ANALYSIS OF FAAST SERVICE DELIVERY MODEL

Michael Daniels

FAAST 820 E Park Ave D – 200 Tallahassee, FL 32301

Contents

Introduction 2
Current Service Delivery Model 2
Table 1 Current Service Delivery Model 2
History of the FAAST Service Delivery Model 3
Table 2 State Level: State Financing Activities 4
Table 3 State Level: Reuse Activities 5
Table 4 State Level: Device Loan 6
Table 5 State Level: Device Demonstration Program (Participants) 7
Table 6 State Leadership: Training Activities 8
Table 7 State Leadership: Public Awareness 9
Table 8 State Leadership: Information Assistance 10
Issues with the Current Service Delivery Model 10
Definition of Hub-and-Spoke Service Delivery Model 12
Research 12
Origin 13
Best-practice Example 13
A-TAC Values 13
Proposal 14
Exploration 14

Introduction

The Florida Assistive Technology Advisory Council (A-TAC) shall assist the state of Florida in carrying out activities mandated in the Assistive Technology Act, Pub. L. No. 108-364 and Florida Statute 413.407. Specifically, the A-TAC shall:

1) Advise and guide FAAST in the development, implementation, and evaluation of the activities carried out through the State Plan for Assistive Technology, including setting measurable goals.
2) Guide FAAST and ensure compliance with the provisions of the Assistive Technology Act of 2004, Pub. L. No. 108-364,
3) Advise the Executive Director on ways to improve the delivery of assistive technology services and devices, including policy, regulations, procedures, and practices.

The Assistive Technology Act categorizes the services FAAST offers by State Level and State Leadership. State Level activities include:

1) State Financing – cash loan, other activities directly provide AT or provide savings
2) Reuse – exchange, refurbish/reassign, open-ended loan
3) Short-term Device Loan – for decision-making, while the device is being repaired, waiting for funding, short-term accommodation, or professional development
4) Device Demonstration – compare features/benefits and determine if appropriate

State Leadership activities include:

1) Training Events,
2) Public Awareness,
3) Information and Assistance, and
4) Technical Assistance.

Current Service Delivery Model

The current service delivery model involves the state headquarters, six regional demonstration centers, and five regional reuse centers. The state headquarters provide administration and technical support to the eleven (11) centers. The table below is a service/entity breakdown:

Table 1 Current Service Delivery Model

Service	State Headquarters	Demonstration Centers	ReUse Centers
State Financing	X		
Device Loan	X	X	
Device Demonstrations		X	
Device Reuse	X		X
Training Events	X	X	
Public Awareness	X		
Information and Assistance	X	X	
Technical Assistance	X		

History of the FAAST Service Delivery Model

FAAST began providing services through regional centers in 1994. FAAST established its first centers in Tampa, Miami, and Jacksonville. Since the state headquarters was in Tallahassee, it served as a regional center for Northwest Florida. Between 1995 and 1999, FAAST contracted with its regional centers to establish satellite sites. With the passage of the Assistive Technology Act in 1998, FAAST discontinued satellite sites due to funding. The model remained consistent until 2005 with the opening of the Atlantic Regional Center in Orlando. One year later, the Gulf Coast Center started providing services to Floridians with disabilities in the Pensacola area. In 2016, FAAST transitioned the Northwest Regional Center to a contractor.

FAAST established its reuse center program in the spring of 2015. FAAST targeted Centers for Independent Living (CILs) because they receive donated equipment. The reuse centers started providing services on January 1, 2016. The objective of the reuse center program was to increase the number of customers receiving recycled and refurbished equipment. FAAST opened its first reuse centers in Pensacola, Tampa, Fort Lauderdale, Fort Myers, and Miami. The contract for the Tampa center moved to Largo beginning in 2018.

The next pages document FAAST services over the years.

