Section VIII.A.3 above, the combined Douglas-Virginia System creates a minimum growth line against which patient data points are compared as they are collected, to determine progress of the patient towards the goal. The combined System therefore discloses a series of thresholds for the goal in the form of the values of the minimum growth line at the points in time at which the patient data is compared to the line. See Section VIII.A.2; Bergeron at ¶63.

This is consistent with an embodiment of the series of thresholds in the '431 Patent, which, as discussed in Section VIII.A.1, utilizes a minimum growth line “against which ongoing data ratings are compared to assess status and level of progress” towards goals. *See* Ex. 1001 at 7:35-37, 57-65. Thus, in the '431 Patent, the series of thresholds can take the form of values of a minimum growth line at times corresponding to collected data points. Bergeron at ¶64.

- (i) ***Limitation 1[h]: determining whether progress towards each goals is being achieved by comparing the series of thresholds that represents progress towards the goal against the compiled data and the baseline for the compiled data; and***

The Douglas-Virginia System discloses determining whether progress towards each goal is being achieved by comparing the series of thresholds against the compiled data and the baseline for the compiled data. As discussed in Section VIII.A.3 above, the combined Douglas-Virginia System compares patient data as it is collected against the values of the minimum growth line at corresponding times to determine whether progress is being made towards the goal. Virginia at 27-28; Bergeron at ¶65. The combined System thus discloses determining whether progress toward the goal is being achieved by comparing the series of thresholds, i.e., the particular values of the minimum growth line, against the compiled data, i.e., the collected patient data. Section VIII.A.3; Virginia at 27-28; Bergeron at ¶65.

Furthermore, the combined Douglas-Virginia System, as also discussed in Section VIII.A.3 above, evaluates each patient data point in the context of the comparison of at least two previous data points to the minimum growth line. Virginia at 27-28; Bergeron at ¶66. That is, for each data point, the combined System evaluates whether it is the third consecutive data point that has fallen below (for an upward trending goal) or remained above (for a downward trending goal) the minimum growth line, and if so, determines that the patient is not on track to meet the goal by the end of the program and that the program may need to be revised. Section VIII.A.3; Virginia at 27-28; Bergeron at ¶66. Because this determination of whether collected data points constitute a third consecutive data point below/above the minimum growth line is performed for each collected patient data point, for patient data points close in time to the beginning of the program, such as the first two data points collected after the baseline data point, the two prior data points will include the baseline data point. Virginia at 27-28; Bergeron at ¶66. Thus, the combined System also discloses determining, at least for these early data points after the start of the program, whether progress toward the goal is being achieved by comparing the series of thresholds, i.e., the particular values of the minimum growth line, against the baseline for the compiled data, i.e., the initial patient data point. Bergeron at ¶66.

This is consistent with the '431 Patent and its prosecution history. As discussed above in Section VIII.A.5(h) for Limitation 1[g], in the '431 Patent, the claimed series of thresholds can take the form of particular values of the minimum growth line at times corresponding to collected data points. Ex. 1001 at 7:57-8:4; Bergeron at ¶67. Moreover, in repeatedly amending the present claim limitation during prosecution, then-Applicant repeatedly cited to paragraphs [0059]-[0061] of the specification, among others, as providing support for this claim feature. '431 PH at 113-121, 164-171, 450-451; Bergeron at ¶67. These cited paragraphs discuss the embodiment in the '431 Patent where “[a] client's goal may be determined to not be on track if two of the three most recent data points are worse than the minimum growth line.” '431 PH at 450-451; Ex. 1001 at 8:16-18; Bergeron at ¶67. Thus, the present claim limitation's comparison of the series of thresholds against the baseline for the compiled data in the '431 Patent can also involve, for patient data points soon after the start of the evaluation (such as the first two data points after the baseline data point), comparing two earlier data points, which will include the baseline data point, against the minimum growth line. Ex. 1001 at 8:5-30; Bergeron at ¶67.

The Douglas-Virginia System also renders obvious determining whether progress towards each goal is being achieved by comparing the series of thresholds against both the compiled data and the baseline for the compiled data. Bergeron at ¶68. First, as discussed in Douglas and in Section VIII.A.3, given that all of the

patient data, including both the “baseline vital factors” and the “updated ... data from the patient,” are stored together in a common “patient record” on the network server, and once the minimum growth line is created, it is also stored on the server, a POSITA would have understood that comparing all of this patient data, including the baseline and ongoing data, to the minimum growth line represented a simple and straightforward, and thus desirable, way to implement the comparing the patient data to the minimum growth line. Douglas at 24:27-37; Bergeron at ¶69.

Second, a POSITA also would have understood, given Virginia’s evaluation of each data point being dependent on the evaluation of previous data points, that comparing the minimum growth line to the patient data including both the baseline and ongoing data points would have enabled the greatest degree of contextualization of the comparison of each data point to the minimum growth line, by including as much patient data as possible in the pool of available patient data. Virginia at 27-28; Bergeron at ¶70.

Third, a POSITA would have understood that implementing the comparison of the minimum growth line to the patient data including both the baseline and ongoing data points represented one of only a finite number of possibilities to implement a comparison of the minimum growth line to the patient data (such as, e.g., either including the baseline data point in the patient data involved in the

comparison or not including it), and thus would have been obvious to try. *KSR Int'l Co.*, 550 U.S. at 402; *Bergeron* at ¶70.

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.

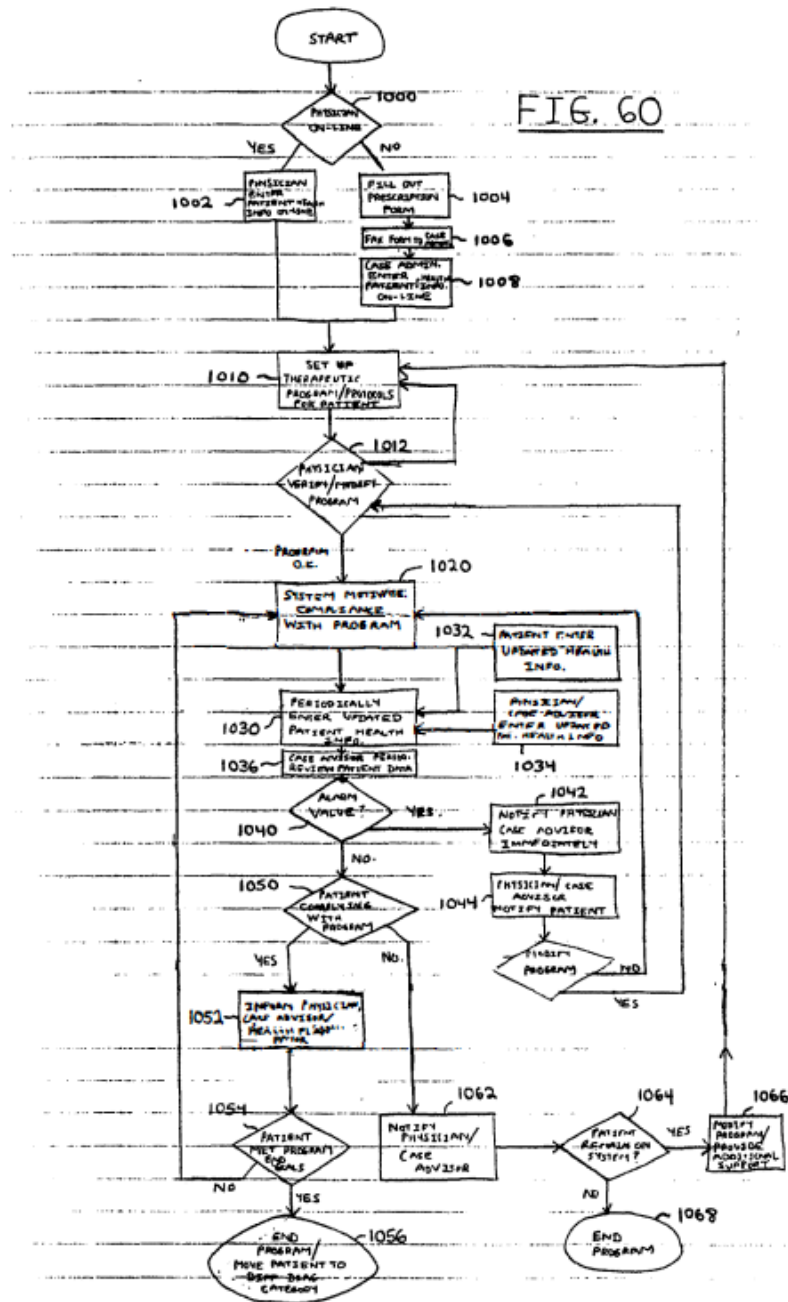
- (j) ***Limitation 1[i]: automatically communicating alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for one of the one or more clients.***

