Compassionate Care in America

Results from the National Study on the Person-Centered, Trauma-Informed Approach

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Full Report

Jewish Federations of North America

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For additional resources on aging, trauma, and the PCTI approach, please visit the Center's website at www.AgingAndTrauma.org. For more information about this report, please contact Aging@JewishFederations.org.

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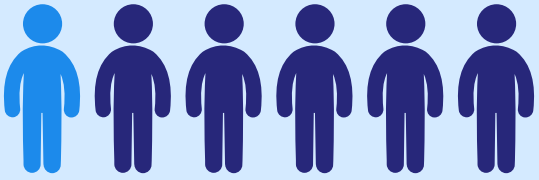
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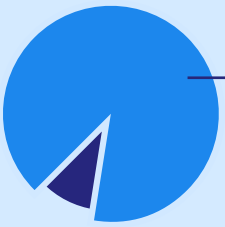
Executive Summary

Aging in the United States

The American population is living longer and, in turn, reshaping the way we view health, caregiving, and community living. In the United States today, more than one in every six people is 65 or older (Administration for Community Living [ACL], 2024). It is projected that there will be over 88 million older adults in the United States in 2060, versus only 35 million older adults in 2000 (ACL, 2024). As Americans live longer, their healthcare needs increase. A recent study through the Centers for Disease Control and Prevention (CDC) found that over 90% of older adults are living with at least one chronic condition, such as heart disease, high blood pressure, or diabetes (Watson et al., 2025). Complicating the aging process is the issue of trauma.

More than **1 in 6 Americans** is 65 years or older.





90%

of older adults have been exposed to a trauma event.

Exposure to traumatic events is omnipresent. Research suggests that almost 90% of American adults have been exposed to at least one traumatic event during their lifetime (Kilpatrick et al., 2013). Although trauma may not be the singular cause of health conditions, it has been shown to be an associated factor in the emergence of lung disease, dental problems, fibromyalgia, chronic fatigue, cardiovascular disease, gastrointestinal disorders, endocrine disorders, and headache disorders (Spitzer et al., 2011; de Oliveira Solis et al., 2017; Rouxel et al., 2016; Häuser et al., 2013; Dansie et al., 2012; McFarlane, 2010; Salleh, 2008). While trauma impacts healthy aging, the normal changes associated with aging can also exacerbate traumatic stress. Common changes such as retirement, shifts in familial roles, the loss of family and friends, social isolation, declining health, and the loss of independence can lead to the reactivation of traumatic stress, even in older adults who had previously been coping well

(Davison et al., 2016; Kaiser et al., 2017; Ladson & Bienenfeld, 2007; Paratz & Katz, 2011; United States Department of Veterans Affairs [VA], National Center for PTSD, 2019).

Whether Americans are aging in their own homes or in assisted living or nursing homes, **the demands on the aging services sector are growing.** However, the number of aging services professionals is falling behind this increase in demand. For example, officials administering Medicaid home- and community-based (HCBS) programs in all 50 states reported shortages in direct support professionals (Burns et al., 2023). As the aging services sector works to expand, family caregivers are stepping in to ensure their loved ones receive the care and support they need. According to a 2020 study by the AARP and National Alliance for Caregiving [NAC], it is estimated that one in six Americans, or about 42 million American adults, are caring for someone 50 or older, up 16% since 2015. The role of trauma in aging can add complexity to caregiving tasks, strain caregiving relationships, and impact caregiver health.

42 million American adults are caring for someone 50 or older, **up 16% since 2015**.

When trauma is not accounted for in aging services, there can be terrible consequences for older Americans. Without recognizing the role of trauma, aging services professionals may not understand its impact on aging or services delivery and may unintentionally do harm. Older adults may be labeled as difficult to care for or be misdiagnosed, receiving inappropriate treatments and medications (Key, 2018; McCarthy & Cook, 2018). Professionals may have inappropriate responses to trauma-related behaviors and conditions, unintentionally retraumatizing the older adults they are trying to support (Key, 2018). Older survivors of trauma who have these negative experiences are less likely to seek services or receive appropriate care in the future.

The person-centered, trauma-informed (PCTI) approach has emerged as the gold standard to account for trauma in aging services and support all aging populations. The PCTI approach is a holistic model of care that promotes the health and well-being of individuals by accounting for the role of trauma across the life course, resisting retraumatization, and promoting the strength, agency, and dignity of people receiving care. The PCTI approach is universal, meaning that it can be used by any person at any level of any organization, in any care setting, and with any population.

The PCTI approach combines two approaches to care—the person-centered approach and the trauma-informed approach—and is guided by ten core principles. These two approaches have been called the "universal precautions" of the social services world (Hodas, 2006), and are increasingly associated with improved client outcomes and reduced health and social services costs (Key, 2018; Menschner & Maul, 2016).

The National Study

In 2015, the Jewish Federations of North America (Jewish Federations) established the Center on Aging, Trauma, and Holocaust Survivor Care (Center) to lead national efforts on the PCTI approach. This work has been supported through grants from the United States Administration for Community Living (ACL) as well as other generous philanthropic contributions. The aim of the Center's work is to improve the health and well-being of Holocaust survivors, older adults with a history of trauma, and their family caregivers, and to build the capacity of the United States' aging services sector to provide PCTI care for these populations. This work is accomplished through grant-making to direct services organizations that implement, evaluate, and scale innovative PCTI interventions, as well as through PCTI training and education.

As part of this work, the Center conducts a national, longitudinal study on the state of PCTI approach capacity among aging services professionals every five years. This report represents findings from the third iteration of the National Study conducted in 2025. The goal of this study is to understand the overall capacity of aging services organizations to use the PCTI approach with Holocaust survivors, older adults with a history of trauma, and their family caregivers; and to track changes in PCTI capacity over time.

The National Study was conducted through an online survey between March and May of 2025 and was distributed to a network of over 3,000 aging services professionals. The National Study dataset is composed of 274 responses, representing a variety of organizations across the aging services sector.

Summary of Findings

The findings of the National Study demonstrate the exciting growth of the PCTI approach across the aging services sector. However, the findings also demonstrate the need for further investments in the abilities of aging services organizations to use the PCTI approach with all aging Americans.

Awareness of Aging, Trauma, and the PCTI Approach

Most aging services organizations understand the impact of trauma on aging and that the PCTI approach can help. Approximately three quarters (71%) of respondents noted that their organization has a high understanding of how trauma impacts aging. Similarly, 75% of respondents noted that their organization was aware of the PCTI approach before participating in the 2025 National Study. However, this leaves a significant gap, as many organizations providing direct or indirect care to older adults do not understand how trauma may impact those they support or the services they provide.

In working to close this gap, it is important to consider two major findings from the National Study. First, **just because an organization currently works with older adults does not mean that the organization will innately understand how trauma impacts this population**. While

7 out of 10 organizations have a deep understanding of how trauma impacts aging.



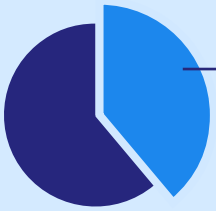
supporting older adults may teach professionals how trauma can impact aging or care delivery, there is a limited relationship between an organization's history of service and its rates of understanding trauma and the PCTI approach. Second, **just because an organization understands how trauma impacts aging does not mean the organization will be familiar with the PCTI approach and vice versa**. An organization's understanding of aging and trauma cannot be used to predict its awareness of the PCTI approach, and an organization's awareness of the PCTI approach does not imply its understanding of aging and trauma.

Capacity to Use the PCTI Approach

Few aging services organizations have capacity to implement the PCTI approach. While service recipients of all organizations participating in the National Study would benefit from the PCTI approach, a little over one third of respondents (39%) demonstrated that their organization has high capacity to implement it throughout their operations.

The National Study reveals four important issues to consider when building the PCTI capacity of the aging services sector. First, **organizational awareness of the PCTI approach does not necessarily translate into organizational PCTI capacity**. While three quarters of organizations are aware of the PCTI approach, just over a third demonstrated deep PCTI capacity. This may be because developing PCTI capacity requires an organization to go far beyond recognition of best practices; it requires effecting structural and cultural changes as it shifts resources and modifies practices to prioritize PCTI principles.

Second, **organizations tend to overestimate their PCTI capacity**. While 39% of respondent organizations objectively demonstrated high PCTI capacity through the Center's Organizational PCTI Approach Index, 56% self-reported high capacity to use the approach. This may be because many respondents tend to equate the mere existence of PCTI programming with true organizational capacity. However, PCTI capacity involves integrating PCTI principles throughout all operational areas including resourcing, systems, staff skill, culture, and partnerships.



39%

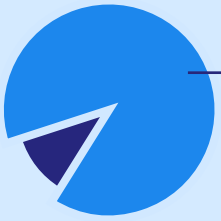
of aging services organizations have deep PCTI capacity.

Third, **the National Study reveals that there are gaps in PCTI care across older adult populations**. Consistent with prior years, the study found that aging services organizations have varied PCTI capacity and PCTI service availability when providing support to different populations of older adults with a history of trauma. This may leave certain older adult populations without access to compassionate care shown to improve care outcomes.

Finally, **PCTI capacity is not evenly distributed between older adult and family caregiver services**. While many organizations report that they can support older adults with the PCTI approach, not all of them have the capacity to extend this care to family caregivers who support older adults.

Benefit of the PCTI Approach

Aging services organizations increasingly understand the benefits of the PCTI approach. Most organizations (89%) noted that the PCTI approach improved care recipient outcomes, staff knowledge and skills, and the organization as a whole. Care recipients were empowered, and trust and relationships between care recipients and professionals improved. The PCTI approach enhanced staff knowledge of how to support care recipients and increased staff ability to create and implement PCTI strategies to serve them. Using the PCTI approach improved the organization as a whole by elevating the quality of services, improving care recipient feedback about services, and enhancing the organization's reputation. These findings showcase the potential of the PCTI approach, **which has a proven track record of improving outcomes and experiences, not just for care recipients, but for staff and the organization too**. As more pressure is put on the aging services sector's capacity to support a growing aging population, it is critical to leverage the impact of the PCTI approach.



89%

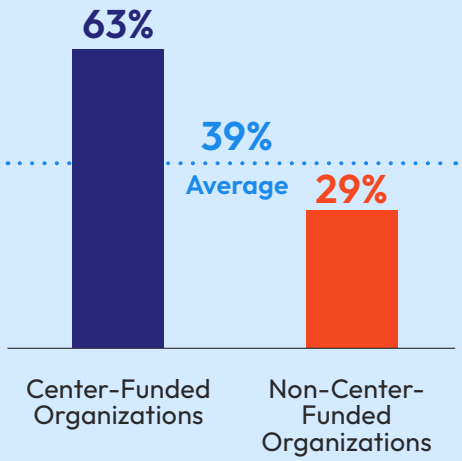
of organizations report the PCTI approach improves care recipient outcomes, staff knowledge, and organizational practices.

Impact of Center Activities

Investments in organizational PCTI capacity are needed and effective. While there is significant work ahead of the aging services sector in making PCTI care widely available, the National Study reveals that dedicating funding and resources through the Center makes a significant difference. Center-funded organizations reported deeper awareness, understanding, and capacity across all study measures when compared to organizations that have never received Center

funding. For example, 63% of Center-funded organizations demonstrated high PCTI capacity compared to only 29% of non-Center-funded organizations. Even for organizations that have never received Center funding, Center resources appear to be impactful. Of organizations using Center resources, 96% of Center-funded organizations and 90% of non-Center-funded organizations reported that these resources improved their organizations' knowledge, practices, and/or services. These statistics demonstrate that providing resources and funding enables organizations to learn about the PCTI approach, integrate it into their organization's operations and services, and improve the health and well-being of older adults and their family caregivers.

Organizations with High or Very High Demonstrated PCTI Capacity





Not only is this support effective, but the aging services sector is eager to receive it. The National Study revealed an overwhelming interest in additional funding as well as educational resources such as webinars, job aids, and in-person conferences and workshops. This feedback is echoed every time the Center issues a request for proposals for a new funding opportunity or provides an educational resource. Year after year, the Center receives more grant applicants for each PCTI grant opportunity and must turn away a larger portion of applicants due to limited funds. Additionally, whenever the Center evaluates webinars or in-person training events, aging services professionals ask for more training opportunities on an increasingly wide array of topics related to PCTI capacity building and service delivery.

Recommendations

Although the field of PCTI care has grown over recent years, a significant gap remains across the aging services sector. Based on the findings from the National Study, the Center makes the following recommendations for professionals working across direct services, organizational leadership, grant-making, advocacy, and policy.

1

Improve understanding about aging with a history of trauma.
Enhance recognition and understanding of how trauma impacts older adults generally, their family caregivers, the specific populations they support, and the services provided.

2

Increase understanding and application of the PCTI approach.
Improve aging services professionals' knowledge of the PCTI approach and its application, and train and coach colleagues to do the same.

3

Build organizational capacity to use the PCTI approach.
Dedicate time and resources to infuse the PCTI approach throughout an organization and its programming in order to provide compassionate care to all older adults and their family caregivers.

4

Expand accessibility of PCTI care.
Learn about care across aging populations and provide compassionate care to all older adults with a history of trauma and their family caregivers.

With these recommendations, aging services professionals across the United States can infuse PCTI considerations into their work to best support older adults with a history of trauma and their family caregivers. When implementing these recommendations, no action is too small. Every step that helps advance use of the PCTI approach advances the entire field of aging services and helps ensure that older Americans can age with safety, dignity, and compassion.

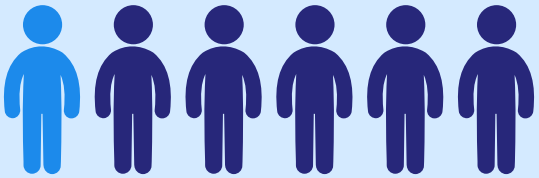


Aging with a History of Trauma

Trends in Aging in the United States

The American population is living longer and, in turn, is reshaping the way we view health, caregiving, and community living. More Americans are living longer, as medical advances save the lives of thousands who require lifelong care for disabilities or chronic illnesses (Talley & Crews, 2007). In the United States, more than one in every six Americans is 65 and older (ACL, 2024). This number is only projected to increase as all Baby Boomers will be 65 and older by 2030 (ACL, 2024). As a result, it is estimated that there will be over 88 million older adults in the United States in 2060, versus only 35 million in 2000 (ACL, 2024).

More than **1 in 6 Americans** is 65 years or older.



At the same time, the American older adult population is changing. By 2060, it is projected that the number of racial- and ethnic-minoritized older adults will nearly double and will comprise nearly half of the American older adult population (Ochieng et al., 2021). As they age, Americans' healthcare needs are increasing. A recent study through the CDC found that over 90% of older adults are living with at least one chronic condition, such as heart disease, high blood pressure, or diabetes (Watson et al., 2025). In addition to health conditions, financial insecurity is another prevalent issue for older adults. In 2022, over 10% of older adults in the United States lived below the poverty line (ACL, 2024). Poverty rates are even higher for racial- and ethnic-minoritized older adults (ACL, 2024). Regardless of health and financial conditions, aging in place is increasingly important to many older adults.

Whether Americans are aging in their own homes or in assisted living or nursing homes, **the demands on the aging services sector are growing**. On one hand, the aging services sector is growing and expanding. As of 2021, there were nearly six million jobs in the sector (Argentum, 2023). This number is expected to increase by over 42% by 2040, resulting in over eight million jobs available (Argentum, 2023). However, the number of aging services professionals is not increasing to match the number of jobs. Officials

administering Medicaid HCBS programs in all 50 states reported shortages in direct support professionals (Burns et al., 2023). This lag is due to the high stress and low wages associated with direct care jobs. According to a report by PHI (2022), because of low wages, part-time hours, limited opportunities for career advancement, and a lack of benefits, "40% of direct care workers live in low-income households, and 43% rely on public assistance, such as Medicaid, food and nutrition assistance, or cash assistance" (p. 2).

There is a mismatch between the amount of long-term care needed by older adults and the amount of care available. Approximately 48% of older adults in the United States have difficulty carrying out activities of daily living without assistance (Freedman & Spillman, 2014). Of those who require assistance, 95% receive some type of help with daily activities from family or close friends and 66% rely solely on family caregivers (Freedman & Spillman, 2014; National Center on Caregiving [NCC], 2003). These percentages are anticipated to grow as the older adult population ages. It is critical for the aging services sector to both expand and improve to keep up with the growing needs of the aging population.

Meanwhile, family caregivers are stepping in to ensure their loved ones receive the care and support they need. A family caregiver is a family member or chosen family member, partner, or friend who provides a broad range of assistance to an adult or older adult with a chronic, disabling, or serious health condition. Family caregivers are not professionally employed to care for their loved ones and may or may not have prior experience in caregiving. They can live with or separately from those they care for, and this responsibility may be short-term, long-term, or indefinite. As the older adult population grows, so does the number of family caregivers. According to a 2020 study by the AARP and NAC, it is estimated that one in six Americans, or about 42 million American adults, are caring for someone 50 or older, up 16% since 2015.

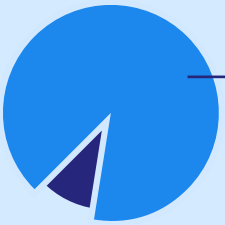
> **42 million** American adults are caring for someone 50 or older, **up 16% since 2015**.

The responsibilities of the family caregiver population are growing as well. According to AARP and NAC in 2025, approximately one quarter of family caregivers cared for two or more individuals, up from 18% in 2015 (AARP & NAC, 2020). Additionally, nearly one third of family caregivers cared for someone for more than five years, and nearly one third cared for someone with dementia, both statistics up from 24% in 2015 (AARP & NAC, 2025; AARP & NAC, 2020). Finally, over 40% of family caregivers reported coordinating care to be difficult, a higher statistic than in 2020 and 2015 (AARP & NAC, 2025; AARP & NAC, 2020). Compounding the challenges of being a family caregiver, many are part of the direct care workforce and professionally care for other older adults. These trends are anticipated to continue as the older adult population booms, healthcare costs rise, and the direct care workforce struggles to bounce back from the COVID-19 pandemic (AARP & NAC, 2020).

Aging and Trauma

Adding to the challenges of caring for America's aging population is the issue of trauma. There is no single definition of trauma. However, according to preeminent experts in trauma-informed care, individual trauma is a person's response to an event, series of events, or set of circumstances that present physical or emotional harm or is life threatening (United States Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Herman, 1997; Van der Kolk, 2014; American Psychological Association [APA], 2022). These traumatic events can occur once or on a repeated basis and can occur quickly or over a long period of time. For example, individual trauma can result from surviving war, genocide, crime, natural disasters, sexual violence, or child abuse. Trauma can also be a result of experiencing systemic racial, economic, religious, or gender discrimination. Trauma can also be intergenerational, with trauma responses being passed down across generations. It can be vicarious; one can experience trauma response because of seeing or hearing of someone else's trauma exposure. Regardless of the type of trauma experienced, these events or circumstances can rupture sense of safety, leaving survivors of trauma feeling vulnerable and isolated.

Exposure to traumatic events is omnipresent. Research suggests that almost 90% of American adults have been exposed to at least one traumatic event during their lifetime (Kilpatrick et al., 2013). For example, more than one in four children in the United States experiences or witnesses interpersonal violence in their lifetime (Finkelhor et al., 2009). More than one in three women and more than one in four men in the United States will experience sexual assault, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). Approximately one in ten older adults will experience elder abuse annually (National Council on Aging [NCOA], 2024).



90%

of older adults have been exposed to a trauma event.

The impact of trauma exposure can endure throughout an individual's lifetime. Felitti et al. (1998) conducted a study on adverse childhood experiences (ACEs) and established a "strong and cumulative" link between trauma experienced in childhood and poor health in adulthood. Since 1998, the understanding of the relationship between ACEs and health outcomes has grown, with ACEs now linked to various health conditions including arthritis, chronic obstructive pulmonary disease, obesity, and heart disease (Okwori et al., 2022; Merrick et al., 2019). These findings have led to the development of a life course perspective on trauma and aging, stressing that aging is a developmental process that spans a person's entire life, and that **experiences, events, and risk exposure in early life can have a profound impact that lingers for decades** (Hu, 2021).

Although trauma may not be the singular cause of health conditions, it has been shown to be an associated factor in the emergence of lung disease, dental problems, fibromyalgia, chronic fatigue, cardiovascular disease, gastrointestinal disorders, endocrine disorders, and headache disorders (Spitzer et al., 2011; de Oliveira Solis et al., 2017; Rouxel et al., 2016; Häuser et al., 2013; Dansie et al., 2012; McFarlane, 2010; Salleh, 2008). Similarly, an association has been shown between trauma exposure and anxiety, depression, suicidal ideation, eating disorders, and substance abuse (Williamson et al., 2021; Jankowski, 2016; Panagioti et al., 2012; Brewerton, 2007; Brady et al., 2016). Finally, trauma exposure has been associated with the onset of Alzheimer's disease and other dementias, sleep disorders, and other cognitive impairments (Mohlenhoff et al., 2017; Yaffee et al., 2010).

While trauma impacts healthy aging, the normal changes associated with aging can also exacerbate traumatic stress. Common changes such as retirement, shifts in familial roles, the loss of family and friends, social isolation, declining health, and the loss of independence can lead to the reactivation of traumatic stress, even in older adults who had previously been coping well (Davison et al., 2016; Kaiser et al., 2017; Ladson & Bienenfeld, 2007; Paratz & Katz, 2011; VA, National Center for PTSD, 2019). The death of a spouse, partner, or friend can end an important source of support and social connection. The loss of physical strength, illnesses, medical procedures, hospital stays, and end-of-life issues can make older adults feel like they can no longer protect themselves. Retirement can disrupt social connections, routine, financial stability, and the sense of self-worth tied to a job. Simultaneously, coping strategies like exercising or socializing can be more difficult to maintain as individuals with a history of trauma age. These circumstances may make individuals feel alone, unsafe, and vulnerable to the reemergence of PTSD (VA, National Center for PTSD, 2019). Chopra (2018) describes case studies of older adults who experience post-traumatic stress disorder (PTSD) for the first time decades after their initial trauma.

As numerous studies show, particular American populations may be more likely to experience trauma and are in greater need of services and support as they age (VA, National Center for PTSD, 2020; Tebes et al., 2019). The Jewish Federations' 2023 Guidance for Aging Services report provides an extensive review of these older adult populations, their rates and types of trauma exposure, how trauma impacts their health as they age, and considerations for population-specific services. Some of the populations included in this report are Holocaust survivors, racial- and ethnic-minoritized communities, older adults with disabilities, older adult survivors of crime, and military veterans.

Trauma exposure among older adults can also impact caregiving. For several reasons, caregiving for an older adult with a history of trauma may be more challenging than caregiving in the general older adult population. First and foremost, symptoms of trauma and PTSD can be difficult to manage for the individual experiencing them as well as for their family or friends. Family caregivers may not know how to soothe the distress, anger,

confusion, or panic as their loved one experiences flashbacks, nightmares, or intrusive thoughts. Family caregivers may also not know how to respond to trauma-related behaviors such as avoidance, hypervigilance, and isolation. These emotions and behaviors add another layer of complexity when a caregiver helps perform medical tasks, daily chores, or end-of-life planning.

Second, as mentioned previously, individuals with a history of trauma have a higher likelihood of experiencing declines in physical, cognitive, and mental health. They may have multiple health conditions, and those health conditions may be more difficult to manage.

Finally, caregivers exposed to their loved one's history of trauma can be vulnerable to vicarious trauma, compassion fatigue, and burnout. While caring for a loved one can be meaningful and rewarding, it can become a traumatic experience, resulting in symptoms such as increased anxiety, depression, and hypervigilance. As a result, those caregivers may experience deterioration to their health at a rate higher than those who care for older adults without a history of trauma.

