INTERNATIONAL ACADEMIC PUBLICATION DOSSIER

THE VIEN GUT MODEL

Integrated Outpatient Care for Complex Chronic Multimorbidity

Part B – OPERATIONAL DOCUMENTS

DOCUMENT B.2

OUTPATIENT TREATMENT PLAN

The WHAT–HOW–DATA-to-operate Architecture under the Vien Gut Model —

From Complex-Stage Control to Sustainable Maintenance — Four Treatment Phases

The Vien Gut Model — International Academic Publication Dossier

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POSITION OF THE DOCUMENT WITHIN THE ACADEMIC DOSSIER OF THE VIEN GUT MODEL

Document B.2 is not a document about a single disease, nor is it a detailed protocol for one specific emergency scenario. B.2 is the central document of Part B — the Operational Model, tasked with describing the architecture of the outpatient treatment plan over time in the Vien Gut Model. If B.1 answers the question of how the operational system is activated during the first clinical encounter, then B.2 answers the next question: once the operational system has been activated, how is the outpatient treatment plan organized to move the patient through the different stages of the treatment journey.

Within the multi-layered architecture of the dossier, B.2 belongs to Layer 1 — the Basic Architecture. It is built directly on the output data of B.1 while also serving as the foundation for B.3, B.4, and B.5. Without B.2, B.3 would struggle to determine in which phase the window of opportunity remains open; B.4 would lack a framework

for allocating patient participation capacity over time; and B.5 would have difficulty embedding enabling conditions and priority principles into a structured operational journey. In other words, B.2 is the document that connects the logic of system activation in B.1 with the logic of sustaining the operational system over time across the whole of Part B.

READER GUIDE FOR B.2

- 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, read A.4–A.5.
- To understand the first clinical visit and the baseline data of the operational system, read B.1.
- 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 over time, read B.4.
- To understand enabling conditions and priority principles when multiple diseases coexist, read B.5.
- To see how this treatment plan is applied to each disease axis, read C.1–C.n.

OPERATIONAL SUMMARY

This document presents the outpatient treatment plan of the Vien Gut Model as a three-layer structure: WHAT consists of treatment targets and treatment principles benchmarked against the current guidelines for each disease axis; HOW is the clinical operational layer that organizes examination, diagnosis, risk stratification, multidisciplinary coordination, polypharmacy management, revisit cadence, and phase-transition mechanisms; DATA-to-operate is the minimum actionable dataset used to identify target-organ damage, pathological spirals, the degree of decline, and the window of opportunity for treatment. On the basis of these three layers, B.2 organizes the treatment journey into four phases: acute stabilization, titration, maintenance, and target assessment. This is not a theoretical staging system, but the direct result of nearly two decades of integrated outpatient practice at Vien Gut, where patients with complex chronic multimorbidity cannot be treated safely through a static, linear, or cross-sectional plan.

B.2 further affirms that high-level treatment targets such as crystal-free status, dialysis deferral, prevention of heart-failure decompensation, and hepatic recompensation cannot be pursued by mechanically adding together single-disease guidelines. For these targets to become feasible in outpatient practice, the treatment plan must be organized as a dynamic architecture: it must know when to first control immediate risks, when conditions are sufficient for active titration, when monitoring cadence may be relaxed, when results should be maintained sustainably, and when the safety valve or reintegration after a disruption must be activated. B.2 is the document that describes this dynamic architecture.

CONTEXT

In the outpatient management of complex chronic multimorbidity, the greatest weakness of the fragmented model lies not only in the fact that each specialty sees the patient through the lens of its own disease, but also in the fact that treatment planning is often organized as a set of disconnected orders at each visit. When the patient is in pain, analgesics are prescribed; when creatinine rises, the patient is told to drink more water; when edema develops, diuretics are changed; when ascites appears, salt-and-water management is intensified — yet very few settings

possess a treatment architecture clear enough to know which phase of the overall journey the patient is in, what the short-term goal is, what the long-term goal is, and what must be prioritized before higher-level targets can be pursued. B.2 was written to fill that gap at the level of treatment planning.

