

ANALYSIS OF SERVICE DELIVERY MODELS

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Analysis of Service Delivery Models

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Action Item

This document is a response to an Action Item from the November 2018 Florida Assistive Technology Advisory Council (A-TAC) meeting. 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. It is for these reasons an A-TAC member mentioned the possibility of FFAST using a hub-and-spoke service delivery model. His stated objective was for FFAST to be proficient in organizing and delivering its services.

The contents of this document do not exactly match the thoughts conveyed by the member. Actions taken by the A-TAC in June 2019 added another dimension to the development of this document. This document is to aid members of the A-TAC's Service Delivery Committee in the development of a new model for Florida.

Introduction

The 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 FFAST in the development, implementation, and evaluation of the activities carried out through the State Plan for Assistive Technology, including setting measurable goals.
- 2) Guide FFAST 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 FFAST offers by State Level and State Leadership. State Level activities include:

- 1) State Financing,
- 2) Reuse,
- 3) Short-term Device Loan, and
- 4) Device Demonstrations.

State Leadership activities include:

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

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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 provides 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 FFAST Service Delivery Model

FAAST began providing services through regional centers in 1994. FFAST 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, FFAST contracted with its regional centers to establish satellite sites. In 1998, FFAST 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 in the Pensacola area. In 2016, FFAST transitioned the Northwest Regional Center to a contractor.

FAAST established its reuse center program in the spring of 2015. FFAST 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. FFAST 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 FFAST services over the years.

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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

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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

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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

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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

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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.

** FFAST 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

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Table 7 State Leadership: Public Awareness

Year	Newsletters	Other print materials	Listsersv/ 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 FFAST Access Magazine
- ^^ Inconsistent definitions and data collection procedures used.
- ^^^ Backup data not available
- * FFAST purchased commercial time to market State Financing Activities
- ** Years media ran stories on FFAST services.
- *** Years websites like Florida Politico published stories on FFAST activities

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

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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

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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 FFAST 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, FFAST has used investment funds to operate the program.
 - b) This practice hurts the program's sustainability.
 - c) All other state programs that perform State Financing activities use a percentage of federal funds for operations.
- 4) FFAST operates seven different Device Loan programs.
 - a) FFAST operates more Device Loan programs than any state.
 - b) FFAST 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, FFAST 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) FFAST 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 a parent organization.
 - a) This practice creates limited name recognition for FFAST.
 - b) The FFAST brand is limited because customers come to the parent organization and might not know it's a FFAST center.
 - c) FFAST is not able to market and fundraise off its successes.

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- 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) FFAST is not able to provide fee-based services.
 - a) Some parent organizations already provide fee-based services.
 - b) FFAST providing the same fee-based services would take money away from the parent organization.

Models of Service Delivery

This section contains definitions and various descriptions of public health and social service delivery models. Please use this section to compare the hub-and-spoke model to other service delivery systems.

- 1) The Public Health Model
 - a) A service delivery model which addresses health and social problems.
 - b) The design considers human factors, characteristics of the source of harm, and the environment, identifies causes and suggests possible interventions.
 - c) The public health model takes a population approach to health promotion and disease prevention.
- 2) The Medical Model
 - a) The medical model is the term coined by psychiatrist R. D. Laing in his *The Politics of the Family and Other Essays* (1971), for the "set of procedures in which all doctors are trained."
 - b) It includes the complaint, history, physical examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment.
- 3) The Human Service Model
 - a) The human services model looks at the client and their environment. The client can be an individual, group of people or an entire population.
 - b) Its philosophy is society should help provide for basic needs.
 - c) Solutions meet the needs of a whole person (holistic care).
- 4) The Consultation Model
 - a) An interactive process that enables people with diverse expertise to generate solutions to mutually defined problems.
 - b) Special education primarily uses this model to deliver related services.
- 5) The Interdisciplinary Model
 - a) A collaboration between two or more health care workers from different disciplines working towards a common goal.
 - b) This model promotes a more coordinated effort at decision making.

