CAPACITY OF ORGANIZATIONS TO SERVE OLDER ADULTS WITH A HISTORY OF TRAUMA:

Results from a National Survey on Person-Centered, Trauma-Informed Care

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EXECUTIVE SUMMARY

The demographics of the American population are changing. In the United States, more than one in every seven Americans is 65 and older (United States Administration for Community Living, 2021). In 20 years, there will be almost 81 million older adults in the United States, more than twice as many as there were in 2000 (United States Administration for Community Living, 2021). At the same time, the older adult population is increasingly diverse – racial and ethnic minority populations have increased from 19% of the American older adult population in 2008, to 23% of older adults in 2018, and are projected to increase to 34% of older adults in 2040 (United States Administration for Community Living, 2021). While the increasing population of older adults brings wisdom, experience, and resilience, this increase in population also emphasizes the need for the expansion of aging services. One aspect of aging services that get far less attention than it should is the topic of aging with a history of trauma.

As many as 90% percent of older adults have been exposed to a traumatic event during their lifetime (Kaiser, 2021). This trauma can be individual, historical, and intergenerational. Whether it happens in childhood, adolescence, or adulthood, trauma can have a dramatic impact on the health and well-being of adults as they age, and on the family caregivers who support them. There is a growing understanding that trauma exposure is associated with physical, mental, and cognitive health conditions such chronic fatigue, cardiovascular disease, gastrointestinal disorders, anxiety, dementia, and sleep disorders. As trauma survivors age, the changes and functional losses associated with aging can re-active traumatic stress and worsen health conditions.

But even with this increased understanding, aging services providers often don't recognize the signs or symptoms of trauma in older adults. While trauma survivors can display resiliency and adaptation, older adults with a history of trauma may also hesitate to seek help, avoid disclosing a history of trauma, or minimize their symptoms. For older adults with a history of trauma, this can result in being misdiagnosed, receiving inappropriate treatments and medications, and potentially being re-traumatized through care.

In response to the omnipresent role of trauma among older adults, a new approach to care has been introduced – person-centered, trauma-informed (PCTI) care. Coined by the United States Administration for Community Living (ACL), defined by The Jewish Federations of North America (JFNA), and codified in the 2020 reauthorization of the Older Americans Act (OAA), this model is an innovative approach to service provision that infuses awareness about the prevalence and impact of trauma into health and social services as a way to promote the health and well-being of older trauma survivors (Eisinger and Bedney, 2018).

PCTI care is an approach to service delivery that incorporates knowledge about trauma into agency programs, policies, and procedures to promote the safety and well-being of clients, visitors, staff, and volunteers (Eisinger and Bedney, 2018). The PCTI care approach combines the core principles of person-centered care – self-determination and individual preference – with the principles of trauma-informed care

outlined by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) – safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues (United States Substance Abuse and Mental Health Services Administration, 2014).

PCTI programs, for example, allow clients to choose the services in which they want to participate, and how they want to participate in these services. They promote a sense of safety and trust by delivering services on time and in a culturally sensitive manner. They avoid re-traumatizing clients by avoiding triggering stimuli, events, and circumstances that could remind clients of previous traumatic events.

In 2015 and 2020, JFNA's Center on Holocaust Survivor Care and Institute on Aging and Trauma (Center) received grants from ACL to build national capacity to provide PCTI care for Holocaust survivors, older adults with a history of trauma, and their family caregivers. Through these grants, the Center increased the number and type of innovations in PCTI care available for these populations. To date, the Center has funded and provided technical support to over 70 subgrantee organizations across the Unites States. These organizations have implemented over 300 PCTI interventions, served over 31,000 Holocaust survivors, trained over 15,000 professional service providers and volunteers, and supported over 5,000 family caregivers.

Additionally, through these grants the Center has built the capacity of aging services organizations across the country to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers. The Center has built national capacity in PCTI care through publications, presentations, webinars, training workshops, and dissemination of information and resources on aging, trauma, and PCTI care.

As part of the grant, the Center conducted a national survey on the state of PCTI care among aging service providers. The goal of this survey was to understand the overall capacity of aging services organizations to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers, and to track increases in capacity over time as a result of Center activities. The survey serves as an initial understanding of the degree to which United-States-based aging services organizations are aware and capable of providing PCTI care for Holocaust survivors, older adults with a history of trauma and their family caregivers.

Almost 200 organizations from across the United States responded to the survey, conducted between February and April of 2021. Survey respondents represent a diverse group of aging service organizations ranging in size, sector, geography, religious affiliation, service type, and client demographic. The findings of the National Survey show that while PCTI care is growing among aging services providers, there remain significant gaps in PCTI care across organizations and client demographics.

Awareness of Aging, Trauma, and PCTI Care

Organizations are increasingly recognizing the PCTI approach and gaining deeper understanding of how trauma impacts aging. Seventy-two percent of respondents noted that their organization was aware of PCTI care before participating in the survey. Additionally, 58% of respondents noted that their organization has a deep understanding of the topic of aging and trauma. There remains significant work ahead to make the PCTI care approach the normative practice among aging service organizations as 28% of respondent organizations were not aware of PCTI care and 42% of respondent organizations did not have a deep understanding of aging and trauma.

The survey reveals two important findings to consider when attempting to close this gap. First, an organization's awareness of PCTI care is not the same as knowledge of aging and trauma. Organizations can be aware of the PCTI approach but not its application to older adults, or vice versa. While efforts to increase PCTI care awareness and understanding of aging and trauma may be complementary and mutually reinforcing, they are not interchangeable. And aging services providers could benefit from increased educational materials on both the PCTI approach as well as how trauma affects their older adult clients. Second, an organization's prior service to vulnerable client populations does not necessarily translate to an organization's awareness of PCTI care or understanding of aging and trauma. Most organizations participating in the survey showed a limited connection between prior service to older adult populations with a history of trauma and their organization's PCTI care awareness and understanding of aging and trauma. Although prior service to vulnerable clients furthers an organization's ability to serve future clients, educational materials on PCTI care and aging with a history of trauma can benefit all organizations – even those organizations that have been working in this field for years.

Capacity to Provide PCTI Care

Smaller than the percentage of those organizations aware of PCTI care, 30% of respondent organizations demonstrated a deep capacity to provide this care to clients. Conversely, 70% of respondent organizations had limited or no capacity to provide PCTI care. While the portion of organizations with demonstrated PCTI care capacity shows the exiting growth of this field, there is significant work ahead to ensure that all older adults with a history of trauma and their family caregivers have access to PCTI care through their local service providers.

Additionally, there is significant work to ensure all older adults with a history of trauma have equal and equitable access to PCTI care. At the same time, we need to ensure that family caregivers have access to PCTI care, as PCTI care for family caregivers is lagging behind PCTI care for older adults with a history of trauma. Respondent organizations reported disparities in PCTI care availability and capacity based on client demographic and family caregiver status. Organizations responding to the survey noted higher capacity to serve older adults with a history of trauma compared to providing the same care to the family and friends that care for older adults. Additionally, there was a wide range of reported PCTI care capacity and availability across the 13 client demographics studied. Organizations reported the highest PCTI care availability

and capacity to serve Holocaust survivors and older adult survivors of domestic and sexual violence. Organizations reported the lowest PCTI care availability and capacity for American Indian, Native Hawaiian, or Alaska Native; Asian American; Latin American; and veteran older adults.

The survey reveals two important findings to consider when increasing the percent of aging service organizations capable of providing PCTI care to clients. First, an organization's PCTI care awareness does not necessarily translate to an organization's PCTI care capacity. While 72% of respondent organizations noted that their organization was aware of PCTI care prior to the survey, only 30% of organizations demonstrated deep capacity to provide PCTI care to clients. Being aware of PCTI care is a relatively simple task; however, developing PCTI care capacity requires an organization to actively implement and prioritize PCTI principles. Second, organizations tend to overestimate their capacity for PCTI care. When comparing an organization's self-reflections to its objective measures of PCTI care capacity, approximately half of organizations participating in the survey overestimated their PCTI care capacity. Thus, when building PCTI care capacity, aging services providers would benefit from objective measures and tools to build their capacity.

Benefit of Providing PCTI Care

While the gaps in PCTI care awareness and capacity signal room for improvement, the increasingly understood benefits of PCTI care are encouraging. Of those organizations aware of PCTI care prior to receiving the survey, respondents associated PCTI care with improvements to service delivery, client outcomes, and organizational operations. Respondents reported that PCTI care in their organization resulted in improved client empowerment, understanding, safety, relationships, feedback, decision-making, peer support, mental health, well-being, service access, physical health, and socialization. Respondents also noted that PCTI care supported their organization's service delivery by providing a structured work approach, furthering staff knowledge, and contributing to organizational sustainability. Additionally, respondents noted that PCTI care improved service to family caregivers and engaged family caregivers in better service delivery for their loved ones.

Simultaneously, organizations are learning about the PCTI care model and its benefits from a growing and diverse set of sources. Organizations are learning from their peers, professional networks, conferences, and trainings. Additionally, organizations are learning by reflecting on their history of service and by leveraging the skills of their staff. The increasing sources for PCTI learning, as well as the view of PCTI care as beneficial to clients and organizations, makes it easier for aging services providers to adopt PCTI care.

Impact of Center Activities

While significant work remains to close the gaps in PCTI care, the survey revealed that out of all variables, Center funding had the most significant effect on organizational PCTI care awareness and capacity. Organizations funded by the Center reported higher rates of PCTI care awareness and capacity across all measures when compared to organizations that did not receive Center funding. Of Center-funded respondents, 93% were aware of PCTI care across their organization, 87% reported a deep understanding

of aging with a history of trauma, and 70% demonstrated a deep capacity to provide PCTI care to clients. Of respondents not funded by the Center, 66% were aware of PCTI care across their organization, 47% reported a deep understanding of aging with a history of trauma, and 9% demonstrated a deep capacity to provide PCTI care to clients.

While the variability of PCTI care availability and capacity remain, organizations funded by the Center showed increased ability to provide PCTI care across all client demographics. When compared to organizations that did not receive Center funding, organizations receiving Center funding reported higher rates of PCTI care availability and capacity for Black or African American older adults; American Indian, Native Hawaiian, or Native Alaskan older adults; Asian American older adults; crime survivor older adults; older adults with disabilities; disaster survivor older adults; sexual and domestic violence survivor older adults; first responder older adults; immigrant or refugee older adults; Latin American older adults; LGBTQ older adults; and veteran older adults. As for Holocaust survivors, 88% of Center-funded organizations reported a deep capacity to provide PCTI care to Holocaust survivors. However, 23% of organizations that did not receive Center funding reported similar capacity to serve Holocaust survivors.

In understanding the influence of Center funding, the survey revealed two important findings. First, the efforts of the Center to build the PCTI care capacity of organizations has proven to be successful. Through expanding innovations in PCTI care, the Center provides PCTI coaching, training, and evaluation support to each subgrantee organization. Additionally, through capacity building initiatives, the Center produces publications, presentations, webinars, training workshops, and disseminates informational resources on aging, trauma, and PCTI care. Organizations funded by the Center benefit from all these efforts and demonstrate increased PCTI care awareness and capacity.

Second, the influence of Center funding not only points toward the success of the Center, but also highlights the importance of dedicated funding for PCTI care. Center funding is often used to supplement staffing costs, finance program activities, and transform physical spaces to be more PCTI. Additionally, through applying for, accepting, and implementing a Center grant, organization leadership and staff make a commitment to implementing the PCTI care approach. Increasing funding dedicated to PCTI care could help organizations overcome informational, resource, and commitment barriers and further build PCTI care capacity among aging services providers. If the goal is to improve aging services organizations' understanding and ability to provide PCTI care, then providing dedicated funding for this endeavor is likely to yield positive results.

Recommendations

Although the field of PCTI care has grown tremendously, there remain significant gaps in PCTI care awareness and capacity among aging service providers. Based on the National Survey findings, the Center makes the following recommendations for aging services professionals working on policy, advocacy, grant making, and service delivery. The network of aging service organizations should:

1. Raise awareness and understanding about topics of aging and trauma.

Increase the understanding of aging services practitioners on the topics of aging and trauma so that aging services organizations have a broader and deeper understanding of the role of trauma in the aging process of their clients. This can be done by adding the topics of aging and trauma into, for example, dental, healthcare, legal, social service, or business administration curricula, or continuing professional education.

2. Raise awareness and understanding of the PCTI care approach.

Leverage diverse learning sources to increase awareness of the PCTI care model so that that aging services organizations have a deeper understanding of its relevance and the application of PCTI care for older adults with a history of trauma and their family caregivers.

3. Deepen organizational capacity to provide PCTI care.

Increase the understanding of aging services professionals of PCTI care capacity. Engage in organizational PCTI care capacity building efforts, so that organizations can provide PCTI care to all clients through all services.

4. Acknowledge and overcome disparities in PCTI care.

Work to address disparities in PCTI care by acknowledging that PCTI care availability and capacity is unevenly distributed based on client demographic groups and between older adults with a history of trauma and their family caregivers. Broaden the understanding that all clients can benefit from PCTI care and direct resources to overcome disparities in care with flexibility and cultural competency.

5. Provide dedicated resources for PCTI care.

Proactively dedicate resources for PCTI care capacity building so that organizations have dedicated funding, infrastructure, knowledge and skill, partnerships, and organizational climate to infuse the PCTI care model and principles throughout all areas of their organizations.

By implementing these recommendations to increase PCTI care awareness and capacity among aging services organizations, we can ensure that more older adults with a history of trauma can age in place with safety and dignity.

1 INTRODUCTION

1.1 AGING IN AMERICA TODAY

We live in an era of opportunity. The American population is aging, bringing dramatic increases in the number of older adults with wisdom, experience, and resilience to pass on to younger generations. Fifty-four million Americans (more than 1 in 7) are currently 65 and older. In 20 years from now, that number will be closer to 81 million (United States Administration for Community Living, 2021). Much of this growth is attributable to the aging of the nation's 73 million baby boomers, 10,000 of whom are turning 65 every day and all of whom will be at least 65 by 2030. America's 18 million veterans are also aging, with a current median age of about 65 (Vespa, 2020). By 2034, older adults are projected to outnumber children for the first time in United States history (United States Census Bureau, 2019).

At the same time, the older population is increasingly diverse. Racial and ethnic minority populations have increased from 19% of the American older adult population in 2008, to 23% of older adults in 2018. This trend is projected to increase as, by 2040, 34% of older adults will represent racial and ethnic minority populations (United States Administration for Community Living, 2021).

Of course, these trends present challenges too. Age continues to be the biggest risk factor for Alzheimer's disease, with 6.5 million Americans currently living with the disease and 7.2 million projected to by 2025 (Alzheimer's Association, 2022). One in three older adults fall each year (National Institute on Aging, 2017), with many losing the ability to live independently as a result. Approximately one quarter of community dwelling older Americans are socially isolated (National Academies of Sciences, Engineering, and Medicine, 2020) and at increased risk for heart disease, stroke, dementia, premature institutionalization, suicide (Cacioppo and Cacioppo, 2014; Czaja, 2017; Holt-Lunstad, 2017; Kaye, 2017; Keefe et al., 2006; Myers and Palmarini, 2017; Ryerson, 2017; Suen et al., 2017). As recent events highlight, pandemics such as COVID-19 have devastating impacts on older adults. All of this adds up to more challenge and burdens on America's 42 million family caregivers who are caring for someone 50 or older (AARP/National Alliance for Caregiving, 2020). The number of family caregivers is likely to increase in the coming years as America ages.

But there is another challenge, one that gets far less attention, and that is the issue of trauma.

1.2 TRAUMA DEMOGRAPHICS, TRENDS, AND IMPACTS

There is no one 'singular' definition of trauma. According to SAMHSA, trauma is a result of "an event, series of events, or set of circumstances which present physical or emotional harm to an individual or are life

threatening." (United States Substance Abuse and Mental Health Services Administration, 2014). Judith Herman (1997), in her groundbreaking book, Trauma and Recovery, writes that traumatic events "confront human beings with the extremities of helplessness and terror," while Van der Kolk (2014) writes that trauma, by definition, is "unbearable and intolerable."

