



Rural PACE Assessment Instrument

The Rural PACE Assessment Instrument provides a framework for assessing a prospective rural PACE program and the relative strengths and weaknesses of its sponsoring organization. The instrument captures the prospective rural PACE sponsor's understanding of the need for PACE services and its ability to successfully position those services in the community. The instrument also includes an assessment of state support for a PACE program. Using these factors, the instrument provides for a rating of strength in each key area.

Objective and Overview

The Rural PACE Assessment Instrument is designed to serve a prospective sponsor as it describes and analyzes the factors shaping its efforts to develop PACE. The instrument can help to identify areas of challenge and opportunity, as well as where additional information is needed. A prospective rural PACE program's consideration of these areas will determine what next steps will be most appropriate. The instrument will serve a prospective rural PACE provider best if it is completed based on the most accurate information available.

The Rural PACE Assessment Instrument consists of four sections:

Section 1: Proposed Rural PACE Program and Service Area Description

This section describes the sponsoring organization, its community, proposed service area and proposed service population.

Section 2: Critical Factors

This section provides for detailed assessment of four critical factors, to be considered in sequence, affecting the development of a new PACE program:

- Critical Factor 1: Service Area's Potential Demand for Services
- Critical Factor 2: Community Relationships and Existing Services
- Critical Factor 3: State Environment
- Critical Factor 4: Organizational Capacity and Commitment

Section 3: Self-Rating

This section contains self-rating scales for each of the critical factors and the key areas within each factor.

Section 4: Next Steps

The final section addresses the next steps the organization will take based on the results of the assessment.

Interpreting Assessment Results

Rural PACE programs that are well integrated into the community have the potential to serve a substantial proportion of eligible, rural elders within their service area. A provider's ability to realize this potential will reflect the external and internal factors included in the instrument.

Externally, the provider will need to consider its relationship with: state aging and medical assistance agencies; local health, housing and aging service providers; and community organizations.

- Do these relationships indicate that a new PACE program would have external support?
- Would a new organization receive sufficient enrollment referrals?
- Could a new organization provide or contract for all necessary PACE services?
- Will state regulators support the program's start-up?

Internally, the provider's mission, financial strength, organizational structure, ability to partner collaboratively, and assignment of key staff will be significant factors in its potential to develop a rural PACE program.

- Does the sponsor's mission support the PACE program's focus on frail elders?
- What are the financial costs and potential sources of funds?
- Are partners needed?
- What staffing plan would need to be put in place?

External and internal strengths in some areas may compensate for weaknesses in one or more other areas. Consequently, a prospective PACE sponsoring organization will need to apply its own knowledge of the importance of these factors based on its specific situation.

Section 1

Proposed Rural PACE Program and Service Area Description

General Information

- A. In one or two paragraphs, describe your organization, the services it provides, clients it serves, and the project team that will be responsible for assessing the potential for rural PACE.
- B. Why does your organization want to do PACE?
- C. In one or two paragraphs, describe your community. Specifically, address how where you provide service affects how you provide services.

Proposed Service Area Description

Summarize your service area in terms of its:

- A. State(s)
- B. Counties
- C. Zip Codes
- D. Geographic Size
 - 1. Greatest distance from end to end
 - 2. Radius from proposed service area to center
- E. Road System and Impact on Transportation
- F. Driving Times from Key Service Areas (e.g., hospital, potential service delivery sites)
- G. Topography Factors (mountains, rivers, etc.)
- H. Seasonal Factors (e.g., snow, heat)
- I. Population Centers - General
- J. Population Centers - Elderly Persons

Note: Consider developing and attaching a map of the proposed service area with key location of health and human services providers, transportation routes, and transportation times identified.

Rurality of Service Area

For your proposed service area:

- A. What is the USDA rural-urban continuum code?
- B. What is the USDA urban influences code?
- C. What is the USDA rural-urban commuting code?

There are many unique challenges in assessing community needs in a rural area as opposed to an urban community. One challenge is attempting to characterize the rurality of each community. It is not adequate just to look at the population of a service area. An area's population density, its distance from an urban area and the economic relationships it has with other communities are some of the other factors that must be considered.