The Person-Centered, Trauma-Informed Approach

When trauma is not accounted for in aging services, there can be terrible consequences for older Americans. Aging services professionals who do not recognize the role of trauma in aging or service delivery may unintentionally do harm. Older adults may be labeled as difficult to care for or treat, or they may be misdiagnosed, receiving inappropriate treatments and medications (Key, 2018; McCarthy & Cook, 2018). Professionals may have inappropriate responses to trauma-related behaviors and conditions and, in turn, unintentionally retraumatize the older adults they are trying to support (Key, 2018). Older survivors of trauma who have these negative experiences are less likely to seek services and receive appropriate care in the future. When professionals account for trauma in aging, they can more effectively serve older adults and their family caregivers.

The PCTI approach has emerged as the gold standard to account for trauma in aging services and to support all aging populations. It is a holistic model of care that promotes the health and well-being of individuals by recognizing the role of trauma across the life course, resisting retraumatization, and promoting the strength, agency, and dignity of people receiving care.

> The **PCTI approach** is a holistic model of care that promotes the health and well-being of individuals by accounting for the role of trauma across the life course, resisting retraumatization, and promoting the strength, agency, and dignity of people receiving care.

The PCTI approach combines two approaches to care: the person-centered approach and the trauma-informed approach. The PCTI approach is universal, meaning that it can be used by any

person at any level of any organization, in any care setting, and with any population. Such approaches have been called the "universal precautions" of the social services world (Hodas, 2006), and are increasingly associated with improved older adult outcomes and reduced health and social services costs (Key, 2018; Menschner & Maul, 2016).

At its core, the PCTI approach is grounded in the six trauma-informed principles developed by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). These principles are understood and implemented in a person-centered way, guided by four commonly recognized principles of the person-centered approach. These principles are defined below.

Trauma-Informed Principles:

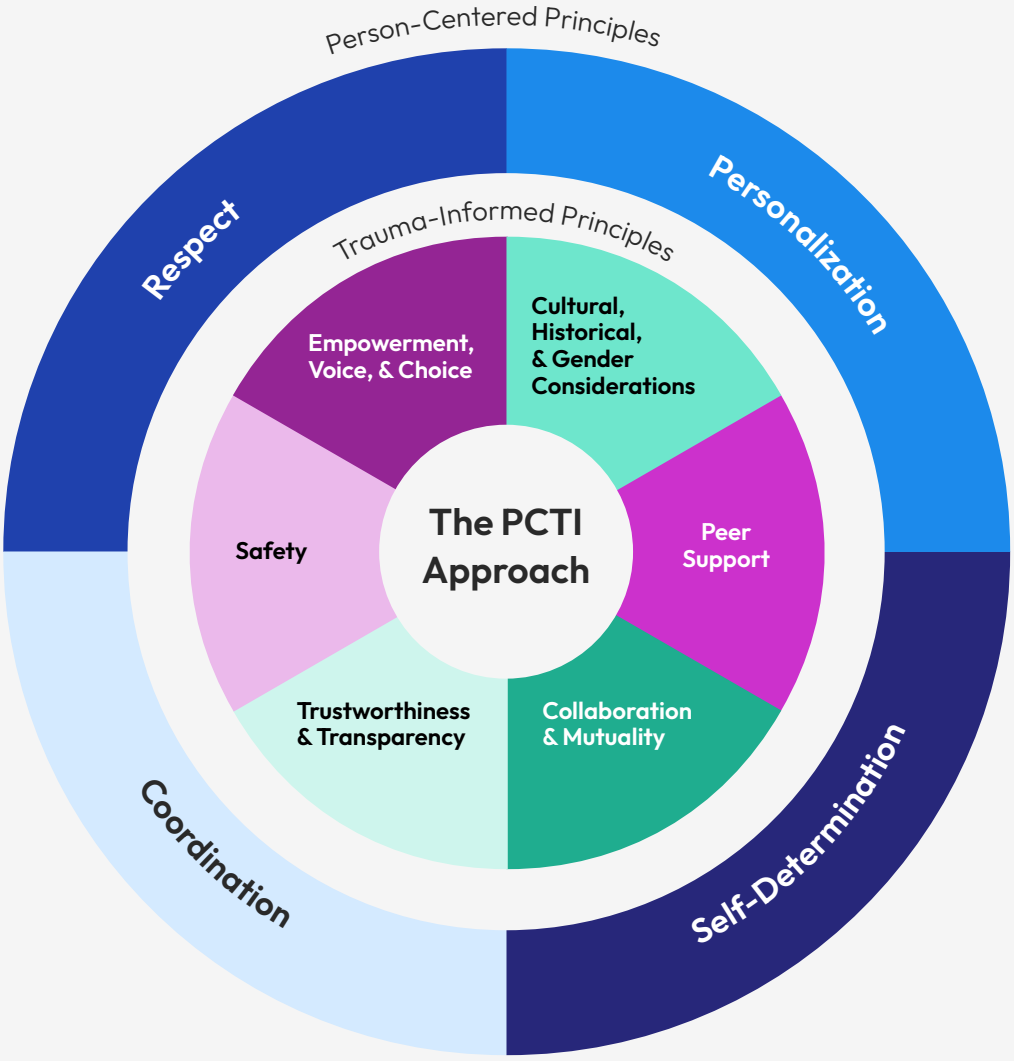
- **Safety.** Creating an environment where people receiving care, their families, and staff feel physically and psychologically secure and free of harm.
- **Trustworthiness and transparency.** Ensuring that operations and decisions are clear and transparent to build and maintain trust among people receiving care, family members, and staff.
- **Peer support.** Connecting people receiving care and their family members with others who have shared experiences to offer mutual understanding, support, and self-help.
- **Collaboration and mutuality.** Leveling power differences and recognizing that all staff, people receiving care, and families have an important role to play in the care and support provided.
- **Empowerment, voice, and choice.** Recognizing and building off an individual's strengths and experiences, ensuring their own goal setting and decision-making.
- **Cultural, historical, and gender considerations.** Providing culturally responsive care and support that account for historical trauma and traditional cultural practices.

Person-Centered Principles:

- **Personalization.** Adjusting care based on the unique needs, goals, preferences, strengths, and values of each individual receiving support.
- **Self-determination.** Ensuring that individuals direct their own care and are empowered to identify, pursue, and achieve their own goals and full potential.
- **Coordination.** Working in partnership and collaboration with an individual, their support system, and other aging services professionals.
- **Respect.** Treating everyone with patience, compassion, and dignity, including the people receiving care, their families, and staff.

The PCTI Approach Model illustrates how these principles interplay. The inner circle comprises the six trauma-informed principles, and the outer circle comprises the four person-centered principles. The model shows how trauma-informed principles must be utilized through the person-centered lens. There is no relationship between the physical proximity of principles on the diagram and how these principles connect. All person-centered principles can relate to all trauma-informed principles and vice versa. For example, the principle of "Respect" can be just as important for "Peer Support" as it is for "Empowerment, Voice, and Choice."

The PCTI Approach Model



Traditionally, the person-centered approach and the trauma-informed approach have been used separately. While aging services professionals may have used the person-centered approach to tailor care to individuals, the role of trauma may have been overlooked. Conversely, aging services professionals may have implemented trauma-informed principles without accounting for the goals and preferences of the person receiving care. By combining both approaches, the PCTI approach considers the interconnectedness of an individual's physical, mental, and social health. It provides space for individuals to lead their care, and for professionals to follow their lead. When individuals lead their care, professionals can see beyond surface-level symptoms to recognize hidden variables such as a history of trauma.

The PCTI approach has broad application and can be used by anyone, personally or professionally. The PCTI Approach Implementation Model illustrates the four broad levels at which the approach can be used: interpersonal, organizational, societal, and public policy. The levels are defined below.

- **Interpersonal.** Relationships between individuals and their families, friends, caregivers, colleagues, aging services professionals, and others. This can include care provided to an individual or peer support between individuals receiving care or fellow caregivers.

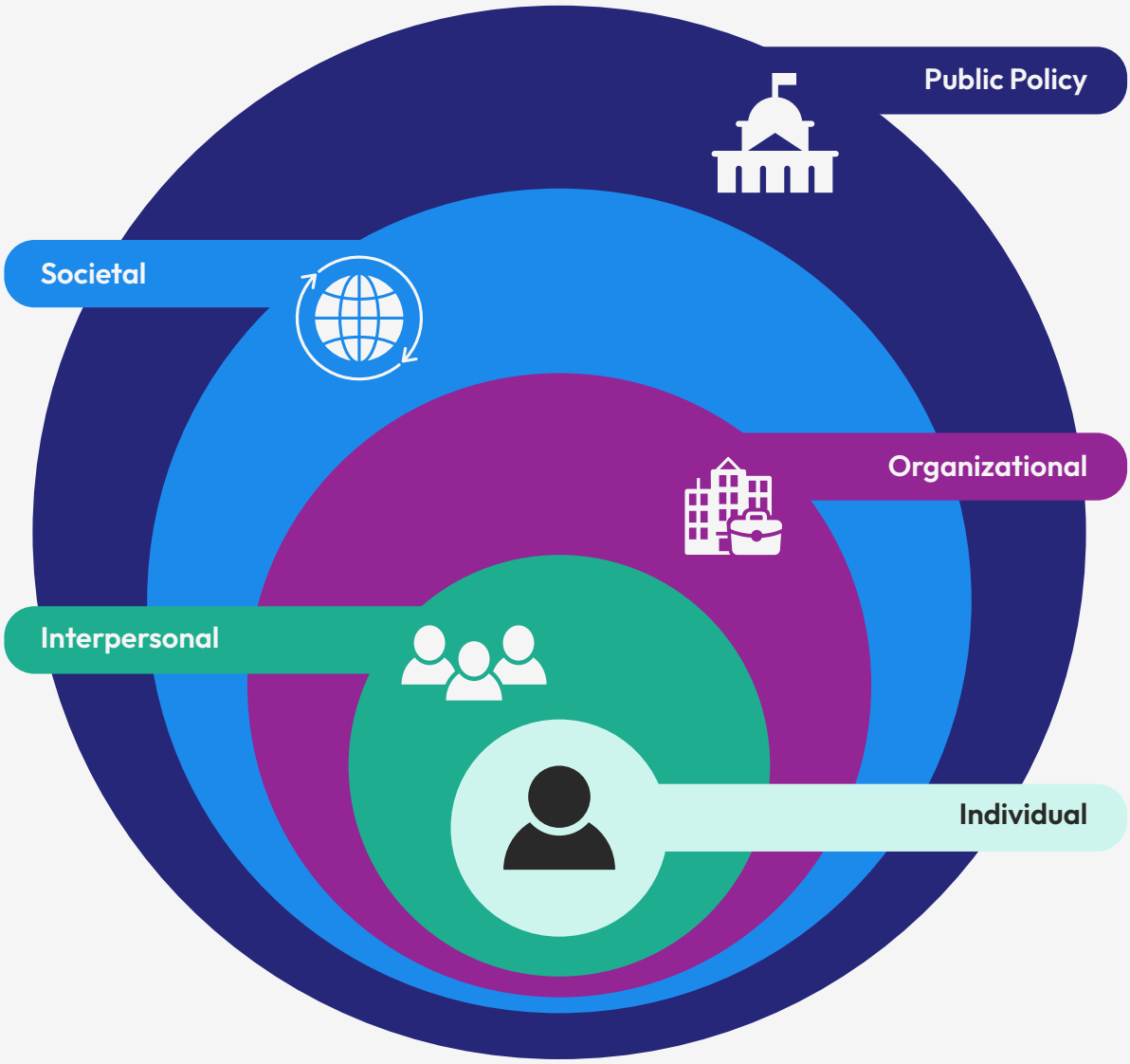
- **Organizational.** Policies, procedures, systems, agency spaces, businesses, schools, etc. This can include an agency's intake procedures, recruitment policies, or physical spaces.

- **Societal.** Culture, norms, and traditions guiding workplaces, neighborhoods, community groups, and religious communities. This can include professional standards, religious customs, or community traditions.

- **Public Policy.** Local, state, and federal laws, regulations, and standards. This can include training mandates, treatment coverage limits, or entitlement programs.

Throughout these levels, the PCTI approach can positively impact an individual or community's health and well-being. For example, on an interpersonal level, professionals or family caregivers can use the PCTI approach to build relationships with the people they are caring for, better understanding their needs, goals, and ideal health outcomes. On an organizational level, individuals can infuse the PCTI approach into their agency's mission statements, intake processes, or staff recruitment procedures. On a societal level, community and religious leaders can use the PCTI approach to create a community that is welcoming of all its members. And on a public policy level, government officials can integrate the PCTI approach into government initiatives or provide grants to direct service agencies to implement the approach. On all levels, **the PCTI approach helps eliminate barriers to care, avoid premature institutionalization, increase utilization of services and access to benefits, save costs, and improve public health**. It also helps improve staff experiences, reduce burnout, and increase staff retention.

The PCTI Approach Implementation Model



The Center on Aging, Trauma, and Holocaust Survivor Care

To increase and improve the use of the PCTI approach throughout the US aging services sector, the Jewish Federations established the Center. The Jewish Federations is an umbrella organization of 146 Jewish Federations and 300 network communities that aim to build flourishing Jewish communities where all members can live comfortably and achieve their full potential. The programs and services Federations provide, or fund include a range of social services for older adults, Holocaust survivors, individuals with disabilities and their families, family caregivers, and economically vulnerable populations of all faiths and backgrounds. This work dates to the early 20th century.

In 2015, the Center was established through a five-year federal grant from ACL as well as other generous philanthropic contributions. Through this grant, the Center became the only federally funded National Resource Center on the PCTI approach and built the capacity of aging services organizations to provide PCTI care to Holocaust survivors and their family caregivers. The focus of this grant was to build the PCTI capacity of the Aging Network, but the work of the Center exceeds this focus.

The Aging Network is a national network of State and Area Agencies on Aging and Native American aging programs that plan and provide services to help older adults age independently and remain in their homes and communities (ACL, 2023). Beyond the Aging Network, the work of this grant builds the PCTI care capacity of all who work in aging services. This includes direct service providers, policy makers, funders, volunteers, and researchers. In 2020, ACL awarded Jewish Federations a second five-year grant to expand its work to other populations of American older adults with a history of trauma, including veterans, victims of crime and natural disaster, and members of racial- and ethnic-minoritized older populations as well as their family caregivers. In 2025, ACL awarded the Jewish Federations a three-year grant to continue and expand its work.

In implementing these grants, the Jewish Federations' Center has two main goals:

1. **Increase the number and type of innovations in PCTI care available for Holocaust survivors, older adults with a history of trauma, and their family caregivers**.

   This goal is achieved by awarding sub-grants to direct service agencies to implement and evaluate innovative PCTI care interventions such as projects for socialization, mental health, health and wellness, cognitive health, family caregiver support, and PCTI training. Since 2015, subgrantee agencies have implemented more than 600 PCTI interventions, served over 49,000 Holocaust survivors and over 24,000 older adults with a history of trauma, trained over 26,000 professional service providers andvolunteers, and supported over 10,000 family caregivers. Evaluations of these programs demonstrate their ability to improve the overall health and

well-being of Holocaust survivors, older adults with a history of trauma, and their family caregivers.

2. **Build the capacity of aging services providers across the country to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers.**

   This goal is achieved through the Center's training and educational initiatives, which include publications, presentations, webinars, training workshops, online courses, and publication and dissemination of resources on aging, trauma, and PCTI care. For example, Center presentations at the American Society on Aging, Gerontological Society of America, and Grantmakers in Aging conferences have highlighted the impact of trauma on the lives of older adults and the importance of the PCTI approach. The Center offers online courses, webinars, and in-person workshops on topics including emerging issues in aging and trauma, promising practices in PCTI care during a pandemic, the impact of trauma on the brain and body, trauma-informed culture change, and applying PCTI principles to older populations with a history of trauma. Center publications have included articles on how to implement PCTI principles and fact sheets on aging, trauma, and family caregiving. These capacity-building resources are centralized on the National Resource Center website.

As part of the second goal, the Center conducts the National Study on the Person-Centered, Trauma-Informed Approach. This National Study provides information on the state of PCTI capacity among U.S. aging services professionals and evaluates the Center's impact. The results of this study are the basis of this report.





Methodology

The National Study is a longitudinal study conducted by the Center approximately every five years. This report represents findings from the third iteration of the National Study, conducted in 2025. The goal of the National Study is to understand the awareness of aging services organizations of the role of trauma in aging, the capacity of aging services organizations to use the PCTI approach, and the impact of Center activities on the awareness and capacity of aging services organizations. This was explored through four research questions:

1. What is the level of **awareness** among aging services organizations about the PCTI approach and the role of trauma in the lives of Holocaust survivors, older adults, and their family caregivers?

2. What is the **capacity** of aging services organizations to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers?

3. What do aging services organizations see as the **benefit** of using the PCTI approach in support of Holocaust survivors, older adults with a history of trauma, and their family caregivers?

4. What is the **impact of the Center's work** on the ability of aging services organizations to use the PCTI approach in support of Holocaust survivors, older adults with a history of trauma, and their family caregivers?

These questions were assessed on an organizational level, measuring an aging services organization's overall PCTI awareness and capacity rather than an individual professional's skill set.

Survey Design and Distribution

The National Study was conducted through an online survey, which was open for public response for five and a half weeks between March and May 2025. This survey was based on previous iterations of the study, which were conducted in 2015 and 2021. Questions and response options were slightly modified to reflect updated language about the PCTI approach, and to clarify the wording of questions and response options. No major content changes were made to the meaning of the questions from the last study. A copy of the full survey can be found in the Appendix of this report.

The survey was implemented through an online survey platform. It was distributed to a network of over 3,000 aging services professionals through a robust dissemination strategy that included email and personal outreach to the Center's partner and peer organizations, current and past subgrantees of the Center, and various professional contacts acquired through the Center's distribution lists. The survey was also distributed through partner distribution lists and networks. Those who received communication about the National Study were encouraged to spread the word by sharing it with their professional networks.

To encourage participation, respondents who completed the survey were eligible to receive a $20 Amazon gift card reward for their contributions. To be eligible to participate in the National Study and receive the reward, respondents had to meet the following criteria at the time of survey submission:

- Their organization was located in the United States,
- Their organization supported older adults directly or indirectly,
- Their organization supported older adults in the United States,
- They could complete the survey on behalf of their organization, and
- Their organizational response had not already been collected for the 2025 study.



Measures

The following section outlines the variables that were studied for each of the four research questions. Data for each of these variables was collected through one or more survey questions.

Research Question 1: Awareness of Aging, Trauma, and the PCTI Approach

Awareness of aging, trauma, and the PCTI approach were defined as an organization's recognition of the PCTI approach and its knowledge about aging and trauma. Two variables were used to assess awareness:

a. Self-reported organizational awareness of the person-centered approach, trauma-informed approach, and person-centered, trauma-informed approach prior to the survey

b. Self-reported level of organizational knowledge of how trauma impacts older adults as they age, how trauma impacts Holocaust survivors, and how trauma impacts family caregiving

The first variable was assessed through quantitative questions in which all survey respondents were asked whether their organization was aware of the person-centered approach, trauma-informed approach, and PCTI approach before receiving the survey. Respondents answered yes, no, or I don't know. A definition of the PCTI approach was provided to ensure respondents had the same basis of understanding about the PCTI approach. To assess the second variable, respondents were asked to rate their organization's level of understanding of three topics: 1) how trauma impacts older adults as they age, 2) how trauma impacts Holocaust survivors, and 3) how trauma impacts family caregiving. Respondents rated understanding on a Likert scale (none, low, medium, high, very high, I don't know).

Research Question 2: Capacity to Provide PCTI Care

Capacity to provide PCTI care was defined as an organization's ability to use the PCTI approach with care recipients both subjectively and objectively. PCTI care capacity was measured through the following variables:

a. Self-reported level of organizational capacity to use the PCTI approach generally, with older adults, and with family caregivers

b. Self-reported organizational use of the PCTI approach in service delivery to 14 service populations

c. Self-reported level of organizational capacity to use the PCTI approach when serving the 14 service populations

d. Objective organizational PCTI capacity as measured through the Center's Organizational PCTI Capacity Index

The first variable was assessed through three questions in which respondents were asked to rate their organization's capacity to use the PCTI approach generally, with older adults, and with family caregivers. Respondents rated capacity on a Likert scale (none, low, medium, high, very high, I don't know).

The second and third variables asked respondents to reflect on their organization's current use of the PCTI approach in service delivery, and on organizational capacity to use the PCTI approach with 14 service populations: African American or Black older adults; American Indian, Alaska Native, or Native Hawaiian older adults; Asian American older adults; family caregivers of older adults; Hispanic or Latin American older adults; Holocaust survivors; immigrant, refugee, or asylee older adults; LGBTQ+ older adults; older adults in high-risk professions; older adult survivors of crime; older adult survivors of disasters; older adult survivors of domestic or sexual violence; older adults with disabilities; and veteran older adults. These populations were selected because research suggests that they experience disproportionate trauma exposure when compared to the national average. Respondents were asked to select the populations their organization supports, to indicate which of those service populations were provided with PCTI care, and to rate their organization's capacity to use the PCTI approach with each selected service population. Respondents rated their organizations' capacity according to a five-point Likert scale (none, low, medium, high, very high, I don't know).

The first three variables under Research Question 2 summarized an organization's subjective or self-reported PCTI capacity. However, the fourth variable, which used the Center's Organizational PCTI Capacity Index, provided an objective assessment of the organization's PCTI capacity. This is an important *distinction*, because how an organization *thinks* it is performing can often vary from how it is *actually* performing. The Center's index, which was developed specifically for the National Study, provides insights into an organization's commitments, relationships, policy, and actions required for successful PCTI approach implementation.

The index is grounded in organizational capacity literature (Children's Bureau Capacity Building Collaborative, 2018; SAMHSA, 2014) and reviews an organization's performance across 16 indicators of PCTI approach capacity in five core capacity categories: Resource, Infrastructure, Knowledge and Skill, Organizational Climate, and Partnership. Within each of the capacity categories, there are individual indicators to assess an organization's demonstrated performance.

The index weighs all demonstrated capacity components equally to provide a holistic view of an organization's capacity to infuse the PCTI approach throughout the organization. An organization demonstrated no or very low capacity if it had a final score between 0 and 3.2, low capacity if it had a final score of 3.3 to 6.4, moderate capacity if it had a final score of 6.5 to 9.6, high capacity if it had a final score of 9.7 to



12.8, and very high capacity if it had a final score of 12.9 to 16. The following are the definitions and indicators used for each capacity category as well as a summary visual.

Capacity Category 1. Resource Capacity

To have PCTI capacity, an organization must have the proper resources in place to support the implementation and sustainment of the PCTI approach. The three indicators measuring PCTI resource capacity are whether an organization has dedicated the following resources to PCTI implementation: staff resources (e.g., number of staff, general skill level, and time availability of staff); material resources (e.g., facilities, equipment, technology); and financial resources (e.g., financial assets, in-kind contributions, local grants).

Capacity Category 2. Infrastructure Capacity

To have PCTI capacity, organizations must have infrastructure that integrates the principles of the PCTI approach into its guiding mission, policies, and spaces. The three indicators measuring PCTI infrastructure capacity include

whether an organization has integrated the PCTI approach into: mission alignment (e.g., mission statement, organizational objectives or values); systems, procedures, and protocols (e.g., operational policies or guidelines); and physical environment (e.g., spaces are designed to be welcoming and promote a sense of safety, community, and connection).

Capacity Category 3. Knowledge and Skill Capacity

To have PCTI capacity, organizations must have trained and skilled staff who are able to implement the PCTI approach at every level. The three indicators measuring PCTI knowledge and skill capacity are whether an organization has the following: change management skills (e.g., management skills of leadership, communication, strategic vision); PCTI program implementation (e.g., PCTI cognitive therapy, socialization activities, client intakes); and availability of PCTI training (e.g., onboarding or continuing education on PCTI care, coaching opportunities).