There is similarly no one 'type' of trauma. For some people such as Holocaust survivors, refugees and victims of war, veterans, first responders, survivors of child abuse and domestic violence, and adults who have experienced racial, economic, and gender discrimination, trauma can be long and drawn out, with exposure occurring on a repeated basis. For others, including those who may have experienced a sexual assault, an act of gun violence, a car accident, or natural disaster, trauma can be sudden and shocking, but just as devastating. Regardless of the type of trauma, these types of shocking and threating events can rupture the sense of safety people need to be able to engage with the world (Janoff-Bulman, 1992), a loss that can leave them feeling vulnerable, abandoned, and alone.

In today's world, the majority of adults have been exposed to a traumatic event during their lifetime (Kilpatrick et al., 2013). More than 1 in 4 children in the United States experiences or witnesses interpersonal violence in their lifetime (Finkelhor et al., 2009). More than 1 in 3 women and more than 1 in 4 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). More than 2 in 5 Americans live in counties hit by climate disasters in 2021 including fires, floods, hurricanes, landslides, and/or severe storms (Kaplan and Ba Tran, 2022).

Studies examining trauma exposure among Black males suggest that as many as 62% have directly experienced a traumatic event and 72% have witnessed a traumatic event (Motley and Banks, 2018). Approximately 34% of Latino immigrant parents have experienced trauma (Perreira and Ornelas, 2013) and post-traumatic stress disorder (PTSD), a mental health condition that can occur in people who have experienced traumatic events. PTSD has been described as "one of the most serious mental health problems" faced by American Indian/Alaska Native populations (Bassett et al., 2014). Similarly at high risk are individuals who identify as lesbian, gay, bisexual, transgender, or queer, who experience trauma at higher rates than the general population (Livingston et al. 2020), and veterans, who are more likely to suffer from trauma-related injuries and mental health disorders than people who have never served in the armed forces (Vespa, 2020).

And all of this was before the COVID-19 pandemic that, at the time this report was written, has killed over 950,000 Americans and left families and communities reeling from the trauma of lost jobs, lost connections, and lost loved ones. As we approach two years of lockdowns, travel restrictions, school shutdowns, and business closures, the long-term impact of this trauma remains unknown.

We know, however, that the impacts of trauma can last for years, even decades, and have a significant negative impact across the life course. Trauma and PTSD have been associated with cardiovascular and lung disease, gastrointestinal disorders, musculoskeletal disorders, endocrine disorders, reproductive disorders, and an increased risk for dementia and HIV (D'Andrea et al., 2011; de Oliveira Solis et al., 2017; Jankowski, 2019; McFarlane, 2010; Mohlenoff et al., 2017; Rouxel et al., 2016; Wyatt et al., 2002; Yaffee et al., 2010).

Adverse childhood experiences (ACEs) such as child abuse and neglect have been linked to mental health conditions and heart disease, reduced educational attainment, lack of health insurance, and unemployment, all of which affect health and well-being over the life course (Felitti et al., 1998). Easton and Kong (2021) found that children who witness domestic violence or experience physical abuse are at greater risk for re-experiencing elder abuse six to seven decades later, and at least five of the ten leading causes of death have been associated with exposure to adverse childhood experiences (Merrick et al., 2019).

We also know that trauma does not have to be experienced directly to have an impact. Studies of intergenerational trauma, for example, have found impaired self-esteem, anxiety, nightmares, and difficulties in interpersonal relationships in the children of Holocaust survivors, with similar issues being noted in the children of Vietnam veterans (Yehuda and Lehrner, 2018). Historical trauma – "trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance," can lead to an increased vulnerability to diminished psychological health in later generations (Mohatt et al., 2014). Among African Americans, for example, the experience of slavery, segregation, and institutionalized racism has contributed to physical and psychological trauma (United States Administration for Children and Families). Members of the disability community, who have historically been subjected to everything from biases to forced sterilizations and institutionalization, may also be vulnerable to the effects of historical trauma (United States Administration for Children and Families).

1.3 TRAUMA AND OLDER ADULTS

Taken together, the interwoven impacts of individual, intergenerational, and historical trauma can pose a dramatic risk factor to the health and well-being of older adults. For example, Holocaust survivors, all of whom are older trauma survivors, have been shown to be at increased risk for heart disease, diabetes, vascular dementia, bone issues, foot problems, dental problems, depression, anxiety, sleep disorders, impaired vision, cancers, and difficulties performing activities of daily living (Kover, 2014; Van Pelt, 2013; Paratz and Katz, 2011). Easton et al. (2019) found that men who were sexually abused in childhood experienced higher levels of depressive symptoms in their fifties, sixties, and seventies compared to men without that history. Kronemyer (2021) and Bruefach et al. (2021) both found that exposure to child abuse and neglect was associated with higher rates of depression among older adults during the COVID-19 pandemic. Gerber et al. (2020) similarly warn that veterans with preexisting trauma histories are at increased risk for being retraumatized by the pandemic. In Israel, restrictions placed on social interactions at the start of the COVID-19 pandemic triggered early life losses for some care home residents, many of whom are Holocaust survivors (Jamieson and Didyk, 2021).

At the same time, normal changes associated with aging, such as retirement, the loss of family and friends, and declining health 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., 2021; Ladson and Bienenfeld, 2007; Paratz and Katz, 2011). There is also growing evidence of a link between trauma, PTSD, and dementia. Veterans with PTSD have a nearly two times higher risk of developing dementia compared to those without PTSD (Mohlenoff et al, 2017; Yaffe et al., 2010), and dementia is associated with the re-emergence of PTSD symptoms. Chopra (2018) describes case studies of older adults who experienced PTSD for the first-time decades after their initial trauma, and Janssen (2018) notes that an older adult with dementia who was assaulted years before may respond to the gentle grab of a wrist by a health care provider as though the assault was occurring in the present, having no awareness that their reaction is being triggered by the original trauma.

But even with all this, aging services providers often don't recognize the signs or symptoms of trauma in older adults (McCarthy and Cook, 2018). Janssen (2018), for example, notes that the interconnection between PTSD and dementia is often unrecognized by staff in residential care facilities, and that even professionals who are aware of the prevalence and symptomology of PTSD may not appreciate its potential impact. At the same time, older adults with traumatic pasts may be hesitant to seek help, or to disclose a history of trauma. They may also minimize their symptoms, blame themselves for what happened to them, or be reluctant to acknowledge trauma-related issues because of perceived stigma (Chopra, 2018; McCarthy and Cook, 2018). Older people with histories of trauma are therefore often misdiagnosed, and receive inappropriate treatments and medications (Key, 2018; McCarthy and Cook, 2018). Older residents of long-term care facilities, for example, are vulnerable to being labeled as difficult if they display trauma-related behaviors or emotions that are misunderstood by staff (Key, 2018).

1.4 FAMILY CAREGIVING

Finally, it is important to note that it is not just older adults who are impacted by traumatic experiences as they age. It's their family caregivers as well. Family caregivers of older adults with a history of trauma can find themselves having to manage the sudden onset of trauma-related behaviors and symptoms in their loved ones. They may have to cope with the re-emergence and/or exacerbation of trauma-related emotions and behaviors as an older person they are caring for experiences the normal changes of aging. Family caregivers of veterans with PTSD, for example, can feel like they live "in an atmosphere of constant chaos…" (National Center for PTSD, 2022). All of this can result in increases in anxiety, depression, hypervigilance, and social isolation among caregivers.

At the same time, family caregivers of older adults with a history of trauma may have to deal with expectations of betrayal in relationships or fears of intimacy in their loved ones. They are often on high alert looking out for, and trying to avoid, reminders or triggers of past traumas that may retraumatize their loved ones. Family caregivers often are called on to manage the fears, anxieties, and distrust associated with health care settings and medical care, often resulting in them taking on more medical tasks themselves.

They are also likely to face the challenges of caring for someone with dementia. Compared with caregivers of people without dementia, twice as many caregivers of those with dementia indicate substantial emotional, financial, and physical difficulties, and evidence suggests that the stress of providing dementia care increases caregivers' susceptibility to disease and health complications (Alzheimer's Association, 2022).

1.5 PERSON-CENTERED, TRAUMA-INFORMED CARE

Fortunately, growing awareness about the prevalence and impact of trauma on individuals, families, generations, racial, ethnic, and sexual minority groups, and society as a whole has led to the emergence of 'trauma-informed' approaches to support those impacted by trauma. According to the Substance Abuse and Mental Health Services Administration (2014), a trauma-informed organization is one in which all people at all levels realize the impact of trauma on individuals and groups, recognize the signs of trauma and respond by applying trauma-informed principles throughout the organization, and actively seek to avoid re-traumatizing clients and staff. Safety, trust, transparency, peer support, collaboration, empowerment and choice, and respect for cultural, historical, and gender issues are infused throughout the organization. Such trauma-informed approaches have been called the 'universal precautions' of the social service world (Hodas, 2006), and are increasingly associated with improved client outcomes and reduced health and social service costs (Key, 2018; Menschner and Maul, 2016).

For older adults, person-centered, trauma-informed (PCTI) care has emerged as an innovative approach that incorporates knowledge about trauma into health and social services as a way to promote the health and well-being of older clients (Eisinger and Bedney, 2018). Coined by the ACL, defined by JFNA, and codified in the 2020 reauthorization of the Older Americans Act, PCTI care combines the core principles of person-centered care – empowerment and choice – with SAMHSA's principles of trauma-informed care. PCTI programs, for example, allow clients to choose the services in which they want to participate and how they want to participate in them, and they promote a sense of safety and trust by delivering services on time and in a culturally sensitive manner. They create operational spaces that promote a sense of physical and emotional safety among clients, visitors, and staff; they train their staff on the prevalence and impact of trauma and on behaviors associated with a history of trauma; and they actively seek to prevent re-traumatization and to re-establish a sense of safety among their clients should re-traumatization occur (Bedney et al., 2020). Unexplained and potentially invasive procedures (even 'routine' procedures such as filling out intake and assessment forms), loud noises, and other stimuli that could remind their clients of previous traumatic events are minimized to the greatest extent possible.

At the same time, extra care is taken to avoid triggers known to be particularly acute for different vulnerable populations. For Holocaust survivors, for example, this means knowing how to sensitively approach routine

tasks such as bathing and medical care, which can trigger traumatic memories and emotions associated with experiences during the Holocaust (Sherman, 2014). Unfamiliar showers in a hospital, for example, can challenge a survivor's sense of safety because gas chambers were disguised as showers during the Holocaust. For other Holocaust survivors, medical care can trigger distressing memories of the brutal medical experiments conducted during the Holocaust (Van Pelt, 2013). To avoid re-traumatization, caregivers and service providers must create an environment that ensures the survivor feels safe and in control.

For older adults who grew up in abusive homes it may mean understanding why they become anxious or withdrawn by the sound of people arguing or images of violence. For older LGBTQ individuals it may mean creating safe spaces with welcoming language that promotes safety and inclusion. And for older veterans it may mean limiting exposure to images of destruction, violence, and war. A PCTI organization infuses these principles into every aspect of organizational functioning as a way to promote the well-being of their clients, staff, and volunteers. To do so requires organizational capacity, including awareness, knowledge and skills, funding, partnerships, and infrastructure support. The goal of JFNA's Center is to help provide the nation's aging service providers with these resources.

1.6 THE JFNA CENTER ON HOLOCAUST SURVIVOR CARE AND INSTITUTE ON AGING AND TRAUMA

The United States Administration for Community Living is the federal leader in promoting the health, well-being, and independence of America's older adults, individuals with disabilities, and family caregivers. In 2015, ACL awarded a grant to JFNA to build the capacity of aging services organizations to provide PCTI care to Holocaust survivors. JFNA is an umbrella organization of 146 Jewish Federations and 300 network communities that provide a range of social services to older adults, Holocaust survivors, individuals with disabilities and their families, family caregivers, and economically vulnerable populations of all faiths and backgrounds. In 2020, ACL awarded JFNA a new grant that included the same goals as the first but expanded the target population to additional groups of older adults with a history of trauma such as veterans, victims of crime and natural disaster, and members of racial, ethnic, and sexual minority older populations as well as their family caregivers. This grant is implemented by JFNA's Center, which 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 through the awarding of sub-grants to agencies to implement and evaluate innovations in PCTI care such as programs for socialization, mental health, health and wellness, cognitive health, family caregiver support, and PCTI training. Through this grant, participating agencies

implemented more than 300 PCTI interventions, served over 31,000 Holocaust survivors, trained over 15,000 professional service providers and volunteers, and supported over 5,000 family caregivers. Evaluations of these programs show their ability to reduce social isolation and improve the physical and mental health and well-being of Holocaust survivors 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 publications, presentations, webinars, training workshops, and dissemination of information and 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 demographics and impact of trauma in the lives of older adults and the importance of the PCTI approach. The Center has offered webinars and 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 diverse 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 by the Center on a website that serves as a national resource hub on PCTI care.

As part of the second goal, the Center conducted the National Survey on Person-Centered, Trauma-Informed Care. This national study provides information on the state of PCTI care capacity among aging services providers and evaluates the Center's impact on increasing this capacity. The results of that survey are the basis for this report.

1.7 READING THIS REPORT

This report is composed of seven sections. The first section, or introduction, provided an overview of the topics of aging, trauma, family caregiving, the PCTI approach, and the Center's work. The second section describes the methodology of the study, including the research questions, data collection tools, data analysis strategies, description of participating organizations, and study limitations. The third section includes detailed quantitative and qualitative analyses of the data as they relate to the study's research questions on PCTI care awareness, capacity, and benefit, as well as Center impact. The fourth section includes a review of the implications of the data analyses for each of the study's research questions. The fifth section of the report includes a list of recommendations for aging services providers based on the findings of the survey. The report concludes with the sixth and seventh sections which include, respectively, a list of references and an appendix of tables with supporting data. Each finding and graph presented in the body of the report has a corresponding data table in the appendix.

Numbers presented in the body of this report are rounded to the nearest whole number, and numbers presented in the appendix are rounded to the nearest hundredth. Due to this, numbers may not reflect absolute figures and may not add up to the totals provided.

It is our hope that this report will spur greater awareness about the prevalence and impact of trauma on older adults, benefits of PCTI care, current gaps in access to PCTI care among diverse and underserved populations, and the action steps care providers can take to improve the health, well-being, and quality of life of older adults with a history of trauma and their family caregivers.

2 METHODOLOGY

2.1 RESEARCH QUESTIONS

The goal of the National Survey is to understand the capacity of aging services organizations to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers, and to track increases in capacity over time as a result of Center activities.

The National Survey had four research questions:

Research Question 1: What is the level of **awareness** among aging services organizations about the role of trauma in the lives of older adults, and about the PCTI approach?

Research Question 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?

Research Question 3: What do aging services organizations see as the **benefit** of providing PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers?

Research Question 4: What is the **impact** of the Center's work on the ability of aging services organizations to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers?

2.2 SURVEY DESIGN AND DISTRIBUTION

The research questions were examined through an online survey combining the use of qualitative and quantitative data, as well as subjective and objective metrics. This survey was designed through a rigorous and iterative process shaped by the Center's expertise in PCTI care and PCTI evaluation, as well as the feedback of the Center's Aging & Trauma Work Group. This group includes organizations serving American Indian and Alaska Native, Asian American, Black and African American, first responder, Latin American, LGBTQ, refugee, and veteran older adults. Members of the Aging & Trauma Work Group helped guide the language used in the survey tool, ensuring that the survey was inclusive, engaging, and welcoming to diverse organizations and communities. After the survey indicators and questions were finalized, the survey was developed through an online survey platform, pilot tested, and disseminated. The survey was pilot tested by JFNA staff and Aging & Trauma Work Group members who completed test submissions to check the survey's flow, function, and content. A copy of the full survey can be found in the appendix of this report.