Unfortunately, there is not general agreement about how to measure rurality. Different government agencies use different methodologies based on their needs. However, among the various methodologies that exist, the rural continuum developed by the US Department of Agriculture's Economic Research Service for counties is helpful (<http://www.ers.usda.gov/Topics/View.asp>). The agency has developed six rural classifications along its continuum and three urban classifications. One note of caution: the methodology changed in 2003, so the backward compatibility of the data with past years is not completely reliable.

The Economic Research Service produces a number of reports that may be helpful. For more information on measuring rurality, the agency's home page on measuring rurality is: <http://www.ers.usda.gov/data/ruralurbancontinuumcodes/>.

The following three reports also may be helpful:

- The rural-urban continuum codes report will provide a continuum code for each county. It is available at: <http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes/>.
- The urban influences code also provides a code for each county based on its proximity to urban centers or towns and the size of those centers or towns (<http://www.ers.usda.gov/Data/UrbanInfluenceCodes/>).
- The rural-urban area commuting codes also provide a code for each county that helps to describe how much of the population is working in larger towns and cities in the surrounding areas and how large those towns and cities are (<http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommunityAreas/index.htm#Table1.>)

Service Area Disease Prevalence

In order to estimate the value of the PACE program to the service area, and begin planning for composition of the PACE program, it is helpful to identify the most prevalent disease in the proposed service area. Effective approaches to manage these diseases might inform the potential PACE sponsor about issues such as risk management, staffing patterns and contracts with other providers. It also might be helpful to be aware of diseases associated with special state or federal reimbursement opportunities, like black lung disease in certain coal mining areas. These considerations may be particularly important in ensuring an appropriate rate is set for PACE in the service area.

- A. What are the most prevalent diseases in your service area?
- B. Are there diseases in your area associated with special state or federal reimbursement programs (e.g., black lung)?

Additional Populations

As providers in a service area consider developing the necessary infrastructure to support a PACE program, their capacity to provide care and services to other underserved populations also may be expanded.

While PACE programs are limited to those aged 55 and older who need a nursing home level of care, organizations sponsoring a PACE program may wish to build on the expertise required for PACE to serve new populations and offer new services.

For example, an organization developing a PACE program may be able to integrate services for the younger disabled population, children with special health care needs, people with AIDS, or the chronically ill who require care management services. While these services would not be reimbursed as PACE services, they may help to spread some of the fixed costs associated with a PACE program and generate some economies of scale.

- A. Does the proposed PACE program's development call for the development of related services as part of its start-up?
- B. Would the organization seek to build on an operational PACE program in order to offer related services to an expanded population?

Section 2

Critical Factors

This section presents the critical factors that will shape a prospective PACE program's likelihood of success.

Critical Factor 1: Service Area's Potential Demand for Services

To estimate a service area's potential demand for services, the instrument looks at the number of people aged 65 and older, their clinical status and income status. Attachment A presents a detailed approach to assessing potential demand for services using Bureau of the Census data for the population in the rural PACE program's planned service area. This approach is described below. Additional state and local data sources also may be useful in estimating demand. Some examples of these sources are identified in the last section.

Key Area: Demographic Need

The demographic needs assessment used year 2000 Bureau of the Census data to estimate the potential population a PACE program could serve. This assessment uses the following factors:

- Aged 65 and older: While eligibility for PACE services begins at age 55, the available Bureau of the Census data is grouped for those aged 65 and older. In this sense the estimate of the potential population a PACE program would serve is conservative, since it does not include those aged 55-64 that could be served. Based on current PACE program experience, the substantial majority of PACE enrollees are over the age of 65, with an average age at enrollment of 80.
- Clinical Status: PACE enrollees must meet their state's clinical criteria for needing a nursing home level of care. To approximate state criteria, the instrument looks at the population's level of disability using three measures, ranging from least to most conservative:
 - o Inability to go outside the home;
 - o Self-care; and
 - o Disability in two or more activities of daily living, one of which is self-care.
- Income: Currently 9 in 10 PACE enrollees are financially eligible to receive Medicaid. While Medicaid financial eligibility consists of income and asset level tests, the instrument looks at income only. Each state's income level for Medicaid eligibility may be different. Most states set the level equal to 300% of Social Security Income. Others specify income levels based on unique formulations. It is not necessary to be financially eligible for Medicaid to enroll in PACE. The instrument presents the number of people both with and without Medicaid financial eligibility that might seek to use PACE services.

