INTERNATIONAL ACADEMIC PUBLICATION DOSSIER

VIEN GUT MODEL

Integrated Outpatient Care for Complex Chronic Multimorbidity

Part B – OPERATIONAL DOCUMENTS

DOCUMENT B.4

THE ROLE OF THE PATIENT

An operational framework from the patient and family side —
from a passive recipient to a participation capacity that can be measured,
trained, and managed over time

Vien Gut Model — International Academic Publication Dossier
First systematized edition — March 2026
Ho Chi Minh City, Vietnam

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POSITION OF THIS DOCUMENT IN THE VIEN GUT ACADEMIC DOSSIER

Document B.4 is not a general health-education handout for patients, and it is not a broad recommendation paper about “patient education.” B.4 is an operational document in Part B — the Operational Model. Its job is to define the role of the patient and family as a part of the care system that can be measured, trained, and managed in complex chronic multimorbidity outpatient care.

Within the multi-layer architecture of the dossier, B.4 belongs to Layer 1 — Basic Architecture. It does not focus on one disease axis like C.1–C.n. Instead, it provides a foundation that every C document needs in order to work in real life. B.4 is not about “which disease to treat.” It is about “how the patient must participate so that the care model can actually keep running.”

That is why B.4 sits at the meeting point between system capacity and patient capacity: the system may be strong in WHAT, HOW, and DATA-to-operate, but if the patient does not have enough capacity to participate, the verification targets may still remain out of reach.

READER GUIDE TO B.4

- 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 definition of the three core 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 operating system, read B.1.
- To understand the four-phase treatment plan, read B.2.
- To understand the necessary and sufficient conditions for keeping the opportunity window open, read B.3.
- To understand enabling conditions and the priority matrix across several diseases, read B.5.
- To see how this patient role is applied in each disease axis, read C.1–C.n.

SUMMARY

B.4 presents the operational framework for the patient and family side of the Vien Gut Model. The main message is simple: in complex chronic multimorbidity outpatient care, the patient can no longer be treated as a passive person who only receives prescriptions and advice. The patient must be seen as an operational part of the treatment system. Readiness, ability to carry out the plan, self-monitoring, support resources, and cooperation all need to be measurable, classifiable, trainable, and followed over time.

B.3 already introduced the idea that the patient side provides the "sufficient conditions" needed to keep the opportunity window open. B.4 turns that idea into a practical framework with eight specific capabilities, three readiness levels, and a step-by-step process for building capacity over time.

For that reason, B.4 is not a soft or secondary document. It is a core HOW document. Without B.4, the integrated outpatient model can easily fall into a systems illusion: assuming that if the doctors are skilled enough, the protocols are good enough, and the data are rich enough, good results will automatically follow. B.4 shows the opposite: if patients do not have enough capacity to take part, even the strongest HOW will struggle to sustain results in complex chronic multimorbidity outpatient care.

BACKGROUND

In most chronic disease care models today, even many advanced ones, patients are still placed in a fairly passive role: they receive a diagnosis, a prescription, diet advice, and a reminder to return for follow-up. Even when ideas such as self-management or patient empowerment are emphasized, the patient role is often still understood mostly as education — knowing more, understanding the disease better, and being more self-disciplined — rather than as an operational layer that can be measured and managed.

In complex chronic multimorbidity, that view is not enough. Patients are not just remembering one prescription or one diet. They are trying to manage several disease axes, many medicines, many warning thresholds, several follow-up schedules, and urgent decisions that may arise between visits.

That is why the Vien Gut Model does not treat the patient as "the center" only in a slogan sense. The patient must become a real operating agent within the system. But this cannot depend only on willpower or good intentions. The model needs a clear framework: what level of capacity the patient currently has, what is missing, what training is needed, who must support the patient, whether cooperation is weakening, and how the system should adjust its HOW when participation weakens. B.4 was written to provide that framework.