The survey was distributed through a robust strategy which included email and personal outreach to partner and peer organizations, current and past subgrantees of the Center, and various professional organization contacts acquired through the Center's distribution lists. The survey was also distributed by ACL.

To ensure that responses to the survey were representative and avoided bias, several measures were put in place. First, responses to the survey were kept anonymous. This aided in creating a psychologically safe environment where respondents could be open and honest about their organization's awareness and capacity to provide PCTI care. Second, the survey was short, taking approximately 15 minutes to complete, and designed to optimize the respondent's experience. Third, incentives were not provided to respondents to complete the survey. The survey was open for public response for three months (between February and April of 2021) to provide organizations enough time to respond given the COVID-19 pandemic.

2.3 MEASURES

2.3.1 DEMOGRAPHICS

Data was collected about demographics of each participating organization. This data included geographic location, service area, staff size, religious affiliation, sector, funding type, service type, and service demographics. This data enabled analysis of the relationship between organization characteristics and variance in organizational performance across research questions.

2.3.2 VARIABLES

Research Question 1: Awareness of Aging, Trauma, and PCTI Care

For the purpose of the survey, PCTI care awareness was defined as an organization's recognition of the PCTI care model and knowledge of aging and trauma. Thus, awareness of PCTI care was measured using two variables:

(1) Self-reported organizational awareness of PCTI care prior to the survey
(2) Self-reported organizational knowledge on topics of aging and trauma

The first variable was assessed through a quantitative question in which all survey respondents were asked whether their organization was aware of PCTI care prior to receiving the survey. Since the survey itself could introduce organizations to PCTI care, it was important to capture organizational awareness of PCTI care before the launch of this survey. Complementing data on organizational awareness of PCTI care, the second variable explored to what degree organizations were knowledgeable of the topics of aging and trauma. To assess the second variable, respondents were asked to quantitatively rate their organization's level of understanding of how trauma impacts aging on a five-point Likert scale (none, low, moderate, high, very high). The knowledge on topics of aging and trauma includes insight into the links between trauma exposure and the aging process, health outcomes, dementia progression, and so on.

Research Question 2: Capacity to Provide PCTI Care

For purposes of the survey, PCTI care capacity was defined as the ability to make available, and/or provide PCTI care to care recipients. The questions that assessed PCTI care capacity were quantitative in nature and produced both objective and subjective measures of organizational PCTI care capacity. PCTI care capacity included five variables:

(1) Self-reported organizational capacity to provide PCTI care to older adults with a history of trauma
(2) Self-reported organizational capacity to provide PCTI care to family caregivers of older adults with a history of trauma
(3) Self-reported organizational PCTI care availability across client demographics
(4) Self-reported organizational PCTI care capacity across client demographics
(5) Objective organizational capacity to provide PCTI care to clients

The first variable on the self-reported capacity of organizations to provide PCTI care to older adults with a history of trauma was explored through one question. In the survey, respondents were asked to quantitatively rate their organization's capacity to provide PCTI care to older adults with a history of trauma on a five-point Likert scale (none, low, moderate, high, very high). A similar question was asked for the second variable on the self-reported capacity of organizations to provide PCTI care to family caregivers of older adults with a history of trauma. To assess this variable, respondents were asked to quantitatively rate their organization's capacity to provide PCTI care to family caregivers of older adults with a history of trauma on a five-point Likert scale (none, low, moderate, high, very high).

The third and fourth variables related to the variability of PCTI care across client demographics were asked through three quantitative questions whereby respondents were asked to explore their organization's service across 13 vulnerable older adult client populations. These populations included sexual, ethnic, and racial minorities (African American or Black; American Indian, Native Hawaiian, or Native Alaskan; Asian American; Latin Americans; and LGBTQ older adults), survivors of violence (crime survivors, Holocaust survivors, and sexual and domestic violence survivors), survivors of disasters, individuals working professions with high rates of trauma exposure (first responders, and veterans), immigrants or refugees, and individuals with disabilities.

First, respondents were asked to select all client demographics for which they currently provide service out of the 13 client populations. Second, respondents were asked to select all client demographics for which their currently provide PCTI care out of the 13 client populations. And finally, respondents were asked to rate their organization's capacity to provide PCTI care across all 13 client demographics. These questions provided insight into the variability of PCTI care across client demographics, both in terms of PCTI care availability and PCTI care capacity. The rate of PCTI care availability and capacity provide insight into both the likelihood for specific populations to have access to PCTI care, as well as the depth of the PCTI care provided.

Complementing this set of questions, the fifth variable examined an organizations' objective PCTI care capacity as assessed through the Center's Organizational PCTI Care Capacity Assessment Tool. The Organizational PCTI Care Capacity Assessment Tool was developed for the purposes of the survey and provides insight into organizations' commitments and relationships required for successful PCTI care implementation. The tool equally weighs all demonstrated capacity components (detailed below) to provide a holistic review of an organization's active capacity to provide PCTI care. This complements an organization's subjective PCTI care capacity as it provides a quantitative assessment that can be compared against subjective ratings.

The tool is grounded in organizational capacity literature (Children's Bureau Capacity Building Collaborative, 2018; United States Substance Abuse and Mental Health Services Administration, 2014) and reviews an organization's performance across 15 indicators of PCTI care capacity in 5 core capacity categories – resource, infrastructure, knowledge and skill, organizational climate, and partnership. Within each of the capacity categories, there are three indicators to assess an organization's demonstrated performance.

Capacity Category 1. Resource Capacity

To have PCTI care capacity, an organization must ensure it can finance, staff, and materially support PCTI care. The three indicators measuring PCTI care capacity in this category are **staff resources** (e.g., number of staff, skill level), **material resources** (e.g., facilities, equipment), and **financial resources** (e.g., financial assets, in-kind contributions).

Capacity Category 2. Infrastructure Capacity

To have PCTI care capacity, an organization must ensure alignment between PCTI care principles and the policy and physical environment of the organization. Alignment with the policy environment of an organization ensures that PCTI principles are integrated and prioritized into the organization's formal mission, systems, procedures, and protocols. Alignment with the physical environment ensures that PCTI principles guide the design of physical spaces to protect both physical and psychological safety of clients and staff. This alignment creates an organizational infrastructure strong enough to support PCTI care delivery. The three indicators measuring PCTI care capacity in this category are **mission alignment** (e.g., written goals establishing PCTI care as an essential part of the organizational mission), **systems, procedures, and protocols** (e.g., operational policies or guidelines for providing PCTI care), and **physical environment** (e.g., spaces are welcoming and promote a sense of safety, community, and connection).

Capacity Category 3. PCTI Knowledge and Skill Capacity

To have PCTI care capacity, an organization's staff must have technical knowledge, skill, and expertise in both the fields of change management and PCTI care. The three indicators measuring PCTI care capacity in this category are **change management skills** (e.g., leadership and communication skills required to usher organizational changes), **PCTI program implementation skills** (e.g., ability to provide PCTI cognitive therapy, socialization activities), and **availability of PCTI training** (e.g., onboarding on PCTI care, continuing education on PCTI care).

Capacity Category 4. Organizational Climate Capacity

To have PCTI care capacity, an organization staff and leadership must prioritize and galvanize around a shared commitment to PCTI care through active engagement in PCTI programming, training, and activities. The three indicators measuring PCTI capacity in this category are **staff commitment** (e.g., participation in trainings, embody PCTI care through action), **leadership commitment** (e.g., prioritization of PCTI care throughout the organization, support of PCTI care initiatives), and **PCTI care championship** (e.g., organization has an assigned staff member or working group to champion PCTI care).

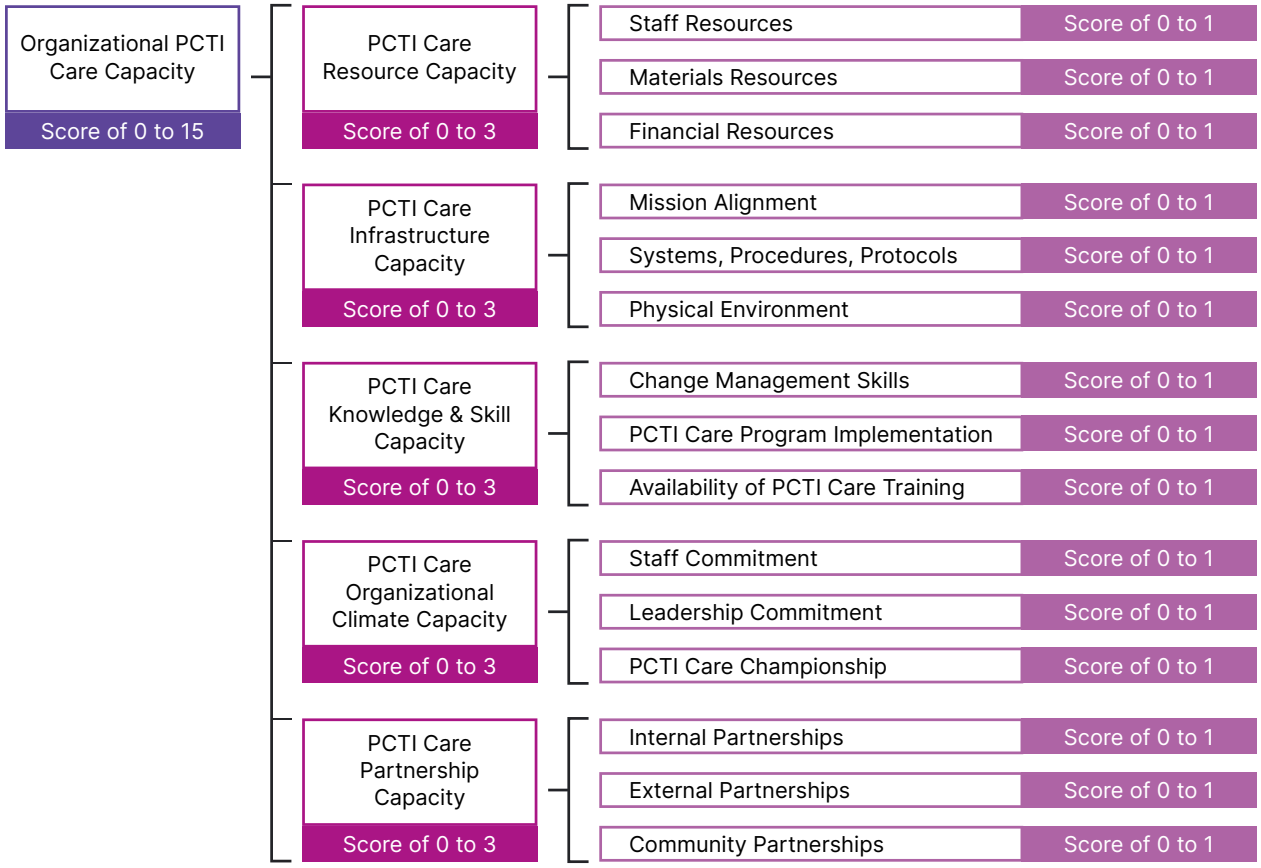
Capacity Category 5. Partnership Capacity

To have PCTI care capacity, an organization must have internal, cross-departmental partnerships, as well as partnerships with other organizations and the community. Providing PCTI care is seldom a solitary act. Instead, tailoring care based on an individual's preferences and history of trauma often requires internal teamwork, external referrals, and community engagement. The three indicators of PCTI care capacity in this category are **internal partnerships** (e.g., cross-departmental collaborations in support of PCTI care), **external partnerships** (e.g., partnership with other organizations serving older adults), and **community partnerships** (e.g., partnerships with older adults in the community).

In the survey, the PCTI care capacity assessment was administered through one question that asked respondents to select all actions that their organization has taken to build PCTI care capacity. This question included response options representing the 15 indicators of organizational PCTI care capacity detailed above. Results of this PCTI care capacity assessment are summarized numerically and through Likert-scale ratings. Responses are aggregated across the survey sample allowing objective organizational PCTI care capacity to be reviewed by capacity indicator, capacity category, or overall.

Numeric rating scales range between 0.00 and 1.00 for each capacity indicator, 0.00 and 3.00 for each capacity category, and 0.00 and 15.00 for overall PCTI care capacity. All number scores (whether for indicators, categories, or overall PCTI care capacity) correspond to five levels of capacity including none, low, moderate, high, or very high. This numeric and rating scale is summarized in the figure below.

Figure 1. Organizational PCTI Care Capacity Assessment Tool Structure



To avoid error, all questions related to PCTI care capacity variables were only asked of those respondents who indicated that their organization was aware of PCTI care prior to receiving the survey.

Research Question 3. Benefit of Providing PCTI Care

The benefit of providing PCTI care was measured through one variable:

(1) Organizational self-reported benefits of providing PCTI care

This variable was measured through a qualitative, open-ended question whereby respondents were asked how providing PCTI care impacts the older adults and family caregivers their organization serves. To avoid error, only those respondents whose organizations had heard of PCTI care prior to receiving the survey were asked about the impact of PCTI care on clients.

Research Question 4: Impact of Center Activities

The impact of the Center's PCTI care capacity building activities was measured through three variables:

(1) Self-reported origin of organizational PCTI care knowledge
(2) Self-reported use of Center resources
(3) Difference in PCTI care awareness and capacity by Center funding status

The first variable was measured through a qualitative, open-ended question whereby respondents were asked how their organization first learned about the concept of PCTI care. The second variable was measured through four questions. The first question was a quantitative, single-choice question where respondents selected 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, multiple-choice question where respondents selected all results of Center resource use (improved program quality, development of new programs, expansion of existing services, increased funding, none, other). The third and fourth were quantitative, Likert-scale question whereby respondents rated whether Center resources resulted in their organization's understanding about and capacity to provide PCTI care (strongly disagree, disagree, neutral, agree, strongly agree).

To avoid error, only those respondents whose organizations had heard of PCTI care prior to receiving the survey were asked questions regarding whether they used Center resources. Additionally, only respondents who indicated use of Center resources were asked the questions regarding the results of Center resource use. Use of Center resources is not contingent upon Center funding and does not include technical assistance provided through Center grants.

The third variable was assessed by comparing an organization's Center funding status against questions from the first and second research questions. Through a quantitative, single-choice question survey respondents were asked to identify whether their organization had ever received funding from Center. Funding status was then used to compare the PCTI care awareness and capacity between those organizations who have received Center funding and those organizations who had not. The differences found between respondent groups was used to assess the impact of the Center's PCTI care capacity building activities.

2.4 DATA ANALYSIS

After the response period was closed, submissions to the survey were downloaded and cleaned. Each survey submission was reviewed for accuracy, completeness, and eligibility (e.g., completed by a respondent outside the United States). In total, 201 survey submissions were received and six were omitted due to ineligibility. The remaining 195 responses form the data set upon which analysis was generated.

Quantitative data analysis was conducted using Microsoft Power BI, a business analytics software program. This program enables interactive exploration of data sets to determine both the distribution of the data set as well as the relationships among data points. Qualitative data analysis was conducted using a combination of framework and content analysis that produced quantitative codes which were analyzed using quantitative methods. As a result, both quantitative and qualitative data were analyzed using descriptive and inferential statistics.

The exploration of relationships within the data set were divided into two categories. First, relationships were explored between an organization's characteristics and its PCTI awareness and capacity. This included analysis of whether an organization's geographic location, service area, size, religious affiliation, sector, funding type, service type, and service demographics affected its PCTI awareness and capacity. Second, relationships were explored among variables of PCTI awareness and capacity. For example, analysis was conducted to determine whether an organization's PCTI awareness affected their PCTI capacity.

2.5 NATIONAL SURVEY SAMPLE

2.5.1 RESPONDENTS

While the survey sample (N=195) is smaller than expected, the sample is rich with data from a diversity of organizations and perspectives. In most organizations, the survey was completed by executive management such as a CEO, C-Suite Officer, or Vice President. Other respondents included, in descending order of frequency, director or manager-level staff, direct service provider staff, or other staff. Survey responses from executive management or directors provide great insight into the awareness and capacity of the organization to provide PCTI care. While perspectives may be different across positions, a respondent's position did not appear to be related to their organization's performance on the survey.