The Douglas-Virginia System discloses automatically communicating alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for a client. As noted above for Limitation 1[h], the Douglas-Virginia System compares the compiled data to one or more of the series of thresholds to determine whether progress toward the goal is being made. The Douglas-Virginia System then automatically communicates alerts in response to determining that the compiled data varies from the one or more thresholds to become significant. *Bergeron* at ¶72.

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

60/60

FIG. 60



At block 1050, Douglas's "system periodically correlates the updated patient health information with program goals to determine the patient's progress and compliance

with the program.” Douglas at 11:26-12:2, FIGS. 60 (block 1050), 5, 6; Bergeron at ¶73. As discussed above in Section VIII.A.3, the Douglas-Virginia System performs this evaluation by comparing the patient data to the minimum growth line. As part of Douglas’s periodic review process, Douglas discloses that “[i]f 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 ¶73. “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 ¶73. A POSITA would have understood Douglas’s “inform[ing]” and “notify[ing]” the physician to disclose automatically communication alerts. Bergeron at ¶73.

The Douglas-Virginia System sends these alerts in response to the variance of the patient data from the minimum growth line becoming significant. For example, Douglas discloses that providing notifications to the physician causes the physician to review the goals for the patient, as “if the patient is not progressing the physician can again “determine[] whether to modify the patient’s therapeutic program, provide

the patient with additional support, or remove the patient from the system (blocks 1064, 1066 and 1068, FIG. 60),” all indications that the variance was significant. 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 ¶74.

Additionally, as discussed above in Section VIII.A.3, in the Douglas-Virginia system, if the patient data “demonstrates performance below that [minimum growth] line for three data points,” then the program may be “revise[d].” This provides a further indication that the variance of the patient data from the minimum growth line is significant. And such a designation in response to three data points falling below the minimum growth line is consistent with the designation of significant given in the ’431 patent, where “[i]f three consecutive data points are worse than the minimum growth line, the third data point may have a status identified as ‘significant.’” Ex. 1001 at 8:18-20.

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.

6. Claim 2: The method of claim 1, wherein the baseline is established utilizing at least one of weight data, provider data, and client data.

In the Douglas-Virginia System, the baseline is established utilizing at least weight data, provider data, or client data. As discussed in Section VIII.A.5(d) (Limitation 1[c]), the baseline in Douglas is created for a patient based on a wide range of parameters. Specifically, Douglas states that “[i]n order to subscribe the patient to the system, his or her baseline vital factors are entered. Such factors may include ... *weight*... .” Douglas at 6:29-31; Bergeron at ¶76. Further, Fig. 6 of Douglas discloses a baseline for weight data on the “Starting Date.”, as well as a number of other data parameters, and Fig. 40 discloses “Weight baseline.” And, as discussed in Section VIII.A.5(f) (Limitation 1[e]), this baseline data can be established based on input from a provider (i.e., provider data) or client (i.e., client data). Bergeron at ¶76.

7. Claim 3: The method of claim 1, wherein the input is utilized to establish accounts associated with the one or more clients.

As discussed above in Section VIII.A.5(b) (Limitation 1[a]), Douglas discloses that the input is utilized for establishing accounts associated with a client. Bergeron at ¶77.

8. Claim 4: The method of claim 1, further comprising: intervening with one of the one or more clients in response to the alerts.

As discussed above in Section VIII.A.5(j) (Limitation 1[i]), in response to the alerts, the physician can modify the patient’s program. Douglas at 11:24-25, 31-34,

36-12:2; Bergeron at ¶78. Such modification discloses the claimed intervening with a client in response to the alerts. Bergeron at ¶78.

9. Claim 6: The method of claim 1, further comprising: performing an assessment of the one or more clients to determine the baseline associated with the one or more clients.

As discussed above in Section VIII.A.5(d) (Limitation 1[c]), in Douglas, “[i]n order to subscribe the patient to the system, his or her baseline vital factors are entered,” where “[s]uch factors may include blood pressure readings, heart rate, height, weight, and cholesterol levels.” Douglas at 6:29-31; Bergeron at ¶79. Additionally, the patient is subscribed to the system in response to “a physician diagnos[ing] an individual with an ailment,” indicating that the physician performs an assessment of the client to determine the baseline associated with the client. Douglas at 6:24-27; Bergeron at ¶79. Further, a POSITA would have understood that it was necessary for a physician or an assistant to perform an assessment of the patient in order to measure the baseline vital factors. Bergeron at ¶79.

10. Claim 7: The method of claim 1, wherein each goal is associated with a plan of action for achieving the goal.

As discussed above in Section VIII.A.5(e) (Limitation 1[d]), Douglas’s “goals 52” and “final goals 62” correspond to the claimed goals. The claimed plan of action is met by Douglas’s overall “therapeutic program.” Douglas at 7:5-8:13, 6:24-27; Bergeron at ¶80. Each goal in Douglas is associated with the therapeutic program

of Douglas (i.e., the plan of action) for achieving the goal. Douglas at 7:5-8:13, 6:24-27; Bergeron at ¶80.

11. Claim 8: The method of claim 1, further comprising: recommending the one or more goals to the one or more clients and the one or more providers in response to receiving the input.

