INTERNATIONAL ACADEMIC PUBLICATION DOSSIER

VIEN GUT MODEL

Integrated Outpatient Care for Complex Chronic Multimorbidity

Part B – Operational Documents

DOCUMENT B.1

THE FIRST CLINICAL VISIT

Activating the integrated operating system — routing to the Clinical Conductor, the multidisciplinary team, and the safety referral valve

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POSITION OF THIS DOCUMENT WITHIN THE VIEN GUT MODEL ACADEMIC DOSSIER

Document B.1 is not a document about a single disease, nor is it a document describing the entire treatment journey over time. B.1 is the opening document of Part B — the Operational Model — and its role is to define the operational design of the first clinical visit in the Vien Gut Model. If A.0–A.5 explain why this model needs to exist, which frame of reference it uses, and what its operational language is, then B.1 answers the first question of the HOW layer: how is the integrated operating system activated from the very first clinical encounter?

Within the dossier's multi-layer architecture, B.1 belongs to Tier 1 — the basic architecture — together with A.0–A.5 and B.2–B.5. This document is the ignition point of the entire operating system: every piece of data gathered during the first visit — T1–T4 risk stratification, the disease-axis map, assessment of the patient's implementation capacity, triggers for opening specialized branches, and thresholds for activating the safety valve — becomes mandatory input for B.2 through B.5. Without B.1, the phase-based treatment plan in B.2 would have no baseline data; the necessary-and-sufficient conditions in B.3 would have no starting point; the assessment of participation capacity in B.4 would lack context; and the enabling conditions in B.5 would have no initial priority map.

READER GUIDE FOR B.1

To understand the overall architectural statement of the dossier, read A.0.

To understand the WHAT – HOW – DATA-to-operate framework, read A.1.

To understand the definitions of the three foundational layers, read A.2.

To understand the operational terminology system, read A.4–A.5.

To understand the four-phase treatment plan, read B.2.

To understand the necessary and sufficient conditions for retaining an outpatient window of opportunity, read B.3.

To understand the role of the patient and family in operations, read B.4.

To understand enabling conditions and the principles of prioritization when multiple diseases coexist, read B.5.

To understand how this model is applied to individual disease axes, read C.1–C.n.

OPERATIONAL SUMMARY

This document describes the operational design of the first clinical visit in the Vien Gut Model. The first visit is not a session for merely recording symptoms, nor is it an administrative “baseline testing” session. It is the activation point of the entire integrated operating system. Its highest objective is to examine and diagnose the patient comprehensively enough to generate an integrated clinical picture; on that basis, to activate the Clinical Conductor, identify the priority disease axis, stratify risk into T1–T4, open the appropriate specialized branches, identify enabling conditions, lay the foundation for the phase-based treatment plan, and be ready to activate the safety referral valve if the outpatient safety margin is exceeded.

The first visit in the Vien Gut Model therefore does not merely “look at the disease”; it must “look at the whole patient”: the primary disease, comorbid conditions, target-organ damage, pathological spirals, degree of deterioration, the patient’s position relative to the zone of guideline coverage, the capacity of the patient and family to participate, and the risk of treatment breakdown if an integrated plan is not built from the outset. This is the opening document of Part B because it establishes the data foundation, the decision foundation, and the responsibility foundation for all subsequent operational documents.

CONTEXT

In complex chronic multimorbidity outpatient practice, treatment goals cannot be determined only after several disconnected visits; they must be initiated from the very first clinical encounter. This is especially true for the group of patients with severe complicated gout accompanied by chronic kidney disease, heart failure, cirrhosis, diabetes, secondary adrenal insufficiency, and overlapping pathological spirals — that is, the original patient group for whom the Vien Gut Model was built.

In this patient population, failing at the very first visit to identify one disease axis, one risk factor, one current medication, one sign of decompensation, or one enabling condition can make the entire treatment plan slower, more dangerous, or collapse from the outset.