2.5.2 RESPONDENT ORGANIZATION CHARACTERISTICS

A. Geographic Spread and Service Area

Organizations from 37 states and territories, and 135 cities across the United States participated in the survey. This geographic range included Northeast, Southeast, Southwest, Midwest, Rocky Mountains, Pacific, and Noncontiguous United States. The highest density of responses was, in descending order, from New York (28 responses), Florida (15 responses), California (12 responses), and Texas (12 responses) (Appendix, Table 35). Sixty-three percent of respondents reported that their organization operated locally, 21% regionally, 10% nationally, and 4% statewide (Appendix, Table 36). There was no association between an organization's geographic location and their geographic service area.

B. Sector, Size, and Religious Affiliation

Most (87%) organizations that responded to the survey were non-profits. However, responses were also submitted by for-profit organizations (5%), and government-based organizations (7%) (Appendix, Table 37). Most (65%) organizations were small, with less than 100 staff. About one quarter (24%) were medium in size, having between 100 and 500 staff, and a small fraction (12%) were large (between 500 and 1000 staff) or very large organizations (more than 1000 staff) (Appendix, Table 38). The majority (67%) of organizations were not affiliated with any religion. Of those 33% of organizations that indicated religious affiliation, 69% noted Jewish affiliation and 28% noted Christian affiliation (Appendix, Table 39). Additionally, the sample includes responses from organizations affiliated with American Indian Tribes.

C. Service Type and Demographics

The sample included 20 different types of organizations. The largest group of organizations, or 41% of the sample, was social service agencies. This was followed by governmental Area or State Agencies on Aging, residential services and support organizations, and nursing homes. The sample also included legal service providers, foundations, advocacy organizations, transportation providers, and healthcare plans (Appendix, Table 40). Organizations responding to the survey served a diversity of demographics. Most commonly, organizations served the following five populations in descending order: older adults with disabilities, African American older adults, family caregivers of older adults, LGBTQ older adults, and veteran older adults. Most organizations sampled served multiple demographics (Appendix, Table 41).

D. Organization Funding Type

Organizations noted a combination of various funding sources. Forty-two percent of respondents received funding from Medicaid, 9% received funding from the U.S. Department of Veteran Affairs, and 28% received funding from the Center. Some respondent organizations received funding from more than one of these funding sources simultaneously (Appendix, Table 42).

These funding sources are important as they are associated with requirements related to type and depth of service provided. For example, the Centers for Medicare and Medicare Services (CMS) prioritizes the availability of trauma-informed care in all CMS facilities, and organizations receiving subgrants from the Center are required to implement their project through a PCTI approach. While the survey was sent to all former and current Center subgrantees, the survey sample was not disproportionately composed of subgrantees, and not all subgrantees provided a response.

2.6 LIMITATIONS

To fully understand the findings, it is important to keep in mind the limitations of this study. First, while the data provides a valuable source of information, the sample of 195 is too small to extrapolate or generalize findings from the survey to all aging services organizations in the United States. While there is no definitive count of aging services organizations in the United States, it is likely to be in the tens of thousands. However, the survey expands our knowledge on the state of organizational PCTI care and awareness.

While many factors could account for this low response rate, including an overall survey burnout, a key factor could have been that the survey was conducted during the COVID-19 pandemic. The survey may have benefitted from additional organizational responses if aging service providers were not already overwhelmed with the pressures and crises of serving older adults during COVID-19. At the time of this survey, aging services organizations had been dealing with the pandemic for approximately a year. Aging services organizations were confronted by an increased demand for their services, increased need of existing clients, and logistical challenges of adapting services to a virtual or modified setting. This resulted in high staff turnover and burnout rates which may have negatively skewed data points related to organizational PCTI care capacity. Many organizations did not have capacity to implement new service approaches during the pandemic, or to complete the survey. On the other hand, during the COVID-19 pandemic, issues of trauma, grief, loss, and isolation gained cultural significance. These facts may have affected the results of the survey.

All these factors should be considered when reviewing results of the survey. The survey serves as an initial understanding of the degree to which United-States-based aging services organizations are aware and capable of providing PCTI care for older adults with a history of trauma and their family caregivers. This study can and should be used to form the basis of future inquiry on the topic.

3

FINDINGS

The following section includes findings from the National Survey as they correspond to the study's four research questions.

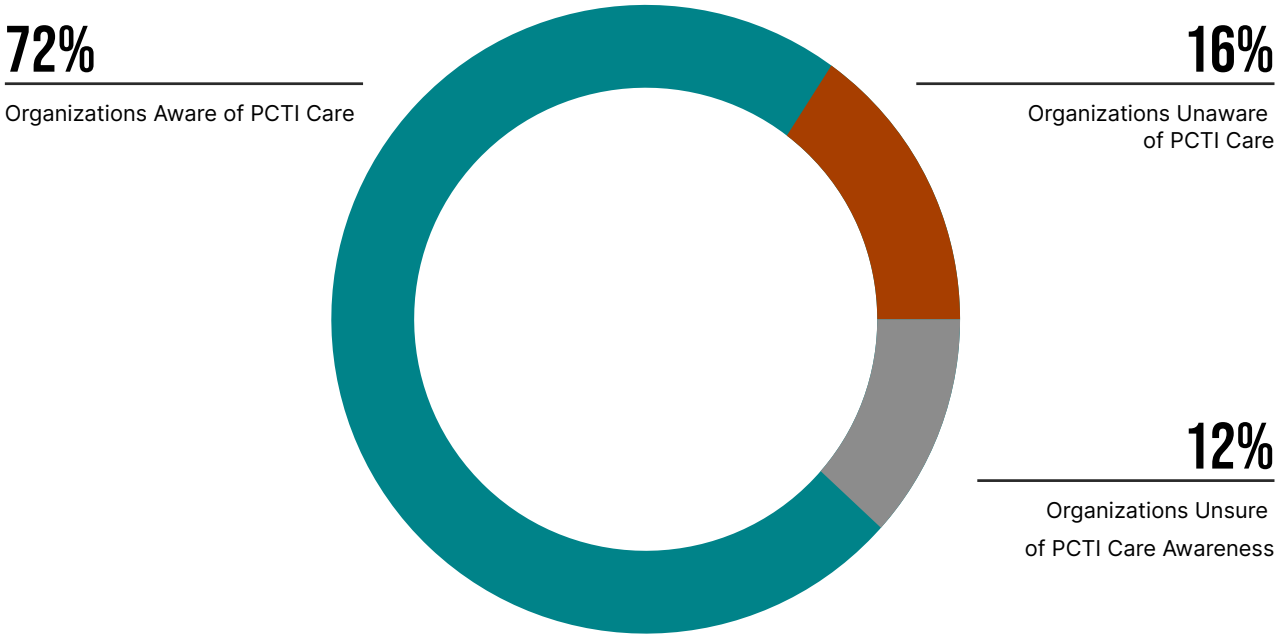
3.1 AWARENESS OF AGING, TRAUMA, AND PCTI CARE

Research Question 1: What is the level of **awareness** among aging services organizations about the role of trauma in the lives of older adults, and about the PCTI approach?

3.1.1 SELF-REPORTED ORGANIZATIONAL AWARENESS OF PCTI CARE

Overall, most survey respondents were aware of PCTI care. Seventy-two percent of survey respondents reported that their organization was aware of PCTI care before receiving the survey. Sixteen percent reported that their organization was not aware of PCTI care before receiving the survey, and 12% were not sure of their organization's PCTI care awareness.

Figure 2. Organizational Awareness of PCTI Care Prior to National Survey

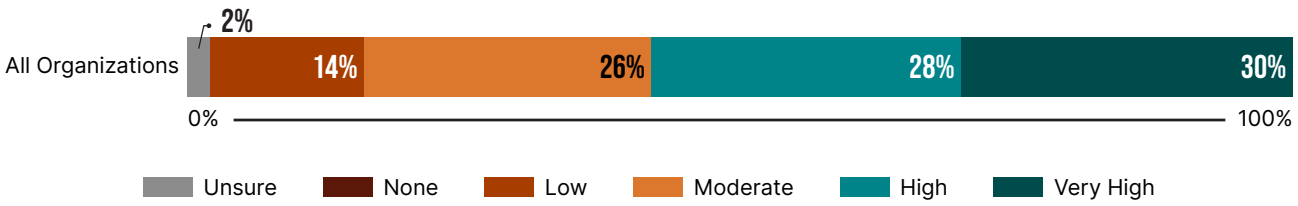


(Appendix, Table 43)

3.1.2 SELF-REPORTED ORGANIZATIONAL KNOWLEDGE OF AGING AND TRAUMA

Overall, a majority of survey respondents reported a deep understanding of aging and trauma. Fifty-eight percent of respondents noted that their organization has high or very high understanding of aging and trauma. Forty percent noted that their organization has medium or low understanding of aging and trauma, and 2% were unsure of their organization's degree of understanding of aging and trauma.

Figure 3. Organizational Knowledge of Aging and Trauma



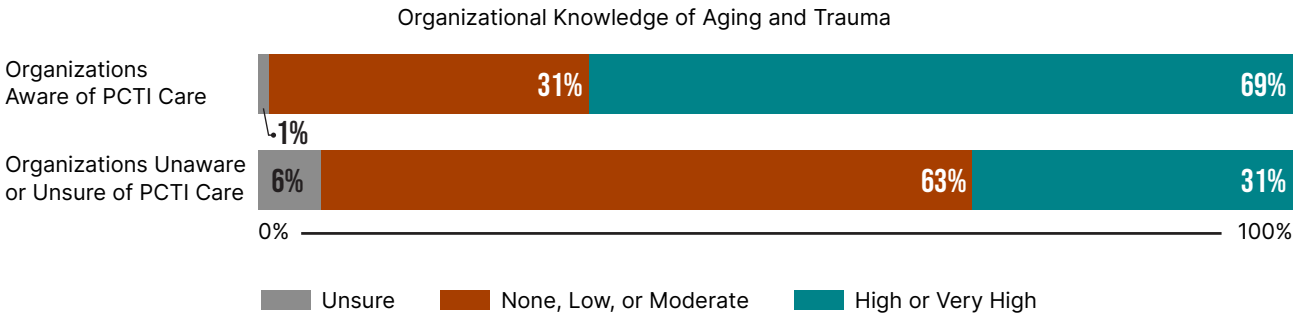
(Appendix, Table 44)

3.1.3 PCTI CARE AWARENESS RELATIONSHIPS

For many organizations, awareness of PCTI care and an understanding of aging and trauma was connected. Organizations that were aware of PCTI care were more likely to have a higher understanding of aging and trauma. Conversely, organizations which had a higher understanding of aging and trauma were more likely to be aware of PCTI care.

For example, of those organizations reporting awareness of PCTI care, 69% reported high or very high understanding of aging and trauma. Comparatively, of those organizations who were unaware or unsure of their awareness of PCTI care, 31% reported high or very high understanding of aging and trauma.

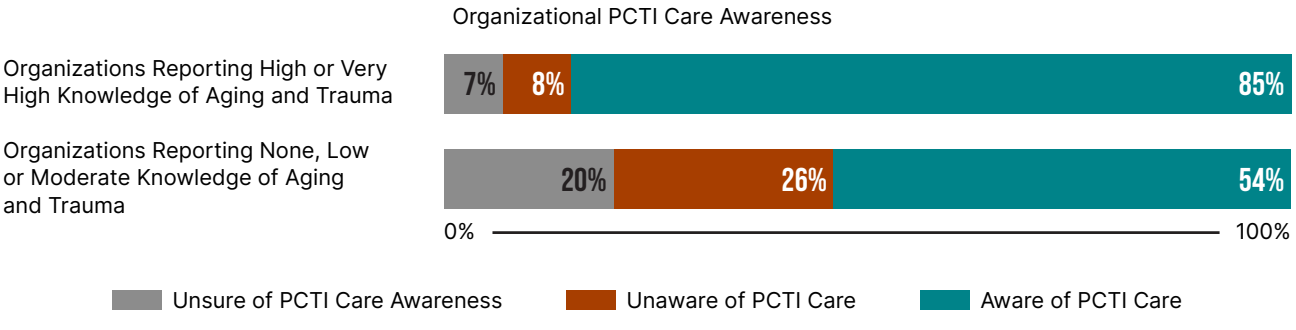
Figure 4. Organizational Knowledge of Aging and Trauma by Organizational PCTI Care Awareness



(Appendix, Table 45)

Additionally, of those organizations reporting very high or high understanding of aging and trauma, 85% reported PCTI care awareness. Comparatively, of those organizations reporting moderate, low, or no understanding of aging and trauma, 54% reported PCTI care awareness.

Figure 5. Organizational PCTI Care Awareness by Organizational Knowledge of Aging and Trauma



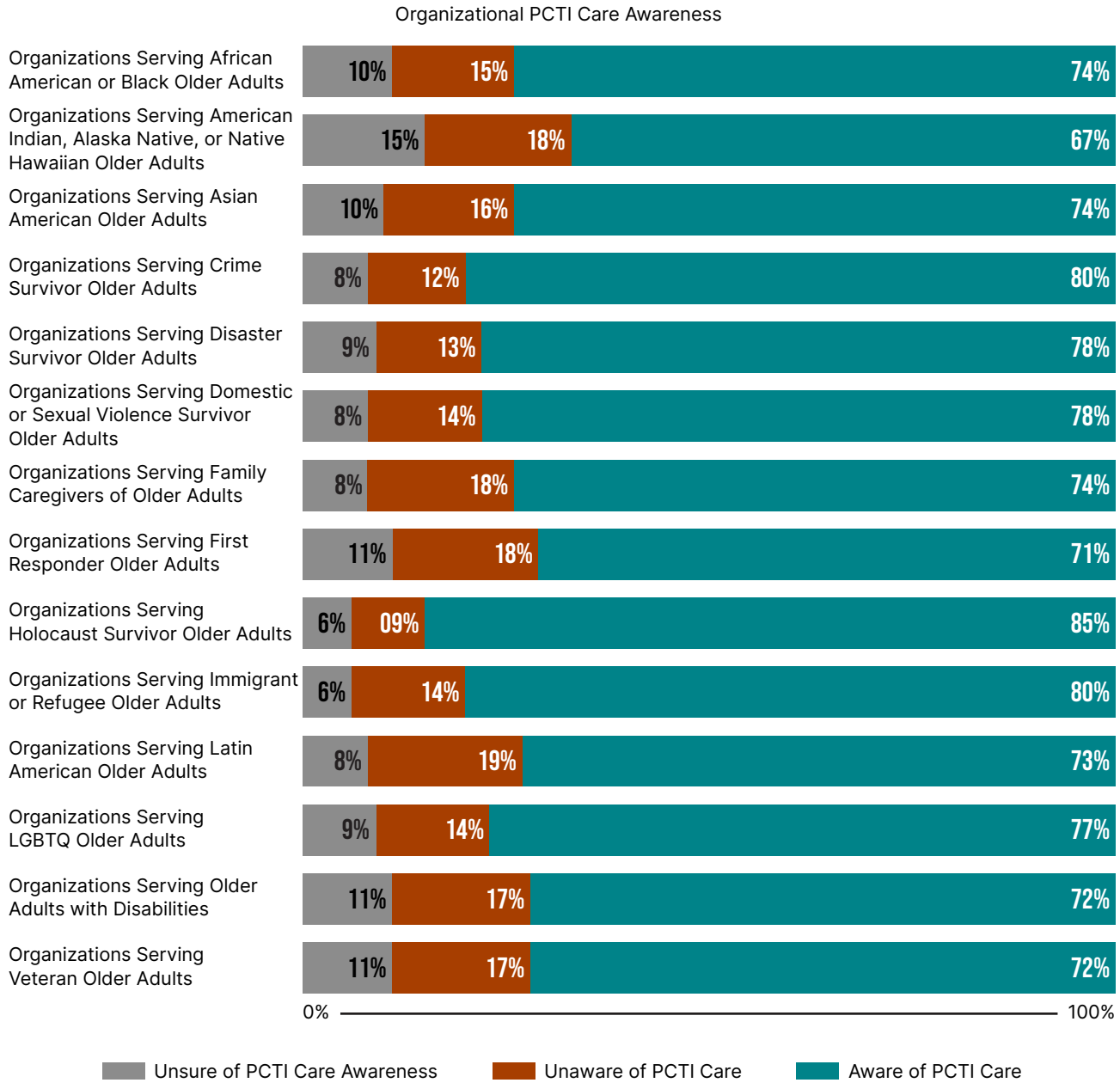
Organizations unsure of aging and trauma knowledge are grouped with those reporting moderate, low, or no knowledge on the topic.