As discussed above in Section VIII.A.5(b) (Limitation 1[a]), the input establishing one or more clients is disclosed in Douglas by, “[i]n order to subscribe the patient to the system, his or her baseline vital factors [being] entered,” where “[s]uch factors may include blood pressure readings, heart rate, height, weight, and cholesterol levels.” Douglas at 6:29-31; Bergeron at ¶81. As discussed in Section VIII.A.5(e) (Limitation 1[d]), “[b]ased on the input information,” which includes the intensity levels as well as patient characteristics “such as age, sex, weight and information,” i.e., including the information input to establish the patient, “the system ... generates a set of goals 52” for the patient as part of “the system suggest[ing] a therapeutic program” for the patient. Douglas at 8:1-9, FIG. 5; Bergeron at ¶81. “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 “the recommended ... final goals 62” to the physician, as shown in FIG. 6. Additionally, “[t]he physician may then recommend [the] health care maintenance or recovery program” to the patient, who “may view their levels of compliance and achievement of [the recommended] goals.” Douglas at 6:24-28,

12:4; Bergeron at ¶81. Still further, as reflected in Fig. 47, Douglas's system "may send the recommendation 346 made by the system and reviewed and/or modified by the physician, to the subscriber 340 with an attached audio e-mail message 344, or alternately via text e-mail or facsimile." Douglas at 21:24-27; Bergeron at ¶81.

12. Claim 9: The method of claim 1, further comprising: modifying the one or more goals in response to the compiled data.

As discussed above in Section VIII.A.5(j) (Limitation 1[i]), based on the compiled data, 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 ¶82.

13. Claim 10: The method of claim 8, wherein modifications are determined to be required if the one of the one or more clients are unable to achieve the one or more goals associated with the one or more clients.

As discussed above in Sections VIII.A.5(i) (Limitation 1[h]) and VIII.A.5(j) (Limitation 1[i]), Douglas discloses "determin[ing] whether to modify the patient's therapeutic program" "if the patient is not progressing toward program goals." Douglas at 11:35-12:2; Bergeron at ¶83.

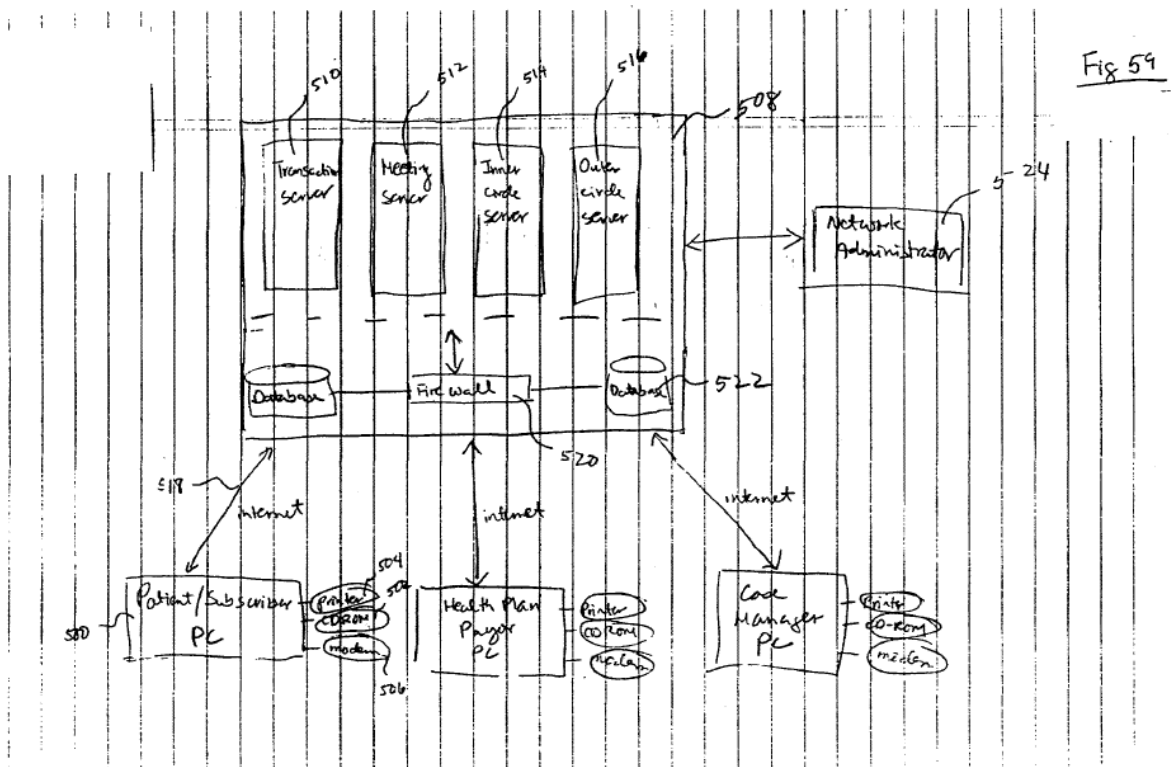
14. Claim 11

(a) Limitation 11[p]: A system for tracking progression toward goals, the system comprising:

See Section VIII.A.5(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:*

The Douglas-Virginia System discloses 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 ¶85. Such PCs include those for “patients, physicians, case advisors, and health plan payors.” Douglas at 24:3-6; Bergeron at

¶85. These PCs are communications devices, as they communicate with the server. Douglas at 24:22-27-34; Bergeron at ¶85.

The communications between PCs 500 and network server 508 are also through a transceiver, which a POSITA would have understood to be “[a] device that can both transmit and receive signals.” Microsoft at 527; Bergeron at ¶86. 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 ¶86.

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 ¶87.

Additionally, 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 ¶88. 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 ¶88. For example, “[c]ontained in each server 508 is a transaction server 510, meeting server 512, ‘inner circle’ server 514, and ‘outer circle’ server 516,” which collectively

perform functions of Douglas’s system, such as “[t]he secure ‘inner circle’ server 514 [being] dedicated to handle sensitive data, such as medical records.”