The originating context of B.2 is the cohort of patients with severe complicated gout accompanied by complex chronic multimorbidity — often simultaneously carrying advanced CKD, heart failure, cirrhosis, diabetes, secondary adrenal insufficiency, anemia, and multiple pathological spirals. [1] In this group, there can be no single "standard prescription" for every moment in time. Treatment is safe only when it is organized by phase: at some times the priority is to keep the patient within the outpatient safety boundary; at some times the conditions are finally sufficient for active titration; at some times monitoring cadence can be relaxed; and at some times the logic must shift from control to sustainable maintenance. B.2 is the document that systematizes exactly that.

OBJECTIVES AND SCOPE OF THE DOCUMENT

Document B.2 has six objectives. First, to define the outpatient treatment plan of the Vien Gut Model as a WHAT–HOW–DATA-to-operate structure. Second, to identify the overall goals of the treatment plan in complex chronic multimorbidity care. Third, to state the principles for constructing an integrated treatment plan. Fourth, to describe the four treatment phases and the mechanisms for moving between phases. Fifth, to place the phase-based treatment plan in relation to polypharmacy, the MDT, the safety valve, and reintegration. Sixth, to clarify the position of B.2 within the whole of Part B and within the academic dossier of the Vien Gut Model.

This document does not include: the detailed design of the first clinical encounter; the necessary and sufficient conditions for identifying the window of opportunity; the operational framework for the patient's role; the enabling-conditions matrix; the protocols for each disease axis; or the roadmap for multicenter validation. Those contents belong to B.1, B.3, B.4, B.5, Part C, and Part D.

1. PROBLEM STATEMENT

The major treatment targets of the Vien Gut Model — crystal-free status on the gout axis, deferral of renal replacement therapy on the CKD axis, reduction of decompensation on the cardiac axis, recompensation on the liver axis, together with the capacity to control severe stages of many other chronic diseases — can be pursued in a meaningful way only when the patient is approached through a structured treatment plan. A patient with complex chronic multimorbidity cannot be treated safely by a series of disconnected orders, nor merely by applying single-disease guidelines one after another in linear fashion. B.2 arises from that recognition: to achieve high-level treatment targets in outpatient care, one must first have a sufficiently robust integrated outpatient treatment plan.

The first clinical visit described in B.1 may generate an integrated clinical picture and an initial stratification, but in itself it is not yet the treatment plan. Once the operational system has been activated, the patient must enter a treatment journey with a logic over time: which phase prioritizes stabilization, which phase is suitable for titration, when monitoring can be relaxed, and when the patient may shift to sustainable maintenance. B.2 is the document that describes that journey. It transforms the baseline data of B.1 into a time-structured architecture so that the whole system can operate continuously rather than merely reacting to isolated events.

2. THE OUTPATIENT TREATMENT PLAN ACCORDING TO WHAT–HOW–DATA-TO-OPERATE

In the Vien Gut Model, the outpatient treatment plan is a three-layer structure. Each layer has its own role and none can substitute for another.

Layer	Role	Determines

WHAT	Treatment targets and treatment principles benchmarked against the current guidelines for each disease axis. [1][2][3][4][5]	Treatment goals, target thresholds, drug principles, and evaluation criteria.
HOW	The clinical operational layer that turns WHAT into real treatment: Clinical Conductor, T1–T4 stratification, polypharmacy management, phase-based scenarios, revisit cadence, MDT, window of opportunity, safety valve. [6]	Which phase the patient is in, which axis takes priority, whether monitoring is dense or relaxed, response thresholds, escalation, or referral.
DATA-to-operate	The minimum dataset needed for action — not to fill a chart, but to answer a decision question. It operates through trends, not isolated snapshots.	Which disease axis is worsening, which pathological spiral is active, whether the window of opportunity remains open, which phase the patient is in, and when to shift phase or activate the safety valve.

From this definition, the Vien Gut outpatient treatment plan is not merely "a long-term prescription," but an operational architecture over time in which WHAT defines what must be achieved, HOW defines how it will be done, and DATA-to-operate defines when cadence, priorities, or the level of safety protection must change.

3. OVERALL GOALS OF THE OUTPATIENT TREATMENT PLAN

The outpatient treatment plan for complex chronic multimorbidity under the Vien Gut Model has five goals.