(Appendix, Table 46)

Although awareness of PCTI care and knowledge of aging and trauma were linked, an organization's awareness of PCTI care and understanding of aging and trauma maynot have been directly linked to the organization's history of service for older adults with a history of trauma or family caregivers. In other words, an organization's service to older adults with a history of trauma or service to family caregivers did not appear to influence their PCTI care awareness or understanding of aging and trauma.

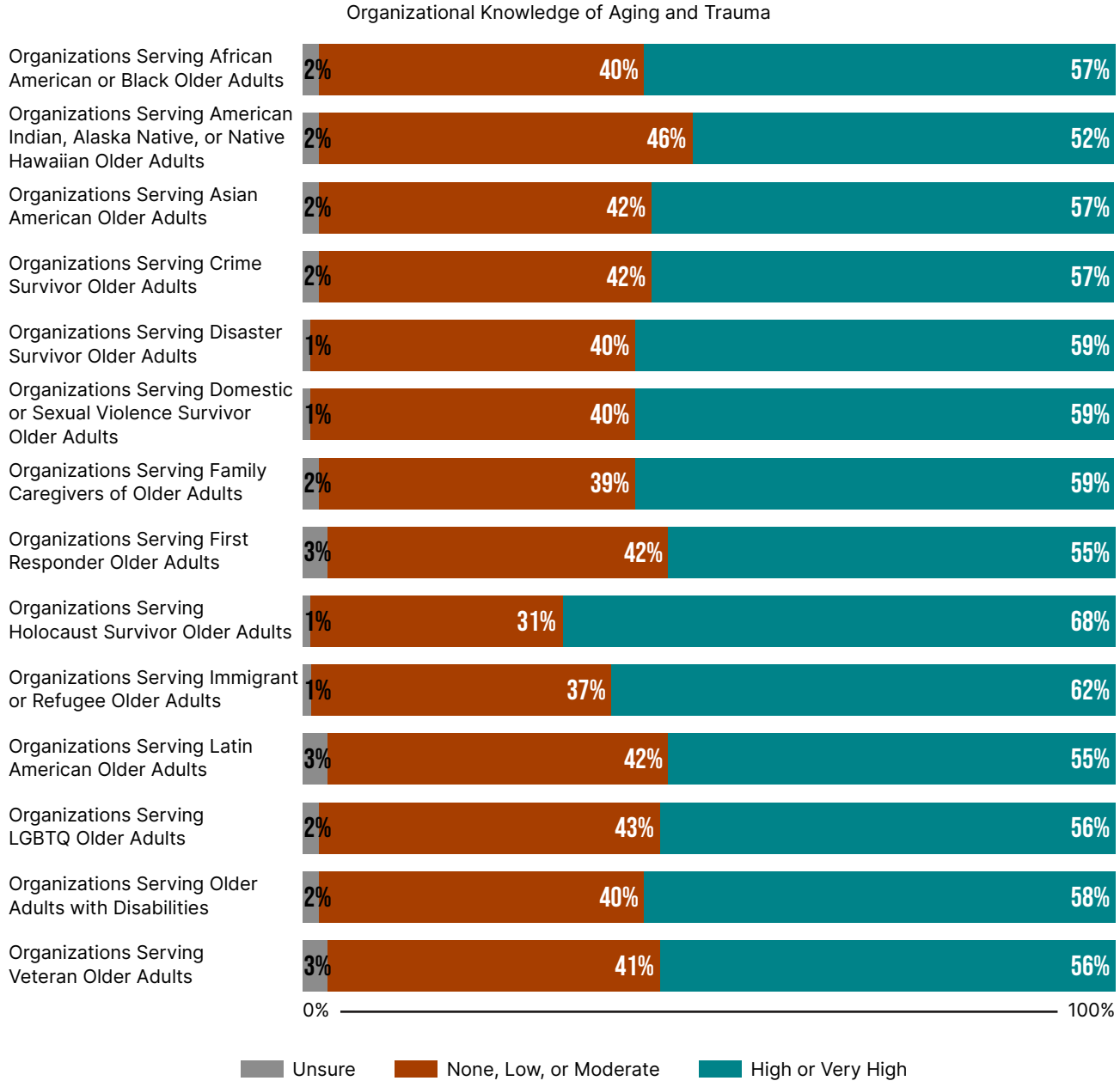
Of the 183 organizations in the survey sample who reported service to older adults with a history of trauma, their PCTI care awareness and understanding of aging and trauma was the same as the sample average. Similarly, of the 128 organizations in the survey sample who reported service to family caregivers, their PCTI care awareness and understanding of aging and trauma was like the sample average. This is relatively consistent when looking at each of the service demographics included in this study. The following figure shows organizational PCTI care awareness levels and aging and trauma knowledge disaggregated by an organization's service demographics.

Figure 6. Organizational PCTI Care Awareness by Demographics of Clients Served



(Appendix, Table 47)

Figure 7. Organizational Knowledge of Aging and Trauma by Demographics of Clients Served



(Appendix, Table 48)

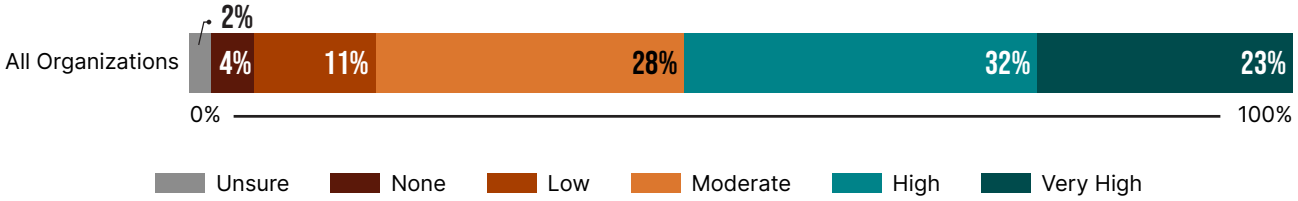
3.2 CAPACITY TO PROVIDE PCTI CARE

Research Question 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?

3.2.1 SELF-REPORTED ORGANIZATIONAL CAPACITY TO PROVIDE PCTI CARE TO OLDER ADULTS WITH A HISTORY OF TRAUMA

Overall, more than half of respondents noted that their organization had deep capacity to provide PCTI care to older adults with a history of trauma. Fifty-five percent of survey respondents reported that their organization had high or very high capacity to provide PCTI care to older adults with a history of trauma. Simultaneously, 43% of respondents noted that their organization had moderate, low, or no capacity to provide PCTI care to older adults with a history of trauma. Two percent of respondents were not sure about their organization's capacity.

Figure 8. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma

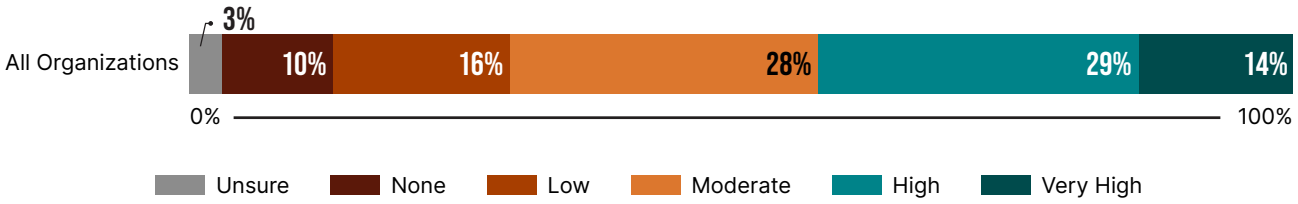


(Appendix, Table 49)

3.2.2 SELF-REPORTED ORGANIZATIONAL CAPACITY TO PROVIDE PCTI CARE TO FAMILY CAREGIVERS OF OLDER ADULTS WITH A HISTORY OF TRAUMA

Overall, less than half of respondents noted that their organization had deep capacity to provide PCTI care to family caregivers. Forty-three percent of respondents noted that their organization had high or very high capacity to provide PCTI care to family caregivers of older adults with a history of trauma. Simultaneously, 54% of respondents noted that their organization had moderate, low, or no capacity to provide PCTI care to family caregivers. Three percent of respondents were unsure about their organization's capacity.

Figure 9. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers

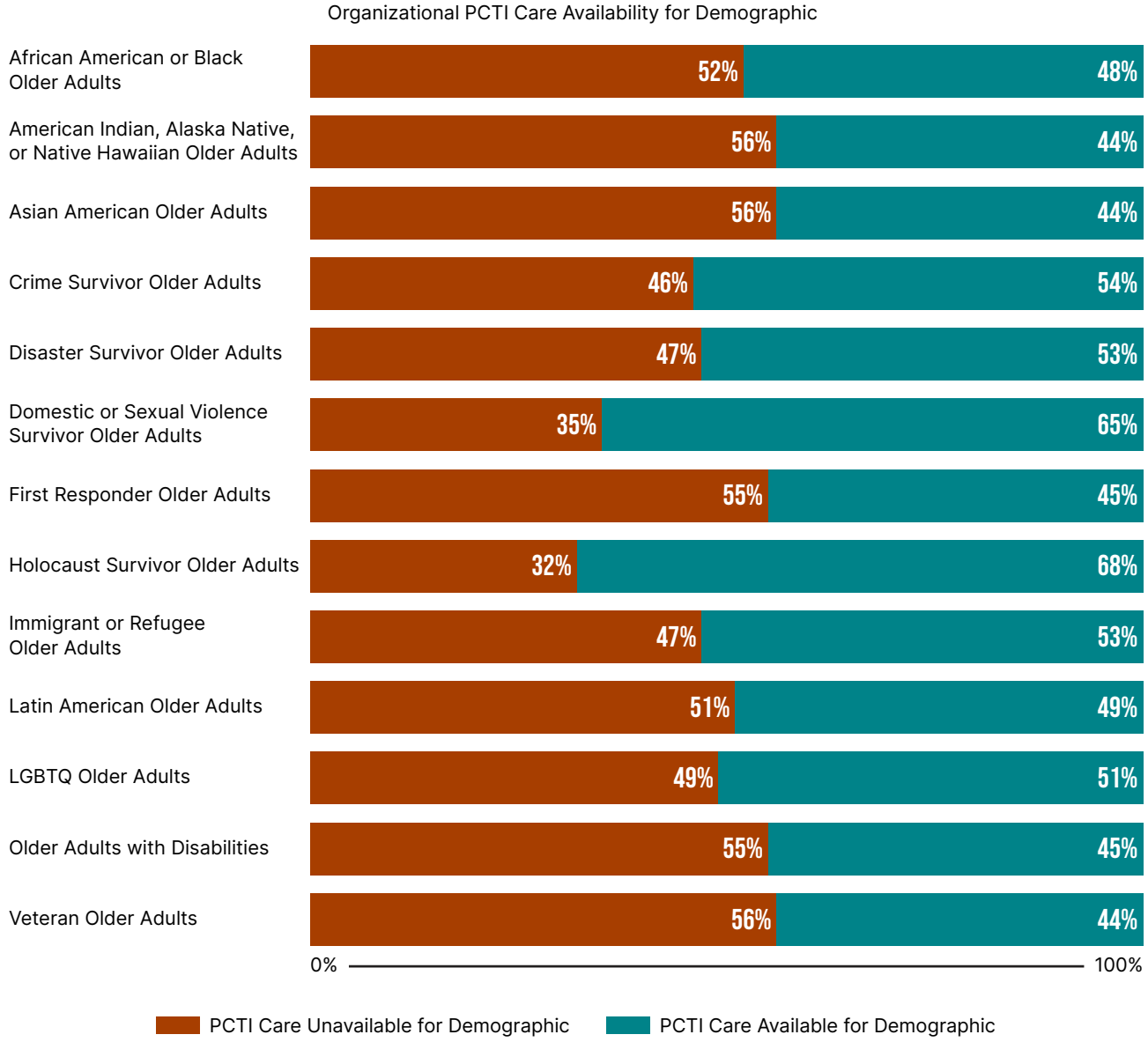


(Appendix, Table 50)

3.2.3 SELF-REPORTED ORGANIZATIONAL PCTI CARE AVAILABILITY ACROSS CLIENT DEMOGRAPHICS

PCTI care provided by aging services organization was unevenly distributed among client groups. The client demographics experiencing the highest rate of PCTI care availability include Holocaust survivors and older adult survivors of sexual and domestic violence. Sixty-eight percent of organizations working with Holocaust survivors, and 65% working with older adult survivors of sexual and domestic violence provided these clients with PCTI care. The client demographics experiencing the lowest rate of PCTI care availability include Asian American older adults; American Indian, Native Hawaiian, or Native Alaskan older adults; and veteran older adults. Forty-four percent of organizations working with Asian American older adults; American Indian, Native Hawaiian, or Native Alaskan older adults; or veteran older adults provided these clients with PCTI care. (See Figure 10 on the following page)

Figure 10. Subjective Organizational PCTI Care Availability Across Client Demographics

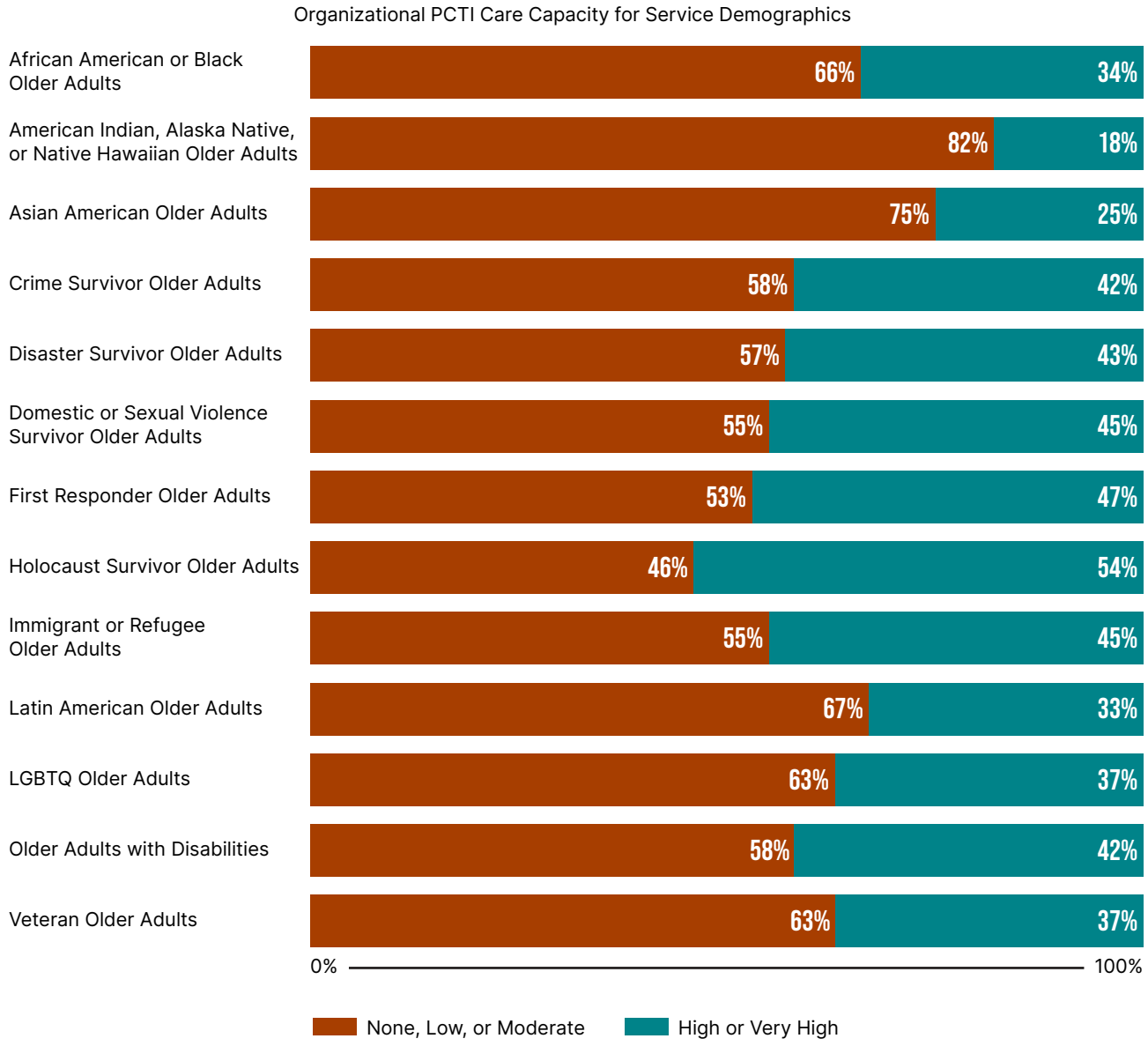


(Appendix, Table 51)