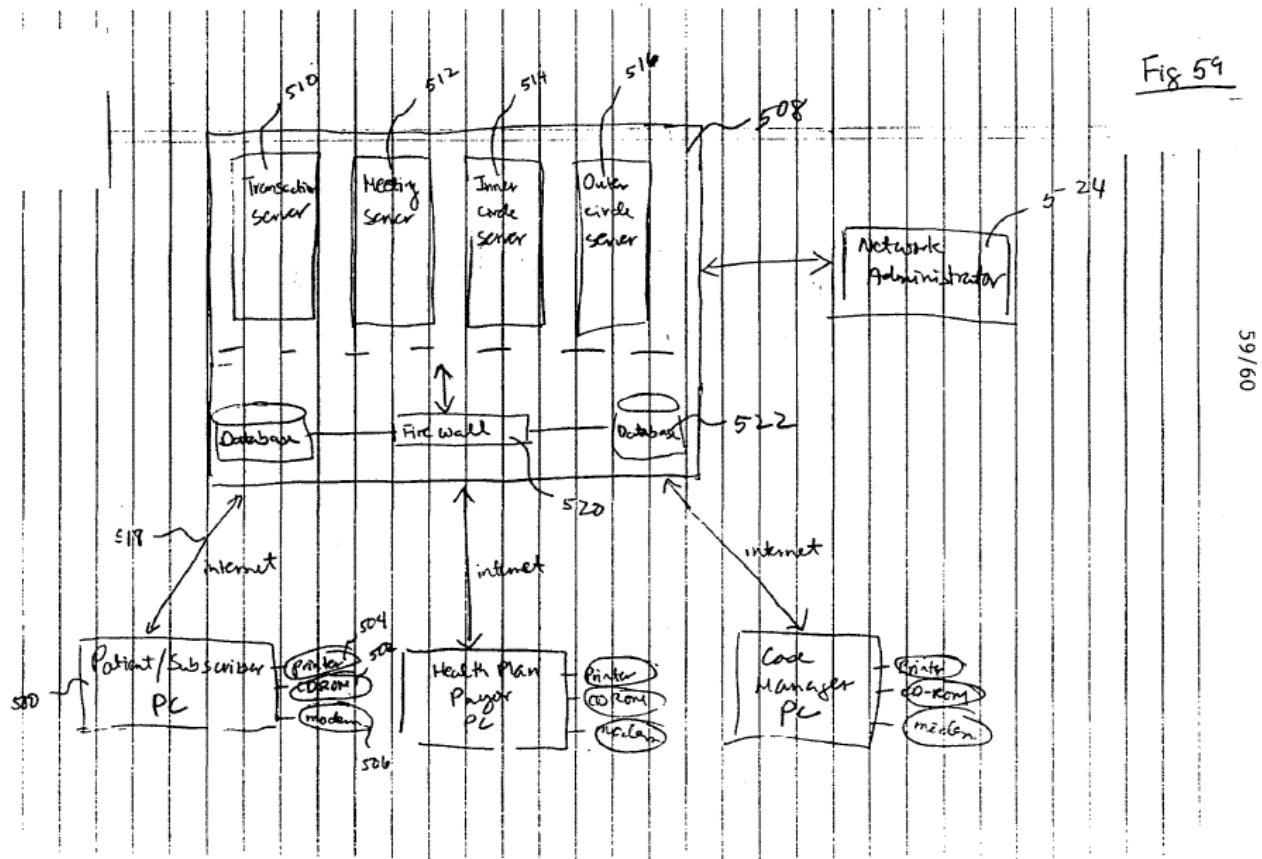
It also would have been obvious for the processor implementing Douglas’s system to reside in network server 508. A POSITA would have understood that locating the processor implementing Douglas’s system in the server containing the health data upon which that system operated—databases 522 of network server 508—would have achieved Douglas’s goal of “protect[ing the] confidentiality of health plan data.” Douglas at 25:14-16; see also Douglas at 10:7-9, 19:29-30, 22:12-14, 24:18-19, 25:5-9; Bergeron at ¶89.

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 associated with a client stored in the server, wherein the client is an individual receiving treatment or assistance;***

See Section VIII.A.5(b) (Limitation 1[a]). Additionally, as discussed for Limitation 1(a), Douglas discloses that the input is utilized for establishing accounts associated with a client. Bergeron at ¶90. Douglas also discloses that the accounts are stored in a server, as this patient account—like other patient accounts in

Douglas's system—is stored on Douglas's network server 508, which contains “[a]ll the information needed by a user of the system,” including the patient, as shown in Douglas's FIG. 59 (reproduced below):



Douglas FIG. 59

Douglas at 24:28-37; Bergeron at ¶90.

- (d) **Limitation 11[c]:** assign the client to one or more providers, wherein the one or more providers include at least one or more individuals available to treat or assist the client;

See Section VIII.A.5(c) (Limitation 1[b]).

- (e) ***Limitation 11[d]: create a baseline associated with the client based on data from at least the client and the one or more providers;***

See Section VIII.A.5(d) (Limitation 1[c]). Additionally, as discussed above in Section VIII.A.6 (Claim 2), the data for creating the baseline is from the client and the provider.

- (f) ***Limitation 11[e]: set one or more goals for the client;***

See Section VIII.A.5(e) (Limitation 1[d]).

- (g) ***Limitation 11[f]: compile data associated with the client received from the one or more providers or sensors over time, wherein the data includes at least one of weight data and provider data;***

See Section VIII.A.5(f) (Limitation 1[e]). Additionally, the data can be “obtained during office visits” or input by the physician, and thus received from the provider, as well as obtained from “devices .. hooked into the [patient’s] computer[,],” and thus received from sensors. Douglas at 10:10-19, 11:1-5, 2:32-36; FIG. 13; Bergeron at ¶94.

- (h) ***Limitation 11[g]: store the compiled data associated with the client in the server;***

See Section VIII.A.5(g) (Limitation 1[f]).

- (i) ***Limitation 11[h]: determine a series of thresholds representing progress towards each goal of the one or more goals;***

See Sections VIII.A.5(h) (Limitation 1[g]).

- (j) *Limitation 11[i]: determine whether progress towards each goal is being achieved by comparing the series of thresholds against the compiled data and the baseline for the compiled data; and*

See Section VIII.A.5(i) (Limitation 1[h]).

- (k) *Limitation 11[j]: automatically communicate alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for the client; and*

See Section VIII.A.5(j) (Limitation 1[i]).

- (l) *Limitation 11[k]: a database in communication with the server configured to store at least the data, the one or more goals, and the series of thresholds associated with the client and the one or more providers.*

Douglas discloses that network server 508 includes “one or more relational databases 522 (such as SQL) that contain all the health plan data” as well as “[a]ll the information needed by a user of the system.” Douglas at 24:28-37; Bergeron at ¶99. This “data” and “information” include Douglas’s disclosure of the data generated by the system and the one or more goals, as well as the Virginia’s disclosure of a series of thresholds, all associated with the client and the one or more providers in the Douglas-Virginia System, 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 ¶99.

Douglas further discloses that network server 508 “ha[s] access to one or more relational databases 522.” Douglas at 24:12-16, 28-30; Bergeron at ¶100. A POSITA would have understood that network server 508 having access to the database 522 discloses that the network server 508 is in communication with the database 522. Bergeron at ¶100.

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.

15. Claim 12: The system according to claim 11, wherein the baseline further performs an assessment of the clients to determine the baseline associated with the client.

In the Douglas-Virginia System, the baseline further performs an assessment of the clients to determine the baseline associated with the client. As discussed above in Section VIII.A.9 (Claim 6), a baseline is created for each client based on an initial assessment of the client. Bergeron at ¶101; *see also* Sections VIII.A.5(d) (Limitation 1[c]) and VIII.A.6 (Claim 2).

16. Claim 13: The system according to claim 11, wherein the alerts indicate that the one or more providers are to intervene with the client.

See Section VIII.A.8 (Claim 4).

- 17. Claim 14: The system according to claim 11, wherein the one or more goals are associated with a plan of action for achieving the one or more goals.**

See Section VIII.A.10 (Claim 7).

- 18. Claim 15: The system according to claim 11, wherein the one or more goals are established by the client and the one or more providers.**

In the Douglas-Virginia System, the one or more goals are established by the client and a provider. As discussed in Section VIII.A.5(e) (Limitation 1[d]), the physician in Douglas's system sets goals for the patient. Douglas also discloses that a patient may participate in establishing the goals. See e.g., Douglas at 6:18-20 ("an individual may want to have a case advisor assist them in losing weight by helping the individual change his or her nutrition, exercise and stress management habits."); Bergeron at ¶104.