Goal	Content
First	To control immediate risks and keep the patient within the outpatient safety boundary whenever this remains possible.
Second	To dismantle the pathological spirals that are continuing to drive the patient downward.
Third	To initiate and sustain guideline-based background treatment on the correct disease axis, in the right order and at an appropriate tempo.
Fourth	To monitor longitudinally so as to detect early the window of opportunity for recovery or the warning signs of decompensation.
Fifth	To progressively bring the patient toward the model's verification targets on one or more axes: crystal-free status, dialysis deferral, prevention of heart-failure decompensation, hepatic recompensation, or other structural–functional targets depending on the patient's profile.

A crucial point is that these goals do not carry equal priority at every moment. In the initial phase, the priority may be to prevent the patient from crossing the outpatient safety boundary. In later phases, priority can progressively shift toward active titration in pursuit of the verification targets. B.2 was written precisely to transform that shifting hierarchy of priorities into a clear phase-based structure.

4. PRINCIPLES FOR BUILDING THE OUTPATIENT TREATMENT PLAN

The outpatient treatment plan in the Vien Gut Model is built on five principles.

Principle	Content
Principle 1	One patient, one integrated frame of reference. A patient may have many diseases, but the treatment plan must have one overall coordinating axis and one shared logic of priority. The Clinical Conductor holds this axis. [6]
Principle 2	Do not apply single-disease guidelines mechanically. The treatment plan must determine whether the patient lies within the guideline coverage zone, the borderline zone, or outside the coverage zone but still meets outpatient criteria. In the inner zone, WHAT can be applied closer to the standard template. In the borderline and outer zones, HOW must be stronger in order to resolve conflicts and protect the safety boundary. [1]
Principle 3	Protect vital organs first; optimize long-term targets second. In every phase, preventing heart, kidney, liver, and other life-threatening breakpoints takes precedence over long-term optimization. Higher targets matter only while the patient remains within a safety boundary that still allows them to be pursued.
Principle 4	Polypharmacy management is a mandatory component. No treatment plan is complete unless it includes active assessment and management of polypharmacy, drug interactions, cumulative toxicity, and treatment burden.
Principle 5	Decide by trend, not by a single snapshot. Any decision to shift phase, refer, or reprioritize must be based on time-series trends, not on a solitary result from a single visit. This is the principle that makes DATA-to-operate indispensable to the whole treatment plan.

5. THE FOUR-PHASE STRUCTURE OF THE TREATMENT PLAN

The outpatient treatment plan in the Vien Gut Model is organized into four phases. The purpose of dividing treatment into four phases is not theoretical elegance, but fidelity to the real practice of complex chronic multimorbidity care: a patient cannot be followed with the same cadence and the same decision logic from beginning to end. Each phase has a different goal, a different degree of stability, a different revisit cadence, different triggers, and a different role for HOW and DATA-to-operate.

Phase	Name	Main Goal	WHAT–HOW–DATA Focus	Revisit Cadence
Phase 1	Acute stabilization	To control complex acute symptoms, reduce the frequency of deterioration episodes, and re-establish a minimal outpatient safety boundary.	WHAT is the foundation; HOW predominates — contingency scenarios, safety valve on standby, dense Clinical Conductor response.	Dense: every few days to 2–4 weeks
Phase 2	Titration	To maintain relative stability, prevent return to the decompensation spiral,	Drug titration has the greatest role (ULT, kidney protection, cardiovascular	More relaxed than Phase 1, but still dense enough

		and move closer to the verification targets.	treatment, cirrhosis management). HOW must be both active and cautious.	
Phase 3	Maintenance	To consolidate gains, preserve favorable trends, reduce the risk of relapse, and move nearer the verification targets.	HOW becomes less acutely reactive and more focused on adherence management and longitudinal follow-up. The patient's role becomes more prominent.	May be extended up to ~6 months depending on the axis
Phase 4	Target assessment + sustainable maintenance	To assess the verification targets (e.g., crystal-free) and then maintain the achieved result sustainably while keeping a professional connection.	HOW shifts toward minimal surveillance, milestone reminders, and sustained contact. The system does not withdraw too early.	Relaxed, but still within a system of surveillance

Phase 1 — Acute stabilization: controlling the complex active manifestations of disease

For each disease axis and each common scenario, the system must already contain contingency plans embedded in DATA-to-operate: when symptoms worsen, when side effects emerge, when laboratory values cross a threshold, when patient cooperation weakens — who receives the information, who performs the first assessment, when the Clinical Conductor is alerted, and when the safety valve is activated. The dense revisit cadence in this phase is an operational choice of the model, not a fixed interval dictated by guideline text.