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- c) The objective is to move away from physician authority to shared decision making.
- d) This design produces a collaborative plan for individuals with input from multi-disciplines.
- 6) The Multidisciplinary Model
 - a) A collaboration between two or more health care workers from different disciplines working towards a common goal.
 - b) The multidisciplinary model draws on knowledge from different health care disciplines.
 - c) Each health care discipline stays within their boundaries.
 - d) Multidisciplinary care does not emphasize an integrated plan.
- 7) The Transdisciplinary Model
 - a) A collaboration between two or more health care workers from different disciplines working towards a common goal.
 - b) The transdisciplinary model's objective is for disciplines to transcend each other to form a new holistic approach.
 - c) The outcome will be completely different from what one would expect from the addition of the parts.
 - d) Transdisciplinary team plans are the result of disciplines integrating to become something completely new.
- 8) One-stop shop
 - a) A public service delivery model which has been in vogue for many decades.
 - b) The goal is to offer multiple public services under a single roof.
- 9) Centralized services
 - a) Centralized service delivery models create a cluster of people in one location who can be called on demand as needed, rather than being spread around an organization.
- 10) 2-Gen Approach
 - a) An emerging model of family services.
 - b) The 2-Gen design merges services which focus on parents needs with programs that focus on children needs.
 - c) The 2-Gen model creates family services, which works simultaneously to improve family situations.
 - d) The 2-Gen model's objective is to create an intergenerational plan.

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 spokes added as needed. When geographic distance makes spoke-to-hub access impractical, an

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additional hub can be created, yielding a multi-hub system. The particular manner of centralization varies across implementing organizations 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 hub-and-spoke 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 using a hub-and-spoke 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 hub-and-spoke 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 health care.

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Best-practice Example

Willis-Knighton Health System is a non-governmental, not-for-profit health care 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 hub-and-spoke 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 hub-and-spoke 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.

Steps to be Taken

A-TAC Values

Before considering any changes to the FFAST 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 FFAST 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.

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The answer to one question could be the foundation of a value statement: Does the A-TAC want FFAST 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 FFAST refer its customers to providers in larger cities like Orlando, Tampa, and Miami or should FFAST design Training Events to improve the assistive technology service capacity of community-based providers?

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 FFAST continue operating seven device loan programs?

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

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

- 3) FFAST 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.

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Needed: Contracting with entities with a built-in clientele is not terrible. However, individuals not able to go to a regional demonstration center still need assistive technology.

- 5) Regional centers operate under the umbrella of a parent organization.

Needed: Subrecipient contracts need to contain clauses that benefit FFAST. Examples include being able to market successes and take advantage of in-kind donations.

Needed: Organizations and agencies to partner with FFAST for a mutual benefit when providing fee-based services.

Needed: Regional centers need to operate under the FFAST banner, which in turn would improve brand identity.

- 6) The quality of services varies from center to center.

Needed: Centers need to have a baseline knowledge level of assistive technology devices and services.

Needed: Centers need to provide general assistive technology services. Some regional demonstrations centers have become too focused on one category of assistive technology.

Considerations for a FFAST Hub-and-Spoke Model

Any hub-and-spoke design for FFAST would need to focus on State Level activities. State Level services put assistive technology in the hands of people. The A-TAC needs to consider the arrangement of services. Who provides general assistive technology services? Who provides complex assistive technology services? Who maintains the assistive technology inventory?

Some generalities of a hub-and-spoke model for the A-TAC to consider are:

- 1) Complex services are centralized.
- 2) Multiple locations provide general services.
- 3) Skill intensive services are centralized.
- 4) Knowledge of local resources is a priority.
- 5) Any model should ensure consideration of Florida's unique geography.
- 6) Any model should ensure consideration of Florida's population demographics.

State Leadership activities are ideal for centralization. These services include Public Awareness, Training Events, Information and Assistance, and Technical Assistance.

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Theoretical Mapping of a FFAST Hub-and-Spoke Model



The Hub

The hub would be the FFAST State Headquarters in Tallahassee. The State Headquarters would provide administration and technical support to spokes while consolidating inventories and other resources. The maximum allocation of federal funds for State Leadership activities is 30%. The A-TAC should centralize these services at the State Headquarters. State Headquarters staff already oversee Public Awareness and Technical Assistance activities. Also, the State Headquarters should centralize Information and Assistance activities. FFAST already operates a toll-free Statewide Help Desk (Information and Assistance). This program needs to expand, and the Technology Awareness Committee could develop a Public Awareness campaign for this purpose. FFAST should develop a statewide training team. The A-TAC, professional associations, partner organizations, and local assistive technology professionals would dictate Training Events. A “FAAST Training Team” could generate revenue by providing fee-based services and Continuing Education Units (CEUs).