3.2.4 SELF-REPORTED ORGANIZATIONAL PCTI CARE CAPACITY ACROSS CLIENT DEMOGRAPHICS

Like service availability, the capacity of aging services organizations to provide PCTI care was unevenly distributed among client groups. The client demographic for which organizations reported the highest rate of PCTI care capacity were Holocaust survivors. Fifty-four percent of organizations working with Holocaust survivors reported a high or very high capacity to provide this client demographic with PCTI care. The client demographic for which organizations reported the lowest rate of PCTI care capacity is American Indian, Native Hawaiian, or Native Alaskan older adults. Eighteen percent of organizations working with American Indian, Native Hawaiian, or Native Alaskan older adults reported a high or very capacity to provide this demographic with PCTI care. (See Figure 11 on the following page)

Figure 11. Subjective Organizational PCTI Care Capacity Across Client Demographics



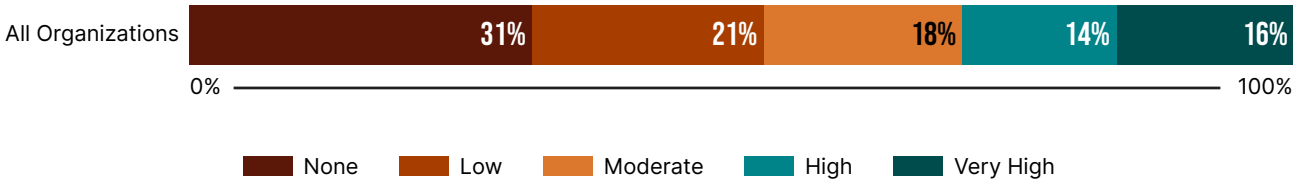
Organizations unsure of PCTI care capacity are grouped with those reporting moderate, low, or no capacity.

(Appendix, Table 52)

3.2.5 OBJECTIVE ORGANIZATIONAL CAPACITY TO PROVIDE PCTI CARE TO CLIENTS

Based on the Center's Organizational PCTI Care Capacity Assessment Tool, a small portion of aging services providers demonstrated objective capacity to provide PCTI care to clients. Approximately 30% of respondents displayed objective ratings of high or very high organizational PCTI care capacity.

Figure 12. Objective Organizational Capacity to Provide PCTI Care to Clients



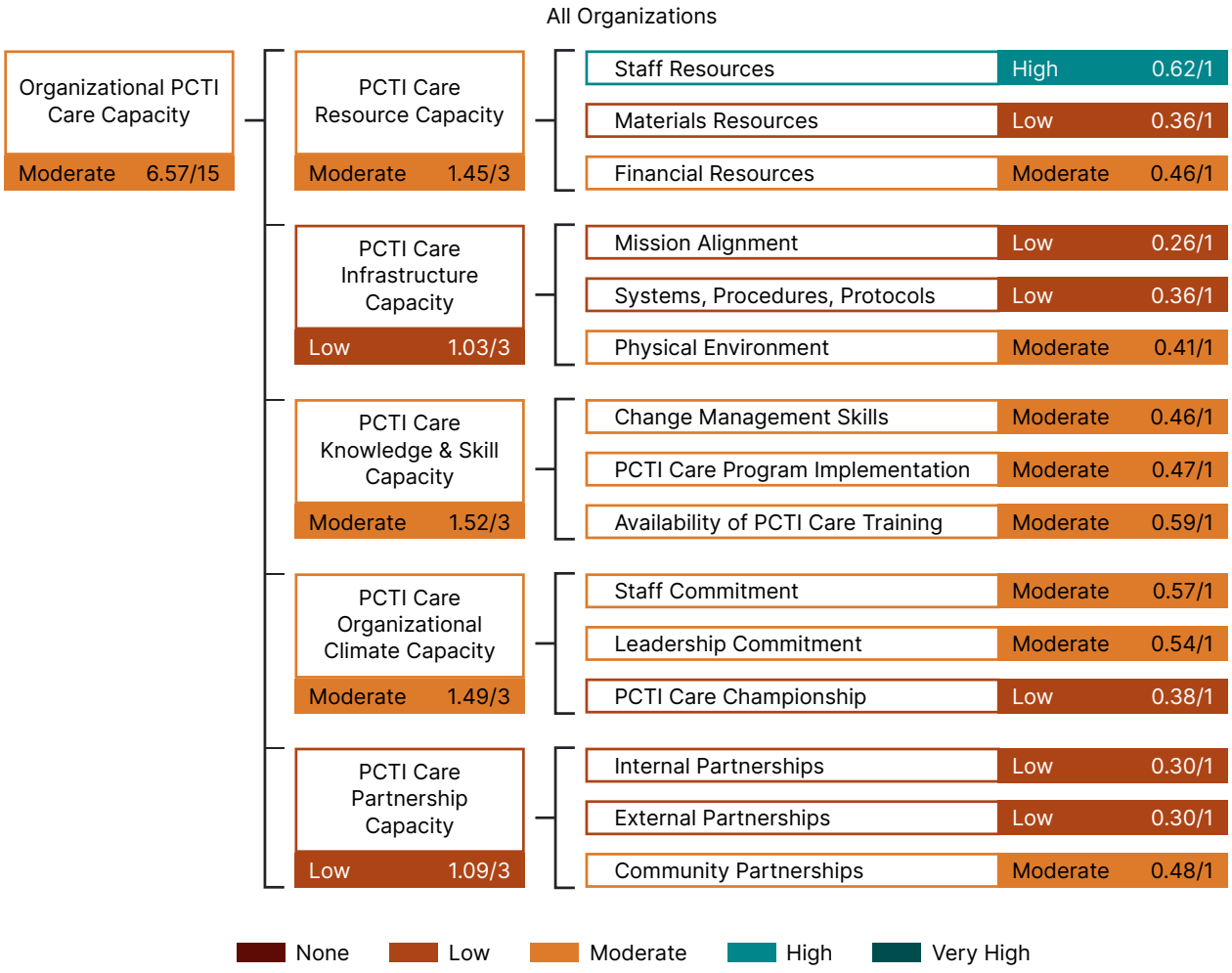
(Appendix, Table 53)

Although a portion of the National Survey sample displayed a high or very high objective capacity to provide PCTI care, the average rating of National Survey respondents was that of moderate organizational capacity to provide PCTI care to clients, with a score of 6.57 out of 15.00.

The overall organizational PCTI care capacity rating is composed of the ratings from the five capacity categories on the Center's Organizational PCTI Care Capacity Assessment Tool. Overall, organizations demonstrated low to moderate capacity across the five capacity areas. Organizations showed moderate capacity in the areas of resource, knowledge and skill, and organizational climate, and low capacity in the areas of infrastructure and partnership. All five capacity areas suggest room for future PCTI care capacity development.

Each of these capacity area ratings is composed of organizational performance on each of the 15 capacity indicators. Overall, respondent organizations displayed low to high capacity across the fifteen capacity indicators. Organizations showed the highest capacity in staff resources dedicated to the implementation of PCTI care. This demonstrates the commitment organizations have made to PCTI care implementation through the hiring, training, and allocation of staff to PCTI care initiatives. Simultaneously, organizations showed the lowest capacity in organizational mission alignment, highlighting the need for writing PCTI care principles into mission and vision statements, organizational objectives, or value statements.

Figure 13. Objective Organizational Capacity Scores and Ratings Across Capacity Categories and Indicators



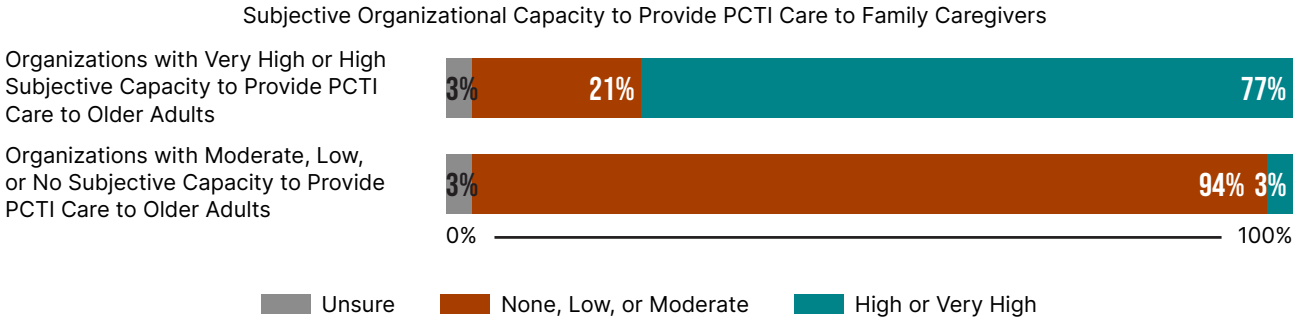
(Appendix, Table 54)

3.2.6 PCTI CARE CAPACITY RELATIONSHIPS

For many organizations, capacity to provide PCTI care for older adults with a history of trauma was linked to capacity to provide PCTI care to family caregivers. Organizations with high or very high subjective PCTI care capacity to serve older adults with a history of trauma were more likely to have high or very high subjective PCTI care capacity to serve family caregivers. Conversely, those organizations with high or very high subjective PCTI care capacity to serve family caregivers were more likely to have high or very subjective PCTI care capacity to serve older adults with a history of trauma.

For example, of those organizations reporting high or very high subjective PCTI care capacity to serve older adults, 77% reported high or very high subjective PCTI care capacity to serve family caregivers. Of those organizations reporting moderate, low, or no subjective PCTI care capacity to serve older adults, 3% reported high or very high subjective PCTI care capacity to serve family caregivers.

Figure 14. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma

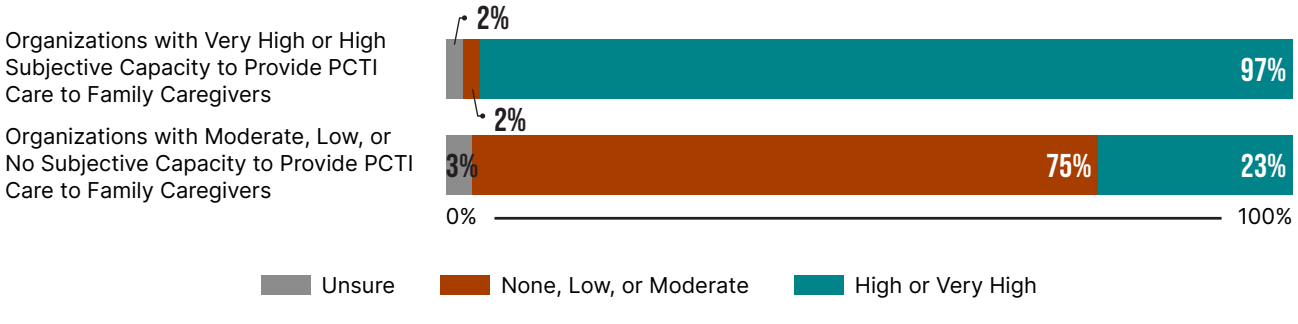


Organizations unsure of PCTI care capacity are grouped with those reporting moderate, low, or no capacity.

(Appendix, Table 55)

Similarly, of those organizations reporting high of very high subjective PCTI care capacity to serve family caregivers, 97% reported high or very high subjective PCTI care capacity to serve older adults with a history of trauma. Of those organization reporting moderate, low, or no subjective PCTI care capacity to serve family caregivers, 23% reported high or very high subjective PCTI care capacity to serve older adults with a history of trauma.

Figure 15. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers

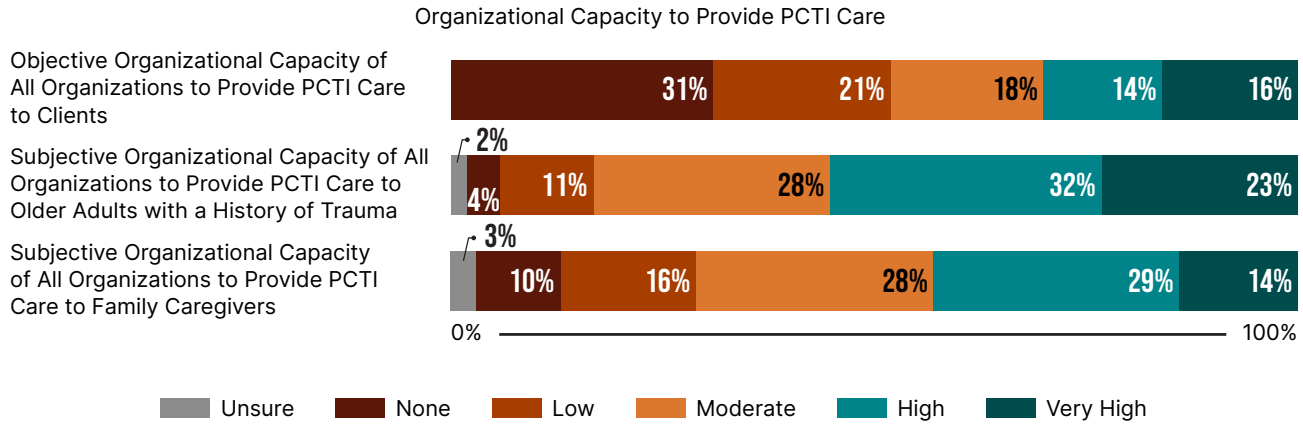


Organizations unsure of PCTI care capacity are grouped with those reporting moderate, low, or no capacity.

(Appendix, Table 56)

Many organizations overestimated their capacity to provide PCTI care. Results from the survey showed a disparity between subjective and objective organizational PCTI care capacity. Overall, organizations reported higher levels of subjective PCTI care capacity than objective PCTI care capacity. When providing a self-assessed rating of PCTI care capacity, 55% of organizations reported having high or very high capacity to provide PCTI care to older adults with a history of trauma, and 43% of organizations reported having high or very high capacity to provide PCTI care to family caregivers. However, when organizations were objectively assessed through the PCTI care capacity assessment, only 30% of organizations demonstrated high or very high organizational capacity to provide PCTI care to clients.

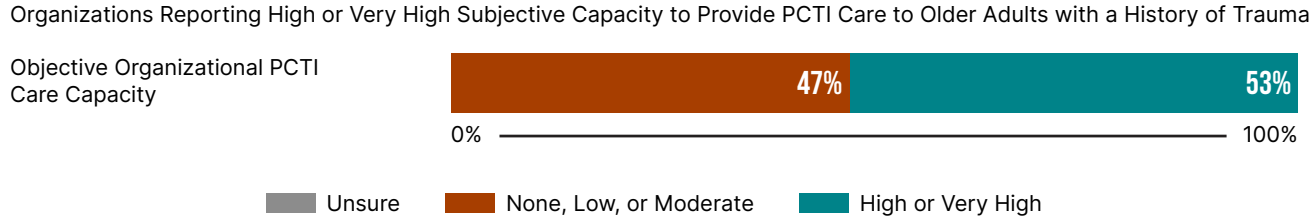
Figure 16. Rates of Objective and Subjective Organizational PCTI Care Capacity



(Appendix, Table 49, 50, 53)

Of organizations which rated their subjective PCTI care capacity for older adults with a history of trauma as high or very high, 47% overestimated their PCTI care capacity.