B.1 was written from that experience. It does not describe a “generic check-up package,” but rather an intentionally designed initial-visit architecture that uses the WHAT of the guidelines as its foundation while being organized through the HOW and DATA-to-operate so that it can be applied to real patients. A.1 and A.2 explained why the WHAT alone is insufficient; B.1 is where that framework first enters practice.

OBJECTIVES AND SCOPE OF THE DOCUMENT

Document B.1 has five objectives. First, to define the role of the first clinical visit as the activation point of the entire integrated operating system. Second, to describe the highest objective of the first visit as the creation of an integrated clinical picture. Third, to establish the principles of the initial assessment, including the minimum paraclinical core, the mechanism for opening specialized branches, risk stratification, and safety-valve activation. Fourth, to describe the mandatory outputs of the first visit. Fifth, to place B.1 in its proper position within the overall logic of Part B and the entire dossier.

This document does not include detailed treatment protocols by phase; the necessary and sufficient conditions for identifying the window of opportunity in severe cases; the framework for patient participation capacity; the principles of prioritization and conflict resolution among multiple enabling conditions; detailed clinical evidence for each target organ; or the framework for multicenter validation. Those contents belong to B.2, B.3, B.4, B.5, Part C, and Part D.

1. PROBLEM STATEMENT

The core treatment goals of the Vien Gut Model — crystal-free status in complicated gout, dialysis deferral in progressive CKD, prevention of heart-failure decompensation, hepatic recompensation, and control of severe stages of other chronic diseases — can only be pursued in a substantive way when the patient is approached through the WHAT – HOW – DATA-to-operate model. This means that the first visit cannot be reduced to asking about symptoms and ordering a few isolated tests. It must be the place where we determine where this patient stands in the disease journey, in which zone of guideline coverage the patient still remains, whether the window of opportunity is still open or already lost, and whether the patient can remain under outpatient care or needs preparation for safety-valve referral.

This spirit is consistent with NICE's approach to multimorbidity: instead of mechanically stacking single-disease guidelines, one must assess disease burden, treatment burden, polypharmacy, and the patient's real-world priorities within an individualized management plan with a clearly identified coordinator. B.1 is the first step in translating that principle into concrete operations within the Vien Gut outpatient model.

2. THE HIGHEST OBJECTIVE OF THE FIRST CLINICAL VISIT

The highest objective of the first clinical visit in a patient with complex chronic multimorbidity is to examine and diagnose comprehensively enough all diseases the patient is currently carrying; at the same time, to assess the severity of each disease, the extent of target-organ damage, identify the active pathological spirals, determine the causes driving disease progression, and on that basis stratify the patient according to treatment safety level so that the appropriate management pathway can be chosen from the outset.

In other words, the first visit must produce an integrated clinical picture. That picture must be sufficiently deep to define at least five layers of information: which disease is the primary disease and which comorbidities are dominant; which target organs are already damaged and to what extent; which disease–disease and disease–drug interactions are creating a spiral of deterioration; which real-life factors are continuing to aggravate disease progression; and whether this patient is currently within the guideline-covered zone, the borderline zone, or outside the guideline-covered zone but still sufficiently safe for outpatient management. This picture is not a list of tests. It is the mandatory product of the first visit and the foundation for integrated decisions by the Clinical Conductor.

3. THE MODEL'S RESPONSE TO THREE PATIENT ZONES

The first visit in the Vien Gut Model is not designed for a "clean" population that fits neatly within the population of single-disease guidelines. It is designed to respond simultaneously to three patient zones.

Zone 1 — Within the coverage zone of single-disease guidelines. These are clinical situations still relatively well aligned with current single-disease recommendations; the guideline can be applied directly, and the HOW mainly serves to organize its proper implementation.

Zone 2 — Borderline zone. The patient begins to show multimorbidity, polypharmacy, organ dysfunction, or conflicts between treatment goals; linear application of guidelines is no longer sufficient, and the HOW must resolve conflicts simultaneously.