Table 2 State Level: State Financing Activities

Year	Approved Loans	Loans Rejected	Dollar Value of Loans	Major AT Financed
2008	6	0	$49, 702	Vision and Vehicle Modifications
2009	9	20	$215,570	Vehicle Modifications
2010	16	28	$298,978	Vehicle Modifications
2011	6	27	$129,301	Vehicle Modifications
2012	3	16	$30,000	Vehicle Modifications
2013	5	35	$60,077	Vehicle Modifications
2014	0	28	$0	N/A
2015	10	0	$48,021	Vehicle Modifications
2016	20	0	$111,558	Vehicle Modifications
2017	33	11	$254,554	Hearing
2018	31	12	$246,070	Vehicle Modifications
2019*	32	10	$258,059	Vehicle Modifications
Total	171	187	$1,652,188	Most Common Type of AT: Vehicle Modifications

* October 2018 through July 2019

Table 3 State Level: Reuse Activities

Year	Device Exchange	Recycled Devices	Open-ended Loans	Total Estimate Savings to Consumers
2008	1	553	0	$107,822
2009	0	569	0	$68,900
2010	0	308	0	$70,266
2011	0	258	0	$100,478
2012	22	220	0	$89,636
2013	2	205	0	$56,620
2014	1	376	0	$56,350
2015*	162	255	682	$233,940
2016	269	557	1,627	$681,246
2017	296	1,166		$360,690
2018	298	1,068		$401,713
2019**	380	1,069		$260,116
Total	1,430	7,483		$2,240,789

* First Year of Regional ReUse Centers
** October 2018 through July 2019

Table 4 State Level: Device Loan

Year	Assist in Decision Making	Loaner during a repair	Accommodation	Professional Development
2008	705	174	60	0
2009	765	84	420	291
2010	859	63	106	241
2011	207	121	19	31
2012	219	113	11	37
2013	225	119	12	39
2014*	891	471	48	154
2015	674	84	94	809
2016	1,094	667	250	759
2017	1,229	194	253	656
2018**	1,679	143	248	215
2019***	1,509	212	379	812
Total	7,727	2,214	1,314	3,512

* No statistical explanation for the increase.
** Greater emphasis placed on Device Loans to Assist in Decision Making
*** October 2018 through July 2019

Table 5 State Level: Device Demonstration Program (Participants)

Year	IWD	Family	Education	Employment	Rehab	Community Living	Technology	Other	Total
1998*									207
1999*									437
2000*									438
2001*									1,577
2002*									2,118
2003*									1,389
2004*									1,275
2005*									293
2006*									3,784
2007*									12,213
2008	640	385	330	62	0	172	0	1	1,590
2009	1,295	1,536	281	267	1,416	561	273	0	5,629
2010	1,279	2,474	432	174	682	562	212	0	5,815
2011	965	1,864	326	131	514	423	159	0	4,382
2012	1,606	3,112	546	218	857	705	265	0	7,309
2013	2,001	3,866	682	272	1,091	819	366	0	9,097
2014**	2,852	5,509	972	388	1,555	1,167	521	0	12,964
2015***	3,226	678	3,247^	64	186	222	22	0	7,645
2016	2,600	493	3,188^	91	465	437	385	0	7,659
2017	2,936	933	2,258^	128	839	351	404	0	7,849
2018^^	946	630	194	20	612	99	204	0	2,705
2019^^^	1,061	703	133	28	682	141	235	0	2,983
Total	21,407	22,183	12,589	1,843	8,899	5,659	3,046	1	99,358

* Data not broken down for Device Demonstrations from 1998 through 2007.
** First year using the new data collection tool.
Incorrectly includes Public Awareness Activities data.
*** Corrected data collection issue from previous year
^ One RDC started reporting Device Demonstrations to its Graduate Students
^^ Greater emphasis placed on providing Device Demonstrations to IWDs
^^^ October 2018 through July 2019

Table 6 State Leadership: Training Activities

Year	IWD	Family	Education	Employment	Rehab	Community Living	Technology	Other	Total
1998									46
1999									254
2000									410
2001									457
2002									499
2003									902
2004									2,519
2005									5,736
2006									5,969
2007									3,664
2008	3,743	498	68	83	0	133	0	3	4,528
2009	2,786	279	69	139	92	105	13	0	3,483
2010*	9,693	2,492	553	277	360	415	57	0	13,847
2011	13,422	3,479	767	385	499	572	79	0	19,203
2012	11,528	3,907	1,758	586	879	781	97	0	19,536
2013	9,149	3,101	1,396	465	697	621	79	0	15,508
2014	10,934	3,706	1,668	556	833	742	95	0	18,534
2015	12,175	552	6,869	174	1,559	109	28	0	21,466
2016**	7,043	572	5,892	359	1,809	191	58	0	15,932
2017	4,410	591	4,888	299	3,100	274	99	0	13,661
2018***	4,528	1,945	1,205	332	3,546	901	153	132^	12,742
2019^	3,612	1,638	726	131	3,809	747	200	1,090^^	11,953
Total	93,023	25,859	3,786	17,183	5,591	958	1,255	1,225	190,849