Capacity Category 4. Organizational Climate Capacity

To have PCTI capacity, the climate of an organization should be one in which the PCTI approach is prioritized and championed. The four indicators measuring PCTI organizational climate capacity are whether an organization demonstrates: staff commitment (e.g., staff participate in voluntary trainings, are actively engaged in becoming PCTI, and embody PCTI care in their actions); leadership commitment (e.g., leadership practice, prioritize, and encourage PCTI care); PCTI championship (e.g., the existence of a PCTI working group or officer); and staff management and hiring (e.g., training supervisors on PCTI recruitment, onboarding, coaching, and mentorship). This last indicator was added to the 2025 National Study based on feedback and research from prior studies.

Capacity Category 5. Partnership Capacity

To have PCTI capacity, organizations must partner and collaborate with others to learn, implement, and sustain PCTI services. The three indicators measuring PCTI partnerships are whether an organization has the following partnerships to support PCTI implementation: internal partnerships (e.g., cross-departmental, or cross-functional partnerships), external partnerships (e.g., with other organizations serving trauma-affected older adult populations), and community partnerships (e.g., with trauma-affected older adult populations in the community).

The following figure shows how all indicators and capacity categories are organized and scored.

Figure 1: Organizational PCTI Approach Capacity Index

Organizational PCTI Approach Capacity			Score of 0 to 16
Resource Capacity	Score of 0 to 3	Staff Resources	Score of 0 to 1
		Material Resources	Score of 0 to 1
		Financial Resources	Score of 0 to 1
Infrastructure Capacity	Score of 0 to 3	Mission Alignment	Score of 0 to 1
		Systems, Procedures, Protocols	Score of 0 to 1
		Physical Environment	Score of 0 to 1
Knowledge & Skills Capacity	Score of 0 to 3	Change Management Skills	Score of 0 to 1
		PCTI Program Implementation	Score of 0 to 1
		Availability of PCTI Training	Score of 0 to 1
Organizational Climate Capacity	Score of 0 to 4	Staff Committment	Score of 0 to 1
		Leadership Committment	Score of 0 to 1
		PCTI Championship	Score of 0 to 1
		Staff Management & Hiring	Score of 0 to 1
Partnership Capacity	Score of 0 to 3	Internal Partnerships	Score of 0 to 1
		External Partnerships	Score of 0 to 1
		Community Partnerships	Score of 0 to 1

To ensure that PCTI capacity was correctly captured, only responses from respondents who indicated that their organization was aware of the PCTI approach prior to receiving the survey were included in PCTI organizational capacity analysis.

Research Question 3: Benefit of Using the PCTI Approach

Benefits of using the PCTI approach were measured through three variables:

a. Self-reported benefits to care recipients

b. Self-reported benefits to staff

c. Self-reported benefits to organizations

Respondents were asked to report benefits of using the PCTI approach across three improvement areas: to care recipients, staff, and organizations. Each improvement area was measured through a multi-select question presenting a list of possible benefits, with the option for respondents to add their own. These questions were modified from previous studies where respondents provided benefits of the PCTI approach in an open-ended text box. Answers from previous studies were coded to produce the multi-select list of benefits used in this study.

Improvement Area 1. Improvements to Care Recipients

The indicators measuring improvements to care recipients include empowered older adults and/or family caregivers, improved trust, improved relationships, improved peer support, improved understanding and skills, increased decision-making ability, increased sense of safety and belonging, improved socialization, improved service access, increased service use, and improved health and well-being.

Improvement Area 2. Improvements to Staff

The indicators measuring improvements to staff include improved understanding of service recipients and how to support them, improved ability to create and implement strategies to serve individuals, improved knowledge and skills, improved confidence, decreased burnout, increased job satisfaction, increased resilience, and improved retention.

Improvement Area 3. Improvements to Organizations.

The indicators measuring improvements to organizations include improved quality of services, increased number of new services, supported expansion of services to new populations and/or locations, improved feedback from service recipients, improved organizational reputation, provided structured work approach, enhanced organizational sustainability, and reduced costs associated with turnover and staff burnout.

To avoid errors, only responses from respondents who reported organizational awareness of the PCTI approach prior to completing the survey were included in this analysis.

Research Question 4: Impact of Center Activities

The following three variables were used to assess the impact of Center activities:

a. Self-reported use of Center resources

b. Self-reported need for additional PCTI resources

c. Difference in study results by Center funding status

The first variable related to Center resources was measured through three questions. First, through a qualitative, single-choice question, respondents indicated whether their organization had used Center resources prior to the survey. These resources include webinars, conference presentations, and information available through the Center's website. The second question was a quantitative, Likert-scale question where respondents rated whether Center resources resulted in organizational change in understanding of trauma, the PCTI approach, and PCTI implementation (strongly disagree, disagree, neutral, agree, strongly agree). The final question was a quantitative, multi-choice question where respondents selected all changes due to using Center resources (improved program quality, development of new programs, expansion of existing services, increased funding, improved policies and procedures, increased staff and volunteer training, none, other).

The second variable was measured through a qualitative, open-ended question where respondents were asked to identify resources that would improve organizational PCTI capacity. This variable helped identify current gaps and needs in capacity-building tools.

To measure the final variable of the impact of Center funding, respondents were grouped into two categories: those who had never received funding from the Center, and those who currently or formerly received Center funding. Funding status was used to compare survey results across the prior three research questions: awareness of aging, trauma, and the PCTI approach; self-reported and demonstrated PCTI capacity and PCTI availability, and capacity across populations; benefits of the PCTI approach; and utilization of Center resources. The differences between these groups were used to assess the impact of the Center's activities.

To better understand survey results, data was collected about the demographics of each participating organization. This data included geographic location, service type, geographic focus, staff size, religious affiliation, sector, funding type, and service populations. This data was used to analyze of the relationship between organizational characteristics and variance in organizational performance across research questions. Identifying information, including respondent name, email, and organization name, were collected for reward purposes and to

ensure that only one response per organization was gathered. The respondent's identifying information was removed from their survey submission during data analysis.

Data Analysis

Once the survey was closed, survey submissions were downloaded and cleaned. Each survey submission was reviewed for accuracy, completeness, and eligibility based on the eligibility criteria. Three hundred and thirty-five response submissions were received, and 61 were omitted due to ineligibility (e.g., organization response already captured). The remaining 274 responses form the data set for the National Study.

Quantitative data analysis was done using Microsoft Power BI, an analytics software program. The program supported a review of the distributions of data set and relationships among data points. First, relationships were explored between organizational characteristics (i.e., geographic location, service area, size, religious affiliation, sector, funding type, service type and service populations) and an organization's PCTI awareness and capacity. Additionally, relationships were explored between variables of PCTI awareness and capacity (i.e., if and how aging and trauma awareness affects PCTI capacity). Results from the 2025 data set were compared to results from prior studies. Quantitative data was rounded to the nearest whole number. As a result, some figures are below or exceed 100%.

National Study Sample

The National Study dataset is composed of 274 responses representing a variety of organizations and respondents. The largest group of surveys (32%) were completed by respondents in a senior management (director) role. Other respondents included, in descending order of frequency, entry level staff (associate or coordinator roles), intermediate staff (senior specialist roles), middle management (manager roles), c-suite (chief operations officer roles), executive staff (vice president roles), and board members. Sixty-seven percent of respondents were direct service providers.

Geographic Spread and Service Area

The survey sample includes responses from organizations in 43 states and territories, including Washington D.C., and 199 cities. Responses were collected from all regions of the United States (Northeast, Southeast, Southwest, Midwest, Rocky Mountains, Pacific, and Noncontiguous). The highest density of responses were from New York (38 responses), California (25 responses), Pennsylvania (24 responses), Ohio (17 responses), and Maryland (17 responses). Fifty-nine percent of organizations reported that their organization operated locally, 23% regionally, 16% nationally, and 2% internationally.

Sector, Size, and Religious Affiliation

Organizations included in the study were split between the social (41%), public (39%), and private sectors (20%). Most organizations (59%) were small, with fewer than 100 employees. About a quarter (27%) were medium-sized with 100-500 employees. A fraction were large with 500 to 1,000 employees (7%) or very large with over 1,000 employees (6%). Most organizations (68%) were not religiously affiliated. Of religiously affiliated organizations, 23% noted Jewish affiliation and 10% noted Christian affiliation.

Service Type and Populations

The sample represented 25 different types of organizations. The largest group was social services organizations (32%), followed, in descending order, by senior housing, Area or State Agencies on Aging, mental health clinics or agencies, foundations or grant-making bodies, government agencies, patient care agencies, and public services. The sample also included, in descending order, senior centers, universities or colleges, advocacy organizations, adult day cares, adult protective services, transportation providers, residential care and assisted living facilities, home care and home health agencies, hospitals, nursing homes, professional associations, research institutions, consultancy agencies, hospice programs, and meals programs.

Organizations responding to the survey served all 14 of the service populations studied: older adults with disabilities (243 responses); African American or Black older adults (214 responses); family caregivers of older adults (199 responses); veteran older adults (199 responses); Hispanic or Latin American older adults (188 responses); LGBTQ+ older adults (184 responses); Asian American older adults (166 responses); older adult survivors of domestic or sexual violence (155 responses); Holocaust survivors (146 responses); older adult crime survivors (145 responses); immigrant, refugee, or asylee older adults (143 responses); American Indian, Alaska Native, or Native Hawaiian older adults (121 responses); older adult survivors of natural disasters (114 responses); and older adults in high-risk professions (90 responses).

Organization Funding Type

Organizations noted a combination of various funding sources. Twenty-five percent of respondents received funding from Medicaid, 7% received funding from the U.S. Department of Veteran Affairs, and 21% received funding from the Center. Some organizations reported receiving funding from more than one funding source simultaneously. These funding sources are important as they are associated with trauma-informed requirements for service provided. For example, the Centers for Medicare and Medicaid

Services prioritizes trauma-informed care in its facilities (LeadingAge, 2022), and organizations receiving funding from the Center are required to implement the PCTI approach into grant activities and programming. While the survey was shared with current and previous Center subgrantees, the portion of responses from Center subgrantees is not disproportionately represented in the sample.

Study Limitations

While the National Study can provide insight into PCTI understanding, awareness, and capacity among aging services professionals in America, it is important to acknowledge that this study serves as a preliminary review of the topic. The data set is not a representative sample of the Aging Network nor the aging services field. There is no definitive count of aging services organizations in the United States; however, it is likely to be in the tens of thousands. Despite the growing sample compared with the last National Study, the response rate is still too small to generalize findings to represent the entire aging services sector in the United States. Participants were not randomly selected to participate in this study and were recruited through Center networks and partners. Thus, the sample may reflect organizations with higher interest and investment in the PCTI approach. Additionally, given the sample size, results from 2025 cannot be compared with the 2021 sample for a definitive explanation of trends over time. The same cohort of organizations were not surveyed in the 2021 and 2025 studies; the 2025 data set reflects new and additional organizations.

Regardless of these limitations, this study serves as an updated exploration of the state of the PCTI approach in the United States. The results of this study can help aging services professionals understand the degree to which aging services organizations are prepared to provide compassionate care to the United States' aging population. The results can also provide professionals with insights for action by identifying areas where the aging services sector can make investments and improvements. As the first chapter highlights, the American population is rapidly changing and aging, and the demands on the aging services sector are only expected to increase. **This study should be used as a tool to drive research, discourse, and decision-making, ensuring that the United States' aging services sector is ready to provide compassionate care for generations to come.**





Detailed Findings

The results of the National Study show promising growth and dedication in making the PCTI approach the universal approach used by aging services professionals. However, the results also point to remaining gaps in knowledge and capacity within the aging services sector. The section below presents detailed findings from the National Study, divided between the four research questions or topic areas of the study: Awareness of Aging, Trauma, and the PCTI Approach; Capacity to Use the PCTI Approach; Benefit of the PCTI Approach; and Impact of Center Activities. The sections that follow summarize the implications of these results and offer recommendations.

1. Awareness of Aging, Trauma, and the PCTI Approach

The first step in providing compassionate care is to understand the need for it. Thus, respondents were asked to rate their organization's understanding of aging with a history of trauma and their familiarity with the PCTI approach.

Understanding of Aging and Trauma

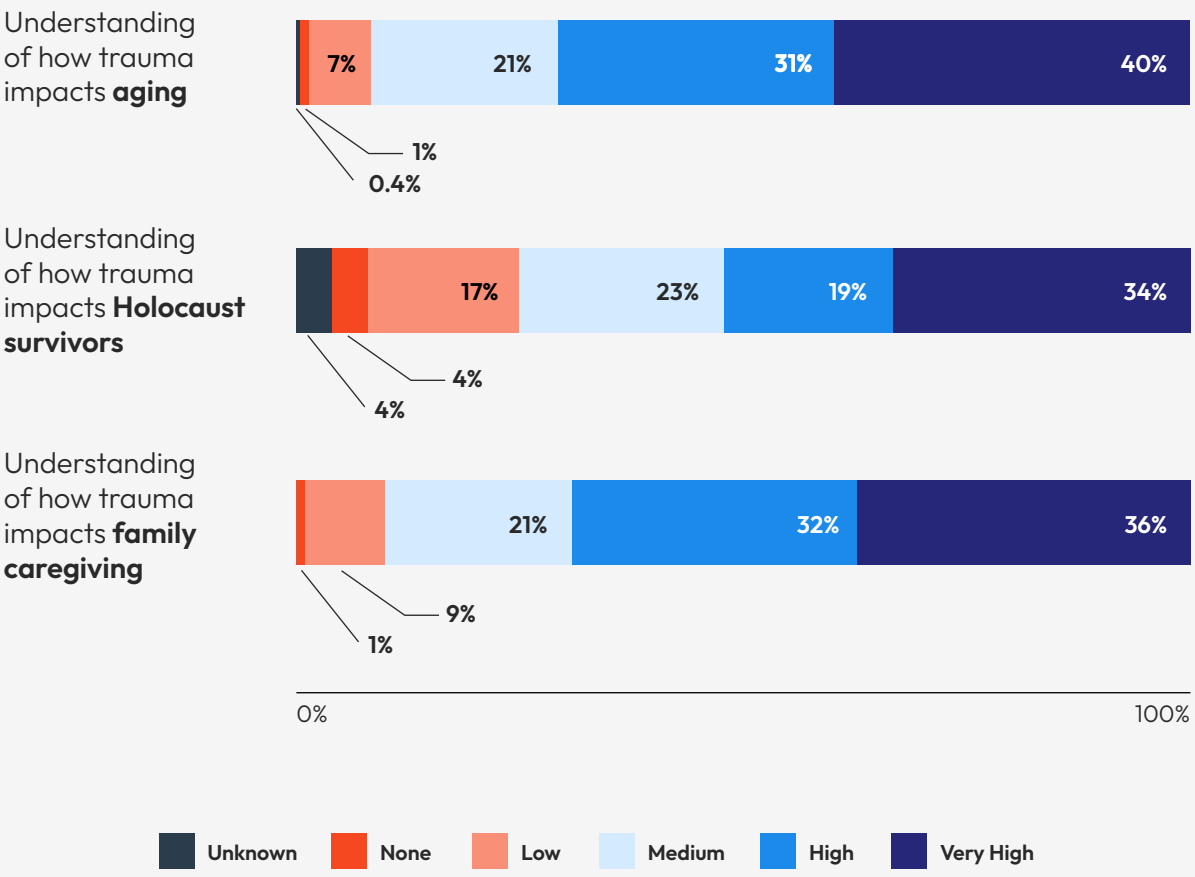
Overall, the majority of organizations reported deep understanding of how trauma impacts aging. Seventy-one percent of organizations reported high or very high understanding, an



increase from the 2021 study where 58% of respondents noted that their organization had high or very high awareness of how trauma impacts aging (Rabin et al., 2022). However, there remains a significant gap as 29% of organizations reported moderate, low, or no understanding of the topic. Less than 1% of respondents were unaware of their organization's understanding of how trauma impacts aging.

Survey results were lower for an organization's understanding of how trauma impacts both Holocaust survivors and family caregiving. **Just over half of organizations reported deep understanding of how trauma impacts Holocaust survivors**. Fifty-three percent reported high or very high understanding, while 44% reported moderate, low, or no understanding of the topic. **More than half of organizations reported deep understanding of how trauma impacts family caregiving**. While 68% reported high or very high understanding, 30% reported moderate, low, or no understanding of how trauma impacts this population. These statistics are shown in Figure 2 below.

Figure 2. Understanding of Aging and Trauma

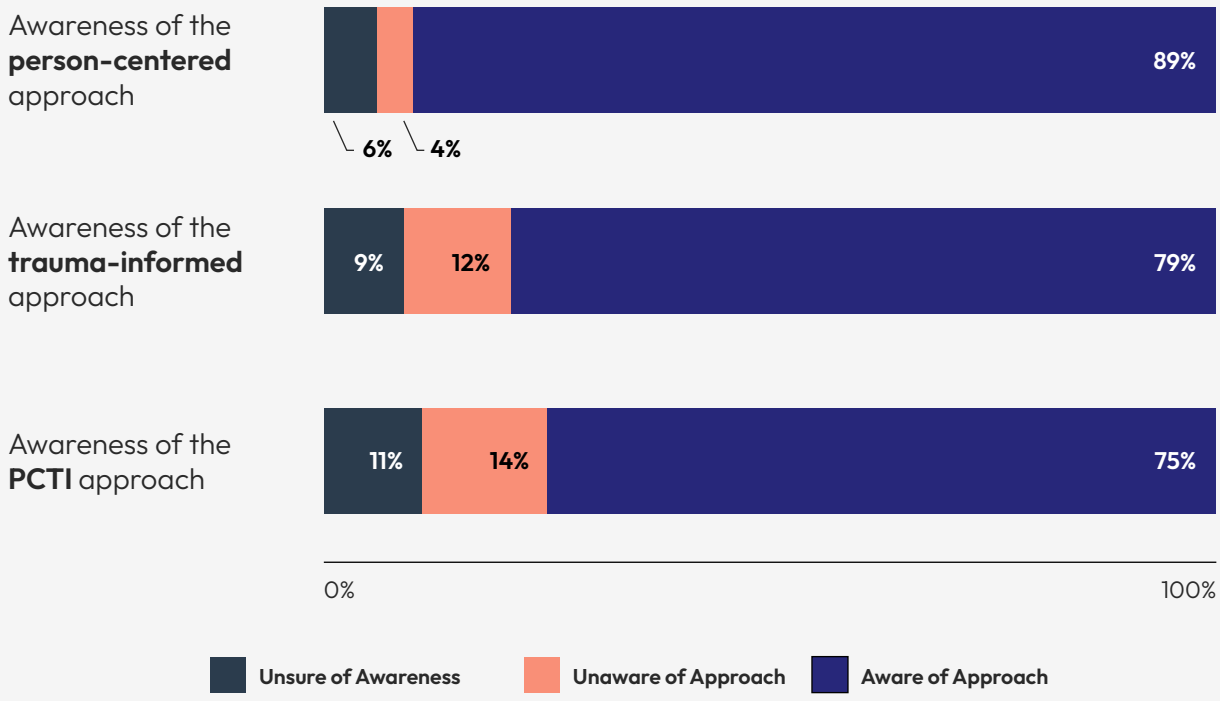


Awareness of the PCTI Approach

Overall, most organizations were aware of the PCTI approach prior to participating in the study. Seventy-five percent of respondents noted that their organization was aware of the PCTI approach, 14% were not aware of the approach, and 11% were unsure of their organization's awareness. These statistics are similar to the results from the 2021 study, where 72% of respondents reported their organization was aware of the PCTI approach (Rabin et al., 2022).

Organizational awareness was higher for the two approaches that compose the PCTI approach – the person-centered approach and trauma-informed approach. **Most organizations were aware of the person-centered approach prior to participating in the stud**y. Eighty-nine percent of respondents reported their organization was aware of the person-centered approach prior to participating in the study, while 4% of respondents reported their organization was not. Similarly, **most organizations were aware of the trauma-informed approach prior to participating in the study**. 79% of organizations were aware of the trauma-informed approach, while 12% were not. These statistics are shown in Figure 3 below.

Figure 3. Awareness of the Person-Centered Approach, Trauma-Informed Approach, and PCTI Approach

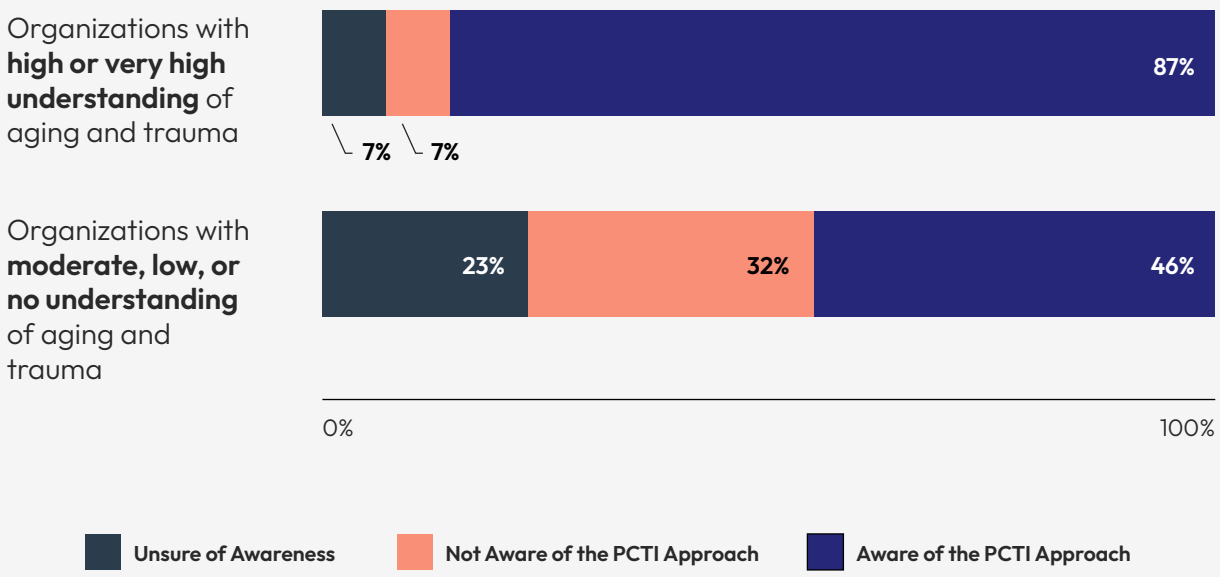


Comparing Aging and Trauma Understanding with PCTI Awareness

To analyze the relationship between an organization's understanding of aging with a history of trauma and awareness of the PCTI approach, the two variables were compared. For many organizations, these two topics were connected.

Organizations that were aware of the PCTI approach were more likely to have a higher understanding of aging and trauma. For example, of those organizations reporting a high or very high understanding of aging and trauma, 87% were aware of the PCTI approach. Meanwhile, of those organizations reporting moderate, low, or no understanding of aging and trauma, only 46% were also aware of the PCTI approach. This relationship can be seen in Figure 4 below.