- 19. Claim 16: The system according to claim 11, wherein the client management program is further executed to: recommend one of the one or more goals to the client and the one or more providers in response to receiving the input.**

See Section VIII.A.11 (Claim 8).

- 20. Claim 17**

(a) Limitation 17[p]: A server comprising:

See Sections VIII.A.5(g) (Limitation 1[f]) and VIII.A.14(b) (Limitation 11[a]) (network server 508).

(b) *Limitation 17[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.14(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 ¶107. 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 ¶107. 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 17[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.14(b) (Limitation 11[a]); Bergeron at ¶108. 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 ¶108.

- (d) *Limitation 17[c]: receive input establishing clients receiving assistance, wherein the clients are individuals receiving treatment or assistance;*

See Sections VIII.A.14(b) and VIII.A.14(c) (Limitations 1[a] and 11[b]).

- (e) *Limitation 17[d]: assign the clients to one or more providers in response to selections from an administrator, wherein the one or more providers include at least one or more individuals available to treat or assist the clients;*

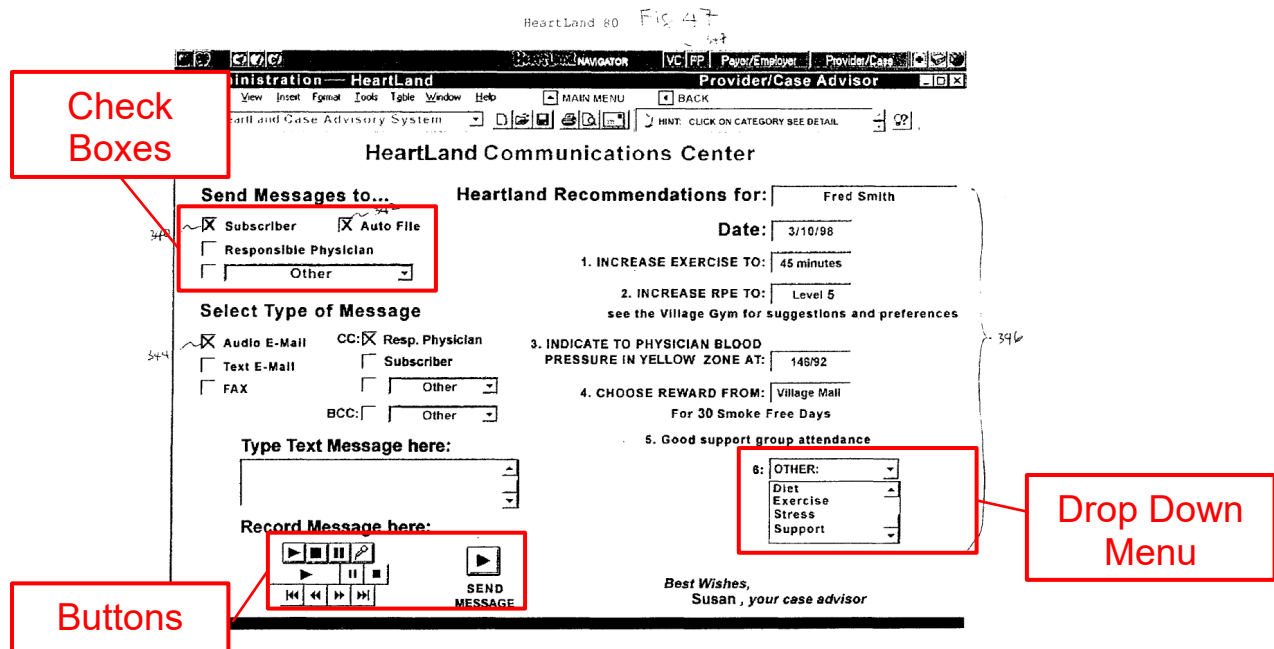
See Sections VIII.A.5(c) and VIII.A.14(d) (Limitations 1[b] and 11[c]). As noted above, in the '616FWD and the '617FWD, the Board construed “‘selection’ as including inputs to a user interface, thereby ‘assigning’ a client to a provider within the system” and “that assigning and selection must be distinct 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 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* Sections VIII.A.5(c) and VIII.A.14(d) (Limitations 1[b]) and 11[c]). 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 ¶111. Douglas’s physician is the claimed provider. *See* ’431 Patent at 5:40-47 (“a provider is ... [a] caregiver” who “care[s] for ... patients.”); Bergeron at ¶111.

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 ¶112. A POSITA would have understood the state of the patient being assigned to the physician to have resulted from such selections by the administrator. Bergeron at ¶112.

Additionally, as the Board found with similar limitations in the ’616FWD and the ’617FWD, Douglas also renders obvious assigning clients to providers in response to selections by the administrator of graphical user interface (“GUI”) components. Bergeron at ¶113. 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 ¶113; *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 ¶114.

First, each of these options represents an obvious “combination of familiar elements according to known methods ... [that] does no more than yield predictable results.” *KSR Int’l Co.*, 550 U.S. at 401 (2007). 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 ¶115. And the button would, like in FIG. 47, act upon the choices—here, to create the patient-to-physician assignment. *Id.* at ¶115. Thus, in options (1) and (2), the functions of the GUI components remain unchanged. *Id.* at ¶115. Each of the options would also lead to the predictable result of the administrator assigning the chosen physician to the patient. *Id.* at ¶115.

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 ¶116; *see also* Douglas at 3:24-5:21, FIGS. 3-6 and 8-58.

(f) *Limitation 17[e]: create a baseline associated with the clients;*

See Sections VIII.A.5(d) and VIII.A.14(e) (Limitations 1[c] and 11[d]).

(g) *Limitation 17[f]: set one or more goals for the clients;*

See Sections VIII.A.5(e) and VIII.A.14(f) (Limitations 1[d] and 11[e]).

- (h) ***Limitation 17[g]: compile data in the memory, the compiled data is associated with the clients received from the one or more providers or sensors over time, wherein the data includes at least one of weight data and provider data;***

See Sections VIII.A.5(f) and VIII.A.14(g) and (Limitations 1[e] and 11[f]). A POSITA would understand that the compiling of the data is done by the processor in Douglas using the memory associated with the processor to store the compiled data. Bergeron at 119.

- (i) ***Limitation 17[h]: determine, for each goal of the one or more goals, a series of thresholds that represent progress towards the goal;***

See Sections VIII.A.5(h) and VIII.A.14(i) (Limitations 1[g] and 11[h]).

- (j) ***Limitation 17[i]: determining whether progress towards each goal is being achieved by comparing the series of thresholds that represents progress towards the goal against the compiled data and the baseline for the compiled data; and***

See Sections VIII.A.5(i) and VIII.A.14(j) (Limitations 1[h] and 11[i]).

- (k) ***Limitation 17[j]: automatically communicate alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for one of the one or more clients.***

See Sections VIII.A.5(j) and VIII.A.14(k) (Limitations 1[i] and 11[j]).