* RDCs stated reporting on internal customers trained.
** FAAST implemented demographics and customers tracking.
*** Greater emphasis placed on Training Individuals with a Disability
^ October 2018 through July 2019
^^ One RDC not following data collection procedures

Table 7 State Leadership: Public Awareness

Year	Newsletters	Other print materials	Listservs/ blogs/ Social media^^	Internet information	Other electronic media	PSA/ radio/ TV/ other media**	Presentations/ expos/ conferences	Total
2008	18,208	14,000^	9,852	514,090^^^	6,092,397*	5170	0	6,653,717
2009	24,227	28,619^	644	376,811^^^	665,052*	224	2,124	1,097,701
2010	12,215	10,921^	7,007	1,685,523^^^	1,406,060*	12750	0	3,134,476
2011	0	5,942^	262	56,150	800	540,640	4,260	6,08,054
2012	0	15,462^	1,617	70844	0	323280	3,300	414,503
2013	0	22,345^	1,681	73,137	0	279,274	11,250	387,687
2014	13,824	149^	81,903	28,903	0	52,200	39,787	786,434
2015	25,369	819^	254,355	88,632	8,529***	62,800	32,711	473,215
2016	27,918	0	558,824	43,978	15,911***	80,654	5,631	
2017	81,177	0	1,356,257	58,783	0	500,000	53,365	
2018	55,698	0	12,4471	58,8802	0	0	19 Events	
2019	45,218	0	116,729	102,188	0	0	14 Events	
Total	93,843	98,257	357,321	2,894,000	8,172,388	1,276,338	93,432	12,985,579

Public Awareness data collection procedures have changed the most over the years. For example, the national standard is to report presentations/expos, conferences by event instead of estimated attendees.

^ Printed version of FAAST Access Magazine
^^ Inconsitent definitions and data collection procedures used.
^^^ Backup data not available
* FAAST purchased commercial time to market State Financing Activities
** Years media ran stories on FAAST services.
*** Years websites like Florida Politico published stories on FAAST activities

2019 FAAST launched a new website. Development of the new site focused on the top four reasons people visited the FAAST website according to data obtained from Google Analytics. The new website only includes information concentrating on these four areas.

Table 8 State Leadership: Information Assistance

Year	AT Device/Service	AT Funding	Total
1998*			1,518
1999*			4,081
2000*			3,725
2001*			5,543
2002*			5,929
2003*			3,824
2004*			4,340
2005*			3,547
2006*			6,470
2007*			3,307
2008	4,430	442	4,872
2009	1,463	661	2,124
2010	1,702	782	2,484
2011	4,031	4,366	8,397
2012	2,967	3,331	6,298
2013	3,954	4,388	8,342
2014**	8,021	9,278	17,299
2015***	27,536	5,123	32,659
2016^	5,935	970	6,905
2017***	16,142	3,400	19,542
2018^^	3,413	85	3,498
2019^^^	2,755	217	2,972
Total	82,349	33,043	157,676

* Data not broken down for Device Demonstrations from 1998 through 2007.
** First year using the new data collection tool.
Experienced issues with tracking individual services.
*** Includes the number of attendees at events in which FAAST exhibited
^ Corrected issue from previous year
^^ First year using FAAST Information and Assistance Tracking (FIAT) Database
^^^ October 2018 through July 2019

Issues with the Current Service Delivery Model

1) Florida is mandated to allocate no less than Seventy Percent (70%) of its federal funds on State Level activities.
   a) Florida places too much emphasis on training events which skew the federal allocation rate.
   b) Florida budgets only $55,000 for device reuse activities.
   c) Florida does not use any federal funds for state financing activities.
2) Regional demonstration centers receive $540,000.
   a) This amount represents approximately half of the FAAST budget.
   b) Seventy Percent (70%) of regional demonstration center activities fall under state leadership.