PURPOSE AND SCOPE OF THE DOCUMENT

B.4 has six goals. First, it defines the patient and family as an operational part of the care model. Second, it clearly separates the system's necessary conditions from the patient's sufficient conditions. Third, it turns the patient's sufficient conditions into eight capabilities that can be measured and trained. Fourth, it creates three readiness levels and support levels. Fifth, it defines cooperation and adherence as longitudinal operational variables. Sixth, it places the patient in the correct place inside the WHAT – HOW – DATA-to-operate architecture.

B.4 does not include the general definition of necessary and sufficient conditions within the opportunity window concept, the four-phase treatment plan, or the full enabling-conditions matrix across several diseases. Those topics belong to B.3, B.2, and B.5. B.4 is also not a disease-specific protocol; disease-axis application belongs to Part C.

1. THE CORE PROBLEM

In complex chronic multimorbidity outpatient care, the patient is not only the person who "adheres." The patient is also part of the operating system in the time between clinic visits. During that time — at home, at work, during symptom changes, while handling side effects, deciding whether to report early, deciding whether to change medicines without telling the team, deciding whether to continue the plan — the model either keeps working or starts to crack.

This makes the patient role in outpatient care fundamentally different from the patient role in inpatient care. In hospital, continuous monitoring can partly compensate for weak patient participation. In outpatient care, it cannot. In outpatient care, the patient's and family's ability to participate is part of the treatment safety boundary itself.

That is why B.4 does not ask the usual question, "How can we make patients more cooperative?" in a moral or persuasive sense. The question of B.4 is operational: how can patient participation become something that is designed, assessed, classified, improved, and managed like any other component of the model?

2. CORE FRAMEWORK: TWO LAYERS OF CAPACITY AND WHERE THEY MEET

The Vien Gut Model clearly separates two layers of conditions in integrated multimorbidity care.

Layer	Belongs to	Simple image
Necessary conditions — treatment capacity	The system: principles, organization, data structure, Clinical Conductor, MDT, safe referral valve, DATA-to-operate, action thresholds, audit trail, and the whole HOW architecture.	The "railway track" — if it is missing, even a very motivated patient has no structured system to rely on.
Sufficient conditions — participation capacity	The patient and family: genuine motivation, correct understanding, practical resources, self-monitoring, support system, cooperation, and skills that can be trained and followed over time.	The "train" — if it is missing, the track may be correct, but nothing can move on it.
Operational meeting point	Integrated care is truly workable only when these two layers fit together: HOW works properly, WHAT is pursued toward the target, and DATA-to-operate reflects the real trend.	B.3 named this principle; B.4 turns it into a practical tool.

3. COMPARING THREE CONTEXTS: GUIDELINES, INTERNATIONAL CONSENSUS, AND THE FRAGMENTED MODEL

Context	How the patient is usually viewed now	What B.4 adds
Single-disease guidelines + international consensus (NICE NG56, WHO)	The patient is acknowledged mainly in principle: patient preferences, self-management, patient-centred care. The message usually stops at "patients should be heard, educated, and involved."	A concrete framework for measuring participation capacity and connecting it directly to risk stratification, follow-up intensity, resource allocation, and operational triggers.

Context	How the patient is usually viewed now	What B.4 adds
Fragmented care model	The patient role is weakened: each specialty gives its own plan, nobody keeps the full picture, and the patient has to combine instructions that may conflict. Overall participation capacity is not assessed or managed as a clinical variable.	B.4 identifies the real gap: the patient carries both the treatment burden and the coordination burden that the system should help carry.
Vien Gut Model (B.4)	Participation capacity is treated as a sufficient condition. It can be measured, trained, classified (A/B/C in the wider model), and managed over time. Cooperation is treated as an operational variable, not a moral judgment.	Eight sufficient conditions + three support levels + the support person as a required component + cooperation managed as part of DATA-to-operate.

4. EIGHT SUFFICIENT CONDITIONS — A SYSTEMATIC VIEW OF THE PATIENT'S CAPACITY TO PARTICIPATE

Vien Gut has organized patient participation into eight sufficient conditions. This is not a list of demands imposed from outside. It is a set of capabilities that can be measured, built, and maintained throughout the treatment journey. When these conditions are present together, they create enough participation capacity for the model's verification targets to remain realistic in complex chronic multimorbidity outpatient care.