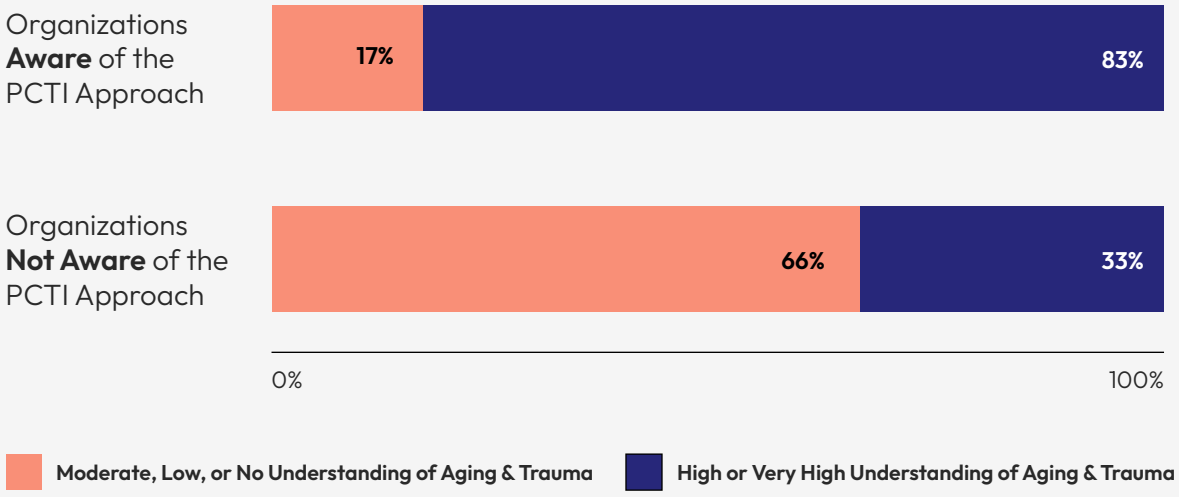
Figure 4. Awareness of the PCTI Approach by Understanding of Aging and Trauma



Similarly, organizations that had a higher understanding of aging and trauma were more likely to be aware of the PCTI approach. For example, of organizations that were aware of the PCTI approach, 83% reported high or very high understanding of aging and trauma. However, of organizations that were not aware of the PCTI approach, only 34% reported high or very high understanding of aging and trauma. This relationship can be seen in Figure 5 below.

Although understanding of aging with a history of trauma and awareness of the PCTI approach are linked, this awareness and understanding are not necessarily connected to an organization's history of service for older adults with a history of trauma. In other words, just because an organization serves older adults does not mean it will understand how trauma impacts those aging individuals or be aware of how the PCTI approach can help. Understanding of trauma impact or awareness of the PCTI approach was not tied to any organizational characteristics, such as geographic location, size, or service population.

Figure 5. Organizational Understanding of Aging and Trauma by Awareness of the PCTI Approach



2. Capacity to Use the PCTI Approach

Awareness of aging, trauma, and the PCTI approach is just one piece of the puzzle in providing compassionate care. To apply this knowledge, organizations need capacity to use the PCTI approach. The study assessed both an organization's self-reported, subjective PCTI capacity and its demonstrated, objective PCTI capacity.

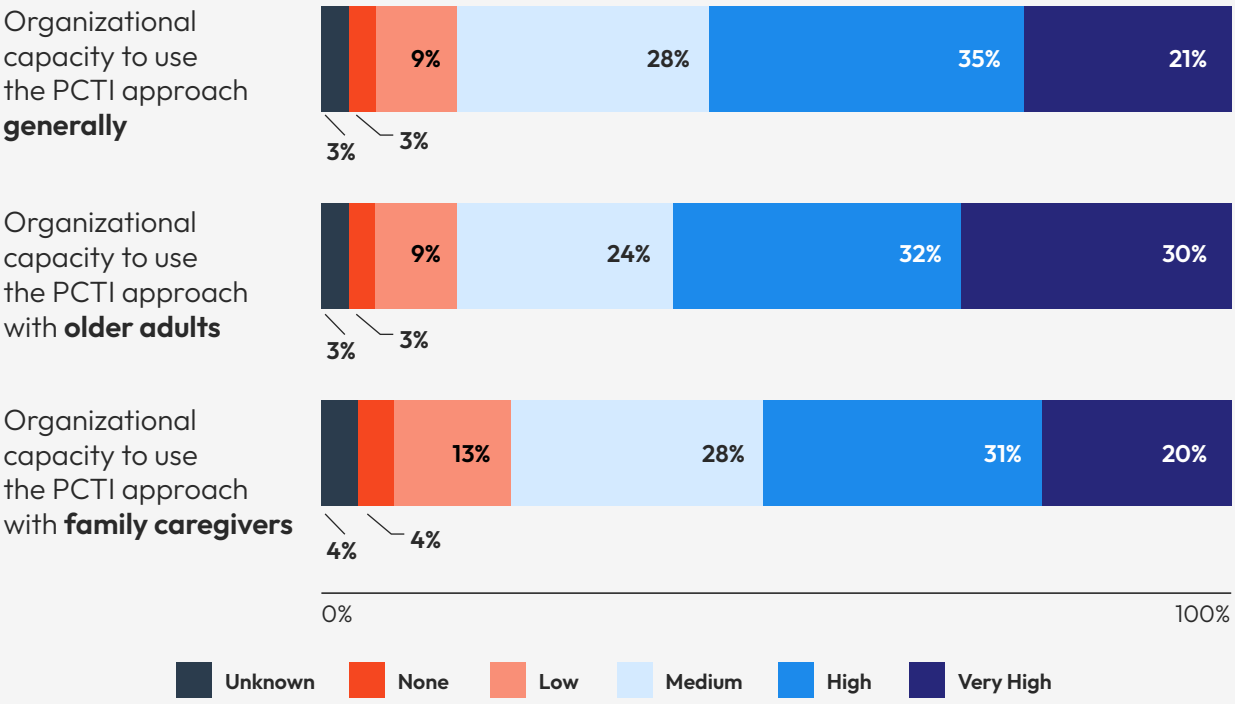
Self-Reported Organizational PCTI Capacity

Overall, slightly more than half (56%) of respondents noted that their organization had high or very high capacity to use the PCTI approach generally. This is relatively consistent with prior study results, as 55% of organizations reported high or very high PCTI capacity in 2021 (Rabin et al., 2022). Meanwhile, 40% of organizations reported moderate, low, or no capacity to use the PCTI approach generally and 3% of organizations were unsure about their organization's capacity.

Similarly, about half of respondents (51%) noted that their organization had high or very high capacity to use the PCTI approach with family caregivers, while 45% reported moderate, low, or no capacity. **Interestingly, a larger segment of respondents noted that their organization had deep capacity to use the PCTI approach with older adults**. Sixty-two percent of organizations reported high or very high capacity to use the PCTI approach with older adults, while 36% reported moderate, low, or no capacity to use the PCTI approach with older adults. These statistics are shown in Figure 6 on the next page.



Figure 6. Organizational Capacity to Use the PCTI Approach Generally, with Older Adults, and with Family Caregivers

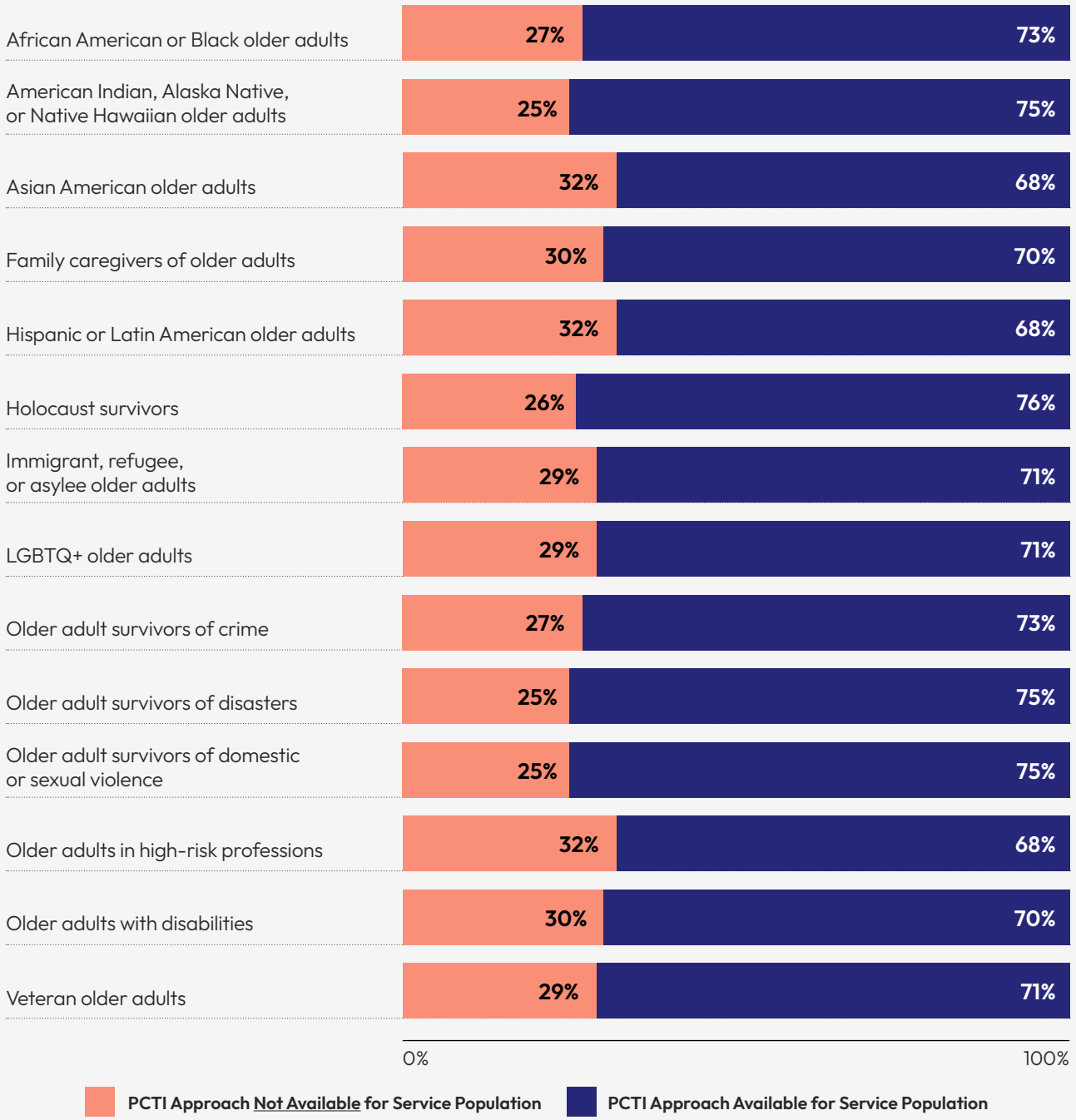


PCTI Capacity Across Populations

To uncover gaps in care, respondents were asked questions about their organization's use of the PCTI approach across 14 service populations. The rate of PCTI approach availability and PCTI capacity were measured for each population.

The availability of PCTI services varied across the 14 service populations. The PCTI approach was most commonly integrated in services for Holocaust survivors; American Indian, Native Hawaiian, or Native Alaskan older adults; older adult survivors of disasters; and older adult survivors of domestic or sexual violence. Seventy-six percent of organizations serving Holocaust survivors reported that the PCTI approach was integrated into their care, while 75% of organizations serving American Indian, Native Hawaiian, or Native Alaskan older adults and older adult survivors of disasters and survivors of domestic or sexual violence reported that the PCTI approach was integrated into their care. Among the service populations studied, the PCTI approach was least used in support of Asian American older adults, Hispanic or Latin American older adults, and older adults in high-risk professions. Sixty-eight percent of organizations serving these populations reported that the PCTI approach was integrated into their care. The availability of care is shown in Figure 7 on the next page.

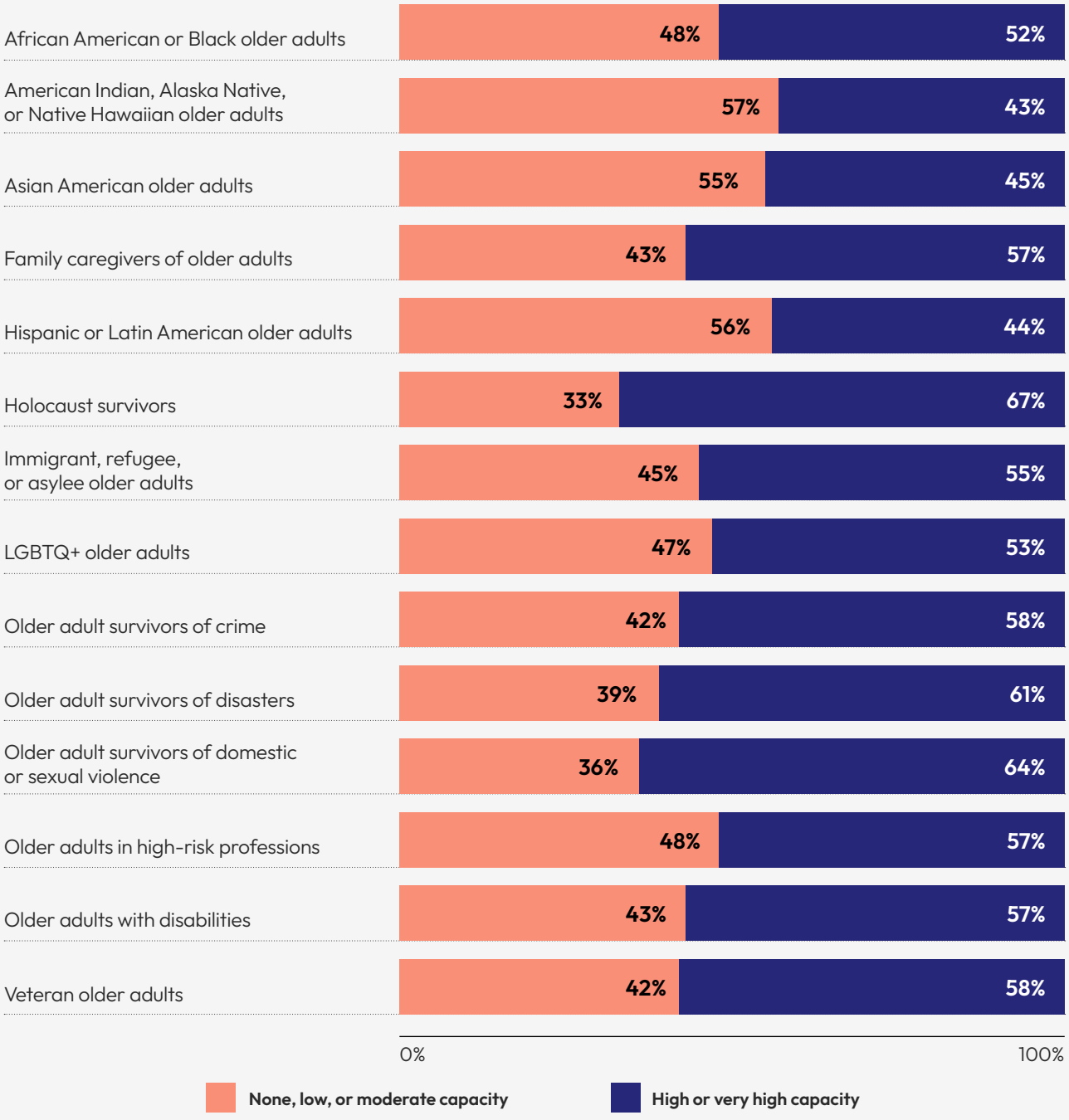
Figure 7. PCTI Approach Availability Across Service Populations



Similar to PCTI approach availability, organizational PCTI approach capacity varied for the 14 service populations. Organizations reported the highest PCTI capacity for Holocaust survivors. Sixty-seven percent of organizations serving Holocaust survivors reported deep capacity to use the PCTI approach with this population. Organizations reported the lowest PCTI capacity

for American Indian, Native Hawaiian, or Native Alaskan older adults, with 43% of organizations reporting deep capacity to use the PCTI approach with this population. The range of PCTI capacity across populations is shown in Figure 8 below.

Figure 8. Self-Reported PCTI Capacity Across Service Populations



Demonstrated Organizational PCTI Capacity

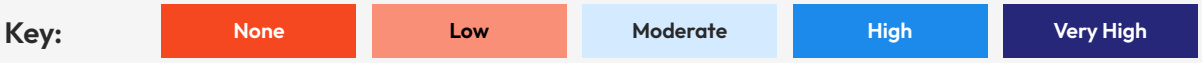
Complementing the analysis of self-reported or subjective capacity, the study assessed an organization's demonstrated or objective PCTI capacity. On average, organizations demonstrated moderate capacity to use the PCTI approach overall, with moderate scores across each of the five capacity categories. Organizations demonstrated the highest average capacity score for the Partnership category, which is composed of internal, external, and community partnerships supportive of PCTI implementation. Organizations demonstrated the lowest average capacity score for indicators related to the Organizational Climate category, such as staff and leadership commitment, PCTI championship, and PCTI staff hiring and management practices. Results suggest room for improvement and development across all five of the PCTI capacity areas. Across all 16 indicators, the indicator with the highest average score was that of PCTI staff resources, and the lowest average score was for PCTI Championship. These trends are shown in Figure 9* on the next page.



***For Figure 9 on next page:** Organizational Climate Capacity is calculated out of a total score of 4 rather than 3, as this category includes four indicators as opposed to other capacity categories including three. Thus, the cut-offs between capacity levels (none, low, moderate, high, very high) differs between Organizational Climate Capacity and other capacity categories.

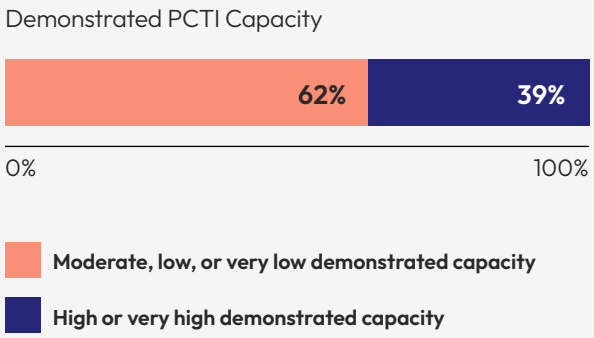
Figure 9: Organizational PCTI Approach Capacity Assessment Scores

Organizational PCTI Approach Capacity			8.10/16
Resource Capacity	**1.53**/3	Staff Resources	**.72**/1
		Material Resources	**.40**/1
		Financial Resources	**.40**/1
Infrastructure Capacity	**1.33**/3	Mission Alignment	**.32**/1
		Systems, Procedures, Protocols	**.51**/1
		Physical Environment	**.50**/1
Knowledge & Skills Capacity	**1.69**/3	Change Management Skills	**.58**/1
		PCTI Program Implementation	**.56**/1
		Availability of PCTI Training	**.56**/1
Organizational Climate Capacity	**1.85**/4	Staff Committment	**.70**/1
		Leadership Committment	**.53**/1
		PCTI Championship	**.27**/1
		Staff Management & Hiring	**.35**/1
Partnership Capacity	**1.70**/3	Internal Partnerships	**.44**/1
		External Partnerships	**.61**/1
		Community Partnerships	**.65**/1



Only a small segment of organizations demonstrated objective capacity to use the PCTI approach when analyzed through Organizational PCTI Capacity Index scores. Just 39% of organizations demonstrated high or very high capacity to use the PCTI approach, while 62% demonstrated moderate, low, or very low PCTI capacity. This statistic is summarized in Figure 10 below. This represents a small increase from the 2021 National Study results, where 30% of organizations demonstrated high or very high capacity to provide PCTI care (Rabin et al., 2022).

Figure 10. Demonstrated Organizational PCTI Capacity



When comparing organizations' self-reported capacity against their Organizational PCTI Capacity Index scores, it appears that many organizations overestimated their capacity to use the PCTI approach. For example, only 52% of the organizations that self-reported high or very high PCTI capacity actually demonstrated high or very high capacity. On the other hand, about one quarter of organizations underestimated their PCTI capacity. **When comparing lower and higher capacity, organizations with higher demonstrated PCTI capacity were more likely to correctly identify their PCTI capacity. Meanwhile, organizations with lower PCTI capacity tended to overestimate their capacity**.

Organizations Incorrectly Estimate PCTI Capacity

48% of organizations **overestimated** their PCTI capacity.

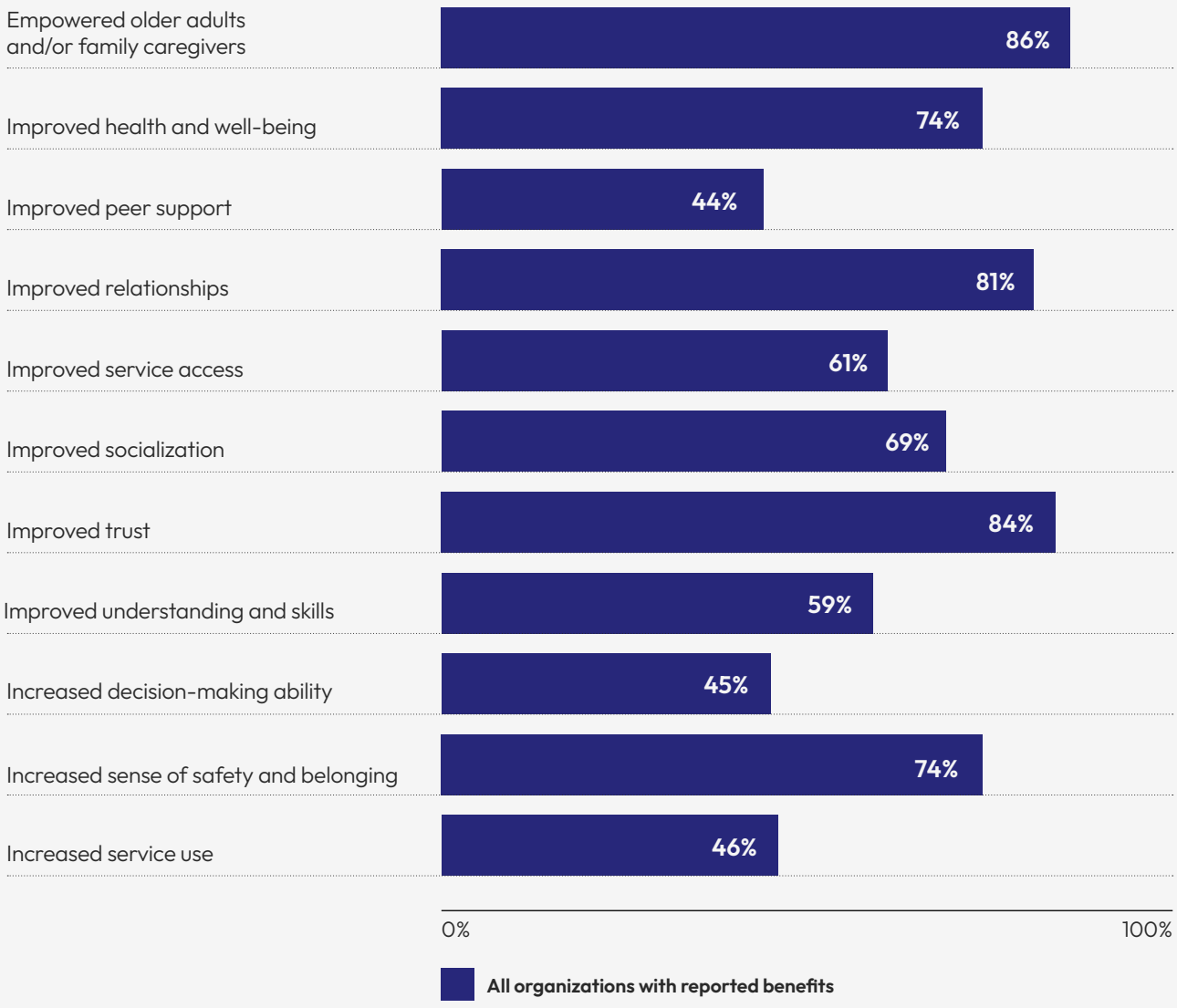
24% of organizations **underestimated** their PCTI capacity.