3) State financing investments are intended to fund the program.
   a) Ever since the inception of state financing activities, FAAST has used investment funds to operate the program.
   b) This practice hurts the program's sustainability.
   c) All other programs that perform state financing activities use a percentage of federal funds for operations.
4) FAAST operates seven different device loan programs.
   a) FAAST operates more device loan programs than any state.
   b) FAAST does not have the funds to purchase inventory for seven device loan programs.
   c) All states either provide device loans through a statewide or regional system.
   d) The current inventory does not contain mobility equipment.
   e) The communication device inventory is out-of-date.
5) **Because of level funding for 14 years, FAAST does not have the resources to reimburse regional centers for travel.**
   a) **Most regions provide services at the center.**
   b) **Regional demonstration centers provide Eighty-eight Percent (88%) of services within a 50-mile radius of the center.**
   c) **Baseline funding for regional demonstration centers has remained the same for 14 years.**
   d) **Fifteen counties do not receive any service.**
6) FAAST has issues with consistent data collection procedures.
   a) Each center seems to interpret device demonstrations, training events, and information and assistance individually.
7) Regional demonstration centers seem to provide services to a built-in clientele instead of customers from the community.
8) Regional centers operate under the umbrella of the parent organization.
   a) This practice creates limited name recognition for FAAST.
   b) The FAAST brand is limited because customers come to the parent organization and might not know it's a FAAST center.
   c) FAAST is not able to market and fundraise off its successes.
9) Parent organizations claim the financial benefits from donations.
10) The quality of services varies from center to center.
    a) Because assistive technology is a discipline-based on problem solving and experience, professionals with these skills are difficult to find.
    b) Most funding sources of assistive technology only recognize clinical certifications.
    c) Only centers based in larger parent organizations have these types of professionals.
11) FAAST is not able to provide fee-based services.
    a) Some parent organizations already provide fee-based services.
    b) FAAST providing the same fee-based services would take money away from the parent organization.

Definition of Hub-and-Spoke Service Delivery Model

Formally defined, the hub-and-spoke service delivery design is a model which arranges assets into a network consisting of an anchor establishment (hub) which offers a full array of services, complemented by satellite sites (spokes) which offer more limited service arrays, routing customers needing more intensive services to the hub. The hub-and-spoke model yields a network consisting of one main office and one or more satellite sites. Hub-and-spoke systems are highly scalable, with satellites added as needed. When geographic distance makes satellite-to-hub access impractical, an additional hub can be created, yielding a multi-hub system. The particular manner of centralization varies across implementing organization depending on services and geographic area.

Research

Research demonstrates this service model as a more efficient method of providing community-based services by reducing replicant operations in multiple sites. Vermont implemented a hub-and-spoke system for opioid abuse care. Vermont saw the number of Medicaid beneficiaries receiving treatment in satellite sites grow from 2,606 in the third quarter of 2017 to 2,899 in November 2018. This proves with marketing and outreach; individuals will seek services in local, community-based sites. Another benefit of the spoke-and-hub design is the utilization of local resources. Satellite sites in Vermont referred 69 individuals to local medical professionals in November 2018 up from 58 in the third quarter of 2017. Most important, Vermont reports no waiting list for services.

California expanded its Medical Assisted Treatment (MAT) program by implementing a spoke-and-hub design. California implemented this system as a way to improve, grow, and increase access to MAT services throughout the state, especially in counties with the highest opioid overdose rates. Satellite sites saw 2% more patients in the first seven months of the program, and growth has continued. Satellite sites served more minorities compared to hub sites. This suggests satellite sites may help to serve more marginalized populations. Like Vermont, California's model increased utilization of local resources. At the start, California's satellite sites made referrals to 159 local medical professionals. Within a year, the number increased to 246.

The University of Miami's (UM) UHealth program functions under a spoke-and-hub design. The goal of UHealth is to coordinate care for its patients to receive the right care at the right facility. UHealth has increased its reach with satellite sites in Naples, Deerfield Beach, and North Miami. Trent Smith, UHealth's chief strategy officer, says, "We can no longer be on campus and say, "We're the experts, come to us.' We're looking for opportunities to continue to serve the demand that exists in the market."