To assist a prospective rural PACE program in considering the results of the demographic assessment, two additional sections present the estimated number of potential PACE participants in terms of:

- The market penetration rate needed to achieve a specified range of enrollment levels; and
 - The estimated enrollment that would be achieved based on a specified range of market penetration rates.
1. What does the demographic needs assessment identify as the potential population that could be served by PACE in your service area based on age and clinical condition?
 2. What is the potential population that could be served by PACE based on age, clinical condition and income level that would indicate Medicaid eligibility?

Supplemental Data Sources

Some potential additional sources of information might be available that can help an organization understand its market. These include:

- State projection of population growth. What projections does the state's eligibility agency use?
- Local health care councils (looks at health care service patterns in primary service areas - PSAs).
- State information on mentally retarded/developmentally disabled (MRDD) population 55-64 years old.

Critical Factor 2: Community Relationships and Existing Services

The development of a PACE program requires an understanding of existing community relationships and services. This understanding lays the foundation for adequate referral networks that will help the program build, census, contracted services to meet PACE participant needs, and public support for the program. Assessing community relationships and existing services is an opportunity to gather information about the resources in the proposed service area that may be used to implement a PACE program. In addition, the assessment is an opportunity to educate other stakeholders and/or referral sources in the service area about the PACE model so that they can be potential partners.

A. Key Area: Access To Long Term Care Services

1. How do people currently access long term care services (i.e., nursing home, home and community based services, adult day care or home care)?
2. Describe your community's referral processes.
3. What is the process for Medicaid clinical eligibility determination?
4. What is the process for Medicaid financial eligibility determination?
5. Describe the relationship of the proposed internal and external referral sources to the proposed PACE sponsor.

Referral Source	Relationship to Sponsor	Expected Impact on Enrollment

6. How will these relationships impact enrollment in PACE?
7. Does your state have a single-entry point for determining clinical and financial eligibility for state-funded services?
8. If yes, does the single-entry point also provide direct services?

B. Key Area: Existing Partnerships

Contractual relationships and other partnerships between providers in the community should be noted and understood. They can provide a foundation for possible partnerships and contractual relationships that may be necessary to provide the broad range of care and services required under PACE. It also is helpful to note what organizations have not worked together in the past or may view each other as potential competitors.

1. Describe any strategic alliances or partnerships between health care, housing or aging service providers in your area.
2. Describe any organizations that are not willing to work with other organizations.

C. Key Area: Existing Staffing

1. Nurse Aide Staffing

For PACE, as with many forms of long term care, an adequate number of nurse aides is key to providing effective care.

- a. Do other health care providers in the proposed service area have difficulty or success in attracting and retaining nurse aide staff?
- b. Are other employment competitors present in the proposed service area that may affect nurse aide recruitment?
- c. Are there numbers of recently unemployed persons who might be interested in becoming trained as nurse aides?

2. Nurse Staffing

Recruiting nursing staff members is essential to providing home care, PACE center services, clinical assessment and care planning in the PACE model.

- a. Do other health care providers in the proposed service area have difficulty or success in attracting and retaining nursing staff?
- b. Are other employment competitors present in the proposed service area that may affect nursing recruitment?

3. Primary Care, Geriatrics and Specialists

Physician relationships will affect the program in terms of the role physicians play as a referral source and the relationship of the physicians to the PACE program's interdisciplinary team.

- a. Will the PACE program have its own primary care physician or does it plan to incorporate community physicians (which will require a CMS waiver) into the program?

- b. Which physicians in the proposed service area currently are providing care for Medicare and Medicaid patients? (Note: These physicians might be the most willing to participate with PACE. They also may be the most resistant to PACE if they will no longer be able to be paid for treating their existing Medicare and Medicaid patients.)
- c. Which primary care providers, particularly if community physicians are going to play a large role in the delivery of PACE services, will be looked to for expertise in geriatrics?

4. Informal Caregiving

One key to the success of the PACE model of care is the extent that it can support family and other informal caregivers to provide care and services in the community. It is important to understand, to the extent possible, the amount of informal caregiving that is present in the community. The Alzheimer's Association, home health agencies and hospitals, as well as a state's department of human services, area agencies on aging or office of adult services, may be able to help quantify to what extent informal caregiving is taking place in the proposed service area.