Zone 3 — Outside the guideline coverage zone but still meeting outpatient criteria. The patient no longer matches the "clean" population of single-disease guidelines, but has not yet crossed the threshold requiring hospitalization or emergency care. This is the thinnest safety margin zone, where the patient can only be retained if the HOW is strong enough and the safety valve is permanently on alert.

A crucial point is that being "outside the guideline coverage zone" does not mean being "outside the standard of care." It means that the patient has moved beyond the simple zone of single-disease guidelines and therefore needs a stronger HOW to maintain outpatient safety. If that safety margin is exceeded, the model does not try to keep the patient; it must activate the referral valve immediately.

4. THE FIRST VISIT IS A COMPREHENSIVE VISIT — THE FOUR VERIFICATION TARGETS ARE NOT FOUR MANDATORY TEST PACKAGES

The first visit in the Vien Gut Model must be designed as a broad but clinically directed visit. Patients coming to Vien Gut may carry any combination of chronic diseases. The Clinical Conductor must see the whole patient — not only through four predefined windows. Therefore, the model's four verification targets are not four mandatory assessment packages to be opened for every patient. They are four priority frameworks for measuring model outcomes. A given axis is opened in depth only when the patient has a clear clinical reason.

Accordingly, the first visit has two layers. The first layer is the invariant mission of every first visit: detect factors that threaten survival, create a complete list of primary disease and comorbidities, identify pathological spirals, stratify risk, and define enabling conditions. The second layer consists of verification axes opened into specialized branches according to clinical indication. This organization avoids both over-ordering and missing major breaking points in the heart, liver, kidneys, and other operational conditions.

5. FIVE PRINCIPLES OF ORDERING DURING THE FIRST CLINICAL VISIT

First, not every patient is assessed in the same way. The first visit must include a minimum safety core to ensure that major breaking points are not missed, but in-depth investigations must follow the disease profile, symptoms, and risk of the individual patient.

Second, every specialized paraclinical order must adhere to up-to-date guidelines of the relevant specialty. The WHAT is not replaced; the HOW only organizes the application of the WHAT to the right patient, at the right time, and at the right level of safety.

Third, the minimum paraclinical core is a system safety core, not a package that fully explores all four axes.

Fourth, every test must be linked to a clear management branch: who is responsible, what the response threshold is, and what the next step is.

Fifth, neither over-ordering nor under-ordering is acceptable. Over-ordering increases burden; under-ordering misses the window of opportunity.

6. THE MINIMUM PARACLINICAL CORE OF THE FIRST CLINICAL VISIT

The minimum paraclinical core of B.1 is not a “general screening package.” It is the minimum dataset required to ensure operational safety for the whole system. Under the current design of B.1, this core includes complete blood count; creatinine, urea, and eGFR; basic electrolytes; urinalysis; AST, ALT, bilirubin, and albumin; blood pressure measurement; a full review of current medications; and screening for glucocorticoid exposure. Depending on risk and clinical context, this may be supplemented by glucose/HbA1c, PT/INR, serum uric acid, 12-lead ECG, and proteinuria/albuminuria.

This core has three operational meanings. First, it creates the baseline dataset for risk stratification. Second, it enables early detection of signs that are pushing the patient beyond the outpatient safety margin. Third, it identifies which disease axis needs to open into a specialized branch on day one. In other words, the minimum paraclinical core of B.1 is the first baseline DATA-to-operate layer, not a list of tests ordered merely to “complete the chart.”

7. THE MECHANISM FOR OPENING SPECIALIZED BRANCHES BY AXIS

The first clinical visit in this model operates through three branch-opening mechanisms.

First trigger: the disease for which the patient presents. If the patient presents for severe gout, CKD, ascites, heart failure, or cardiovascular symptoms, the corresponding specialized branch is opened immediately, while still preserving the heart–liver–kidney safety core because those data determine the feasibility of the entire treatment plan.