No.	Sufficient condition	Main meaning
1	Real motivation and commitment to long-term goals	The patient accepts a phase-based journey, does not demand shortcuts, understands that symptom relief is not the final goal, and accepts that protecting vital organs comes before speed.
2	Correct understanding that leads to correct action	The patient understands enough to act correctly: complete the first 7-day checklist, tell serious red flags from usual fluctuations, and explain back the reason for the key treatment steps.
3	Ability to organize practical resources	The patient can arrange follow-up according to the risk-based schedule, has a way to pay, travel, and stay connected, and avoids breaks in care that could have been predicted in advance.
4	Ability to self-monitor at home and report in time	The patient can watch the key warning signs for the priority disease axis, record basic home data when needed, and know when to report early. Without this, the time between visits becomes a second blind zone.

No.	Sufficient condition	Main meaning
5	A real support system when the patient cannot manage alone	There is a real support person who understands the plan, helps manage medicines, watches symptoms, and communicates with the care system. This becomes essential in older patients, cognitive decline, heavy polypharmacy, red-zone patients, and Phase 1.
6	Cooperation and trust in the process (therapeutic alliance)	The patient accepts one care team and one coordinated plan: reports all medicines, does not mix prescriptions on their own, does not hide herbal products, and understands that referral is a safety valve, not abandonment.
7	Participation in structured training and education	Training is needed to turn intention into real ability. Many patients have good intentions but cannot sustain the plan because they have never been trained well enough.
8	Cooperation that is checked, reassessed, and reinforced continuously	Cooperation is dynamic. It can improve or worsen. It must be managed like a longitudinal operational variable, reassessed over time, reinforced when weak, and supported by adjusting the HOW when needed.

5. SUPPORT LEVELS NEEDED BY DIFFERENT PATIENTS

Not every patient needs the same level of support. The Vien Gut Model classifies patients into three support levels based on disease burden, number of medicines, degree of independence, and risk level.

Support level	Typical features
Minimal	The patient is fully independent, does not have very heavy polypharmacy, has no meaningful cognitive decline, and is in the green zone or a stable yellow zone. Family mainly understands the basic plan and helps with communication if needed.
Regular	The patient has one or several severe disease axes, uses about 6–10 medicines, or has mild to moderate cognitive decline. A fixed support person should attend follow-up visits and help supervise medicines day to day.
Full-time / mandatory	The patient is in the red zone, has major polypharmacy, multi-organ disease, meaningful cognitive decline, or is in intensive Phase 1 care. A dedicated companion is needed to understand the plan, manage medicines, monitor symptoms and basic signs, and serve as the main communication bridge with the model.

This classification has direct practical value: it does not only decide whether the patient “needs someone to come along.” It also tells the model how much HOW must be added to compensate for the part of participation capacity that

the patient does not yet have. That is where B.4 connects directly with the patient-zone framework in B.3 and the phase-based treatment plan in B.2.

6. THE ROLE OF THE SUPPORT PERSON IN THE OPERATING SYSTEM

In the Vien Gut Model, the support person is not merely a social companion. The support person is part of the sufficient-condition layer. This person should be identified at the first visit, included in onboarding, and updated whenever the caregiver changes. In patients at support levels B and C, a change in support person without re-evaluating the sufficient conditions is one of the most common reasons for breaks in longitudinal follow-up.

No.	Role	What this means
1	Understand treatment goals	Know the goals of each phase, the priority logic, and the current treatment plan.
2	Manage medicines	Help manage medicines and avoid confusion, especially in heavy polypharmacy, cognitive decline, or red-zone situations.
3	Watch for warning signs	Monitor warning signs together with the patient and recognize red flags early.
4	Communicate with the system	Use the correct channel at the correct time and act as the main bridge when early reporting is needed.
5	Help maintain the resources needed to carry out the plan	Help protect time, money, travel, and continuity during the most intensive follow-up periods.