- 21. Claim 18: The server according to claim 17, wherein the set of instructions are further executed to: physically intervene with the one or more of the clients in response to the alerts, wherein the physical intervention is performed by the one or more providers.**

See Sections VIII.A.8 (Claim 4) and VIII.A.16 (Claim 13). Additionally, 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; Bergeron at ¶123. A POSITA would have understood that such data presenting a health risk is a subset of the data showing the patient is not on track to master the goal, and thus such immediate action is also in response to the notifications discussed above in Section VIII.A.5(j) (Limitation 1[i]), and where such immediate action includes physical intervention. Bergeron at ¶123.

Further, as also discussed above Limitation 1[i], 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. Bergeron at ¶124. A POSITA would have understood that both of these actions can include or render obvious a physical intervention. Bergeron at ¶124.

- 22. *Claim 19: The server according to claim 17, wherein the one or more goals is associated with a plan of action for achieving the one or more goals, and wherein the one or more goals are established by the client and the one or more providers utilizing the baseline.***

See Sections VIII.A.7 (Claim 7), VIII.A.17 (Claim 14), and VIII.A.8 (Claim 15). Additionally, as discussed in Section VIII.A.8 (Claim 15), the goals are established by the client and the provider and such goals are established utilizing the baseline. See Sections VIII.A.5(d) and VIII.A.5(e) (Limitations 1[c] and 1[d]); Bergeron at ¶125.

- 23. *Claim 20: The server according to claim 17, wherein the set of instructions are further executed to: recommend the one or more goals to the clients and the one or more providers in response to receiving the input.***

See Section VIII.A.11 and VIII.A.19 (Claims 8 and 16).

B. Ground 2 – Douglas and Sweeney Render Obvious Claims 1-4 and 6-20

1. *Sweeney Overview*

Sweeney discloses a “system ... to monitor an improvement to a subject’s physiological condition.” Sweeney at [0037]; Bergeron at ¶127. A “subject 110 can visit a clinician to receive treatment or a therapy.” Sweeney at [0038]; Bergeron at ¶127. The clinician may recommend that “the subject’s physiological condition [] meet a target condition by a target time, such as to improve the subject’s physiological condition, (e.g., a reduction in fever, a weight loss, a reduction in side

effects, etc.) or to maintain the current physiological condition.” Sweeney at [0038]; Bergeron at ¶127.

“[The] target condition and corresponding target time can be specified as part of a goal improvement profile.” Sweeney at [0038]; Bergeron at ¶128. The goal improvement profile can be generated by an “improvement profile generator 115,” “such as by using at least one of a physiological data history 170 of the subject 110, physiological data of a population 175 that is comparable to the subject 110, or clinician input 180.” Sweeney at [0039]; Bergeron at ¶128. In addition to “a point 210 specifying a target condition to be reached by a corresponding specified target time 212,” the goal improvement profile can include “a goal improvement path, such as a linear path 215 or a curvilinear path 230” that is “specified over time.” Sweeney at [0045], FIG. 2A; Bergeron at ¶128. For example, the goal improvement path can be specified “between a starting physiological condition 220 . . . and the target condition 210 to be reached by the corresponding specified target time 212.” Sweeney at [0045], FIG. 2A; Bergeron at ¶128.

To determine whether “the subject 110 is progressing towards meeting the target condition,” a “comparison circuit 145 can be used to compare [the] goal improvement profile to [the] physiological condition of the subject.” Sweeney at [0040], [0048]; Bergeron at ¶129. “In an example, the comparison circuit 145 can be configured to compare the physiological condition of the subject to the goal

improvement profile 265 at one or more times between a start time 297 and the target time 298.” Sweeney at [0048], FIG. 2B; Bergeron at ¶129.

FIG. 6B depicts “examples of the physiological condition of the subject 660, 670, 680[, 690] and the goal improvement profile 620, such as can be compared by a comparison circuit 145:”

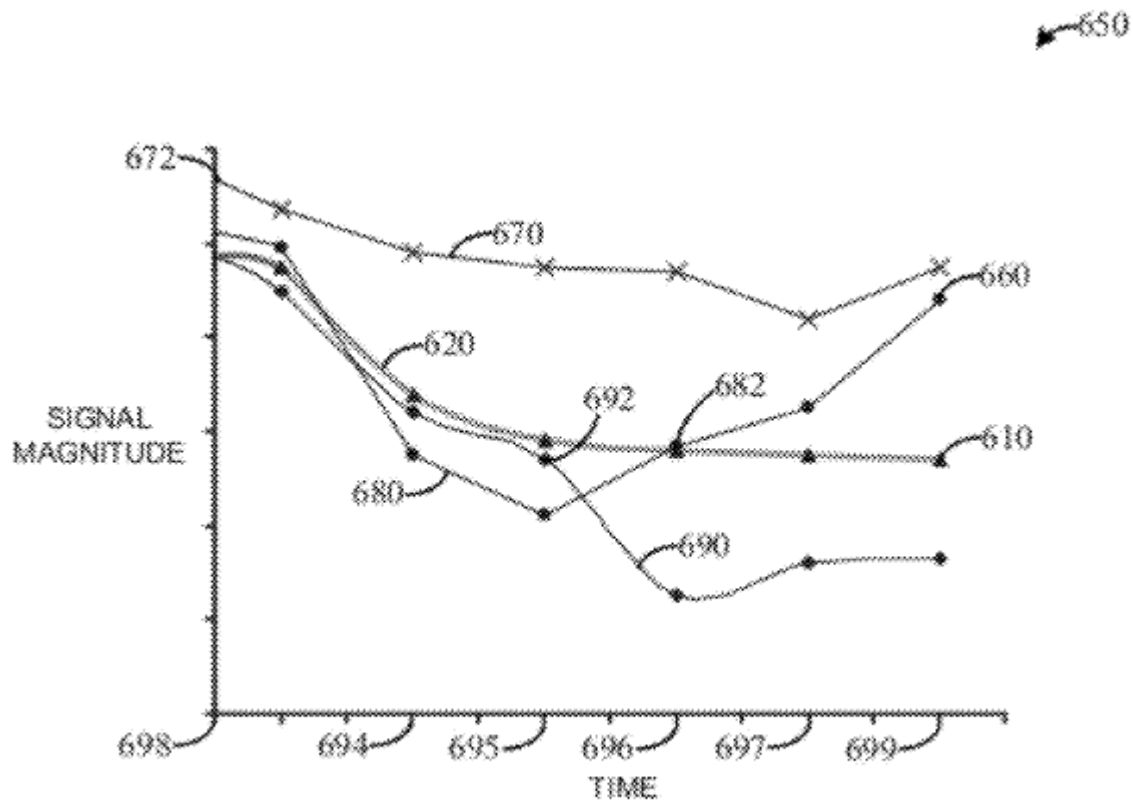


FIG. 6B

Sweeney at [0064]; Bergeron at ¶130.