Second trigger: typical symptoms or signs. Dyspnea, edema, crackles, chest pain, palpitations, syncope, ascites, jaundice, oliguria, recurrent joint pain, tophi, and similar findings are triggers that may open a specialized branch during the visit itself without waiting for the visit to end.

Third trigger: severely abnormal screening results. Very advanced renal failure, electrolyte disturbances, signs of hepatic decompensation, severe anemia, high-risk ECG findings, or any situation suggesting that the patient has exceeded the outpatient safety margin will cause the system to switch immediately from routine evaluation mode to structured response mode, reassess stratification, and activate the referral safety valve if T4 criteria are met.

This is precisely where B.1 differs from a cross-sectional specialty visit. The visit does not wait until “all data have been completed before making a decision.” It allows decisions to open branches, escalate monitoring, or refer immediately while data are still being generated, provided there are sufficient operational triggers.

8. T1–T4 RISK STRATIFICATION IS A MANDATORY OUTPUT OF THE FIRST VISIT

T1–T4 stratification is not an administrative detail. It is a mandatory product of the first visit. Without stratification, the Clinical Conductor cannot determine the rhythm of follow-up, the density of monitoring, the mechanism for activating the safety valve, or connect B.1 to B.2 in a structured manner. B.1 describes stratification as mandatory baseline data so that B.2 can define the initial treatment phase; B.3 in turn uses this same stratification to determine the patient zone and the level of necessary conditions that apply.

Operationally, T1–T4 does not simply reflect the severity of each individual disease; it reflects the integrated total disease burden: the risk of life-threatening events, the degree of instability, the number of disease axes active simultaneously, and the narrowness of the outpatient safety margin. That is why this is a multi-axis stratification rather than the sum of single-disease stratifications.

9. THE CLINICAL CONDUCTOR AND THE MULTIDISCIPLINARY TEAM ARE ACTIVATED FROM DAY ONE

One of the core differences of B.1 is that the first visit does not end with the examining physician. From the first visit, the Clinical Conductor must be established as the holder of the overall picture, while the multidisciplinary team must be positioned as a sensing-response chain rather than a set of disconnected service providers. This is consistent with the operational definitions in A.4 of the Clinical Conductor and the MDT, and it is the foundation that prevents the whole of Part B from falling back into a fragmented model.

This means that the laboratory does not simply “issue test results”; diagnostic imaging does not simply “perform an ultrasound”; the pharmacist does not simply “dispense medication”; and nurses and outpatient care do not simply “remind the patient to return.” From the very first visit, each position must already know which sensor role it is holding, which signals fall under its responsibility, which thresholds must be escalated, and to whom within the system they must be reported. That is what makes B.1 a document that activates the whole HOW, rather than merely an intake document.

10. MANDATORY OUTPUTS OF THE FIRST CLINICAL VISIT

After the first clinical visit, the system must generate at least six mandatory outputs.

First, an integrated clinical picture, including a complete list of primary disease and comorbidities, the degree of target-organ damage, pathological spirals, factors driving disease progression, and the patient’s position relative to the guideline coverage zone.

Second, T1–T4 risk stratification.

Third, identification of the priority disease axis and the specialized branches that need to be opened.

Fourth, the minimum baseline data required for B.2 to determine the initial treatment phase.

Fifth, a preliminary assessment of participation capacity and implementation barriers, serving as input for B.4.

Sixth, a decision either to retain the patient in structured outpatient care or to activate the safety referral valve.

If the first visit does not generate these outputs, then regardless of how many tests are ordered or how completely symptoms are documented, B.1 has not fulfilled its operational role. The essence of B.1 is not to gather information simply to “know what the patient has,” but to produce sufficiently structured information for the system to begin treatment in the right way.