- a. To whom would the area agency on aging refer an interested family member for more information?
- b. Does the state allow programs that pay family members as caregivers? (This could be both a possible source of caregiving staff and potential competition for potential PACE enrollees.)

D. Key Area: Telemedicine/Technology

Telemedicine and new technologies increasingly are being utilized in rural areas to overcome some of the challenges associated with greater distances and the common shortage of health care professionals. Telemedicine can be used for expert consultation, to enhance delivery in clinic settings, and to deliver care and services in the home.

Some examples of the successful use of telemedicine include: reading X-rays, radiology, ultrasounds, telepharmacy (when the pharmacist is away), speech therapy, wound care, dermatology, psychology, diabetes monitoring, chronic disease management, case management, case team coordination, continuing education of health care staff, and potential administrative functions such as billing and coding. For more information, refer to NPA's "Technology in Rural PACE" issue brief.

1. What telemedicine/technology programs exist or could be developed in your service area?
2. Can specialist care be provided using existing telemedicine/technology programs to offset shortages of these providers in your service area?

E. Key Area: Related Long Term Care Services

Existing health care and aging services providers should be identified in the proposed service area.

1. Publicly Funded Long Term Care Services: What long term care services that are publicly funded (i.e., Medicaid or state-only funded) are available to serve your target population?
 - a. adult day care
 - b. home care
 - c. case management
 - d. personal care

- e. assisted living
- f. consumer-directed care
- g. home and community based waivers (see #3 below)
- h. skilled nursing facility
- i. meals assistance
- j. transportation
- k. other: (_____)

2. Home and Community Based Programs: Using Attachment B, list the home and community based waiver programs in your proposed service area. Please describe these programs.
3. Home and Community Based Long Term Care Providers: Using Attachment C, list the home and community based long term care providers in your proposed service area. Please describe these providers.
4. Nursing Facilities: Describe the nursing facilities that serve your market.

Provider Name	# of beds	Enrollment/ Occupancy	Waiting List?	Cost	Comment (re: quality, reputation, potential for partnership)

5. Assisted Living: Describe the assisted living facilities that serve your market.

Provider Name	# of beds	Enrollment/ Occupancy	Waiting List?	Cost	Comment (re: quality, reputation, potential for partnership)

6. Housing: Describe the low income and affordable housing providers in your service area. What proportion of the residents is elderly? Are supportive services offered on site (specify what services)?

Provider Type	Capacity - Number of Housing Units	Proportion of Residents that are elderly - estimated	Services Provided	Comment

7. Primary, Acute and Specialist Care: Describe the primary, acute and specialist care providers in your service area, including any rural hospitals, federally qualified health centers or physician groups/practices that will be important to consider.

Provider Type	Services Provided	Comment

Critical Factor 3: State Environment

The PACE provider agreement that allows providers to enroll participants and receive PACE capitated payments is a three-way agreement between the state, the provider and the Centers for Medicare and Medicaid Services (CMS). It is important that providers work with their states to ensure, to the greatest extent possible, that they are ready to support a PACE program. (NPA recently has developed many technical assistance resources to aid states.)

A. Key Area: State Long Term Care Programs

1. What is your sense of your state's commitment to home and community based services relative to institutional care?
2. How is PACE consistent or inconsistent with the state's long term care goals?
3. Does the state have existing innovative programs that serve older persons with chronic care needs?
4. Does the state currently have a PACE program or one under development elsewhere?
5. Has the state ever explored PACE before? If so, with what result and why?
6. What state agencies might need to be involved with supporting PACE (e.g., health, licensing, Medicaid, budget, aging, insurance, housing, governor's office staff).

B. Key Area: State Financing

1. Does the state view money spent on PACE enrollees as a shift from another expenditure it otherwise would have to make or as new money it has to find? Do different departments view this question differently?
2. Does the state have resources it is ready to commit to funding new PACE services?

C. Key Area: Medicaid Eligibility

1. What state agency determines eligibility? Is it supportive?
2. What are the state's requirements related to financial eligibility/clinical eligibility? Are one of these areas particularly stringent compared with other states?
3. Will PACE be an easy fit (from the state's perspective) with other programs requiring eligibility determination?
4. How long does eligibility determination usually take?