For State Level activities, State Headquarters would continue administering the State Financing (New Horizon Loan Program). State Headquarters would continue its role as coordinator of AT List, the state’s device exchange. The A-TAC should consider centralizing Device Loans. Consolidation would fold six Device Loan programs into the Statewide Device Loan Program.

Additional benefits of centralization and consolidation to FFAST could include:

- 1) Consistent data collection procedures because the State Headquarters receives training directly from AT3, the Assistive Technology Act’s technical assistance project.

Analysis of Service Delivery Models

- 2) Active monitoring of services provided and developing corrective action plans when inefficiencies appear.
- 3) Improved branding of FFAST services.
- 4) Expansion of customer base since FFAST is only a community-based organization with our focus solely on assistive technology.
- 5) Development of fee-based services.

Becoming the hub would require FFAST to hire one additional Team Member, an Assistive Technology Professional. This position would coordinate Information and Assistance, Training Events, and Device Loans. The most critical role the Assistive Technology Professional would play is clinical support to the spokes. Specifics will follow in the next section.

Spokes

In this section, “satellite sites” are spokes. Satellite sites need to operate per the values the A-TAC develops. The A-TAC should distribute satellite sites across Florida, allowing the majority of Floridians with disabilities needs addressed locally. Satellite sites should be community-based organizations, accessible, easy to locate, and an existing member of the disability community.

Satellite sites should provide only State Level activities (Device Reuse, Device Loans, and Device Demonstrations). These activities will focus on general assistive technology knowledge. Personnel at satellite sites will need to have a firsthand familiarity of equipment and devices like aids for daily living, computer access, home automation, adaptive toys, video magnification, and sound amplification. FFAST should provide each site with a core inventory of assistive technology equipment.

Satellite sites should develop a database of local resources. This knowledge of local resources is vital to addressing customer’s needs. The objective is to address a customer’s needs with local resources. If local resources are lacking, a satellite site will work with the FFAST Training Team to offer professional development to local resources. Increasing local resources capacity to meet assistive technology needs is the objective.

For customers with complex needs, satellite sites will refer these people to the Assistive Technology Professional at the State Headquarters. The Assistive Technology Professional will be the organization’s “clinical” expert for assistive technology. This dynamic is one of the key components of the FFAST hub-and-spoke model. The State Headquarters serves customers needing intensive services ranging from complex funding needs, formal evaluations, training on a specific device, and professional development opportunities. Satellite sites should serve the general needs of FFAST customers. Assistance may vary from referrals to state programs, presentations on FFAST services, basic assistive technology device demonstrations, and assessing a person for a refurbished piece of equipment.

Analysis of Service Delivery Models

- 4) The State Headquarters will provide consistent technical assistance to each satellite site.
- 5) The State Headquarters will provide on-going, onsite professional development.
- 6) FFAST and each satellite site will host an event to introduce the community to FFAST services.
- 7) The State Headquarters will survey satellite site customers to ascertain the quality of services.
- 8) The State Headquarters will distribute core equipment inventory to each satellite site.
- 9) The State Headquarters will train each satellite site on the inventory and how to use it to conduct Device Demonstrations.
- 10) The State Headquarters will prepare a detailed report on first-year activities along with an action plan to improve performance issues.

The second year of using the hub-and-spoke model focus should be:

- 1) Implementation of the Action Plan to improve Year 1 performance issues.
- 2) The State Headquarters will survey providers listed in the local resource database to ascertain assistive technology needs.
- 3) The State Headquarters will develop a training plan to meet local resources assistive technology needs.
- 4) The State Headquarters will conduct local in-person Training Events per the training plan.
- 5) The State Headquarters will provide one in-person training for one professional from each satellite site to kick-off the year.
- 6) The State Headquarters will provide consistent technical assistance to each satellite site.
- 7) The State Headquarters will provide on-going, web-based professional development.
- 8) The State Headquarters will survey satellite site customers to ascertain the quality of services.
- 9) The State Headquarters and satellite sites will develop and publish an operations manual.
- 10) The State Headquarters will prepare a detailed report on second-year activities, results of the action plan, and a new action plan to improve performance issues from Year 2.