In one example, “the comparison of the subject's physiological condition 670 to the goal improvement profile 620 can indicate that the subject did not respond to therapy, such that the subject's physiological condition 670 remains substantially the

same as the initial physiological condition 672 at a start time 698, such as at the time of a therapy or at the start of an ongoing therapy.” Sweeney at [0064]; Bergeron at ¶131. In another example, “comparing the physiological condition path 680[] to the goal improvement profile 620 at one or more specified times or time intervals, such as at 694-697 within the target time period,” “can indicate that the subject is progressing toward the target condition 610 until an intermediate time, such as the point 682,” but then after that time “that the subject has failed to progress as expected.” Sweeney at [0065]; Bergeron at ¶131.

2. Modification of Douglas

It would have been obvious to modify the Douglas system to determine whether goals are being met by comparing the patient data in Douglas to a goal improvement profile at a plurality of times as in Sweeney, resulting in the Douglas-Sweeney System. Bergeron at ¶132. In such a combined System, a goal improvement profile as taught in Sweeney can be created for each of the final goals 52, 62 of Douglas, having a target condition set to the goal value in Douglas, and a target time set to align with the “period” for which the program is desired to run in Douglas. Sweeney at [0038]; Douglas at 7:5-7, 8:10-13, 20:1-11, FIGS. 6, 40; Bergeron at ¶132. The combined System further includes, instead of the sole interim one month goal of Douglas, a goal improvement path of the goal improvement profile, such as a linear or curvilinear path specified over time between a starting

point and the target condition at the target time, as in Sweeney. Sweeney at [0045]; Bergeron at ¶132. As discussed in Sweeney, the goal improvement profile, and thus the goal improvement path, can be composed either based on the physiological data of the subject, with a starting point set equal to a starting physiological condition of the subject at a start of the program, or be based on physiological data of a population comparable to the subject or clinician input, in which case the starting point may be set to a value other than the starting physiological condition of the subject. Sweeney at [0039], [0045], [0053], [0064]-[0065], FIG. 6B (goal improvement profile 620, subject data 670, 680); Bergeron at ¶132. The combined System, to perform the evaluation of “the patient’s progress and compliance with the program” of Douglas, can “compare [the] goal improvement profile to [the] physiological condition of the subject” of Sweeney, such as “at one or more times between a start time 297 and the target time 298.” Sweeney at [0040]; Douglas at 11:26-28; Bergeron at ¶132.

3. Motivation to Combine

A POSITA would have been motivated to determine whether customized goals are being met in Douglas by comparing the patient data to a goal improvement profile as in Sweeney, because this would have provided a specific framework for evaluating progress at a plurality of times from a start time to a projected end time of a therapeutic program in Douglas. Bergeron at ¶133. That is, Douglas discusses “periodically correlate[ing] the updated patient health information with the program

goals to determine the patient's progress and compliance with the program.” Douglas at 11:26-28, 20:5-10; FIG. 46; Bergeron at ¶133. However, Douglas specifically discusses only a single interim one-month goal 61 for a given final goal 62. Douglas at 8:10-13; FIG. 6; Bergeron at ¶133. But Sweeney teaches a framework for determining progress towards goals at a plurality of times during treatment, by comparing physiological data of a patient at a plurality of times from a start to the target time to corresponding values of a goal improvement profile at those times. Sweeney at [0039], [0045], [0048], [0064]-[0065]; Bergeron at ¶133. A POSITA would have understood that Sweeney's framework would have provided a concrete evaluation protocol and detailed comparison data at a plurality of times, which could have been used to drive decisions on whether to modify the program or provide the patient with additional support. Bergeron at ¶133.

Additionally, a POSITA would have understood that comparing the physiological data of the patient to the goal improvement profile as done in Sweeney 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' system in essentially the same way that it works in Sweeney, with the results of the combination being predictable. *KSR Intern. Co.*, 550 U.S. at 401; Bergeron at ¶134.

4. Claims 1-4 and 6-20

For claim elements or any part of claim elements not explicitly discussed below, the Douglas-Sweeney System renders obvious the limitations of claims 1-4, and 6-20 of the '431 Patent for the reasons discussed above for Ground 1 in Section VIII.A for Douglas alone.

- (a) *Limitations 1[g], 11[h], and 17[h]: determining, for each goal of the one or more goals, a series of thresholds that represents progress towards the goal (or similar);***

The Douglas-Sweeney System discloses determining, for each goal, a series of thresholds that represents progress towards the goal. As discussed above in Section VIII.B.2, the combined Douglas-Sweeney System discloses comparing patient data at a plurality of times to values of a goal improvement path of a goal improvement profile at those times. Sweeney at [0039], [0045], [0048], [0064]-[0065]; Bergeron at ¶135. These values of the goal improvement path at the plurality of comparison times are the claimed series of thresholds. Bergeron at ¶135. And, as discussed in Sweeney, the values of the goal improvement path represent “whether the physiological condition of the subject is progressing towards meeting the target condition,” and thus disclose a series of thresholds that represents progress towards the goal. Sweeney at [0045]; Bergeron at ¶135.

- (b) *Limitations 1[h], 11[i], and 17[i]: determining whether progress towards each goals is being achieved by comparing the series of thresholds that represents progress towards the goal against the compiled data and the baseline for the compiled data; and (and similar)*

The Douglas-Sweeney System discloses determining whether progress towards each goal is being achieved by comparing the series of thresholds against the compiled data and the baseline for the compiled data. As discussed above in Section VIII.B.2 and Section VIII.B.4(a) (Limitations 1[g], 11[h], and 17[h]), the Douglas-Sweeney System determines whether progress towards each of the goals is being achieved by comparing the values of the goal improvement path of the goal improvement profile against the patient data at a plurality of times between the starting time and the target time. Sweeney at [0040], [0045], [0056]; Bergeron at ¶136. For comparison times occurring at interim points after the start time and before the target time, this discloses the claimed comparison of the series of thresholds, in the form of the values of the goal improvement path at those times to the compiled patient data. Bergeron at ¶136.

Further, a POSITA would have understood that comparison of the goal improvement profile to the patient data as discussed in Sweeney as also including comparing the goal improvement profile to the starting physiological condition of the patient, i.e., the baseline data point. Bergeron at ¶137. For example, when the goal improvement profile is developed from data separate from the patient data, such

as from “physiological data of a population 175 that is comparable to the subject 110, or clinician input 180,” the goal improvement path can have a value at the starting point that is different than the starting physiological condition of the patient, such as shown in FIG. 6B of Sweeney, where the goal improvement profile 620 has a value at start time 698 that is different than the starting value 672 of the exemplary physiological condition data 670 of the patient. Sweeney at [0039], [0053], [0064]-[0065], FIG. 6B; Bergeron at ¶137. In this case, a POSITA would have understood that Sweeney’s broad instruction to “compare a goal improvement profile to a physiological condition of the subject 110” as including comparing the goal improvement profile to all of the patient data, including not only the patient data after the start time and before the end time, but also the starting physiological condition of the patient, *i.e.*, the baseline. Sweeney at [0040], [0062]; Bergeron at ¶137.