3. Benefit of the PCTI Approach

As momentum builds around the PCTI approach, the benefits of the framework for care recipients, staff, and organizations as a whole are increasingly recognized. Whether an organization already has deep PCTI capacity or is looking to grow its capacity, use of the PCTI approach results in improvements across all aspects of an organization's work.

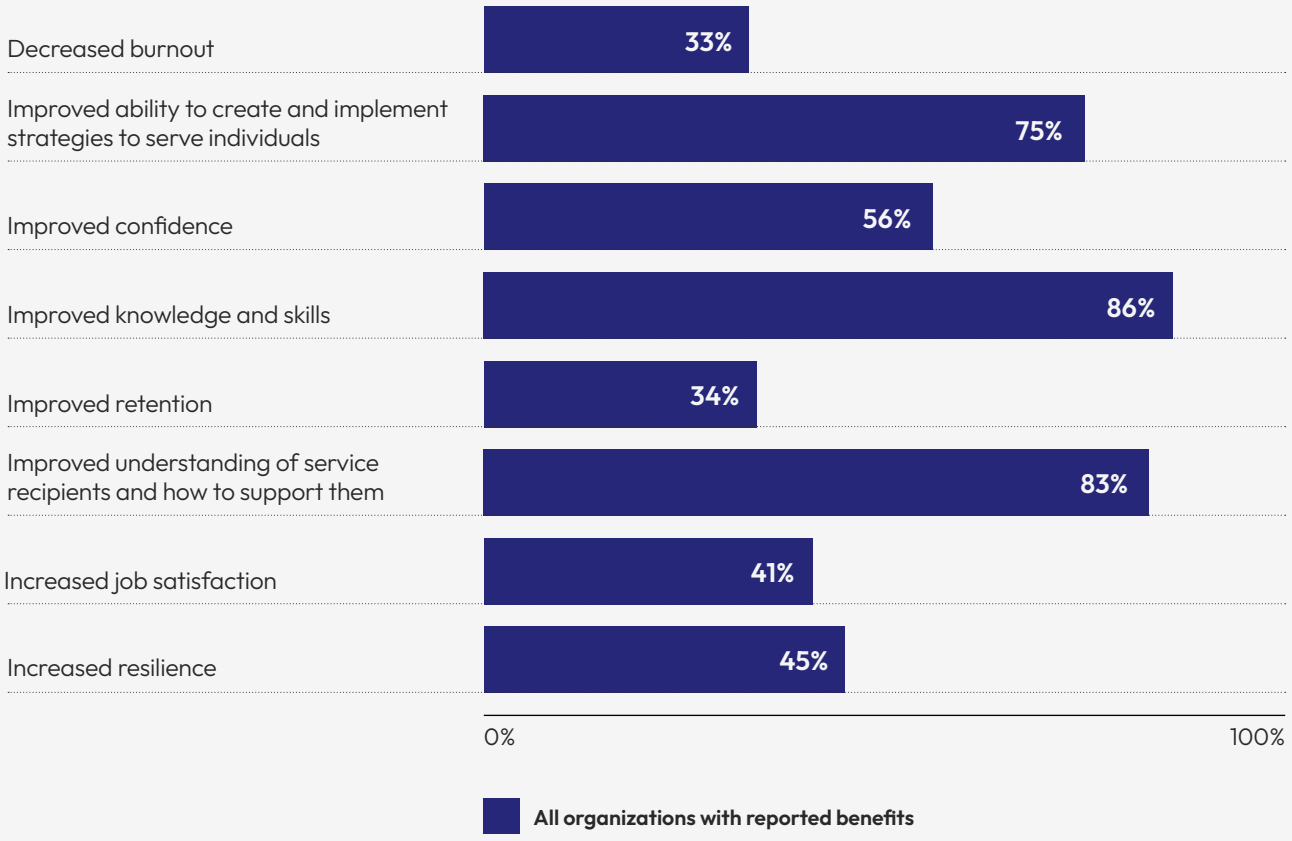
Most respondents (89%) reported that the PCTI approach impacted the older adults and family caregivers supported by the organization, resulting in improved care recipient outcomes and experiences. The three most frequently reported improvements include individual empowerment (86%), improved trust (84%), and improved relationships (81%). The least frequently reported improvements included increased service use (46%), increased decision-making ability (45%), and improved peer support (44%). These statistics are detailed in Figure 11 below.

Figure 11. Improvements to Care Recipients as a Result of the PCTI Approach



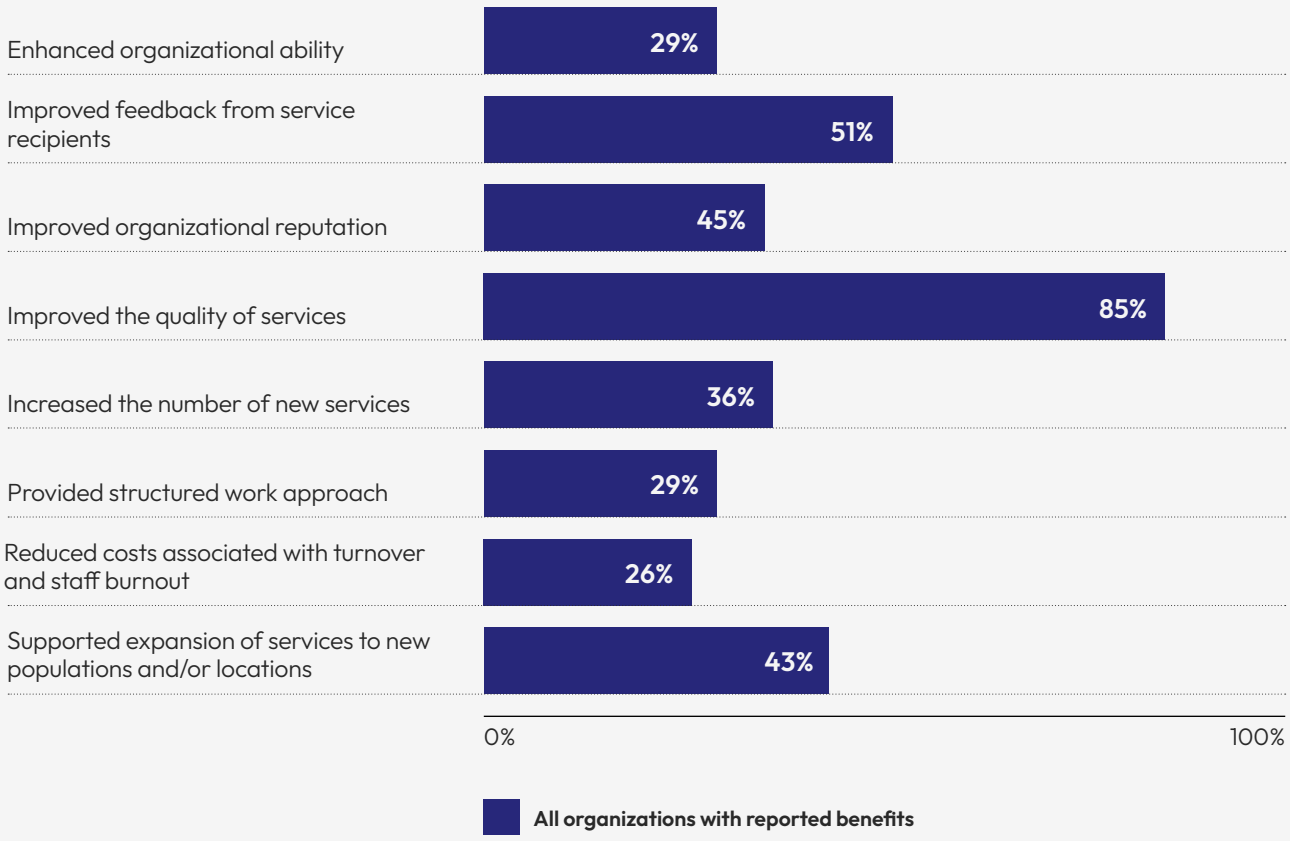
Additionally, most organizations (89%) reported that the PCTI approach improved staff experience and knowledge. The three most reported improvements include knowledge and skills of staff (86%), staff understanding of service recipients and how to support them (83%), and staff ability to create and implement strategies to serve individuals (75%). The least frequently reported improvements include increased job satisfaction (41%), improved staff retention (34%), and decreased staff burnout (33%). These statistics are detailed in Figure 12 below.

Figure 12. Improvements to Staff as a Result of the PCTI Approach



Finally, most organizations (89%) reported that the PCTI approach impacted their organization as a whole, improving their practices and procedures. The most frequently reported improvement was quality of services (85%). The next highest reported improvements were feedback from service recipients (51%) and organizational reputation (45%). The least frequently reported improvements include structured work approach (29%), enhanced organizational sustainability (29%), and reduced costs associated with turnover and staff burnout (26%). These statistics are detailed in Figure 13 below.

Figure 13. Improvements to the Organization as a Result of the PCTI Approach



4. Impact of Center Activities

As PCTI capacity continues to grow, it is important to recognize which resources best support organizations. Since its creation in 2015, the Center has emerged as a leader in providing this support through PCTI program implementation and capacity building. The impact of the Center's work was demonstrated through the 2021 National Study, as organizations that received direct Center support through PCTI implementation grants demonstrated higher PCTI awareness, capacity, and impact (Rabin et al., 2022). This remains consistent with findings from the 2025 National Study.

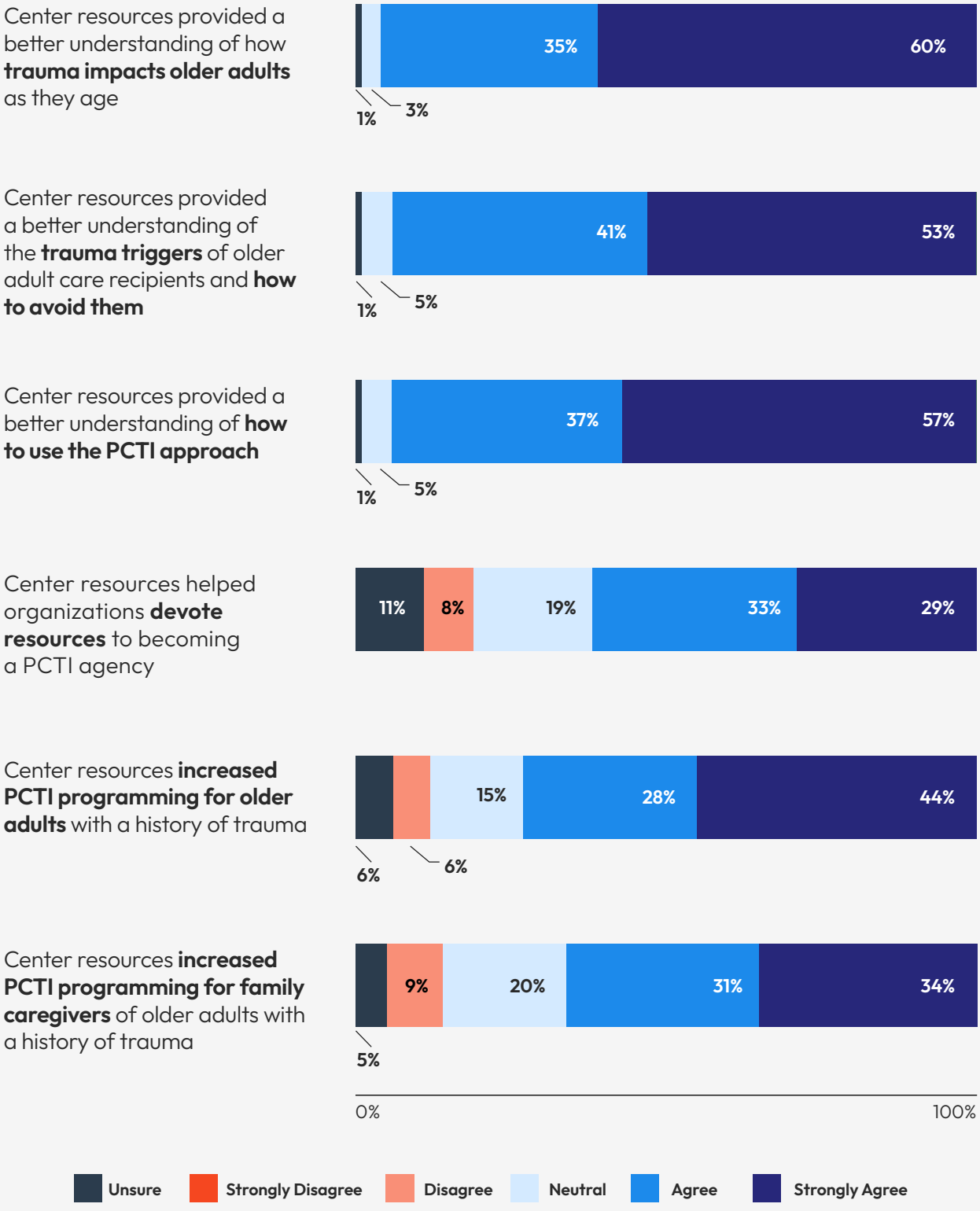
Impact of Center Resources

To better understand the impact of the Center's resources, respondents were asked whether their organization used these resources and about the impact of their use. Overall, 34% of respondents noted that their organization used Center resources, including webinars, reports, conference presentations, and the Center website. **The majority of organizations that have used Center resources (94%) reported that the resources have improved organizational knowledge or practices**.

Most organizations reported that use of the Center's resources resulted in increased knowledge. For example, most organizations agreed or strongly agreed that their understanding about aging with a history of trauma (95%), trauma triggers (94%), and the PCTI approach (94%) has improved. Additionally, **respondents reported that use of the Center's resources improved their organization's practices and programming**. As a result of using Center resources, respondents noted that their organizations have allocated more resources to becoming a PCTI organization (62%) and have increased PCTI programming for older adults (72%) and family caregivers (65%). These statistics are shown in Figure 14 on the next page.

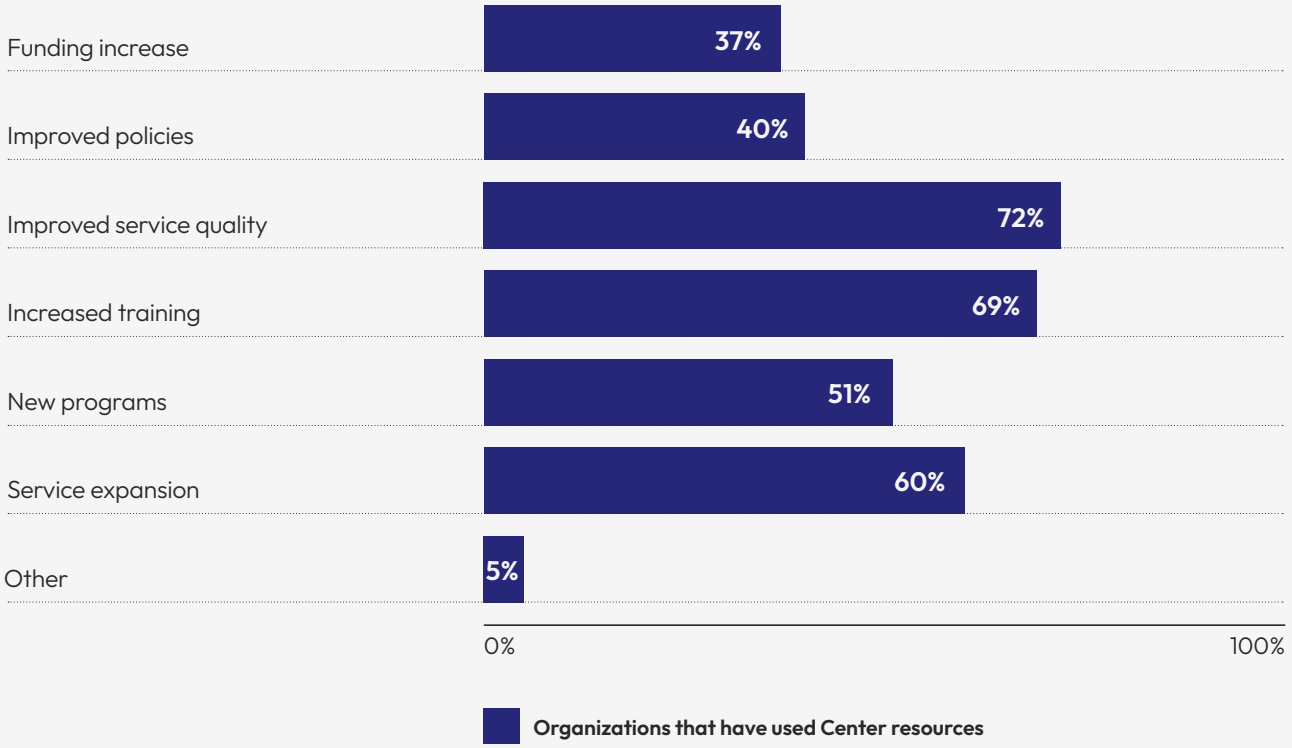


Figure 14. Organizational Knowledge as a Result of Center Resources



Overall, the majority of those who used Center resources reported at least one improvement to their organization's operations. The two most frequently reported organizational improvements were improved quality of existing products, programming, or services (72%) and increased training opportunities (69%). The two least frequently reported organizational improvements were improved policies and procedures (40%) and increased funding dedicated to older adults and family caregivers (37%). These statistics are shown in Figure 15 below.

Figure 15. Organizational Improvements as a Result of Center Resources





Beyond rating the impact of Center resources, respondents were asked to identify additional resources that would increase organizational capacity to use the PCTI approach. Respondents identified a variety of resources including training events (68%), grants (48%), additional educational materials (43%), and coaching (21%).

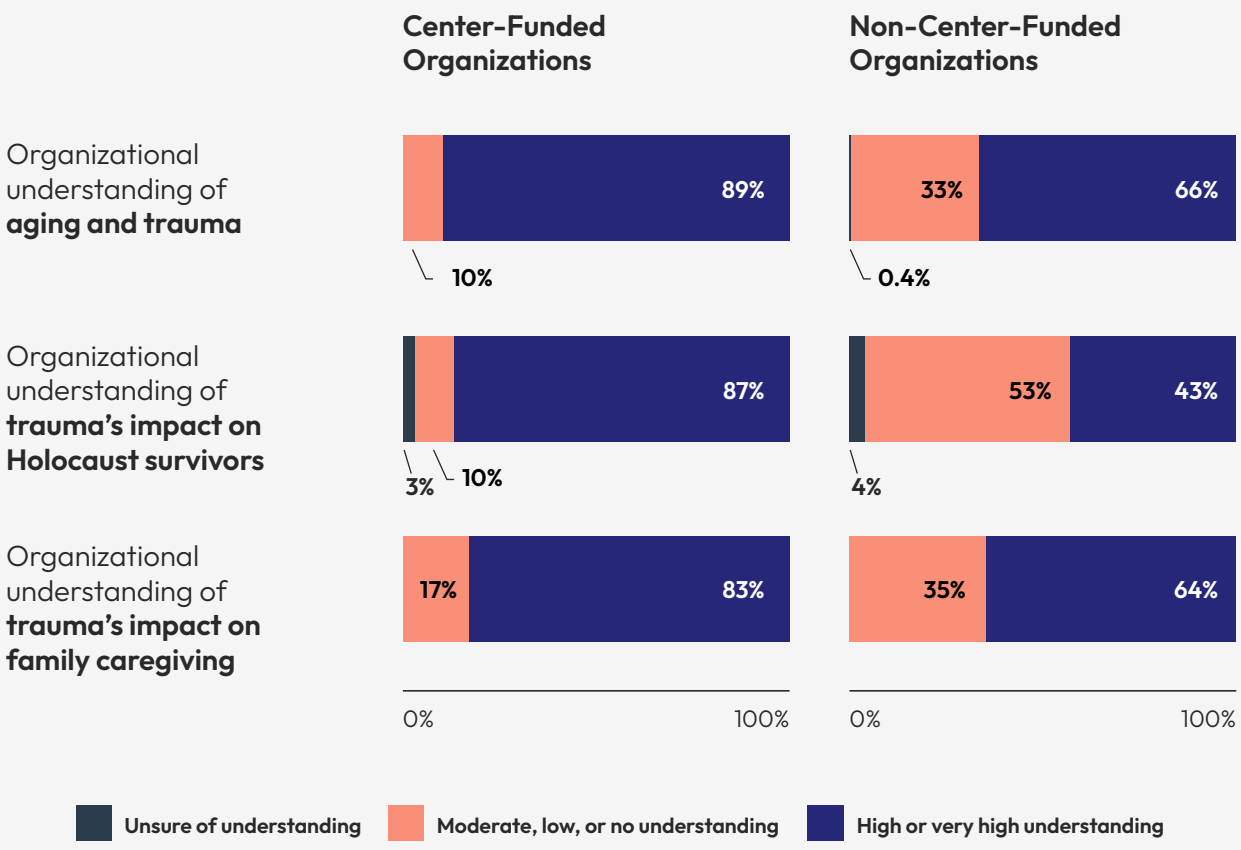
Impact of Center Funding

To further understand the Center's impact, the results of organizations funded by the Center were compared to those that had never received Center funding. **Overall, organizations funded by the Center performed better on all measures of the 2025 National Study** including awareness

of topics of aging and trauma, awareness of the PCTI approach, self-reported PCTI capacity, PCTI capacity across populations, and demonstrated PCTI capacity.

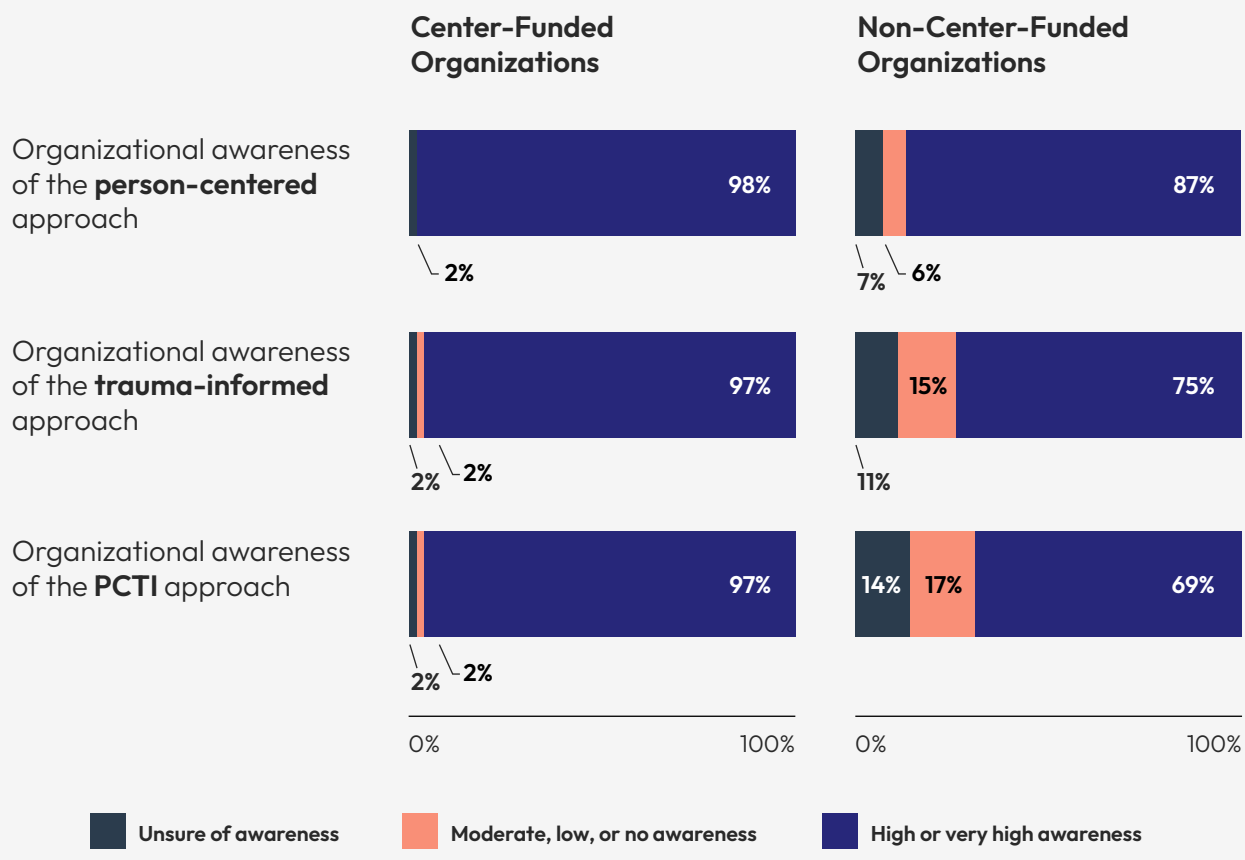
Organizations funded by the Center reported higher understanding of the impact of trauma on aging compared to non-Center-funded organizations. Eighty-nine percent of Center-funded organizations reported deep understanding of how trauma impacts aging, compared to 66% of non-Center-funded organizations. Eighty-seven percent and 83% of Center-funded organizations reported deep understanding of how trauma impacts Holocaust survivors and family caregiving, respectively; 43% of non-Center-funded organizations reported deep understanding of how trauma impacts Holocaust survivors, and 64% reported deep understanding of the impact on family caregiving. These trends are shown in Figure 16 below.