Critical Factor 4: Organizational Capacity and Commitment

How will your organization sustain the overall development of a PACE program? Who will lead this effort? Will a team be created to support planning and development of the program? From where will you recruit members of your team? With what services offered through PACE or care management strategies used by PACE does your organization have experience? Beyond service delivery and care management, consider what administrative and financial infrastructure will need to be developed.

A. Project Resources and Related Experience

1. Key Area: Leadership and Key Staff

- a. Who is the contact person for the PACE project?
- b. Is there a potential clinical leader (i.e., either nurse or physician) who can provide support for the program? Who is this? What is his/her background and interest in rural PACE?
- c. In exploring the development of a PACE program, who has agreed to serve on the leadership team? Where will the team be within your organizational structure?
- d. To what extent is your organization's chief financial officer aware of and supportive of PACE?
- e. What experience and background will team members contribute to the team's effectiveness in developing a prospective PACE organization?

Note: In large organizations, PACE programs succeed when placed in a strong relationship with key administrative staff within the organization. Having direct links to key decision makers within the organization strengthens the program's ability to respond quickly to issues that occur during start-up phases of program development.

2. Key Area: Experience

In which of the following does the proposed organization, including all partners, have experience?

- a. direct provision of acute care
- b. direct provision of long term care
- c. transportation
- d. providing community based care (specify: _____)
- e. senior housing
- f. serving dual-eligible, frail population
- g. use of interdisciplinary teams
- h. managing risk (specify: _____)
- i. developing service networks
- j. medical care
- k. adult day care
- l. home care
- m. telemedicine
- n. care management
- o. other (specify: _____)

3. Key Area: Resources and Timelines

- a. Can the organization devote resources sufficient to develop a plan for the implementation of a PACE program?
- b. What considerations regarding the sustainability of the program have you identified?
- c. What potential sources of capital and start-up funding are available (e.g. foundations, state funds)? How will these be accessed?

B. Organizational Support

1. Key Area: Priorities and Mission

- a. What is the organization's mission?
- b. How does the organization's mission relate to your community's goals and priorities?
- c. What other organizational priorities currently are being evaluated?

2. Key Area: Strategic Fit

- a. Has the organization considered how PACE fits into its strategic long range plan? If yes, describe the strategic plan as it relates to PACE.
- b. Is the organization interested in providing a full range of integrated services or is its focus on specializing in a particular health service/setting?

Section 3 Self-Rating

Rate your organization's strength with regard to each of the key areas on a scale of one to five, with five being the most favorable. In addition, rate the completeness of the information for each key area, with five being the most complete.

	Strength	Completeness
CF1, A Demographic Need	1 2 3 4 5	1 2 3 4 5
CF2, A Access to LTC Services	1 2 3 4 5	1 2 3 4 5
CF2, B Existing Partnerships	1 2 3 4 5	1 2 3 4 5
CF2, C Existing Staffing	1 2 3 4 5	1 2 3 4 5
CF2, D Telemedicine/Technology	1 2 3 4 5	1 2 3 4 5
CF2, E Related LTC Services	1 2 3 4 5	1 2 3 4 5
CF3, A State LTC Programs	1 2 3 4 5	1 2 3 4 5
CF3, B State Financing	1 2 3 4 5	1 2 3 4 5
CF3, C Medicaid Eligibility	1 2 3 4 5	1 2 3 4 5
CF4, A. 1 Leadership and Key Staff	1 2 3 4 5	1 2 3 4 5
CF4, A. 2 Experience	1 2 3 4 5	1 2 3 4 5
CF4, A. 3 Resources and Timeline	1 2 3 4 5	1 2 3 4 5
CF4, B. 1 Priorities and Mission	1 2 3 4 5	1 2 3 4 5
CF4, B. 2 Strategic Fit	1 2 3 4 5	1 2 3 4 5

Total Score (maximum of 70 possible) _____

Highest Scoring Key Area(s) for Strength:

1. _____
2. _____
3. _____

Lowest Scoring Key Area(s) for Strength:

1. _____
2. _____
3. _____

Areas Requiring More Information Before Proceeding:

1. _____
2. _____
3. _____

Section 4

Next Steps

- A. Discuss the results of the self-assessment with your PACE development team.
- B. Contact the National PACE Association (at ruralpace@npaonline.org or 703/535-1517).