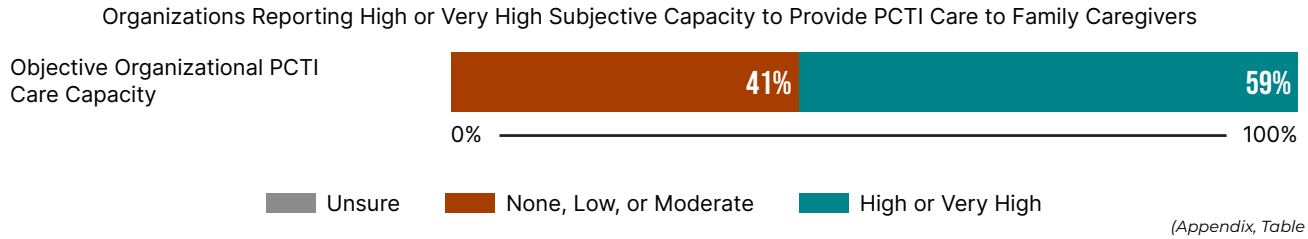
Figure 17. High or Very High Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Objective Organizational PCTI Care Capacity



(Appendix, Table 57)

Similarly, of organizations which rated their subjective PCTI care capacity for family caregivers as high or very high, 41% overestimated their PCTI care capacity.

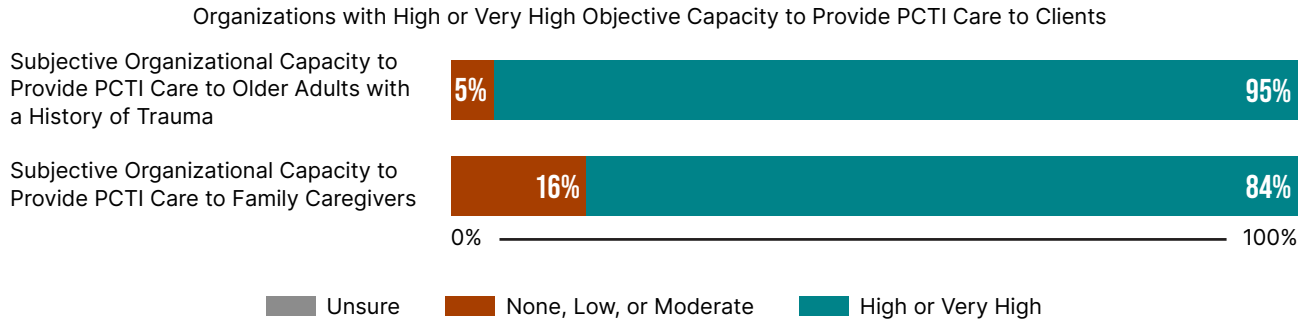
Figure 18. High or Very High Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Objective Organizational PCTI Care Capacity



(Appendix, Table 58)

Few organizations with high or very high objective PCTI care capacity under-estimated their subjective PCTI care capacity. Of organizations with high or very high objective PCTI care capacity, only 5% under-valued their subjective capacity to provide PCTI care to older adults with a history of trauma, and 16% under-valued their subjective capacity to provide PCTI care to family caregivers.

Figure 19. High or Very High Objective Organizational Capacity to Provide PCTI Care to Clients by Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma and Family Caregivers



(Appendix, Table 59)

3.3 BENEFIT OF PROVIDING PCTI CARE

Research Question 3: What do aging services organizations see as the **benefit** of providing PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers?

3.3.1 SELF-REPORTED BENEFITS OF PROVIDING PCTI CARE

Overall, survey respondents identified a diversity of benefits of PCTI care for their older adult and family caregiver clients including improved service delivery, client outcomes, and organizational operations.

Note, these responses were elicited from an open-ended question rather than a closed-ended multiple-choice question. This means that the results below represent the benefits of PCTI care that are at the forefront of the respondent's mind. These results do not represent an exhaustive list or frequency of PCTI care benefit. Rather, these results are exploratory in nature and represent the initial thoughts of organizational respondents on the topic.

First, 69% of respondents noted that PCTI care positively impacted their clients' care experience through improved service delivery. This benefit was achieved through client empowerment, understanding, safety, relationships, feedback, decision-making, and peer support. Primarily, respondents noted that the client care experience was improved by the PCTI care modality, improving the organization's ability to empower older adult and family caregiver clients. Respondents noted that the PCTI care approach enabled clients to feel accepted, respected, supported, cared for, and empowered to make choices. Respondents also noted that the PCTI care service modality enabled organization staff to feel supported and empowered as well. Respondents noted that PCTI care enabled family caregivers to improve the experience of the older adults for which they care. Through a PCTI care approach, both the impact on and impact generated by family caregivers was improved.

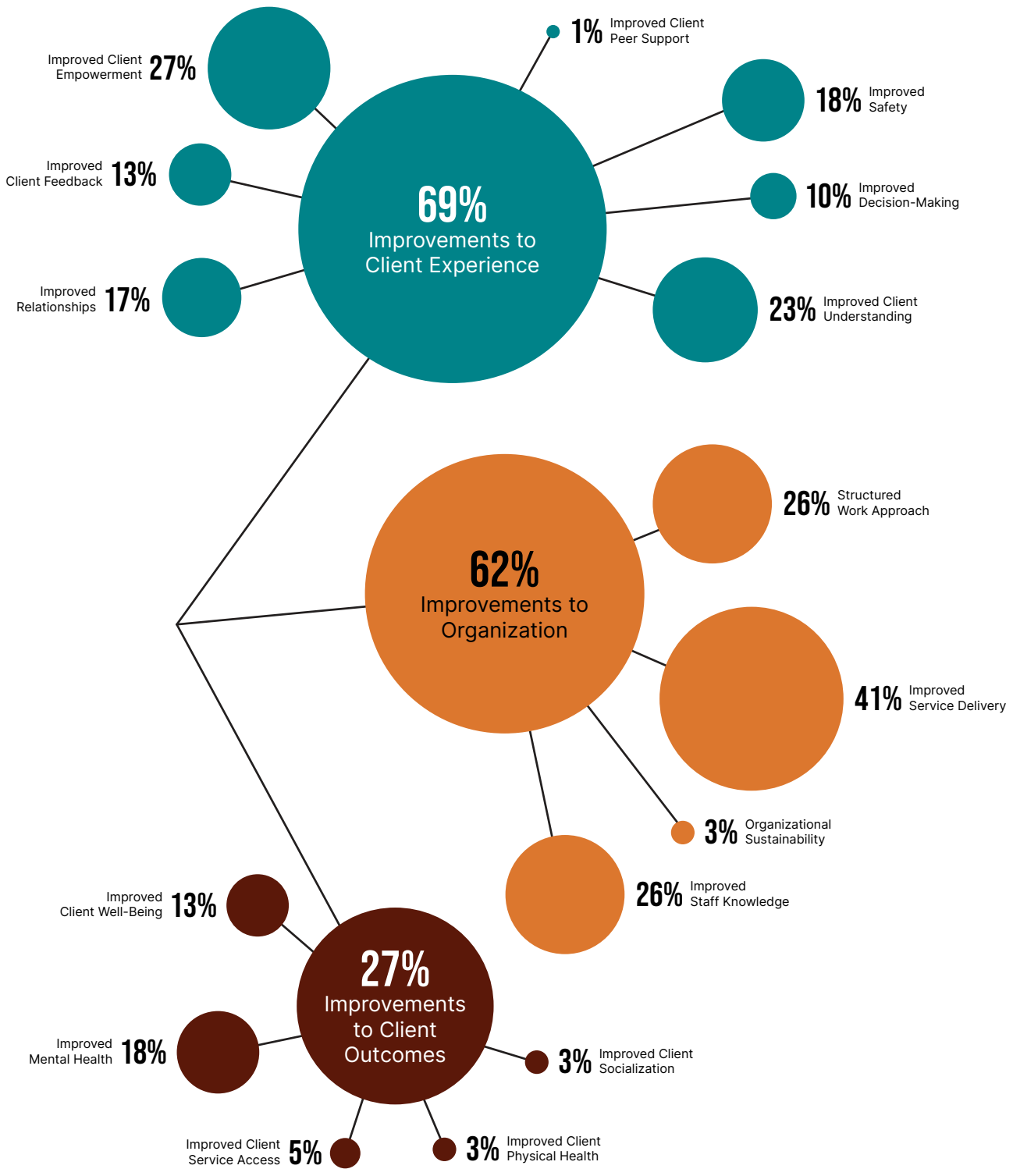
Additionally, respondents noted that using the PCTI care modality improved their staff's understanding of older adult and family caregiver clients in terms of improved cultural competency, valuing client histories, and having increased empathy towards their clients. Respondents also explained that using the PCTI care modality improved their organization's ability to provide and protect the emotional and physical safety of older adults and family caregiver clients throughout service delivery; improve relationships, build trust and comfort, and foster open dialogue and communication between staff and clients; and have more collaborative and shared decision-making between staff and older adult and family caregiver clients.

Second, 62% of respondents indicated that PCTI care positively impacted their organization's operations. Forty-one percent of respondents noted that using PCTI care improved the organization's service delivery, including providing service to older adults and family caregivers that was higher quality and more effective;

26% noted that using PCTI care provided them with a structured and strengths-based approached to work with older adults, family caregivers, and anyone with a history of trauma. Twenty-six percent noted that using PCTI care improved their staff's knowledge on the topics of trauma, aging, trauma triggers, grief, client needs, and client behaviors; and 3% noted that using PCTI care enabled their organization to be seen as a leader in their field, improving their reputation and funding eligibility.

Third, 27% of respondents indicated that PCTI care improved client outcomes through improvements in mental health, well-being, service access, physical health, and socialization. Respondents noted that using PCTI care improved the overall well-being of clients through improved health, faster and more complete healing, and improvements to their everyday life. Using PCTI care improved client outcomes as PCTI care fostered an environment where clients could improve medication management and adherence, as well as adopt and sustain health maintenance tools. Respondents also mentioned that using PCTI care aided in their clients' mental health improvements. Because PCTI care makes mental health service delivery easier for both clients and staff, PCTI care was noted as creating an enabling environment where client and staff anxiety and frustration was reduced, the stigma about mental health services could be addressed and reduced, re-traumatization could be avoided, mental health service participation could be increased, and coping skills could be taught. Additionally, PCTI care enabled for greater client participation in social services and fostered an environment whereby clients decreased their loneliness and social isolation.

Figure 20. Perceived Benefit of PCTI Care Use



(Appendix, Table 60)

3.4 IMPACT OF CENTER ACTIVITIES

Research Question 4: What is the **impact** of the Center's work on the ability of aging services organizations to provide PCTI care to Holocaust survivors, older adults with a history of trauma, and their family caregivers?

3.4.1 SELF-REPORTED ORIGIN OF ORGANIZATIONAL PCTI CARE KNOWLEDGE

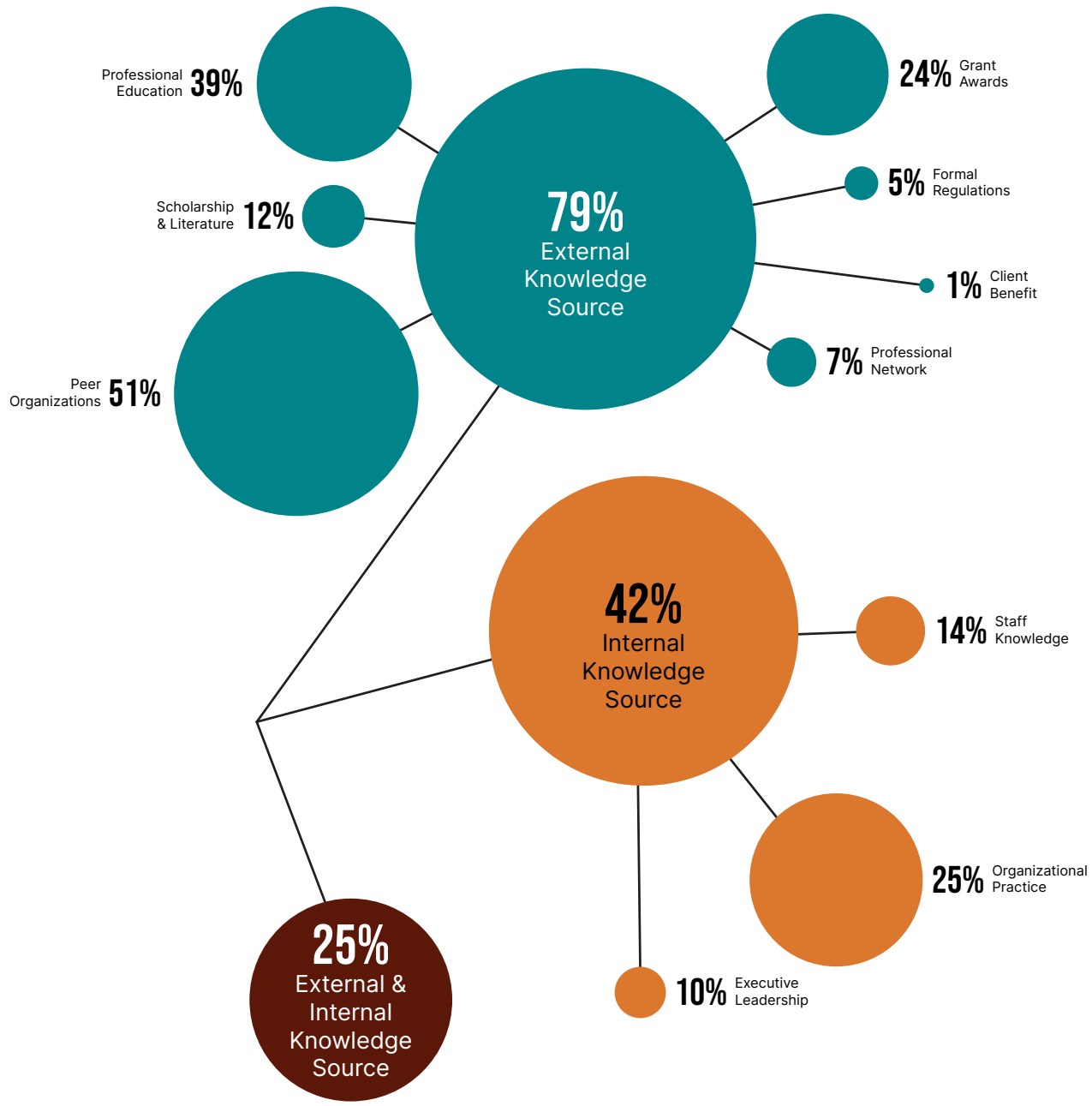
Organizations learned about PCTI care from a diversity of internal and external sources, the most common of which was the Center. Most organizations, or 79%, learned about PCTI care from sources external to their organization through conferences and continuing education, grant applications, and publications. Fifty-one percent reported that their organization learned about PCTI care from other organizations such as the Center, ACL, Centers for Medicare and Medicare Services, and the American Society on Aging. The organization mentioned the most frequently was Center, with thirty-two percent of respondents indicating that their organization learned of PCTI care from the Center.

About two fifths, or 42%, of organizations learned about PCTI Care from sources internal to their organization. This included learning of PCTI care as a result of their organization's prior service delivery practices or organizational leadership. These respondents noted that their organization had a long-standing history of providing either person-centered care, trauma-informed care, or PCTI care. While the original awareness of PCTI care may have emanated from outside the organization, organizations had institutional history of providing this type of care or were founded based on these principles.

