

**ACADEMIC PUBLICATION SET**

## **VIEN GUT MODEL**

Integrated Outpatient Care for Complex Chronic Multimorbidity

### **Part A — Foundation**

Vien Gut Model Academic Publication Set

#### **DOCUMENT A.1**

### **EBM REFERENCE FRAMEWORK: WHAT + HOW + DATA-TO-OPERATE**

From gap to operable structure

**Vien Gut Model — Academic Publication Set**

First systematic compilation — March 2026

Ho Chi Minh City, Vietnam

## AUTHORS & ACADEMIC LEAD

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Independent medical researcher | Founder of Vien Gut | Overall design of HOW — DATA-to-operate / operational layer

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## HOW AND DATA-TO-OPERATE DESIGN TEAM — VIEN GUT

**Nguyễn Đình Quang Huy** Participating in HOW — DATA-to-operate design | System operations management, transfer organization — Vien Gut Model

**Huỳnh Phước Đại, Nguyễn Sơn** Patient-facing language editing | Communications data management, deployment and transfer support — Vien Gut Model

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## ACADEMIC SUPPORT & WHAT (GUIDELINE) BENCHMARKING — INTERNATIONAL EXPERT GROUP

**Thomas Bardin, Pascal Richette** Co-authors of EULAR Recommendations — together with experts in cardiology, nephrology, hepatology, diabetology, diagnostic imaging, and biostatistics at Université Paris Cité, France and Sorbonne Université. Transfer of WHAT from gout treatment guidelines and comorbidities, international WHAT benchmarking; HOW design support — Vien Gut Model.

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## DATA GOVERNANCE TEAM — VIEN GUT

**Trương Ánh Dương, Huỳnh Hồng Đức** Data governance, transfer support — Vien Gut Model

**Lê Việt Anh** Data governance — Vien Gut

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## TREATING PHYSICIANS + MULTIDISCIPLINARY TEAM AT VIEN GUT POLYCLINIC

Clinical HOW deployment: Risk stratification, opportunity window, longitudinal monitoring, risk control, polypharmacy management, referral safety valve activation — Vien Gut Model.

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## RESEARCH SITE

Franco-Vietnamese Center for Gout and Chronic Disease Research, Vien Gut Polyclinic, 13A Hong Ha Street, Tan Son Hoa Ward, Ho Chi Minh City, Vietnam.

# EXECUTIVE SUMMARY FOR EXPERT REVIEWERS

## EXECUTIVE SUMMARY FOR EXPERT REVIEWERS

### DOCUMENT A.1 — EBM REFERENCE FRAMEWORK: WHAT + HOW + DATA-TO-OPERATE

*From gap to operable structure*

Nguyen Dinh Quang — Vien Gut Model  
Tháng 3/2026 — Ho Chi Minh City, Vietnam

## 1. Context and central question

Document A.1 originates from a practical observation: well-trained physicians with full access to international guidelines still struggle when treating patients with complex chronic multimorbidity. The cause does not lie in guideline quality, but in the fact that guidelines are only one of three layers necessary to operate integrated care. The remaining two layers — HOW and DATA-to-operate — do not exist in the current EBM chain as systematically designed components.

*Guidelines specify WHAT to achieve, but do not specify HOW when multiple guidelines conflict on the same patient, and do not provide LONGITUDINAL DATA to activate decisions (DATA-to-operate).*

## 2. The EBM chain and its structural break point

The document analyzes the EBM chain through 8 steps — from basic research to guideline development — and identifies that the first 7 steps function excellently for single diseases, but step 8 (clinical application) is the break point when the subject is a patient with complex chronic multimorbidity.

Cause	Description
Single-disease guidelines	RCTs exclude patients with severe multimorbidity — evidence is generated on “clean” populations
No integration mechanism	No guideline describes how to coordinate when a drug beneficial for one axis harms another
No coordinator	The EBM chain ends at “physician applies guideline” — does not identify who bears overall responsibility
No longitudinal data	Chronic multimorbidity requires time-series data — guidelines rely only on cross-sectional snapshots

### 2.1. The EBM feedback loop — and its structural limitation

The EBM chain has a self-improving feedback loop: identify limitations → new research → updated guidelines. This loop functions excellently for WHAT (guidelines keep improving), but does not produce HOW. The structural reason: HOW is not a product of RCTs or basic research — HOW is a product of structured integrated clinical practice over extended time. The EBM chain was not designed to produce this layer.