A POSITA also would have found it to have been obvious for the comparison of the goal improvement profile to the patient data of the combined System to include comparing the goal improvement path to the starting physiological condition of the patient, *i.e.*, the baseline. Bergeron at ¶138. For example, a POSITA would have understood, at least in the case of the goal improvement path having a value at the starting point that is different than the starting physiological condition of the patient, that the comparison of the goal improvement profile to the baseline data

point would have provided a valuable point of comparison in understanding the progress of the patient towards meeting the goal over the entire course of treatment, and thus would have been motivated to do so. Bergeron at ¶138.

See also Sections VIII.A.5(i), VIII.A.14(j), and VIII.A.20(j) (Limitations 1[h], 11[i] and 17[i]) for a discussion of Douglas in the Douglas-Virginia System satisfying these claim limitations.

(c) *Limitations 1[i], 11[j], and 17[j]: automatically communicating alerts in response to the compiled data varying from one or more of the series of thresholds to become significant for one of the one or more clients. (and similar)*

In the Douglas-Sweeney System, Douglas automatically communicates alerts in response to the compiled data of Douglas varying from one or more of the series of thresholds of Sweeney to become significant for the clients for the same reasons as discussed in Section VIII.A.5(j) (Limitation 1[i]), but with the series of thresholds of Virginia in the Douglas-Virginia System replaced with the series of thresholds as in Sweeney in the Douglas-Sweeny System. Bergeron at ¶140. *See also* Sections VIII.A.5(j), VIII.A.14(k), and VIII.A.20(k) (Limitations 1[i], 11[j] and 17[j]) for a discussion of Douglas in the Douglas-Virginia System satisfying these claim limitations.

- (d) ***Limitation 11[k]: a database in communication with the server configured to store at least the data, the one or more goals, and the series of thresholds associated with the client and the one or more providers.***

In the Douglas-Sweeney System, the database 522 in Douglas is in communication with the server and is configured to store at least the data and the one or more goals associated with the client and provider for the same reasons as discussed in Section VIII.A.14(l) (Limitation 11[k]) for Douglas in the Douglas-Virginia System. It also would have been obvious to also store the goal improvement profile associated with the client and providers, which includes the series of thresholds, from Sweeney, in the database 522 of Douglas for similar reasons, e.g., because the “databases 522 (such as SQL) [] 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 ¶141. *See also* Section VIII.A.14(l) (Limitation 11[k]) for a discussion of Douglas in the Douglas-Virginia System satisfying this claim limitation.

C. Grounds 3 and 4 – Douglas, Virginia, and Chitiveli (Ground 3) and Douglas, Sweeney, and Chitiveli (Ground 4) Render Obvious Claim 5

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]; Bergeron at ¶142. Chitiveli FIG. 1 (reproduced below) “illustrates an example computing infrastructure 100” embodying those techniques:

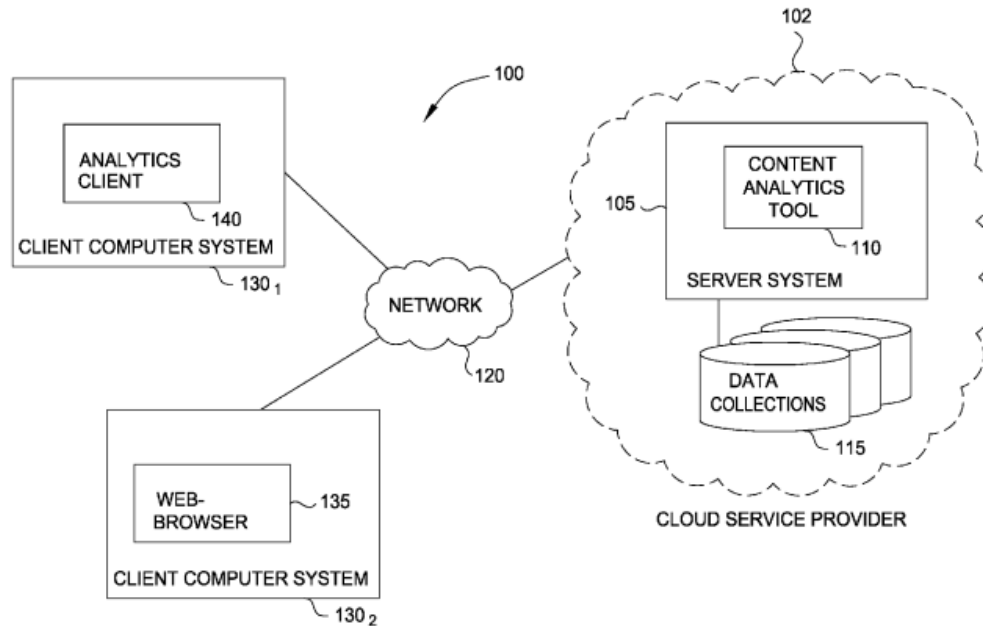


FIG. 1

Chitiveli at ¶[0035]; Bergeron at ¶142. 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 ¶142. 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 ¶142. 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 ¶142. 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 ¶142.

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 ¶143.

2. Modification of Douglas-Virginia and Douglas-Sweeney

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.14(b) (Limitation 11[a])); Bergeron at ¶144
- receives data from client devices such as a “desktop or laptop computer systems” (Chitiveli at ¶[0036]; *see* Section VIII.A.1 and VIII.A.5(f) (Limitation 1[e])); Bergeron at ¶144 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.5(f), VIII.A.5(h), and VIII.A.5(i) Limitations 1[e], 1[g], and 1[h])); Bergeron at ¶144.

It would have been obvious to implement the Douglas-Virginia System (Ground 3) and the Douglas-Sweeney System (Ground 4) 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 ¶145. The modifications of Douglas by Virginia (Ground 1) and Sweeney (Ground 2) are not affected. The resulting systems are referred to as the Douglas-Virginia-Chitiveli System (Ground 3) and the Douglas-Sweeney-Chitiveli System (Ground 4).

3. *Motivation to Combine*

As a POSITA would have recognized, such modification of Douglas-Virginia and Douglas-Sweeney by Chitiveli would have provided several benefits. Bergeron at ¶146. 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 ¶147. Second, it would have provided increased availability of Douglas's system. NetSuite at 1; Bergeron at ¶148. 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 ¶149. 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 ¶150.

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

4. ***Claim 5: 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 receive the data and track progress of the goals.***

Ground 3: See Section VIII.A.5 (Claim 1).

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

Grounds 3 and 4: See Sections VIII.C.2-VIII.C.3. The Douglas-Virginia-Chitiveli System (Ground 3) and the Douglas-Sweeney-Chitiveli System (Ground 4) 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 ¶153. The combined Systems also each discloses that a client management program is executed by the computing or communications devices and is utilized to receive the data and track progress of the goals, since, in the system, PCs 500 used by physicians to transmit patient data to the network server for tracking patients' progress toward their goals in Douglas (see Section VIII.A.5(i) (Limitation 1[h])) would have done so using a client application like Chitiveli's analytics client 140. Bergeron at ¶153. Such client applications disclose the claimed client management program, and they are utilized in the combination so that Douglas's system can receive the data and track progress of the goals. Bergeron at ¶153.

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.

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 13,977 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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