Phase 2 — Titration: disease is temporarily more stable, and medication has begun to work

This is not yet a phase of absolute safety; the referral safety valve must still remain on active standby. HOW in this phase must be active enough not to miss the window of opportunity, yet cautious enough not to push the patient outside the outpatient safety boundary. Revisit intervals may be relaxed compared with Phase 1, but still need to be dense enough to preserve the system's sensitivity to downward trends.

Phase 3 — Maintenance: the target has started to show favorable movement, and the patient is aware of adherence

The focus is no longer on "treating an acute episode" but on keeping the treatment trajectory from breaking down. This is the phase in which the sufficient conditions on the patient side — self-monitoring capacity, cooperation, and the family support system — begin to exert a stronger influence. HOW must adjust accordingly: less acute reaction, more adherence management, longitudinal follow-up, and behavioral support.

Phase 4 — Target assessment and sustainable maintenance

Phase 4 does not mean that treatment is fully ended. HOW shifts toward minimal surveillance, milestone reminders, maintenance of communication, and keeping the patient within the information field of the system — this is precisely the layer that prevents a high-level treatment result from being lost merely because the system withdrew too early once the patient had improved.

6. PHASE-TRANSITION MECHANISM

A phase transition must not be determined by the subjective feeling that "the patient seems better," nor by a single improved laboratory result. In the Vien Gut Model, a phase transition is an operational decision based on three groups of data: target-organ trends, the status of pathological spirals, and the real-world execution capacity of the patient and family. Only when all three data groups show that the patient is ready for the next phase does the system advance the phase. If one of the three groups remains unstable, the patient must remain in the current phase or may even move back to an earlier phase.

This is crucial because, in complex chronic multimorbidity, "stable on one axis" does not mean "stable as a whole person." A patient may have less joint pain while the kidneys are worsening, or the edema may be reduced while cirrhosis is beginning to decompensate, or serum urate may look favorable while patient cooperation is declining. For this reason, a phase-transition decision is always a cross-axis and cross-layer decision — looking simultaneously at WHAT, HOW, and DATA-to-operate.

7. ORDERING PRINCIPLES WITHIN THE OUTPATIENT TREATMENT PLAN

B.2 retains the five ordering principles already stated in the original version, but places them within the logic of the phase-based plan.

Principle	Content
First	Do not evaluate every patient in the same way. Patients enter the phase-based plan with different disease combinations, so specialized branches must be opened according to the real disease, symptoms, and risks of each individual patient.
Second	Every disease-specific advanced investigation must remain anchored to the updated guidelines of the relevant specialty. WHAT is not replaced; HOW only organizes the application of WHAT to the right person and the right phase.
Third	The minimum paraclinical core is a system safety core, not a "four-axis comprehensive package."
Fourth	Each test should be ordered only when the system already knows what it will do if the result is abnormal.
Fifth	Avoid both over-ordering and under-ordering.

In B.2, these five principles apply not only to the first visit but to the entire rhythm of test ordering and monitoring across the phases of outpatient treatment.

8. THE MINIMUM PARACLINICAL CORE AND THE LONGITUDINAL MONITORING FOUNDATION

The minimum paraclinical core is established in B.1, but it does not end there. In B.2, it becomes the longitudinal monitoring foundation of the entire treatment plan. Complete blood count, creatinine, urea, eGFR, electrolytes, urinalysis, liver enzymes, albumin, blood pressure, current medications, and glucocorticoid exposure are not merely day-one data. They are baseline variables that will be reread in every phase to answer a very practical operational question: is the patient moving forward, standing still, or slipping downward?