Origin

Strategic centralization unlocks the many benefits of the hub-and-spoke model, which makes it ideal for the transportation industry. Due to resource scarcity and intensive demands for profits, the hub-and-spoke design is perhaps best known in broad society for its use by air carriers. They operate these networks to accomplish more with less. The model has been adopted by and used successfully in many other industries, including retail, education, social services, and healthcare.

Best-practice Example

Willis-Knighton Health System is a non-governmental, not-for-profit healthcare provider delivering comprehensive health and wellness services through multiple hospitals, numerous general and specialty medical clinics, an all-inclusive retirement community, and more. The system holds market leadership in its served region, centered in the heart of an area known as the Ark-La-Tex, where the states of Arkansas, Louisiana, and Texas converge.

During the 1980s, Willis-Knighton Health System sole hospital experienced an increase in patient volume. This success allowed expansion. A second hospital opened in 1983, which led its management to determine the relationship between the two facilities. At the outset, the organizational design replicated services at both hospitals, which went against Willis-Knighton Health System's culture of efficiency. Management explored various models before selecting the hub-and-spoke design. They based their decision on the model's reputation for efficient and effective service delivery.

In 1983, the Willis-Knighton Health System became a spoke-and-hub organization. Their experience confirmed the efficiency and value of the hub-and-spoke design. Now, Willis-Knighton Health System plans its services, operational protocols, and architectural designs through a spoke-and-hub prism.

With over three decades of delivering healthcare services using the hub-and-spoke organization design, Willis-Knighton Health System can confirm a range of benefits afforded by the model. These benefits include:

a. Consistency across operations,
b. Increased efficiencies,
c. Enhanced quality,
d. Enhanced coverage, and
e. Improved agility.

A-TAC Values

Before considering any changes to the FAAST service delivery model, the A-TAC needs to make a value statement. The starting point for the development of a value statement begins with location. Where do Floridians with disabilities receive assistive technology services?

It is a fact FAAST has received level funding for 14 consecutive years. Does the A-TAC focus all available funding on services or travel? Regional demonstration centers provide services in proximity to their physical locations. Fifteen counties do not receive any assistance.

The answer to one question could be the foundation of a value statement: Does the A-TAC want FAAST to provide community-based services? Over and over, surveys indicate individuals with disabilities have issues accessing transportation. A network of community-based partners could alleviate this hurdle. In the same vein, should FAAST refer its customers to providers in larger cities like Orlando, Tampa, and Miami or should FAAST designed Training Events to improve the assistive technology service capacity of community-based providers?

Proposal

The professional staff of FAAST proposes the A-TAC explore transitioning to a spoke-and-hub model. The assistive technology industry, in and of itself, is immensely complex, and its immersion in and exposure to the greater political, economic, social, and technological environment only adds to associated complexities. FAAST needs to be proficient in organizing and delivering its services. A spoke-and-hub model has the potential of being an effective and efficient, community-based design.

Exploration

The exploration process should begin by reviewing and offering solutions to issues in its current service delivery model.

1) Florida is mandated to allocate no less than Seventy Percent (70%) of its federal funds on State Level activities.

   Action Taken: In June 2019 the A-TAC voted to begin using federal funds for state financing activities operations and limiting drawing funds from investment to no more than $150,000.

   Needed: Does FAAST continue operating seven device loan programs?

   Needed: Does FAAST need to increase funding for device reuse activities?

   Needed: FAAST needs to improve the inventory of the Statewide Device Loan Program.

2) Regional demonstration centers receive $540,000.

   Needed: Is the current service delivery model of six regional centers offering device loans, device demonstrations, training events, and information and assistance a viable model in the age of limited public funds?

Needed: Should FAAST focus on services putting assistive technology in the hands of Floridians with disabilities?

3) FAAST has issues with consistent data collection procedures.

   Needed: A model that allows a contractor to focus on a few activities.

   Needed: A model that focuses contractors on services putting assistive technology in the hands of individuals with disabilities.

4) Regional demonstration centers seem to provide services to a built-in clientele instead of customers from the community.

   Needed: Contracting with entities with a built-in clientele is not terrible. However, the majority of customers should be individuals with disabilities.