11. REAL-WORLD ILLUSTRATION — CASE DTH

B.1 currently uses case DTH as a powerful illustration of two core principles of the first clinical visit. First, the first visit must identify both the cause of disease and the factors driving progression, rather than merely documenting diagnoses visible on the surface. In case DTH, the first visit identified decompensated F4 Child–Pugh B cirrhosis caused by alcohol-related liver disease, thereby opening the entire sequence of interventions in alcohol cessation, nutrition, and phase-based FibroScan monitoring.

Second, the minimum paraclinical core must be sufficiently strong to detect serious abnormalities that can simultaneously push the patient into T4 and activate the safety valve on day one, such as severe hyperkalemia, very severe anemia, and profound secondary adrenal insufficiency.

The value of this illustration does not lie in merely recounting a difficult case. It shows that B.1 is not an administrative intake document, but a document about how the first visit can change the entire trajectory of a patient if it is structured enough to see what fragmented care previously failed to see.

12. COMPARISON WITH THE FRAGMENTED TREATMENT MODEL

In the fragmented model, the first visit is usually organized according to the receiving specialty. A patient with joint pain enters the rheumatology frame; a patient with edema and dyspnea enters the cardiology frame; a patient with elevated creatinine enters the nephrology frame. This organization may be suitable for many simple situations, but in complex chronic multimorbidity it creates three consequences: lack of an overall view, lack of a coordinator, and lack of the ability to detect multi-axis pathological spirals from the first day. B.2 already describes the measurable consequences of fragmented care quite clearly, and B.1 is the first document that redesigns that starting point itself.

Therefore, the value of B.1 does not lie in “examining more carefully,” but in examining differently at the level of architecture. It transforms the first clinical visit from a point of information capture into a point of activation for an integrated operating system. That is a structural difference, not merely a difference in diligence.

13. LIMITS OF THE DOCUMENT’S SCOPE

B.1 includes: the operational process of the first clinical visit within the integrated model; the goal of generating an integrated clinical picture; the principles for ordering the minimum paraclinical core; the mechanism for opening specialized branches; risk stratification; the initiating roles of the Clinical Conductor, the MDT, and the safety valve; and the mandatory outputs of the first visit.

B.1 does not include: detailed treatment protocols by phase; the window of opportunity at the level of necessary-and-sufficient conditions; tools for evaluating patient capacity; principles of prioritization and conflict resolution among multiple enabling conditions; evidence for each target organ; or the framework for multicenter validation. Those contents belong respectively to B.2, B.3, B.4, B.5, Part C, and Part D.

14. POSITION OF B.1 WITHIN THE VIEN GUT DOCUMENT SYSTEM

B.1 is the starting point of the entire operating system. Every piece of data collected during the first visit — T1–T4 risk stratification, the integrated clinical picture, triggers for opening specialized branches, and the initial assessment of the patient’s implementation capacity — becomes mandatory input for all documents from B.2 to B.5. B.2 receives the baseline data and stratification in order to define the initial treatment phase; B.3 uses stratification and baseline data to determine the window of opportunity; B.4 integrates the patient’s participation capacity into the operational framework; and B.5 uses the safety core and the initial lesion map to deploy enabling conditions and the conflict-resolution matrix.

In other words, if A.0 is the academic entry point of the entire dossier, then B.1 is the operational entry point of the whole model. That is why B.1 must stand at the beginning of Part B.

CONCLUSION

The first clinical visit in the Vien Gut Model is not a visit for recording symptoms. It is the activation point of the entire integrated operating system. Its highest task is to generate an integrated clinical picture sufficiently deep that the patient is not seen as a chain of disconnected diagnoses, but as a body

carrying multiple disease axes, multiple pathological spirals, multiple risks, and multiple windows of opportunity.

It is from this first visit that the Clinical Conductor is activated, the MDT is placed into a sensing-response chain, risk stratification is established, baseline data are created, specialized branches are opened at the right time, and the safety valve is placed on active alert. B.1 therefore does not merely open Part B. It opens the entire operational logic of the Vien Gut Model.

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