On this foundation, specialized disease-axis branches are opened and sustained at different rhythms. The gout axis needs longitudinal follow-up of serum urate, inflammatory flares, tophi, and imaging. [3] The kidney axis needs eGFR, creatinine, albuminuria, electrolytes, and sometimes renal elastography. [2] The cardiac axis needs NT-

proBNP/BNP, ejection fraction, and decompensation events. [4] The liver axis needs FibroScan, albumin, PT-INR, ascites, and Child–Pugh assessment. [5] Thus, in B.2, DATA-to-operate does not mean "more data," but rather the data sufficient to connect the treatment phase with the real state of each disease axis.

9. POLYPHARMACY MANAGEMENT AND MULTIDISCIPLINARY TEAM COORDINATION BY PHASE

Polypharmacy management cannot be an afterthought added after the treatment plan already exists. In complex chronic multimorbidity, it must be embedded in the core of the plan from the outset. In Phase 1, the focus is on avoiding acute toxicity and blocking dangerous interactions. In Phase 2, the focus is on titrating in the right sequence to reach targets without pushing vital organs into decline. In Phase 3, the focus is on reducing treatment burden and preserving adherence. In Phase 4, the focus is on sustainable maintenance without allowing the patient to "cut off" therapy simply because they feel improved.

Similarly, the MDT does not have an invariant role across all phases. In the initial phase, the laboratory, diagnostic imaging, pharmacist, and Clinical Conductor usually operate in a denser reaction mode; in later phases, nursing, outpatient care, communication/visual medicine, and adherence follow-up become more prominent. This shows that a phase-based treatment plan is not merely a schedule of appointments, but a reorganization of the role of the entire system around the patient's real state.

10. THE SAFETY VALVE AND REINTEGRATION ARE NOT OUTSIDE THE TREATMENT PLAN

A common mistake of many outpatient models is to treat referral as a sign of failure of the treatment plan. B.2 does not take that view. In the Vien Gut Model, the referral safety valve is part of the plan from the beginning. It does not stand outside the treatment journey. In each phase, the system must know which threshold means that the patient has crossed the outpatient safety boundary, who activates the referral, what data are handed over, and under what conditions the patient can be reintegrated after an inpatient episode.

In other words, referral does not sever the treatment plan. It is a segment of that plan when the outpatient safety boundary is no longer sufficient. This is especially important in red-zone patients, where the interval between "still manageable as an outpatient" and "already beyond the outpatient threshold" may be very short. A phase-based treatment plan can only be considered complete if the safety valve and the reintegration loop after referral have been pre-built into it.

11. PRACTICAL ILLUSTRATION — CASE DTH AS A FOUR-PHASE JOURNEY

Case DTH is a typical illustration of the four-phase logic of B.2. In Phase 1, the goal was not to lower urate rapidly, but to handle hyperkalemia, profound anemia, and severe secondary adrenal insufficiency simultaneously in order to re-establish the minimal safety boundary. In Phase 2, once some baseline variables had stabilized, urate-lowering therapy was started cautiously and interventions such as alcohol cessation entered a structured treatment logic. In Phase 3, a favorable trend became increasingly clear: serum urate fell, GGT fell, FibroScan improved, ascites disappeared, and hemoglobin improved. In Phase 4, the patient reached a relatively sustainable stable state with a more relaxed revisit cadence, but still within the surveillance field of the system. [6]

Table. Multi-axis indicators in Case DTH across the four-phase journey (Source: Appendix 5b — Anonymous Case DTH, Document C.1)

Indicator	Baseline (01/2021)	Mid-journey	Most recent (01/2025)	Change
Uric acid	599 µmol/L	322 → 288	276 µmol/L	−54%
eGFR (CysC)	11 mL/min	≈11 (stable)	9.67 mL/min	Declined after loss to follow-up
Creatinine	307.8 µmol/L	Stable	651.8 µmol/L	↑ after >1 year lost to follow-up
GGT	397.1 U/L	Decreased gradually	87.1 U/L	−78%
Cortisol	2.1 µg/dL	Recovered gradually	4.51 µg/dL	×2.1
ACTH	1.3 pg/mL	Recovered gradually	22.14 pg/mL	×17
K^+	5.6 mmol/L	Returned to normal	4.24 mmol/L	Normalized
Na^+	128 mmol/L	Improved gradually	136 mmol/L	Normalized
Hemoglobin	5.2 g/dL	Increased gradually	11.53 g/dL	×2.2
Cirrhosis	Decompensated F4, ascites, grade III splenomegaly	Improved gradually	F4→F3, ascites resolved, splenomegaly 0	Recompensation
Tophi R / L	850 / 468 mm²	660/420 → 588/363	430 / 315 mm²	−49% / −33%
Troponin T hs	47.27 pg/mL	—	150 pg/mL	↑ after loss to follow-up