Figure 16. Understanding of Aging and Trauma by Funding Status



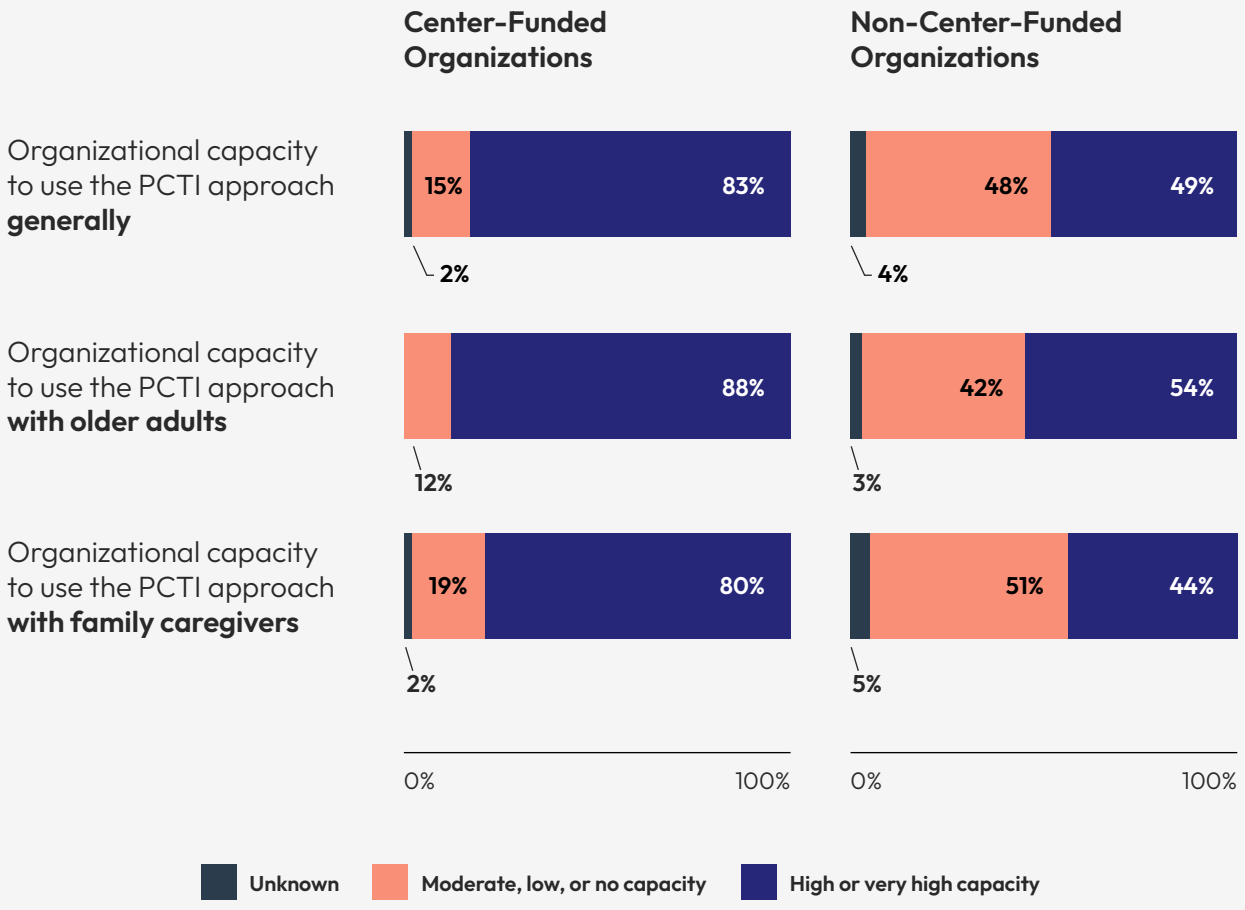
The same trend is seen for awareness of the person-centered, trauma-informed, and PCTI approaches. **Organizations funded by the Center reported higher awareness of these approaches across their organization**. Ninety-eight percent of Center-funded organizations reported organizational awareness of the person-centered approach, and 97% reported awareness of the trauma-informed and PCTI approach. Meanwhile, 87% of non-Center-funded organizations reported organizational awareness of the person-centered approach, 75% reported awareness of the trauma-informed approach, and 69% reported awareness of the PCTI approach. These trends are shown in Figure 17 below.

Figure 17. Understanding of PC, TI, and PCTI Approaches by Funding Status



Center-funded organizations reported higher PCTI capacity compared to non-Center-funded organizations. Eighty-three percent of Center-funded organizations reported deep capacity to use the PCTI approach generally, while only 49% of non-Center-funded organizations reported deep capacity. Similarly, 88% of Center-funded organizations reported deep capacity to use the PCTI approach when supporting older adults, compared to 54% of non-Center-funded organizations. Finally, 80% of Center-funded organizations reported deep capacity to use the PCTI approach with family caregivers, while only 44% of non-Center-funded organizations reported the same. These trends are shown in Figure 18 below.

Figure 18. Self-Reported PCTI Capacity by Funding Status



Trends in self-reported capacity by Center funding status were consistent when analyzing PCTI service availability and organizational PCTI capacity across the 14 service populations. **Center-funded organizations reported higher PCTI availability for the majority of service populations and deeper capacity across all the service populations**. For example, 83% of Center-funded organizations that support Asian American older adults reported using the PCTI approach when providing services to that population. However, 65% of non-Center-funded organizations reported using the PCTI approach with Asian American older adults. Similarly, 92% of Center-funded organizations that support Holocaust survivors reported using the PCTI approach when providing services to that population, while 67% of non-Center-funded organizations reported using the PCTI approach with Holocaust survivors. Interestingly, non-Center-funded organizations reported a slightly higher availability of PCTI services for older adult survivors of disasters (75%) compared to Center-funded organizations (74%). However, Center-funded organizations reported much deeper capacity. Seventy-eight percent of Center-funded organizations reported deep capacity to use the PCTI approach with older adult survivors of disasters, while only 56% of non-Center-funded organizations reported deep capacity to use the approach with the same population. These trends are shown in Figures 19 and 20 on the next pages.



Figure 19. PCTI Availability Across Populations by Funding Status

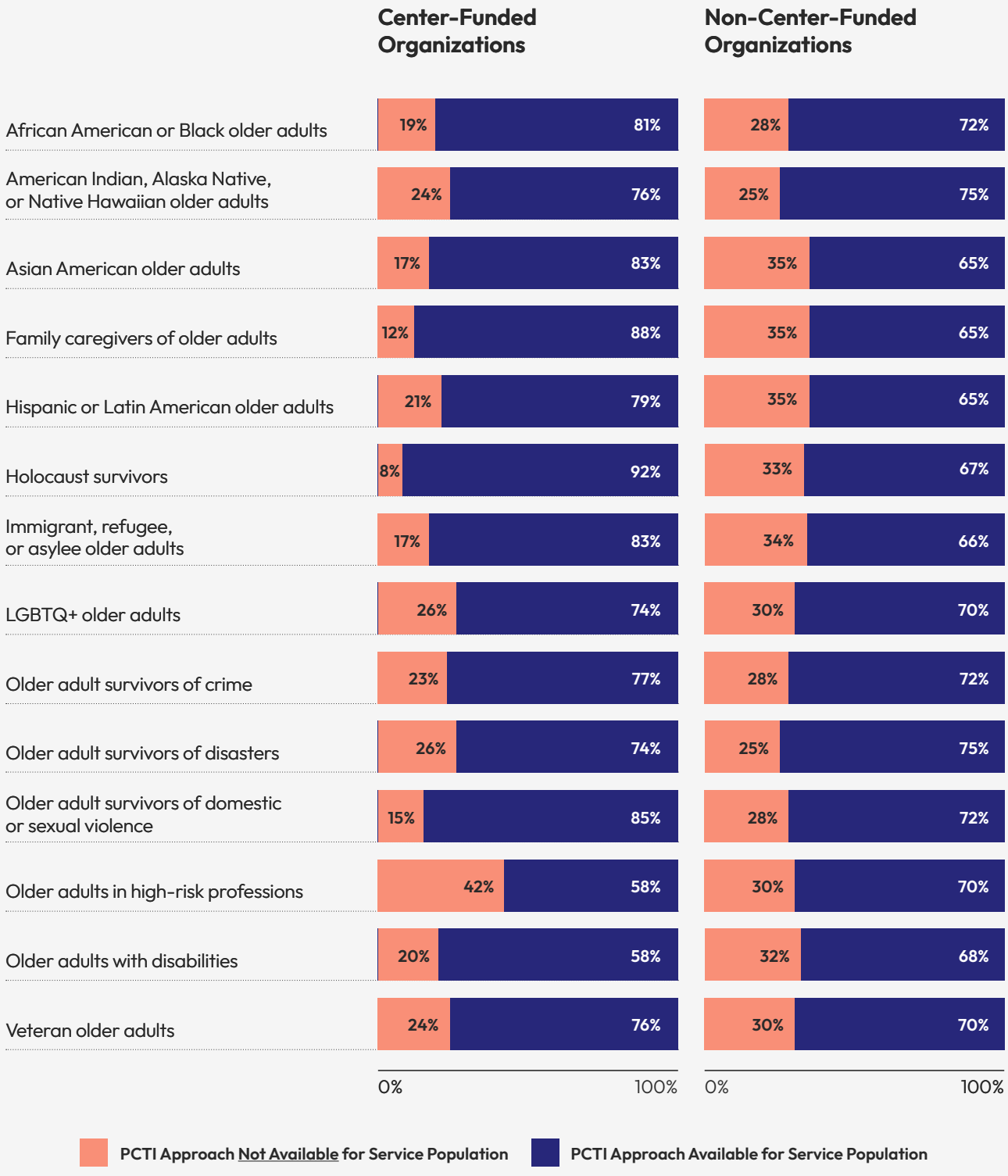
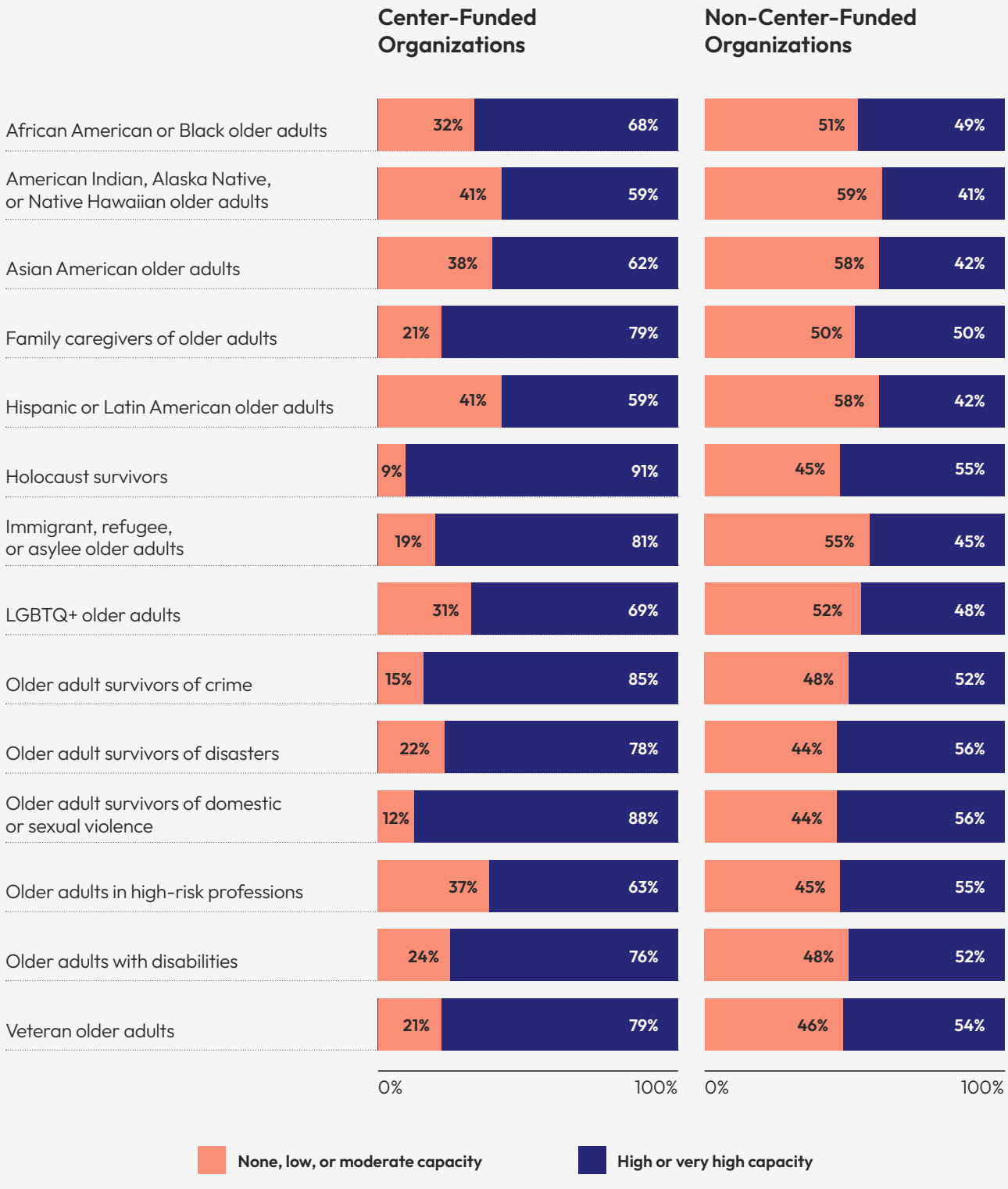
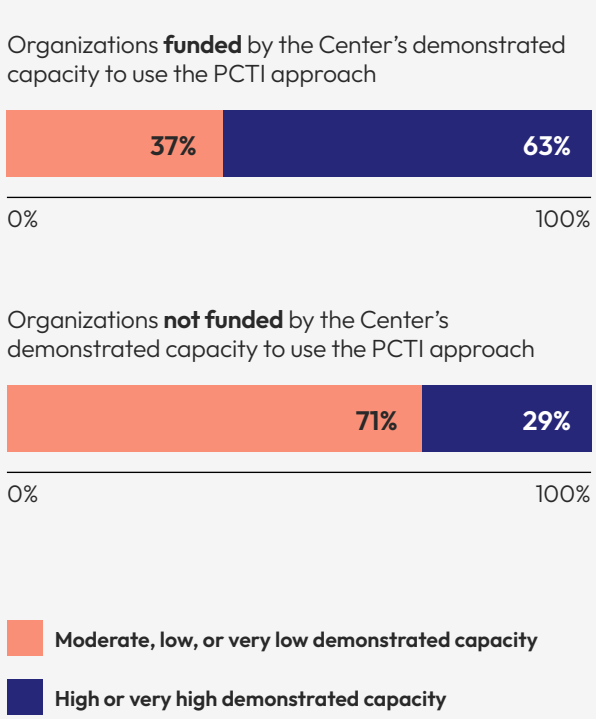


Figure 20. PCTI Capacity Across Populations by Funding Status



Overall, organizations funded by the Center demonstrated higher PCTI capacity compared to organizations that had never received Center funding. Sixty-three percent of Center-funded organizations demonstrated high or very high PCTI capacity, while only 29% of non-Center-funded organizations demonstrated high or very high PCTI capacity. This comparison is shown in Figure 21 below.

Figure 21. Demonstrated Organizational PCTI Capacity by Funding Status



Center-funded organizations demonstrated higher scores on the Organizational PCTI Capacity Index overall, for each category and for each of the 16 indicators. Center-funded organizations demonstrated a high overall PCTI capacity, while non-Center-funded organizations demonstrated a moderate overall PCTI capacity. More specifically, Center-funded organizations received average scores that were between 0.58 - 1.05 higher than non-Center-funded organizations' scores across the five categories. The biggest reported difference was in the Resources category. Center-funded organizations demonstrated high average capacity for PCTI materials resources and PCTI financial resources, while non-Center-funded organizations demonstrated low average capacity for these indicators. There was also a large difference in the Partnerships category. Center-funded organizations demonstrated high average capacity for internal partnerships supportive of PCTI implementation, while non-Center-funded organizations demonstrated low average capacity for this indicator. The difference in capacity between Center-funded and non-Center-funded organizations is broken down by indicator, capacity category, and overall score in Figure 22* on the next page.

***For Figure 22 on next pages:** Organizational Climate Capacity is calculated out of a total score of 4 rather than 3 as this category includes four indicators as opposed to other capacity categories including three. Thus, the cut-offs between capacity levels (none, low, moderate, high, very high), differs between Organizational Climate Capacity and other capacity categories.

Figure 22: Demonstrated Organizational PCTI Capacity by Funding Source

Organizations Funded by the Center

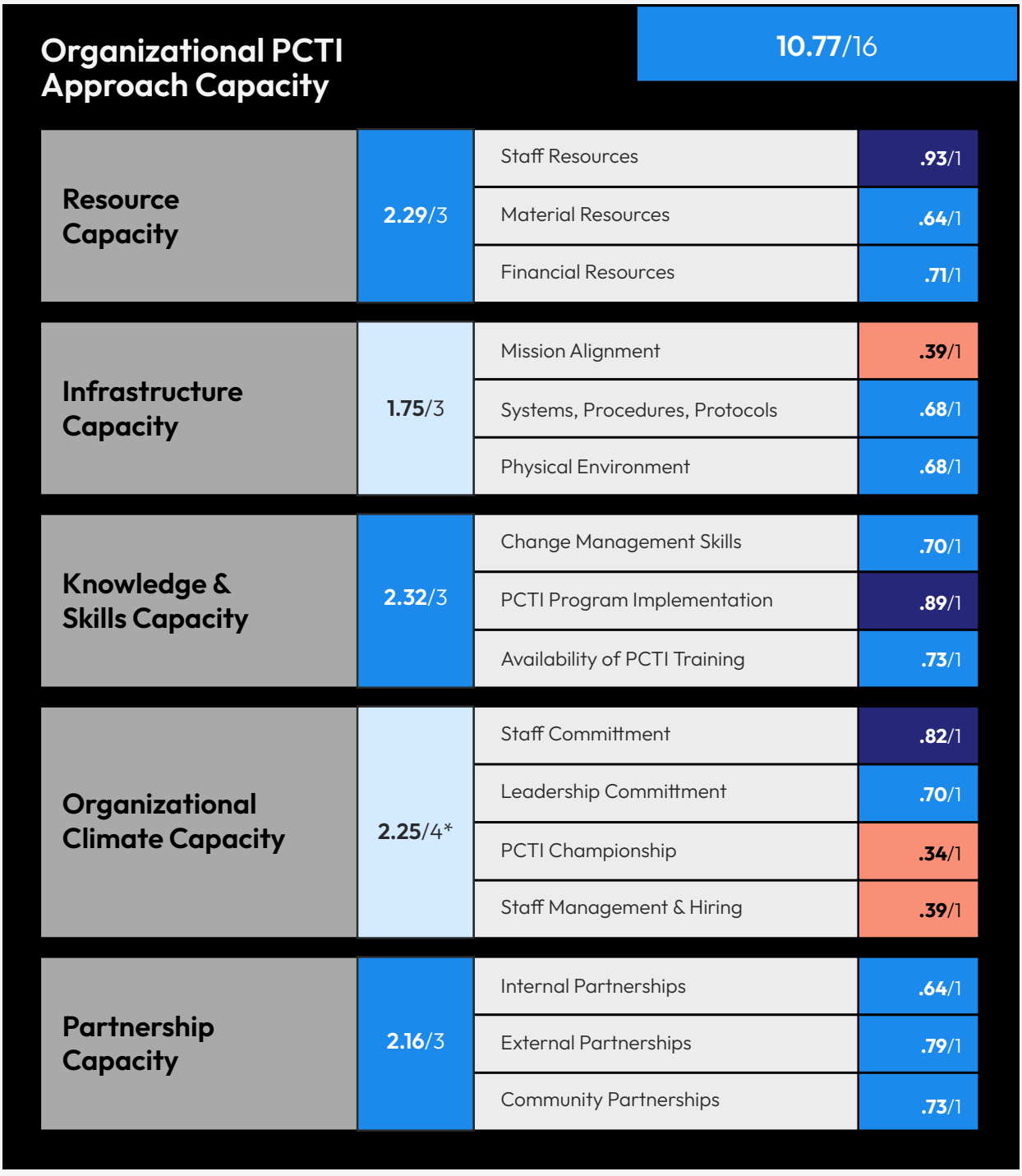


Figure 22 Continued

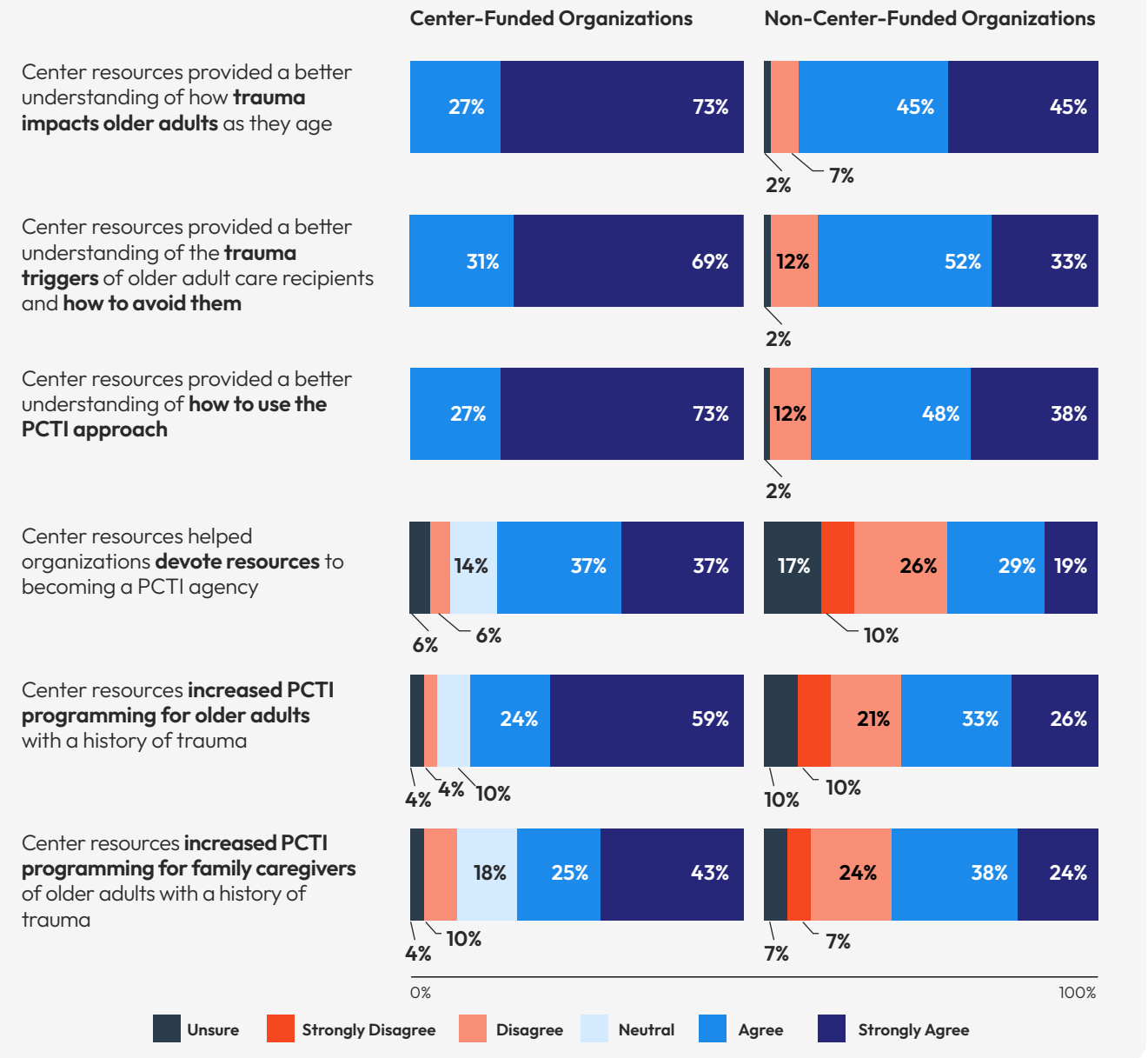
Organizations Not Funded by the Center

Organizational PCTI Approach Capacity	7.10/16		
Resource Capacity	**1.24**/3	Staff Resources	**.64**/1
		Material Resources	**.32**/1
		Financial Resources	**.28**/1
Infrastructure Capacity	**1.17**/3	Mission Alignment	**.30**/1
		Systems, Procedures, Protocols	**.44**/1
		Physical Environment	**.44**/1
Knowledge & Skills Capacity	**1.46**/3	Change Management Skills	**.54**/1
		PCTI Program Implementation	**.43**/1
		Availability of PCTI Training	**.49**/1
Organizational Climate Capacity	**1.70**/4*	Staff Committment	**.66**/1
		Leadership Committment	**.47**/1
		PCTI Championship	**.25**/1
		Staff Management & Hiring	**.33**/1
Partnership Capacity	**1.52**/3	Internal Partnerships	**.36**/1
		External Partnerships	**.54**/1
		Community Partnerships	**.62**/1