## 3. The three-layer framework WHAT – HOW – DATA-to-operate

The Vien Gut Model does not replace EBM — it completes EBM by adding the two missing layers. These three layers are inseparable — they form a single integrated framework:

Layer	Content
WHAT	Guidelines and evidence — already exist, need to be reorganized into a clinical priority map for each specific multimorbid patient. The challenge is not lacking guidelines but organizing multiple single-disease guidelines into a unified plan.
HOW	Structured clinical operations — the missing layer in EBM. Specifically describes: who does what, when, based on which thresholds, with what SLA response time, when to activate the safety valve. Built by Vien Gut over 18 years of practice.
DATA-to-operate	Longitudinal decision-activating data — not research data but structured clinical data,

connecting WHAT with HOW in real time.
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### 3.1. The three layers cannot operate independently

Which layer is missing?	Consequence	Clinical illustration
Missing HOW	WHAT remains on paper, not converted into integrated action	Gout + CKD G4 + heart failure: 3 conflicting guidelines, no one coordinating
Missing DATA-to-operate	HOW operates blind, decisions based on single snapshots	eGFR decline not visible → safety valve activated too late
Missing WHAT	HOW + DATA operate without standards	Does not occur in the VG Model — WHAT is always retained from guidelines

## 4. Link to four verification targets (Part C)

The WHAT–HOW–DATA-to-operate framework is the operational foundation for all four verification targets — none can be achieved with WHAT alone:

Target	WHAT (Guideline)	HOW (Operations)	DATA-to-operate
<b>C.1 Crystal-free</b>	Urate-lowering T2T (ACR/EULAR)	Phased approach, kidney–liver-safe polypharmacy management	Ultrasound caliper mm <sup>2</sup> longitudinal crystal monitoring
<b>C.2 Kidney preservation</b>	KDIGO 2024 CKD management	Resolving urate-lowering drug conflicts with kidney function	Time-series eGFR, creatinine, albuminuria
<b>C.3 Reduced cardiac decompensation</b>	ESC 2021 heart failure	Balancing diuretics–urate lowering–kidney protection	BNP/NT-proBNP, EF, emergency hospitalization frequency
<b>C.4 Cirrhosis recompensation</b>	EASL 2018 decompensated cirrhosis	Polypharmacy management avoiding hepatotoxicity, coagulation monitoring	Child–Pugh, MELD, FibroScan, albumin time-series

## 5. Position in the document system

A.1 is the central theoretical framework of Part A. It lays the foundation for the entire publication set by identifying the structural break point in the EBM chain and presenting the three-layer framework as the solution. Position: A.0 (architectural declaration) → A.1 (EBM framework — this document) → A.2 (three-layer definitions) → A.3 (gap evidence) → A.4–A.5 (terminology). Part B deploys HOW + DATA-to-operate into operational processes. Part C verifies outcomes on target organs.

## 6. Conclusion

The EBM chain is a great achievement of modern medicine — but was designed according to single-disease logic. When the subject is a patient with complex chronic multimorbidity (4–7 severe diseases simultaneously, multiple pathological spirals, multiple guideline conflicts), the EBM chain encounters a structural break point at the application step. The WHAT–HOW–DATA-to-operate framework of the Vien Gut Model is the result of systematization from 18 years of integrated clinical practice — filling the structural gap that the EBM chain was not designed to produce.

*The Vien Gut Model does not replace EBM — it completes EBM by adding the two missing layers (HOW and DATA-to-operate) and verifying outcomes on four target organs.*

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## REFERENCES (abbreviated)

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*Note: Complete list (13 references): see full A.1 document.*

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*Vien Gut is ready to share the entire model with the international medical community as a public good, serving the goal of improving complex chronic multimorbidity care in 129 low- and middle-income countries.*

Complete document system: A.0–A.5 | B.1–B.5 | C.1–C.4 | Part D