The value of this illustration does not lie in a single difficult case, but in showing that the four phases are not a schematic theory imposed from above. They are a model of what actually happens in the outpatient journey of a very ill patient when the operational system is sufficiently tight to both protect safety and continue moving the treatment plan toward high-level targets.

12. COMPARISON WITH THE FRAGMENTED TREATMENT MODEL

In the fragmented treatment model, the treatment plan is usually understood as a set of prescriptions and orders at each visit, with each specialty managing one segment. What is missing is a shared time framework, a shared phase-transition logic, a single person with final responsibility, and a longitudinal data mechanism strong enough to keep the patient from falling into the gaps between specialties. The result is that a patient may be "treated" a great deal while still not having a treatment plan in the real sense of the term.

B.2 is precisely the document that shows how the Vien Gut Model differs: it transforms the treatment plan from a set of disconnected orders into a time-structured architecture in which each decision is placed in the correct phase, with the correct degree of priority, and in the correct operational context. This difference does not merely make treatment "more systematic"; it is the condition that allows high-level treatment targets to be pursued without an unacceptable trade-off in safety.

13. LIMITS OF THE DOCUMENT'S SCOPE

Content	Included in B.2	Reference document
Definition of the outpatient treatment plan according to WHAT–HOW–DATA-to-operate	Included	B.2 — Section 2

Overall goals of the outpatient treatment plan	Included	B.2 — Section 3
Principles for building the treatment plan	Included	B.2 — Section 4
Four-phase structure and phase-transition mechanism	Included	B.2 — Sections 5–6
Ordering principles by phase	Included	B.2 — Section 7
Role of DATA-to-operate, polypharmacy management, MDT, safety valve, reintegration	Included	B.2 — Sections 8–10
Details of the first clinical visit	Not included	B.1
Necessary and sufficient criteria of the window of opportunity	Not included	B.3
Framework for assessing the patient's participation capacity	Not included	B.4
Enabling conditions matrix	Not included	B.5
Specific protocols for each disease axis	Not included	Part C (C.1–C.n)
Design of multicenter validation	Not included	Part D

14. POSITION OF B.2 WITHIN THE VIEN GUT DOCUMENT SYSTEM

B.2 is the central document of Part B because it organizes the time dimension of the entire operational model. B.1 creates the baseline data and activates the operational system; B.2 transforms those data into a time-based plan; B.3 determines the window of opportunity of each plan; B.4 allocates the patient's participation capacity to each phase; and B.5 embeds enabling conditions and priority principles into the structure of the plan. In other words, if B.1 is the "operational entry point," then B.2 is the "operational track" on which the patient moves through the treatment phases.

CONCLUSION

The outpatient treatment plan in the Vien Gut Model is not merely a schedule of follow-up visits plus a long-term prescription. It is a three-layer operational architecture, organized into four phases, designed to move the patient with complex chronic multimorbidity through very different stages of the treatment journey while preserving the safety boundary, dismantling pathological spirals, and progressively approaching the verification targets.

The strength of B.2 lies in turning outpatient treatment into a time-structured process, with a logic of phase transition, with data that inform decisions, with a mechanism of priority, and with the capacity to learn back from its own results. For this reason, B.2 is not only a treatment-plan document. It is the document that shows that the HOW of the Vien Gut Model has been organized into a complete operational trajectory.

REFERENCES

[1] NICE NG56. Multimorbidity: clinical assessment and management.

[2] KDIGO. 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease.

[3] FitzGerald JD, et al. 2020 American College of Rheumatology Guideline for the Management of Gout.

[4] ESC and ACC/AHA/HFSA guideline documents on heart failure.

[5] EASL guideline documents on decompensated cirrhosis.

[6] Foundational and operational documents in the academic dossier of the Vien Gut Model: A.0–A.5, B.1, B.3–B.5, C.1–C.n.