Key: None | Low | Moderate | High | Very High

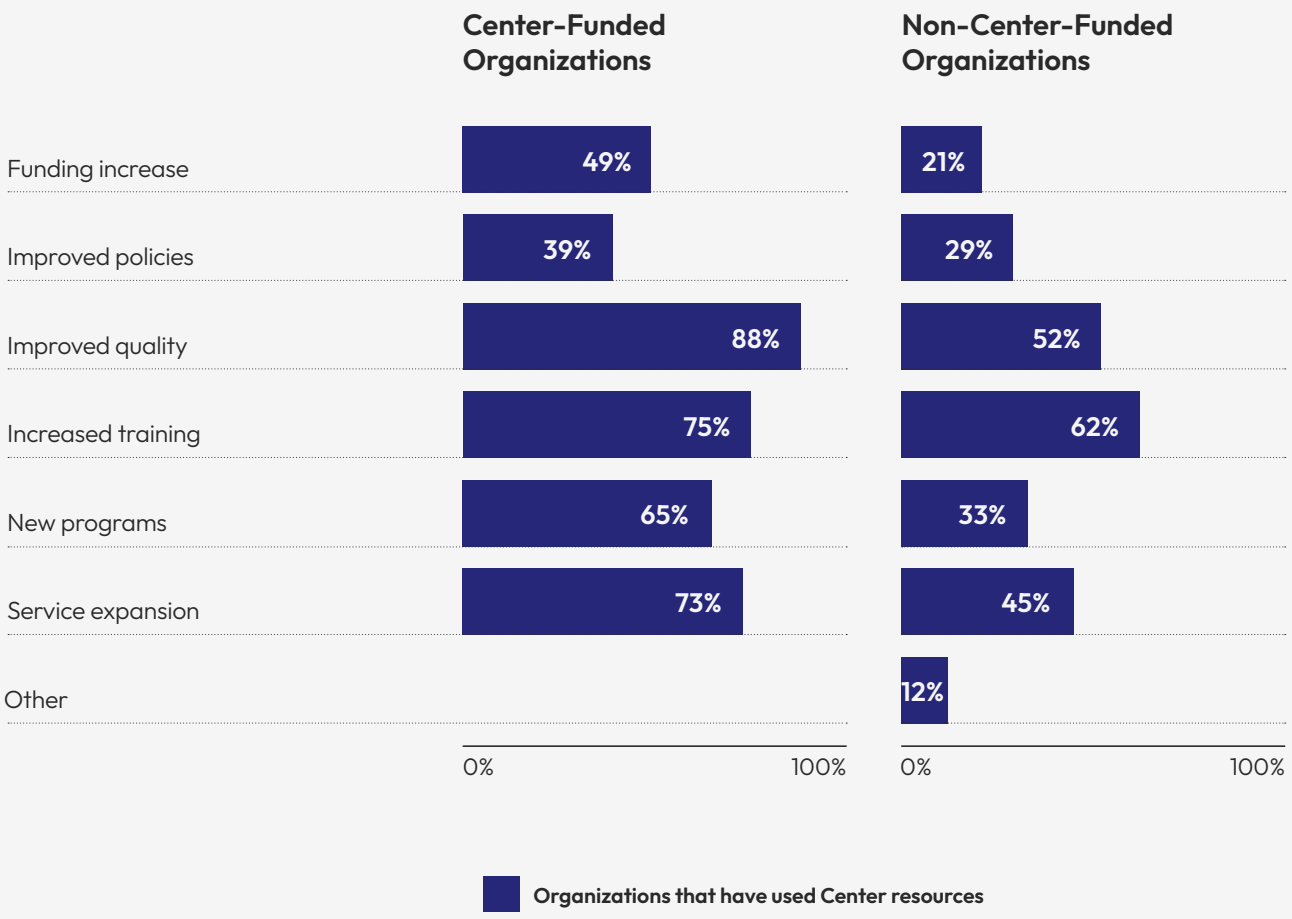
Finally, while 96% of Center-funded organizations and 90% of non-Center funded organizations reported organizational improvements due to Center resources, **Center-funded organizations reported more improvements to their organizational knowledge and operations as a result of Center resources compared to organizations that have never received Center funding**. For example, 100% of Center-funded organizations reported that Center resources improved organizational understanding of aging and trauma, trauma triggers, and the PCTI approach. Meanwhile, 90% of non-Center-funded organizations reported that Center resources improved understanding of aging and trauma, 85% reported improved understanding of trauma triggers, and 86% reported improved understanding of the PCTI approach. These trends are shown in Figure 23 below.

Figure 23. Organizational Knowledge Change Due to Center Resources by Funding Status



Center-funded organizations also reported improvements to service provision as a result of Center resources. Eight-eight percent of Center-funded organizations improved the quality of existing products, programming, or services due to the Center's resources, while only 52% of non-Center-funded organizations made similar improvements. Seventy-three percent of Center-funded organizations reported that service delivery or organizational reach expanded due to Center resources. Only 45% of non-Center-funded organizations reported similar improvements. These trends are shown in Figure 24 below.

Figure 24. Organizational Improvements as a Result of Center Resources by Funding Status






APOLLO

Implications

The detailed findings of the National Study demonstrate the exciting growth of the PCTI approach across the aging services sector. At the time of this study, 75% of organizations were aware of the PCTI approach, and 39% objectively demonstrated deep organizational capacity to use the PCTI approach. These data points, along with the other findings of this report, show that the aging services sector has made tremendous progress recognizing and using the PCTI approach since the start of the Center's work on the topic in 2015.

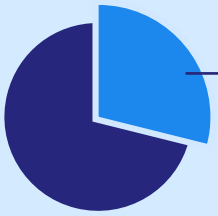
However, the detailed findings also demonstrate the need for further investments in the abilities of aging services organizations to provide PCTI care for all aging Americans. For example, 14% of organizations reported they were unaware of the PCTI approach, and 62% demonstrated moderate, low, or no capacity to use the PCTI approach. These trends are concerning as it means that while trauma has a significant impact on the health and well-being of older adults, many organizations may not be incorporating this consideration into service delivery. These statistics expose a missed opportunity for the aging services sector to meet the growing needs of an aging America. Integrating trauma considerations and the PCTI approach into service delivery stands to benefit all involved in aging services—older adults and family caregivers, staff and volunteers, and aging services organizations themselves.

Incorporating the PCTI approach among aging services professionals is no small task. While there may be momentum building in the sector, deepening the capacity and understanding of organizations to implement the PCTI approach requires a deep understanding of current trends in using the PCTI approach. Understanding the implications of this study is critical for the aging services sector to recognize how far it has come, where organizations are in their PCTI journeys, and where the sector must go as we look towards the future. The following section includes eight implications derived from the findings of the National Study that should guide PCTI approach implementation.

1. An organization's service to older adults does not necessarily lead to deep organizational understanding of how trauma impacts aging or family caregiving

While supporting older adults may teach professionals how trauma impacts aging or care delivery, there is a limited relationship between an organization's history of service and its understanding of trauma and the PCTI approach. While all organizations participating in the National Study support older adults, 29% reported moderate, low, or no understanding of how trauma impacts aging. Only a little more than half of organizations reported deep

understanding of how trauma impacts family caregiving. Thus, it should not be assumed that all organizations in the aging sector are aware of the impacts of trauma on those they serve.



29%

reported moderate, low, or no understanding of trauma impacts aging.

2. Awareness of the PCTI approach and knowledge of aging and trauma are not the same.

As the National Study shows, an organization's knowledge of aging and trauma does not ensure that the organization is aware of the PCTI approach, and vice versa. For example, 14% of organizations with a deep understanding of aging with trauma were not aware or were unsure of their organization's awareness of the PCTI approach. And conversely, 17% of organizations aware of the PCTI approach had limited understanding of aging and trauma. This discrepancy is important to note because an understanding of both is needed to provide the best possible care for older adults and create meaningful change in aging services. While efforts to increase awareness of the PCTI approach and understanding of aging and trauma may be complementary and mutually reinforcing, they are not interchangeable.

3. Awareness of the PCTI approach does not translate into organizational PCTI capacity.

While an organization may be aware of the PCTI approach, that awareness does not always lead to use and capacity. Awareness of the existence of the PCTI approach is relatively easy to achieve, as it requires limited intention, commitment, and ability. To be aware of the PCTI approach, one must at a minimum know of the framework's existence. However, developing PCTI capacity requires an organization to undergo structural and cultural changes as it shifts resources and modifies practices to prioritize PCTI principles. As such, it is unsurprising that while many organizations are aware of the approach, few organizations have capacity to implement it. While three quarters of organizations reported awareness of the PCTI approach, just over a third demonstrated deep capacity to use the PCTI approach. Professionals charged with improving aging services should venture beyond awareness-raising campaigns and instead support their organizations in increasing their ability to implement the PCTI approach.

4. Organizations tend to overestimate their PCTI capacity.

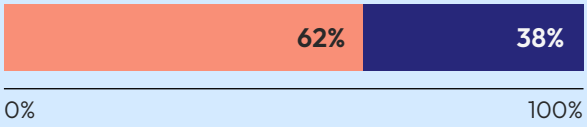
As organizations move beyond awareness and into implementation, it is critical that they have a realistic view of their capacity to use the PCTI approach. However, the National Study revealed that organizations tend to overestimate their capacity to use the PCTI approach. While 56% of respondent organizations self-reported deep PCTI capacity, only 39% of respondent organizations demonstrated that they actually have deep capacity. Organizations with high demonstrated capacity tended to report their capacity more accurately, while organizations with low demonstrated capacity tended to overestimate their abilities. This discrepancy may be a result of organizations incorrectly interpreting PCTI capacity to mean simply providing PCTI services. However, PCTI capacity requires applying the approach throughout all organizational operations, from resources and partnerships to organizational climate and infrastructure. To achieve a fully PCTI organization, all aspects of the organization must include the PCTI approach, not just those aspects that focus on direct services.

Organizations reported lower PCTI capacity.

75% of organizations are aware of the PCTI approach.



38% of organizations have capacity to implement the PCTI approach.



5. The PCTI approach is unevenly available and applied across older adult populations.

PCTI services are not equally available to all aging Americans. Consistent with prior years, the 2025 National Study revealed that aging services organizations have varied PCTI capacity and PCTI service availability for different populations of older adults with a history of trauma. This may leave certain older adult populations without access to compassionate care shown to improve care outcomes. For example, Holocaust survivors are the most likely to receive PCTI care, as 76% of organizations serving them provide them with PCTI services, and 67% have high capacity to provide them with PCTI care. Hispanic or Latin American older adults are the least likely to receive PCTI care, as 68% of organizations serving them provide them with PCTI services, and 44% have high capacity to provide them with PCTI care.

76% of organizations provide PCTI care to Holocaust survivors.

Gaps in care have long been documented in health and human services (McDaniel et al., 2017). Imbalances for care recipients has been reported in many forms, including access to care, use of services, quality of support, and care recipient outcomes. Gaps in care come from many sources, ranging from the systems from which older adults seek care to the individuals providing the care.

Organizational systems as well as individual bias can perpetuate gaps in care, especially for minoritized populations (Nelson, 2002). These trends continue even with the use of the PCTI approach. While it can be used as a framework to overcome systemic, institutional, and cultural barriers, the PCTI approach alone cannot eliminate gaps in care. Aging services professionals should acknowledge and work to overcome gaps in PCTI care so that all older Americans can benefit from the PCTI approach.

6. PCTI capacity is not evenly distributed between older adults and family caregivers.

The levels of PCTI support provided to older adults and to family caregivers are not consistent. While 62% of organizations reported deep capacity to use the PCTI approach with older adults, only 51% reported deep capacity to use the approach with family caregivers. These statistics indicate that while many organizations may feel they have the ability to support older adults using the PCTI approach, a subset of these organizations cannot extend this care to the family caregivers who support older adult care recipients.

In recent years, the aging services sector has increased PCTI implementation for family caregivers, including expanding resources to address the specific needs of family caregivers who support older adults with a history of trauma. However, PCTI support for family caregivers lags behind. This gap leaves many family caregivers without critical support that can improve their caregiving experiences, improve their own health and well-being, and ultimately improve the health and well-being of the older adults they support. As the family caregiver population grows and the responsibilities of family caregivers expand, it is essential to improve the aging services sector's capacity to provide family caregivers with PCTI programming.

7. The PCTI approach improves all aspects of aging services.

While organizations have different levels of ability to implement the PCTI approach, organizational leaders are increasingly recognizing its numerous benefits. The PCTI approach has been shown to improve outcomes and experiences not just for care recipients, but for staff and organizations, too.

Improvements resulting from the PCTI approach do not exist in a vacuum; improving one aspect of an organization has various consequences. For instance, improvements to staff knowledge, skills, and ability to implement PCTI strategies may result in improved health and well-being of care recipients and increased quality of organizational services. As more pressure is put on the aging services sector's capacity to support a growing aging population, it is critical to leverage the impact of the PCTI approach. The PCTI approach continues to elevate care as the gold standard in improving service delivery and demonstrates the ability to make lasting impacts on all organizations.

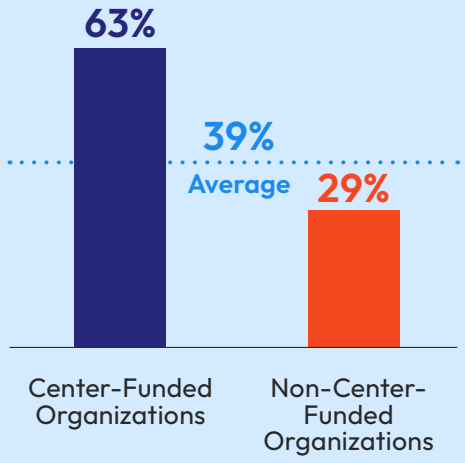
Organizational leaders **increasingly recognize** the benefits of the PCTI approach.

8. Investments in organizational PCTI capacity are needed and effective.

While there is significant work ahead of the aging services sector in making the PCTI approach widely used, the National Study revealed that dedicated resources and funding through the Center made a significant difference in organizational PCTI capacity. Center-funded organizations reported deeper awareness, understanding, and capacity across all study measures. For instance, 63% of Center-funded organizations demonstrated high PCTI capacity compared to only 29% of non-Center-funded organizations.

Center-funded organizations reported **deeper awareness, understanding, and capacity** across all study measures.

Organizations with High or Very High Demonstrated PCTI Capacity



Center-funded organizations are more exposed to the PCTI approach through specialized training and resources from the Center, improving knowledge, program quality, and capacity. The additional technical support and capacity building that comes with Center funding plays a large role in

ensuring organizations can successfully use PCTI resources and implement the PCTI approach throughout their services. Even for organizations that have never received Center funding, Center resources appear to be impactful. Eighty-eight percent of Center-funded organizations improved the quality of existing products, programming, or services due to the Center's resources, while only 52% of non-Center-funded organizations made similar improvements. Ninety-six percent of Center-funded organizations and 90% of non-Center-funded organizations reported that these resources reported improved their organization's knowledge, or practices, and/or services.

Not only is this support effective, but the aging services sector is eager to receive it. An overwhelming interest was shown through the National Study in additional funding as well as educational resources such webinars, job aids, and in-person conferences and workshops. This feedback is echoed every time the Center issues a request for proposals for a new funding opportunity or provides an educational resource. Year after year, the Center has more grant applicants for each PCTI grant opportunity and must turn away a larger portion of applicants due to limited funds. Additionally, every time the Center evaluates webinars or in-person training events, aging services professionals ask for more training opportunities on an increasingly wide array of topics related to PCTI capacity building and service delivery.





Recommendations

Awareness of the impact of trauma and the PCTI approach have grown, but a significant gap remains across the aging services sector. A lack of understanding of how trauma can impact aging, along with limited capacity to use the PCTI approach will put further strain on the aging services sector. Without improving capacity to use the PCTI approach, aging services organizations risk falling further behind in meeting the needs of an aging American population.

Improving the availability, access, and quality of PCTI care for all older adults and family caregivers requires everyone to understand the impacts of trauma regardless of sector, geography, professional specialization, or seniority. Doctors, nurses, advocates, government officials, social workers, transportation workers, lawyers, policy makers, funders, philanthropists, and researchers all have a vital role to play. Making the PCTI approach the standard operating framework for the aging services sector requires a cultural shift in the way organizations operate, requiring advocacy, dedication, diligence, and action from every professional.

The following section includes four main recommendations to increase PCTI implementation across the aging services sector. Each is followed by a list of sample implementation strategies. These lists are not exhaustive but provide some general ideas of where aging services professionals can begin.

1

Improve understanding about aging with a history of trauma.

The first step in providing compassionate care to America's aging population is to acknowledge and understand the role that trauma plays in aging and service delivery. While trauma is a nearly universal experience among older adults, almost one third of National Study respondents noted that their organization does not have a deep understanding of aging and trauma. In practice, this gap in understanding carries significant consequences for older Americans. Professionals may unintentionally mistreat, misdiagnose, or retraumatize those for whom they care, leading to poor health and well-being outcomes. Thus, it is imperative for all professionals across the aging services sector to recognize and improve their understanding of how trauma impacts older adults generally, the specific populations they support, and family caregivers.

The following are sample strategies professionals can implement to improve recognition and understanding of aging with a history of trauma.

1. **Consider personal and professional impacts of trauma**, including vicarious and secondary trauma, how trauma may impact interpersonal relationships, and how individual experiences of trauma may impact the support provided.

2. **Engage the community to learn how trauma impacts community members** by forging deep relationships within communities and with service partners. Create physically and psychologically safe and accessible spaces, workgroups, and partnerships that invite community members and partners to share their experiences, goals, and expertise.

3. **Ensure all staff and volunteers are trained on topics of aging and trauma**. This involves training direct service providers, administrative staff, executive leaders, and board members. Review foundational concepts as well as job specific competencies through in-person, virtual, asynchronous, or group-based courses or workshops.

4. **Create and share educational materials on aging and trauma** such as fact sheets, guides, and reports and distribute them to colleagues, partner organizations, community members, and policy makers. Infuse materials with lived experiences and professional expertise that add to the discourse on aging with a history of trauma.

5. **Integrate aging and trauma considerations into program planning and implementation** to improve service delivery. For professionals, this means including considerations for aging, trauma, and community needs in service development. For funders, this means requiring grantees to engage with aspects of trauma in grant proposals and workplans.

6. **Allocate, apply for, or award funding for training** to ensure professionals and organizations have the necessary resources to understand the connection between trauma, aging, service delivery, and community support.

7. **Advocate for, design, or implement regulations that require organizations to be knowledgeable about aging and trauma**. This can include creating new requirements or implementing and strengthening existing requirements such as those of the Centers for Medicare and Medicaid Services (LeadingAge, 2022).

2



Increase understanding and application of the PCTI approach.

Another aspect of providing compassionate care to America's aging population is to form a deep understanding of the PCTI approach and recognize how to integrate it into aging services. While the PCTI approach has emerged as a best practice in aging services, many organizations are not familiar with it. Approximately one fourth of National Study respondents noted that their organization was not familiar with the PCTI approach prior to

participating in the study. Additionally, only about two thirds of respondents reflected that their organization had a deep capacity to provide PCTI care. This is a missed opportunity as the PCTI approach has shown to benefit care recipients, staff, and organizations. Thus, aging services professionals should strive to improve their own as well as their colleagues' understanding and application of the PCTI approach.

The following are sample strategies professionals can implement to improve understanding and application of the PCTI approach.

1. **Learn about the model and its principles**, as well as how to make PCTI decisions in real-world situations. Consider how the PCTI approach is relevant in personal and professional settings, and how it can be used across various populations, services, and job functions.

2. **Identify the ways in which the PCTI approach is currently used by individuals, colleagues, or organizations**. Consider which of these PCTI practices work well, and which practices have room for growth.

3. **Further integrate the PCTI approach into individual practices** and help others to use the approach through mentoring and coaching. By supporting others, expertise can be gained and shared to create entire networks capable of using the PCTI approach, enabling service experiences to be PCTI from start to finish.

4. **Connect with peers, colleagues, and organizations to build a PCTI community of practice.** Share and learn from one another's challenges and promising practices in implementing the PCTI approach. Facilitate comprehensive partner networks to share information and resources.

5. **Champion and advocate for the use of the PCTI approach across the aging services sector**. Initiate or engage in committees advocating for the inclusion of the PCTI approach into organizations, professional fields, and community spaces. Create advisory committees to determine implementation plans and goals.

6. **Create local, state, and federal rules, regulations, and standards for the PCTI approach**, providing a guide and incentive for aging services. This can include tying funding to PCTI organizational practices and service delivery, establishing a minimum PCTI training standard, and integrating the PCTI approach into local and state multisector aging plans.

3

Build organizational capacity to use the PCTI approach.