Attachment A: Potential PACE Population Estimate

The following section presents a detailed explanation of the sources used from the Senior Life Report in the calculation of the factors and the final estimate. Apply these calculations to the Estimated Market of Potential PACE Participants Summary Demographic Report to generate the answers for Critical Factor 1: Service Area's Potential Demand for Services, Key Area: Demographic Need.

1. Total Population, 2003 (estimated from 2000)
This number comes directly from the Senior Life Report under the "Population by Age" section, in the "Total Population" row. It includes all ages.
2. Total Population 65+
This number comes directly from the Senior Life Report under the "Population by Age" section, "Total Population" category in the "Age 65 and over" row.
3. Total Population 75+
This number is a sum of the age categories Age 75 and older (75 to 79, 80 to 84, 85+) under the "Population by Age" section, "Total Population" category.
4. Total Civilian Noninstitutionalized Persons 65+
This number is the sum of Males and Females Age 65 and older (65 to 74, 75+) under the "Mobility and Disability Civilian Noninstitutionalized Persons Age 16 and over" section, "Disability by Sex and Age" category, "Male" row and "Female" row.
5. Total Civilian Noninstitutionalized Persons 65+ with a disability or combination of disabilities (Self-Care Disability and Go-Outside-Home Disability)
These numbers come directly from the Senior Life Report under the "Mobility and Disability Civilian Noninstitutionalized Persons Age 16 and over" section, "Total Disability" category.
6. % of Civilian Noninstitutionalized Persons 65+ with a disability or combination of disabilities indicating clinical eligibility for PACE
These numbers are the product of the number of total civilian noninstitutionalized persons 65+ with a disability (#5) divided by total civilian noninstitutionalized persons 65+ (#4).
7. Estimated population 65+ that would be clinically eligible for PACE
This applies the disability rates calculated for the noninstitutionalized population aged 65+ to the total number of people 65+, both institutionalized and noninstitutionalized, from number 2 above.
8. Total 65+ Households, 2003 (estimated from 2000)
This number is a sum of the total householders for each of the categories "Householder Age 65-74" and "Householder Age 75 and over" under the "Household Income by Age of Householder" section.
9. 65+ Households with income < \$20,000
This number is a sum of the age categories Householder Age 65 and older that are less than or equal to an income of \$18,000. This can be done simply for each age category less than \$15,000. For the other income range of \$15,000 - \$24,999, 50% of the number of households is used as an estimate of the number of households with an income between \$15,000 and \$20,000. This is done because we are estimating the number of those households that fall within the Medicaid financial eligibility limit and \$20,000 is approximately one-half of the way between \$15,000 and \$24,999 for income.

Estimated Market of Potential PACE Participants

Summary Demographic Report: Sun and Snow Health Centers

Assumptions: Income eligibility set at \$20,000; population aged 65+ only

POPULATION	
1. Total Population, 2003 (estimated from 2000)	36,000
2. Total Population 65+	11,520
3. Total Population 75+	8,640

CLINICALLY ELIGIBLE POPULATION			
4. Total Civilian Noninstitutionalized Persons 65+	7,158		
	Self-Care Disability	Go-Outside-Home Disability	2+ ADLs (one of which is self-care)
	2004	1718	1575
5. Total Civilian Noninstitutionalized Persons 65+ with a disability indicating clinical eligibility for PACE			
6. % of Civilian Noninstitutionalized Persons 65+ with a disability indicating clinical eligibility for PACE	28%	24%	22%
7. Estimated population 65+ that would be clinically eligible for PACE	3226	2765	2534

10. % of 65+ Households with income < \$20,000
This number is the product of the number of 65+ households with income less than \$20,000 (#9) divided by the total 65+ households (#8).
11. Estimated population 65+ that would be financially eligible for Medicaid coverage of PACE (those w/ income <\$20,000)
This number is the product of % of 65+ households with income less than \$20,000 (#10) multiplied by the total population 65+ (#2).
12. Estimated clinically eligible population for whom Medicaid would pay for PACE
This number is the product of the estimated population 65+ with income less than \$20,000 (#11) multiplied by the percentage of people aged 65 and older who would be clinically eligible for PACE (#6).

Attachment C: Home and Community Based Long Term Care Providers

Provider Type/Name	Range of Services Provided	Quality and Reputation	Referral Potential	Rural PACE Partner Potential
Adult Day Care				
Personal Care				
Home Care				
Hospice				
Other				