7. COOPERATION IS NOT A PERSONAL MORAL JUDGMENT — IT IS AN OPERATIONAL VARIABLE

B.4 makes one point very clear: cooperation must not be treated as a moral judgment. A patient is not “good” or “bad” just because cooperation is strong or weak. Cooperation is an operational variable. When cooperation falls, the system should not only blame the patient. The system must also ask what part of the HOW needs to become stronger, what part of the plan needs simplification, what resources must be added, and what part of the patient training needs to be repeated or redesigned. This is a basic difference between B.4 and the traditional approach that simply tells patients to “adhere better.”

Table 7a. Four questions the system must ask when cooperation weakens

No.	When cooperation weakens, the system must ask	Meaning
1	Does the HOW need to become stronger?	Which part of the operating process must be reinforced to compensate for the gap?
2	Does the treatment plan need to be simplified?	Which part of the plan is too complex for the patient to follow consistently?

No.	When cooperation weakens, the system must ask	Meaning
3	Do practical resources need to be added?	Which resources — time, money, travel, or support person capacity — need to be strengthened?
4	Does training need to be repeated or redesigned?	Which part of the patient training is still not strong enough or is not suitable for this patient?

Table 7b. Cooperation variables inside DATA-to-operate

No.	Cooperation variable	Meaning inside DATA-to-operate
1	Attending follow-up visits on time	Shows commitment and the ability to maintain the practical resources needed for care.
2	Completing tests at the planned time points	Makes sure DATA-to-operate contains enough information to detect trends.
3	Reporting symptoms early	Reduces the second blind zone between clinic visits.
4	Reporting all medicines fully	Allows safe polypharmacy management and detection of interactions.
5	Using the correct communication channel at the correct time	Lets the system respond before the patient crosses the safety threshold.

8. HOW B.4 CONNECTS TO B.3 AND B.2

Document	What it has already done	What B.4 adds
B.3	Named the patient-side sufficient conditions at the principle level.	Turns them into 8 concrete conditions, 3 support levels, and an operational logic that can be checked over time. B.4 operationalizes B.3.
B.2	Organized the treatment journey into four phases.	Answers a practical question for each phase: what patient capacity is needed, what support level is needed, and how the system should compensate when participation capacity is weak. B.4 is the other half of B.2.

9. SCOPE LIMITS OF THIS DOCUMENT

No.	Content	Included in B.4?	Reference document
1	Conceptual framework for the role of the patient	Included	B.4 — Section 2

No.	Content	Included in B.4?	Reference document
2	Difference between necessary and sufficient conditions	Included	B.4 — Section 2
3	Eight sufficient conditions for the patient and family	Included	B.4 — Section 4
4	Classification of support levels	Included	B.4 — Section 5
5	Role of the support person	Included	B.4 — Section 6
6	Managing cooperation as an operational variable	Included	B.4 — Section 7
7	System-level definition of the opportunity window	Not included	B.3
8	The four-phase treatment plan	Not included	B.2
9	Enabling conditions matrix and priority rules	Not included	B.5
10	Disease-axis protocols	Not included	Part C
11	Dialogue and validation framework	Not included	Part D

10. PLACE OF B.4 IN THE VIEN GUT DOCUMENT SYSTEM

B.4 completes the second half of the operational architecture. B.1 and B.2 show how well the Vien Gut system is organized. B.3 shows what conditions are needed to keep the opportunity window open. B.4 goes one step further: it shows what part the patient and family must play inside that system. If B.1 is the activation point, B.2 is the track, and B.3 is the condition that allows the train to keep moving, then B.4 answers the next question: does the train have enough engine power and enough coordination to keep moving forward in real life?

CONCLUSION

In complex chronic multimorbidity outpatient care, the patient can no longer be seen as a passive recipient of treatment. The patient is an operating component of the care model. To sustain treatment over time, the system needs more than correct WHAT, strong HOW, and enough DATA-to-operate. It also needs the patient and family to have enough participation capacity to turn that architecture into continuous real-world action.

For that reason, B.4 is not only a document about the “role of the patient.” It is a document about how to make that role measurable, trainable, classifiable, compensable, and manageable over time. In this way, the Vien Gut Model avoids a common illusion in many care systems: the belief that if the doctors are skilled enough, patients will automatically keep up. B.4 states the opposite: if the system truly wants to be strong, it must also design the patient side into the architecture of the system itself.

REFERENCES

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