Once aging services professionals become knowledgeable in how trauma impacts aging and how the PCTI approach can help, the next step is to build strong institutions that have deep and holistic capacity to use the PCTI approach. The National Study showed that respondents tend to overestimate their organization's PCTI capacity. While a little over half of respondents thought their organization had high PCTI capacity, only a little over one third actually had high PCTI capacity as demonstrated through the Center's Organizational PCTI Capacity Index. If this finding is reflective of sector-side trends, it reveals the stark reality that most organizations supporting older adults do not have capacity to do so in a PCTI way. To provide compassionate care, it is essential to expand organizational PCTI capacity across all operational areas.

The following are sample strategies professionals can implement to build organizational PCTI capacity.

1. **Identify how the PCTI approach fits in with an organization** and how it aligns with the organization's vision, mission, objectives, and programs. Integrate the approach into mission statements, documents, policies, and procedures to reflect this alignment.

2. **Assess and systematically review an organization's PCTI capacity** across all five capacity categories and 16 capacity indicators in the Center's Organizational PCTI Capacity Index. Identify areas of strength and improvement and create a strategic and practical plan to improve organizational PCTI capacity.

3. **Allocate financial, material, and staffing resources** to ensure that organizations have sufficient resources to implement PCTI practices, programming, and strategic plans for PCTI capacity building. This includes ensuring organizations have PCTI-trained staff available and that those staff work in welcoming and empowering spaces.

4. **Lead by example to ensure that the PCTI approach is demonstrated throughout the organization**, not only by direct service providers but also by executive leadership and board members. Organizational leadership can create a climate and cultural environment that embodies the PCTI approach.

5. **Foster PCTI partnerships across departments and with external organizations** to support the implementation of the PCTI approach. This includes building communities of PCTI practice, forming comprehensive referral networks supportive of holistic care, and ensuring programs, policies, and spaces are informed by community partners.

6. **Invest in training and professional development of the aging services workforce** while addressing issues of job-related stress

and burnout. Provide continuing education courses, implement PCTI hiring and supervision practices, and provide resources for managing vicarious or secondary traumatic stress.

7. **Evaluate and report on the impact of implementing the PCTI approach** across individual responsibilities or the organization's programs. Share with the aging services sector through meetings, articles, or conference presentations about how this impact was achieved, and how similar PCTI initiatives can be repeated, scaled, and sustained.

4

Expand accessibility of PCTI care.



Finally, to provide compassionate care to all older adults with a history of trauma and their family caregivers, aging services professionals and organizations should have capacity to serve all populations through the PCTI approach. The National Study revealed significant gaps in the availability of PCTI services and an organization's capacity to use the PCTI approach across the 14 populations studied.

The following are sample strategies professionals can implement to make the PCTI approach accessible to all older adults and their family caregivers.

1. **Explore personal attitudes, beliefs, and unconscious biases about service populations supported** and how this may impact interpersonal and professional relationships and work responsibilities. Understand how these beliefs may be formalized in organizational policies, procedures, and culture.

2. **Learn how national trends in aging, trauma, and PCTI care apply to communities and on a local level**. Explore first-person perspectives about how community members experience and respond to trauma. Learn how to implement the PCTI approach based on the preferences and strengths of different populations.

3. **Elevate all voices** by making space for community members to direct service planning and delivery, and to share their history, strengths, culture, and service delivery successes in public forums. Advocate for the inclusion of multiple different voices and perspectives throughout local, state, and federal aging services.

4. **Ensure that individual and organizational practices reflect the preferences and cultures of populations served**. Create programming and physical spaces that reflect the cultural traditions and preferences of care recipients by inviting the community to express their needs, preferences, and strengths, and to direct program design. Hire staff that reflect community demographics.

5. **Support the identity of care recipients, staff, and volunteers** through inclusive language and signage. Offer translation services, pictorial signage, and accessibility options such as teletypewriter (TTY) technology and large print materials. Create organizational policies that are inclusive of many populations.

6. **Modify programs and funding requirements to ensure that services are accessible for all communities**. This can include adjusting intake requirements to reflect cultural practices or adapting evaluation forms and practices to be PCTI for the populations supported.

7. **Support organizations to develop PCTI capacity for each community they support** by dedicating financial, material, and staff resources to PCTI services. Make funding available for PCTI staff training for population-specific care, transforming organizational policies, procedures, and culture, and providing culturally aware PCTI services.

With these recommendations, aging services professionals across the United States can infuse PCTI considerations into their work to best support older adults with a history of trauma and their family caregivers. When implementing these recommendations, no action is too small. Every step that helps advance use of the PCTI approach advances the entire field of aging services. By implementing these recommendations, professionals can better ensure that older Americans age with safety, dignity, and compassion.





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Appendix

National Study Survey Tool

Page 1. Instructions

National Study on the PCTI Approach

Thank you for your interest in participating in the National Study on the Person-Centered, Trauma-Informed (PCTI) Approach. The purpose of this study is to understand how the PCTI approach is used among organizations supporting older adults and family caregivers.

The PCTI approach is a holistic model of care that promotes the health and well-being of individuals by accounting for the role of trauma across the life course, resisting retraumatization, and promoting the strength, agency, and dignity of people receiving care.

Regardless of your organization's familiarity with the PCTI approach, we encourage you to participate in this study and complete it to the best of your knowledge. As an organization supporting older adults, you have key insights into the care of older populations and your responses will help advance and expand the field of aging services.

Time Commitment

Study participation should take approximately 30 to 35 minutes and can be completed in multiple sessions. You can complete the survey in multiple sessions by clicking "Save and Continue" at the bottom of the page. You will then enter your email address and receive a custom link to resume the survey at any time. To return to a previous page in the study, use the back button at the bottom of the page. Responses will not be saved if browser back button is used.

Compensation

Eligible respondents who complete the survey will be entered to win a $20 Amazon gift card, while funds last. Winners will be notified after the close of the study.

Respondent Eligibility

Individuals are eligible to participate in the study if the following criteria are met.

- Their organization is located in the United States,
- Their organization supports older adults directly or indirectly,
- Their organization supports older adults in the United States,
- They can complete the survey on behalf of their organization, and
- No one from their organization has already completed the survey.

After clicking 'Next' at the bottom of this page, you will see the eligibility questionnaire.

Data Use

Responses to this study will be anonymized and reported in aggregate. Any identifying information provided for the purpose of issuing compensation with be kept confidential and will not be associated with responses. Identifying information will not be shared with external parties.

Reporting Findings

Findings from this study will be used to publish a report on the state of the PCTI approach in the aging services field. This report is anticipated to be published during the winter of 2025 and will be made available to the public for free.

Authors

This survey is conducted by the Jewish Federations of North America's Center on Aging, Trauma, and Holocaust Survivor Care (Center). The Center servs as a national resource hub on the PCTI approach, funding and training organizations across the United States in providing PCTI care.

If you have questions or would like support participating in the study, please reach out to Carmel Rabin, Director of Research and Evaluation at the Center at Carmel.Rabin@JewishFederations.org.

Page 2. Eligibility Questionnaire

Please answer the following questions to ensure your eligibility to participate in this study.

1. Is your organization located in the United States?* (Single-choice question)
   - ○ Yes
   - ○ No

2. Does your organization support older adults directly or indirectly?* (Single-choice question)
   - ○ Yes
   - ○ No

3. Does your organization support older adults located in the United States?* (Single-choice question)
   - ○ Yes
   - ○ No

4. In your current role, are you able to speak on behalf of your organization?* (Single-choice question)
   - ○ Yes
   - ○ No

5. Has anyone from your organization already submitted a response to this survey?* (Single-choice question)
   - ○ Yes
   - ○ No

6. CAPTCHA (Image selection question)

Page 3A. Non-Eligible Respondents

Thank you for your interest but you are not eligible to participate in this study. If you would like to receive updates from the Center, including a copy of the National Study report (forthcoming winter 2025), please include your information below. Otherwise, feel free to close this browser.

1. First Name (Open-ended text question)
2. Last Name (Open-ended text question)
3. Email Address (Open-ended text question)

Page 3B. Eligible Respondents

Congratulations! You are eligible to participate in this study. Eligible respondents will receive a $20 Amazon gift card at the close of the study, while funds last. To issue this gift card, the following information is needed. Note, this information is not connected to your survey response and is kept confidential.

1. Please provide your organization's full legal name.* (Open-ended text question)
2. Please provide your name. * (Open-ended text question)
   First:
   Last:
3. Please provide your email address.* (Open-ended text question)
   Note, communications about the gift card will be sent to this.
4. Please confirm your agreement with the following statement: (Single-choice question)
   ☐ I certify that I am completing this survey only once and the responses provided are accurate to the best of my knowledge.*

Page 4. Eligibility Questionnaire

1. What is the location of your organization?
   If multiple, list your organization's headquarters location.*

   (Open-ended question and drop-down question of U.S. states and territories)

   City:

   State:

2. Which category best describes your organization?*

   (Single-choice question, open-ended text response for 'Other' selection)

   - ○ Adult Day Care
   - ○ Adult Protective Services
   - ○ Area/State Agency on Aging
   - ○ Consultancy
   - ○ Foundation/Grantmaking
   - ○ Government Agency
   - ○ Home Care/Home Health Agency
   - ○ Hospice
   - ○ Hospital
   - ○ Higher Education
   - ○ Information Technology
   - ○ Legal Services Provider
   - ○ Meals Program
   - ○ Mental Health Clinic/Agency
   - ○ Nursing Home
   - ○ Patient Care/Healthcare
   - ○ Public Services
   - ○ Professional Association
   - ○ Research Institute
   - ○ Residential Care Facility/Assisted Living
   - ○ Recreational Services
   - ○ Senior Center
   - ○ Senior Housing
   - ○ Social Service Agency
   - ○ Transportation Provider

- O Veterans Affairs Facility
- O Victim Services Program
- O Other:

3. Which category best describes your organization? (Single-choice question, open-ended text response for 'Other' selection)
   - O International
   - O National
   - O Regional
   - O Local
   - O Other:

4. Which category best describes your organization? (Single-choice question, open-ended text response for 'Other' selection)
   - O Social Sector
   - O Public Sector
   - O Private Sector
   - O Other:

5. How many full-time employees does your organization have? * (Single-choice question)
   - O Under 100
   - O Between 100 and 500
   - O Between 500 and 1,000
   - O Over 1,000

6. What is your position at your organization? * (Single-choice question, open-ended text response for 'Other' selection)
   - O Board Member
   - O C-Suite (ex., Chief Operations Officer)
   - O Executive Staff (ex., Vice President)
   - O Senior Management (ex., Director)
   - O Middle Management (ex., Manager)
   - O Intermediate or Experience Staff (ex., Senior Specialist)
   - O Entry-Level Staff (ex., Associate, Coordinator)
   - O Other:

7. Are you a direct service provider? * (Single-choice question)

- ○ Yes
- ○ No

Page 5. PCTI Approach Awareness

1. To the best of your knowledge, before receiving this survey, was your organization aware of the trauma-informed approach? * (Single-choice question)

- ○ Yes
- ○ No
- ○ I Don't Know

2. To the best of your knowledge, before receiving this survey, was your organization aware of the person-centered, trauma-informed approach? * (Single-choice question)

- ○ Yes
- ○ No
- ○ I Don't Know

The PCTI approach is a holistic model of care that promotes the health and well-being of individuals by accounting for the role of trauma across the life course, resisting retraumatization, and promoting the strength, agency, and dignity of people receiving care.

Page 6. PCTI Approach Awareness

1. To the best of your knowledge, please rate your organization's level of understanding of the following topics: * (Single-select, Likert question set)

	None	Low	Medium	High	Very High	I Don't Know
How trauma impacts older adults as they age	○	○	○	○	○	○
How trauma impacts Holocaust survivors	○	○	○	○	○	○

How trauma impacts family caregiving	○	○	○	○	○	○

Page 7. PCTI Approach Capacity

1. To the best of your knowledge, please rate your organization's level of understanding of the following topics: *

(Single-select, Likert question set)

	None	Low	Medium	High	Very High	I Don't Know
Generally	○	○	○	○	○	○
With older adults	○	○	○	○	○	○
With family caregivers of older adults	○	○	○	○	○	○

Page 8A. Supporting Older Adult Populations

1. Which of the following older adult populations does your organization support, directly or indirectly? (Select all that apply) *

(Multi-select question, open-ended text response for 'Other' selection, open-ended text response for 'None' selection)

- ☐ African American or Black older adults
- ☐ American Indian, Alaska Native, or Native Hawaiian older adults
- ☐ Asian American older adults
- ☐ Family caregivers of older adults
- ☐ Hispanic or Latin American older adults
- ☐ Holocaust survivors
- ☐ Immigrant, refugee, or asylee older adults
- ☐ LGBTQ+ older adults
- ☐ Older adults in high-risk professions (i.e., first responders, police officers, social workers)
- ☐ Older adult survivors of crime
- ☐ Older adult survivors of disasters
- ☐ Older adult survivors of domestic or sexual violence
- ☐ Older adults with disabilities

- ☐ Veteran older adults
- ☐ None
- ☐ Other:

If 'None' plese explain:

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2. Please explain your answer to the previous question, that your organization does not serve any older adults.*

(Conditional open-ended text question if previous response 'None')

Page 8B. Supporting Older Adult Populations

(Multi-select question, ~~open-ended text~~ response for 'Other' selection, open-ended text response for 'None' selection. Response options conditionally appear based on response options selected for question 1 on page 8A.)

1. Of those older adult populations that your organization supports, for which populations does your organization use the PCTI Approach to support?* (Select all that apply)
   - ☐ African American or Black older adults
   - ☐ American Indian, Alaska Native, or Native Hawaiian older adults
   - ☐ Asian American older adults
   - ☐ Family caregivers of older adults
   - ☐ Hispanic or Latin American older adults
   - ☐ Holocaust survivors
   - ☐ Immigrant, refugee, or asylee older adults
   - ☐ LGBTQ+ older adults
   - ☐ Older adults in high-risk professions (i.e., first responders, police officers, social workers)
   - ☐ Older adult survivors of crime
   - ☐ Older adult survivors of disasters
   - ☐ Older adult survivors of domestic or sexual violence
   - ☐ Older adults with disabilities
   - ☐ Veteran older adults
   - ☐ None
   - ☐ Other:

   If 'None' please explain:

Page 8C. Supporting Diverse Populations

1. To the best of your knowledge, please rate your organization's capacity to use the person-centered, trauma-informed approach with each population your organization supports. *

(Single-select, Likert question set, open-ended text response for 'Other' selection. Likert questions appear conditionally based on response options selected for question 1 on page 8A.)

	None	Low	Medium	High	Very High	I Don't Know
African American or Black older adults	○	○	○	○	○	○
American Indian, Alaska Native, or Native Hawaiian older adults	○	○	○	○	○	○
Asian American older adults	○	○	○	○	○	○
Family caregivers of older adults	○	○	○	○	○	○
Hispanic or Latin American older adults	○	○	○	○	○	○
Holocaust survivors	○	○	○	○	○	○
Immigrant, refugee, or asylee older adult	○	○	○	○	○	○
LGBTQ+ older adults	○	○	○	○	○	○
Older adults in high-risk professions (i.e., first responders, police officers, social workers)	○	○	○	○	○	○
Older adult survivors of crime	○	○	○	○	○	○
Older adult survivors of disasters	○	○	○	○	○	○

Older adult survivors of domestic or sexual violence	○	○	○	○	○	○
Older adults with disabilities	○	○	○	○	○	○
Veteran older adults	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Page 9. PCTI Approach in Practices

1. Thinking about your organization's resource investments in the PCTI approach, which of the following statements are true? Select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ My organization has invested fiscal resources to use the PCTI approach. (e.g., financial assets, in-kind contributions, local grants).
- ☐ My organization has invested staffing resources to use the PCTI approach. (e.g., number of staff, general skill level, and time availability of staff).
- ☐ My organization has invested material resources to use the PCTI approach. (e.g., facilities, equipment, technology).
- ☐ None
- ☐ Other:

2. Thinking about your organization's guidelines and policies that uphold the PCTI approach, which of the following statements are true? Select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ My organization has written goals establishing the PCTI approach as an essential part of the organizational mission. (e.g., mission statement, organizational objectives or values).
- ☐ My organization has systems, procedures, and protocols for the use of the PCTI approach. (e.g., operational policies or guidelines).

- ☐ My organization has offices and other spaces that are informed by the PCTI approach. (e.g., spaces are designed to be welcoming and promote a sense of safety, community, and connection).
- ☐ None
- ☐ Other:

---

3. Thinking about your organization's practice of the PCTI approach, which of the following statements are true? Select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ My organization's staff have the technical ability to foster organizational change. (e.g., management skills of leadership, communication, strategic vision).
- ☐ My organization trains staff on the PCTI approach. (e.g., onboarding or continuing education on PCTI care, coaching opportunities).
- ☐ My organization implements PCTI programs and services. (e.g., PCTI cognitive therapy, socialization activities, client intakes).
- ☐ None
- ☐ Other:

---

4. Thinking about your organization's commitment to the PCTI approach, which of the following statements are true? Select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ My organization's leadership demonstrate commitment to adopting the PCTI approach. (e.g., leadership practice, express priority, and encourage PCTI care).
- ☐ My organization's staff demonstrate commitment to using the PCTI approach. (e.g., staff participate in voluntary trainings, are actively engaged in becoming PCTI, embody PCTI care in actions).
- ☐ My organization has an assigned staff member or group of staff to champion the PCTI approach. (e.g., PCTI working group or officer).
- ☐ My organization implements the PCTI approach in staff hiring and management practices (e.g., training supervisors on PCTI recruitment, onboarding, coaching, and mentorship).
- ☐ None
- ☐ Other:

5. Thinking about your organization's partnerships that support the PCTI approach, which of the following statements are true? Select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ My organization has internal partnerships to support provision of the PCTI approach. (e.g., cross-departmental, or cross-functional partnerships).
- ☐ My organization has external partnerships to support provision of the PCTI approach. (e.g., partnerships with other organizations serving trauma-affected older adult populations).
- ☐ My organization has community partnerships to support provision of the PCTI approach. (e.g., partnerships with trauma-affected older adult populations in the community).
- ☐ None
- ☐ Other:

Page 10. PCTI Approach Benefits

1. How has the PCTI approach impacted the older adults and family caregivers your organization's support? Please select all that apply. *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ Empowered older adults and/or family caregivers
- ☐ Improved trust
- ☐ Improved relationships
- ☐ Improved peer support
- ☐ Increased decision-making ability
- ☐ Increased sense of safety and belonging
- ☐ Improved understanding and skills
- ☐ Improved health and well-being
- ☐ Improved socialization
- ☐ Improved service access
- ☐ Increased service use
- ☐ None
- ☐ Other:

2. How has the PCTI approach impacted your organization's staff and volunteers? *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ Improved understanding of service recipients and how to support them
- ☐ Improved ability to create and implement strategies to serve individuals
- ☐ Improved knowledge and skills
- ☐ Improved confidence
- ☐ Increased resilience
- ☐ Improved retention
- ☐ Decreased burnout
- ☐ Increased job satisfaction
- ☐ None
- ☐ Other:

3. How has the PCTI approach impacted your organization as a whole? *

(Multi-select question, open-ended text response for 'Other' selection)

- ☐ Improved the quality of services
- ☐ Increased the number of new services
- ☐ Supported expansion of services to new populations and/or locations
- ☐ Improved feedback from service recipients
- ☐ Improved organizational reputation
- ☐ Provided structured work approach
- ☐ Enhanced organizational sustainability
- ☐ Reduced costs associated with turnover and staff burnout
- ☐ None
- ☐ Other:

Page 11. PCTI Resources

1. Where did your organization first learn about the person-centered, trauma-informed (PCTI) approach? *

(Open-ended text question)

2. What resources would be helpful to increase your organization's capacity to use the PCTI approach? This can include any type of resources such as financial grants, educational materials, training events, coaching,and more.

(Open-ended text question)

3. Has your organization used resources about the PCTI approach provided by Jewish Federations of North America's Center on Aging, Trauma, and Holocaust Survivor Care (formerly The Jewish Federations of North America's Center on Holocaust Survivor Care and Institute on Aging and Trauma)? This includes webinars, reports, conference presentations, website, and more. *

(Single-select question)

- ○ Yes
- ○ No
- ○ I don't know

4. Please indicate how much you agree or disagree with the following statements. As a result of the Center's resources, my organization... *

(Single-select, Likert question set. Conditionally appears based on 'Yes' response to question 3 on Page 11)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
...has a better understanding of how trauma impacts older adults as they age.	○	○	○	○	○

...has a better understanding of the trauma triggers of our older adult care recipients and how we can avoid them.	○	○	○	○	○
...has a better understanding of how to use the PCTI approach	○	○	○	○	○
...has devoted resources to becoming a PCTI agency.	○	○	○	○	○
...has increased our PCTI programming for older adults with a history of trauma.	○	○	○	○	○
...has increased our PCTI programming for family caregivers of older adults with a history of trauma.	○	○	○	○	○

5. Has your organization made any of the following changes as a result of using Center resources? *

(Multi-select question, open-ended text response for 'Other' selection. Conditionally appears based on 'Yes' response to question 3 on Page 11.)

- ☐ Improved the quality of existing products, programming, or services for older adults with a history of trauma and/or their family caregivers.
- ☐ Provided new products, programming, or services for older adults with a history of trauma and/or family caregivers.
- ☐ Expanded service delivery and/or reached more older adults with a history of trauma and/or family caregivers.
- ☐ Increased funding dedicated to older adults with a history of trauma and/or family caregivers.
- ☐ Improved organizational policies and procedures
- ☐ Increased training opportunities for staff and volunteers
- ☐ No changes have been made to the organization
- ☐ Other:

Page 12. Organization Information

1. Has your organization received grant funding from Jewish Federations of North America's Center on Aging, Trauma, and Holocaust Survivor Care (formerly the Center on Holocaust Survivor Care and Institute on Aging and Trauma)? *

(Single-select question)

- ○ Yes
- ○ No
- ○ I don't know

2. Does your organization receive any funding from Medicaid? *

(Single-select question)

- ○ Yes
- ○ No
- ○ I don't know

3. Does your organization receive any funding from the United States Department of Veteran Affairs? *

(Single-select question)

- ○ Yes
- ○ No
- ○ I don't know

4. Is your organization religiously affiliated? *

(Single-select question)

- ○ Yes
- ○ No

5. Which religious affiliation best describes your organization? *

(Single-select question, open-ended text response for 'Other' selection. Conditionally appears based on response of 'yes' to question 4 on Page 12.)

- ○ Buddhist
- ○ Christian
- ○ Hindu
- ○ Indigenous
- ○ Islamic
- ○ Jewish
- ○ Other:

Page 13. Thank You Page

Thank you for completing the survey. Your input is invaluable to advancing the aging network's understanding and implementation of the PCTI approach. By providing feedback, you have helped us move one step closer in supporting the nation's population of older adults and family caregivers.

With the successful completion of the survey, you are now eligible for one of the study's gift cards, while funds last. After the close of the study, we will follow up with more information.

For more information about the Center and the PCTI approach, visit https://www.AgingandTrauma.org.

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1. If you would you like to be considered to receive a $20 Amazon gift card, while funds last, please opt into receiving compensation below. (Single-select question)
   - ○ Yes, I would like to be considered to receive a gift card.
   - ○ No, I would not like to be considered to receive a gift card.

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2. If you would like to receive information from the Center, including updates about this study and the National Study Report, please opt into continued communications below. (Single-select question)
   - ○ Yes, I would like to receive communications from the Jewish Federation's Center
   - ○ No, I would not like to receive communications from the Jewish Federation's Center (excluding communications about study compensation).

Thank you for advancing the field of person-centered, trauma-informed care!

Jewish Federations of North America

The Center on Holocaust Survivor Care
Institute on Aging and Trauma