The hub-and-spoke plan should be fully implemented by Year 3. Activities for Year 3 should focus on:

- 1) Implementation of the Action Plan to improve Year 2 performance issues.
- 2) Implementation of the operations manual.
- 3) Continuation of Training Events.
- 4) The State Headquarters will provide one in-person training for one professional from each satellite site to kick-off the year.

Analysis of Service Delivery Models

- 5) The State Headquarters will provide consistent technical assistance to each satellite site.
- 6) The State Headquarters will provide on-going, web-based professional development.
- 7) The State Headquarters will survey satellite site customers to ascertain the quality of services.
- 8) The State Headquarters will prepare a holistic report on completion of the hub-and-spoke model.

Analysis of Service Delivery Models

Appendix A

- 1) Med-E-Lert
- 2) Touch N Talk
- 3) Echo Pen Learning
- 4) Step Pad Learning
- 5) Grip-In Mug
- 6) Briggs Duo Cup Handle
- 7) Big Grip Utensil
- 8) Freedom Wand
- 9) BigKeys keyboard
- 10) BigKeys keyguard
- 11) Marble Mouse USB
- 12) Pocketalker 2.0 with headphones/neck loop
- 13) Sennheiser RS120 On-Ear Wireless RF Headphones with Charging Dock
- 14) Deluxe Sonic Alert DB200 Wireless Doorbell and Telephone Transmitter
- 15) Honeywell Premium Portable Door Chime, 3 Push Buttons
- 16) iPad
- 17) Gumdrop iPad case with stand
- 18) Douni (A7) 20 W Portable iPad BT speaker
- 19) Blue 2 BT switch/interface
- 20) Hook+ Switch Interface Movement
- 21) Finger-mounted conductive stylus
- 22) EXTYLUS for Touch Screen Smartphone, Tablets Movement
- 23) iTalk 2 w/ levels
- 24) Switch activated toy
- 25) UpEasy/ Seat Assis
- 26) Zoomax Snow 7 Portable Video Magnifier with OCR
- 27) Full Page Magnifier
- 28) 12 piece Pencil Grip Assortment Pack
- 29) Liftware Steady Starter Kit
- 30) Weighted Utensils with Contoured Handles
- 31) Utensil Holder
- 32) Sologrip one-handed jar opener
- 33) PandaGrip Universal Jar Lid Opener Physical
- 34) Swedish Cutting Board Physical
- 35) Homecraft Clamp-on Vegetable Peeler
- 36) Standers Auto Handy Bar Transfer Aid
- 37) Deluxe Swivel Seat Cushion
- 38) Ribbed handle Zipper Pull and Button Hook
- 39) Dragon Naturally Speaking
- 40) SmartNav 4 AT
- 41) n-ABLER Pro Joystick

Analysis of Service Delivery Models

- 42)Penclic Ambidextrous Wireless Mouse
- 43)Eye Mobile Plus Physical
- 44)Adesso Easy Cat 2 Button Glidepoint Touchpad (Black)
- 45)Kensington Expert Wireless Trackball Mouse
- 46)Candy Corn Proximity Sensor Switch
- 47)iSwitch
- 48)Buddy Button Switch
- 49)Jelly Bean Twist
- 50)Big Red Switch
- 51)Go Talk 9+
- 52)Chattervox Amplifier
- 53)Laser Pointer (handheld)
- 54)Jobar Playing Card Holders
- 55)Read and Write for Google Chrome
- 56)TouchChat Communication
- 57)Predictable
- 58)Proloquo2Go
- 59)ClaroCom
- 60)Sounding Board
- 61)SayIt
- 62)Assistive Express
- 63)Voice Dream Reader
- 64)Keeble
- 65)Pictello
- 66)FTVS
- 67)Seeing Ai Talking Camera
- 68)TapTapSee
- 69)Notability
- 70)SnapType Pro
- 71)Writing Wizard
- 72)Pillboxie
- 73)Choiceworks