**A Healthcare DAO Stack: In Abstract, w/o detail**

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Description automatically generatedNvlope LLC**

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Public Summary for Comment

**How to comply with DHHS, FCC, JC, et al, without taking insurance**? Through governance tokens with utility, the Healthcare stack could provide better outcomes with blockchain efficiency. Lean management and Six-Sigma would be almost automatic if PoQv stays steady or continues to rise.

PoQv determines value for the service. “Did it work?”

Challenge: Providing Care and liquidity without sacrificing continuation of treatment.

Answer: A DAO with liquidity pools, governance tokens and vested participation for a patient.

PoH, SSI, Admission

PoAuthority, VC

Commencement of Service

Proof of Quality Outcomes

Proof of Proper Administration

Information Required (amount)

Web3 Healthcare Stack/Level of Employee Participation

*Level of information required per level increases and human participation decreases. At some point, the PoH and SSI responsibility decreases as PoH becomes more interoperable with varied industry use.*

## **PoH: Proof of Humanity:** *POH, SSI, Admission*

* Requires the most human activity to process at start.
  + A DAO patient would require this one time.
  + ***Interoperability with other institutions to conform to FHIR standards a must.***
* Proof of Humanity most likely proven by *Presence of Human*.
* Blockchain integration, *onboarding patient address and starting dSLA contracts for service lines.*
* Diagnostics and Creation of BioNFTs to start chain.

## **PoA:** Verifiable Credentialing or NTNFT (non-transferrable NFT, soulbound)

* All PoA must complete PoH first. *AI with valued guidance is not considered a PoA, although it may one day for routine visits in a MXR setting.*
* NFTs with privileging, e.g. authority to touch patient address and nym.
  + Physician Licensing, Degrees, Credentials. NFTs are the most efficient but oracles, APIs, parachains and cross chains are all choices for the institution.
* **Governance and utility coins.**
* **Token Gating for most applications. ”*Are they a member and what type?”***
  + **Interorganizational and vendor contracts**
  + **Intraorganizational Digital Doors.**
  + Everyone in the DAO organization will need to touch the SSI/dID at some time.
    - Physicians among the highest authority, and
    - Admissions under the lowest authority
    - (*cannot rule out automatic check-in with RF signals/AIoT on a blockchain like Helium ($HNT). Creating lighted pathways per person, AR/AI personal concierges. Augmented and Artificial Case managers.*

## **Commencement of Service**: *Exam*

* dSLA-Smart Contract executed. Components include:
  + SSI
  + Reason for visit
  + Proper Authorities
  + Proper Equipment
  + The Tx method at PoH (*DeFi for payment, digital liquidity, insurance*)
  + Joint Commission/ACR Approved facilities to use. (*or, other growing bodies)*

## **Proof of Quality Outcomes**, Value-driven compensation OR Patient-driven

* Increasing Rates of recidivism for healthcare settings (or providers) would decrease the value of the provider and the value of the digital information created. *Lower digital liquidity. Lower ‘value’ or Lower Expectations.*
  + *A patient doesn’t expect or require extensive service.*
* Decreased Rates of recidivism increase value of provider and digital information created. *Higher digital liquidity. More ‘value’ or Higher Expectations*
  + *A patient requires greater service and/or extensive service*
* Incentive: Practice better and agile medicine.
  + eg, A.I., MXR, Home Health Suites to reduce implicit encumbrance, eg a chronic patient driving an hour to see a physician costs a lot more than currency.
* Capturing both markets in health is key through PROOF: Proactive and Inactive patients, e.g. *public ledgers*

## **Proof of Proper Administration:** *Consensus Ledgers, HD Key Conflation Reporting*

* All preceding consensuses create the final ledger for Organizations’ smart contract to
  + Achieve internal thresholds for Process Improvement, audit OCC service lines
  + Determine alignment with DHHS, JC, FCC, DEA, etc. through Facility Ledger
  + Enterprise statistics

**They could continue to operate and comply with governing institutions and may not take insurance. New streams of revenue would compensate patients for participating and reward practitioners with higher results. Some effects may come naturally without the bureaucratic noise that reduce all capabilities.**

**Outcomes:**

*Advantages:*

* *Doctors can do what they love; practice medicine. Patients are not encumbered with passwords, constant verifications, paperwork, and human-error corrections.*
* *Digital liquidity created as incentive for retention of DAO patients.*
* *Reluctance by other providers to accept “remittance” process*
  + *Increased Payments will drive Forced Adoption and be a choice of a growing demographic*
  + *PAR with all providers and higher Fee Schedules*

Problems*:*

* *Agency costs*
* *Reluctance by other providers to accept “remittance” process. Slow process at first.*
* *W3/Blockchain UX Process and disappointing expectations for imaginative patients.*