Additionally, respondents noted that their organization's awareness of PCTI care was illuminated by their work with vulnerable populations. Vulnerable populations mentioned included survivors of domestic and sexual violence, Holocaust survivors, trauma survivors, and individuals from the LGBTQ population. While service to vulnerable populations did not necessarily result in PCTI awareness, these respondents noted that their organization's awareness was informed by the vulnerable populations they serve. Some respondents also noted that their organization learned about PCTI care because of knowledge, skills, and abilities their staff brought to the organization. Their staff arrived at their organization with the knowledge of providing either person-centered care, trauma-informed care, or PCTI care. Respondents indicated that staff informing the organizations' awareness of PCTI care had a background in clinical, mental health, nursing, or pastoral care.

As external and internal learning sources are not mutually exclusive, a smaller portion of organizations, or 25%, learned about PCTI care through both avenues. These respondents indicated that their organization's understanding and awareness of PCTI care was a result of looking both inward and outward.

Figure 21. Origin of Organizational PCTI Care Awareness



(Appendix, Table 61)

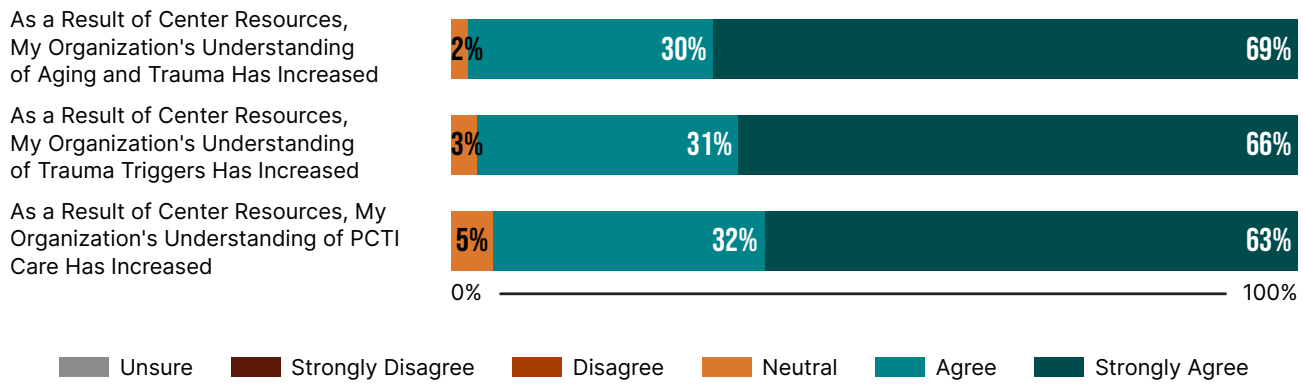
3.4.2 SELF-REPORTED USE OF CENTER RESOURCES

Overall, about one third of respondents used Center resources. Thirty-one percent of respondent organizations indicated that they used Center resources including past webinars, conference presentations, and/or publications made available on the Center's website. Of those who used Center resources, most were Center subgrantees (85%) and a small portion are organizations who have never received Center funding (15%).

A. Center resources improved knowledge of PCTI care

All respondents who used Center resources reported improving their understanding of aging and trauma. Most respondent organizations agreed or strongly agreed that because of Center resources, their organization gained a better understanding of aging and trauma, trauma triggers, and PCTI care.

Figure 22. Center Resources and Changes in Understanding of Aging, Trauma, and PCTI Care

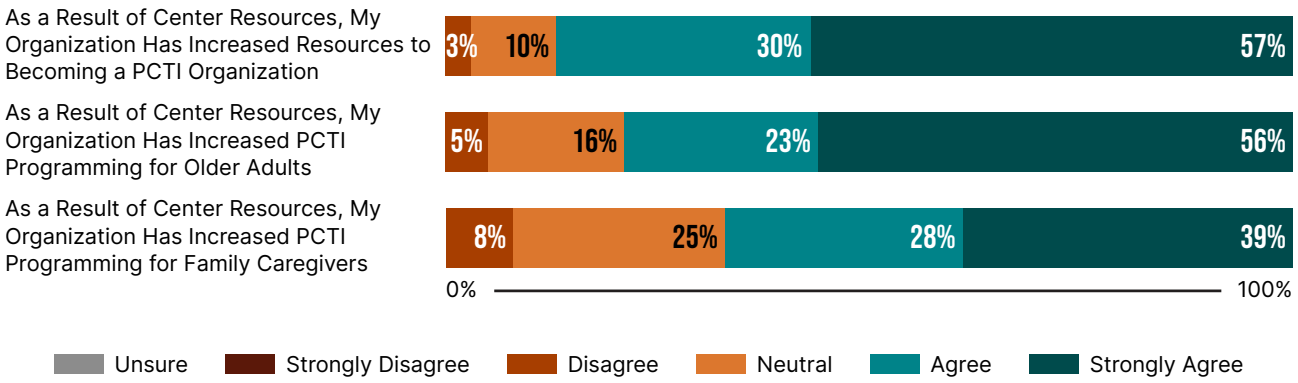


(Appendix, Table 62)

B. Center resources increased the implementation of PCTI care

Most respondents who used Center resources reported that this resulted in improvements in their organization's PCTI care implementation. Ninety percent of respondent organizations who reported use of Center resources agreed or strongly agreed that Center resources resulted in improvements to at least one area of their organization's PCTI care implementation. Additionally, most respondent organizations agreed or strongly agreed that because of Center resources, their organization had increased resources to becoming a PCTI organization, providing PCTI care for older adults, and providing PCTI care for family caregivers. This finding could mean that an organization has increased resources to draw from or commit to becoming PCTI.

Figure 23. Center Resources and Changes in Implementation of PCTI Care

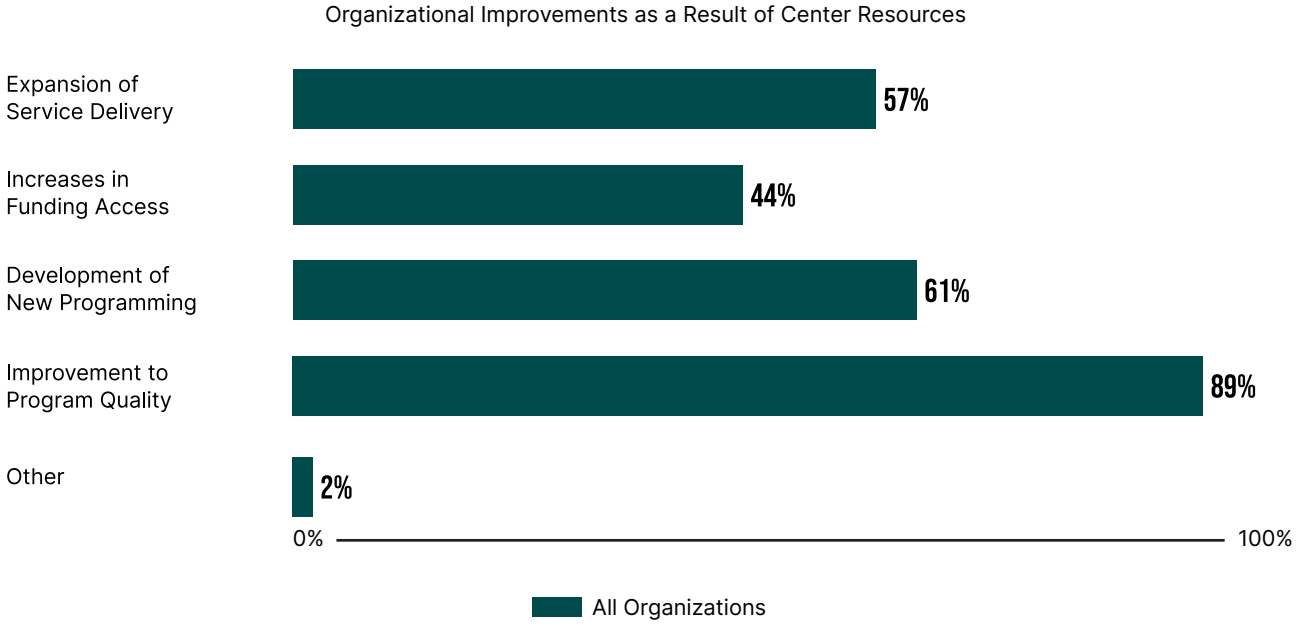


(Appendix, Table 63)

C. Center resources promoted organizational change

Most respondents who used Center resources reported that this resulted in positive changes in their organization. Ninety-three percent of respondent organizations who reported use of Center resources noted that these resources resulted in at least one area of positive organizational change. These areas of organizational change are shown in the figure below.

Figure 24. Center Resources and Organizational Change



(Appendix, Table 64)

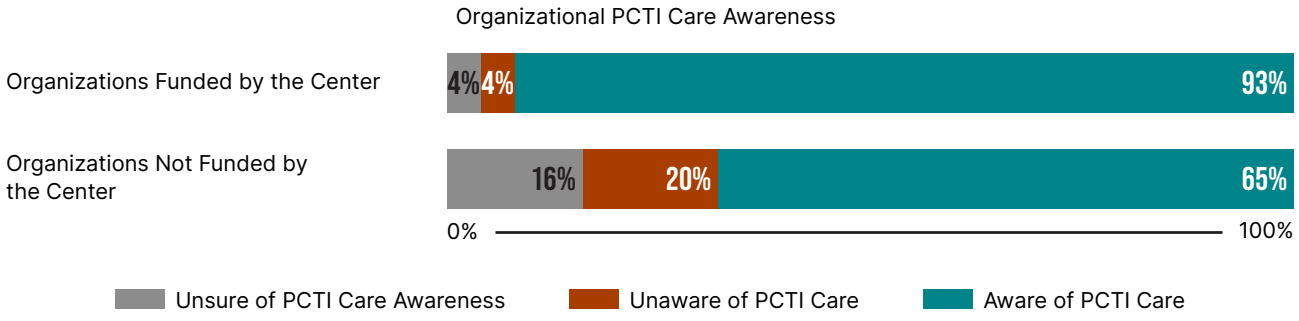
3.4.3 DIFFERENCE IN PCTI CARE AWARENESS AND CAPACITY BY CENTER FUNDING

Organizations funded by the Center reported higher rates of PCTI care awareness and capacity across all measures when compared to organizations that did not receive Center funding. Slightly less than one third, or 28%, of respondent organizations, received funding from the Center, and 72% of respondent organizations did not receive Center funding.

A. Center funding improved awareness of aging and trauma, and PCTI care

Organizations funded by the Center had higher awareness of PCTI care and knowledge of aging and trauma compared with those organizations that were not funded by the Center. Of those organizations receiving Center funding, 93% reported organizational awareness of PCTI care prior to receiving the survey. This compares to 66% who reported awareness of PCTI care and did not receive Center funding.

Figure 25. Organizational PCTI Care Awareness by Center Funding

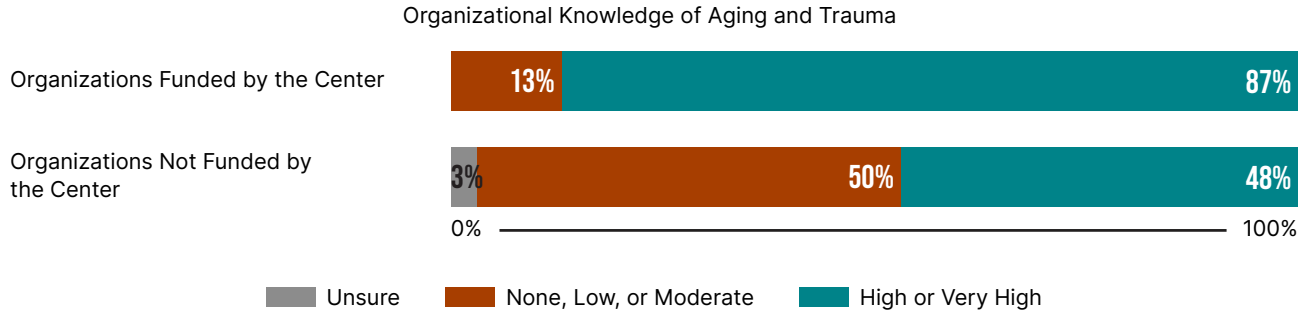


Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 65)

Similarly, of those organizations receiving Center funding, 87% reported high or very high understanding of aging and trauma. This compares to 47% who reported high or very high understanding of aging and trauma who did not receive Center funding.

Figure 26. Organizational Knowledge of Aging and Trauma by Center Funding



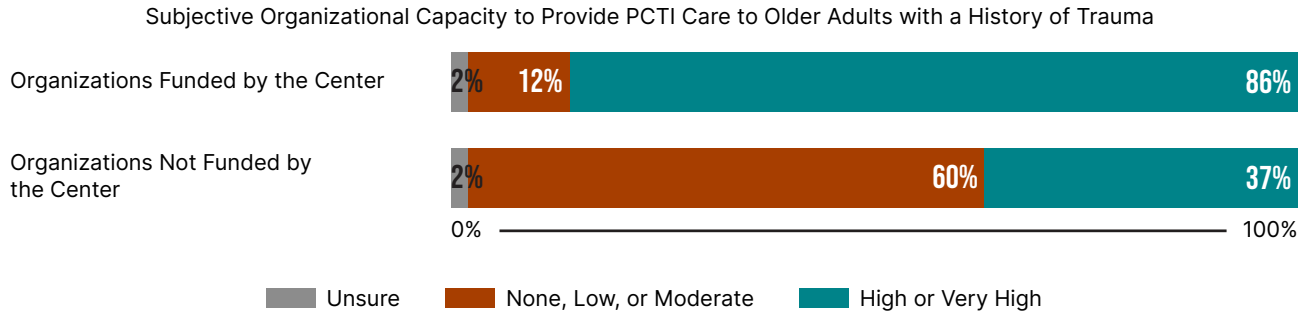
Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 66)

B. Center funding increased PCTI care availability and capacity

Organizations funded by the Center had higher rates of PCTI care availability and capacity compared with those organizations that were not funded by the Center. Center funding positively impacted both subjective and objectives ratings of organizational PCTI care capacity and improved PCTI care capacity and availability across all client demographics. Of those organizations receiving Center funding, 86% reported high or very capacity to provide PCTI care to older adults with a history of trauma. This compares to 37% who reported high or very high capacity to provide PCTI care and did not receive Center funding.

Figure 27. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Center Funding

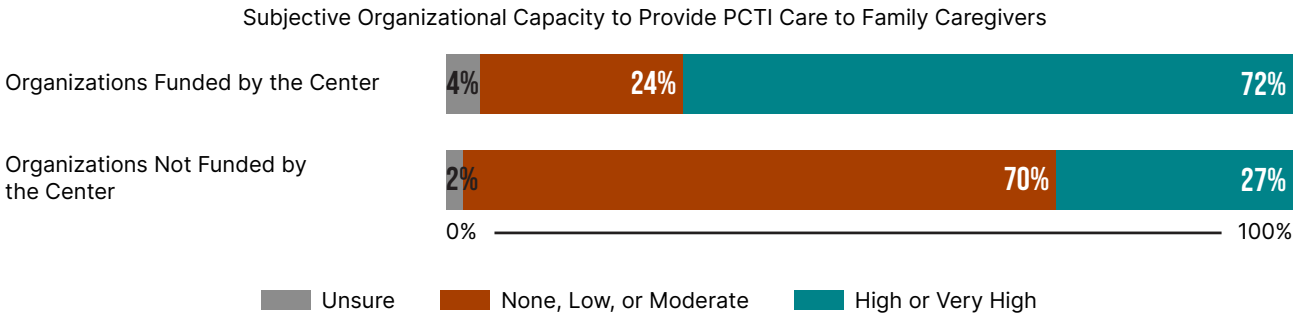


Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 67)

Similarly, of those organizations receiving Center funding, 72% reported high or very high capacity to provide PCTI care to family caregivers of older adults with a history of trauma. This compares to 27% who reported high or very high capacity to provide PCTI care and did not receive Center funding.

Figure 28. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Center Funding



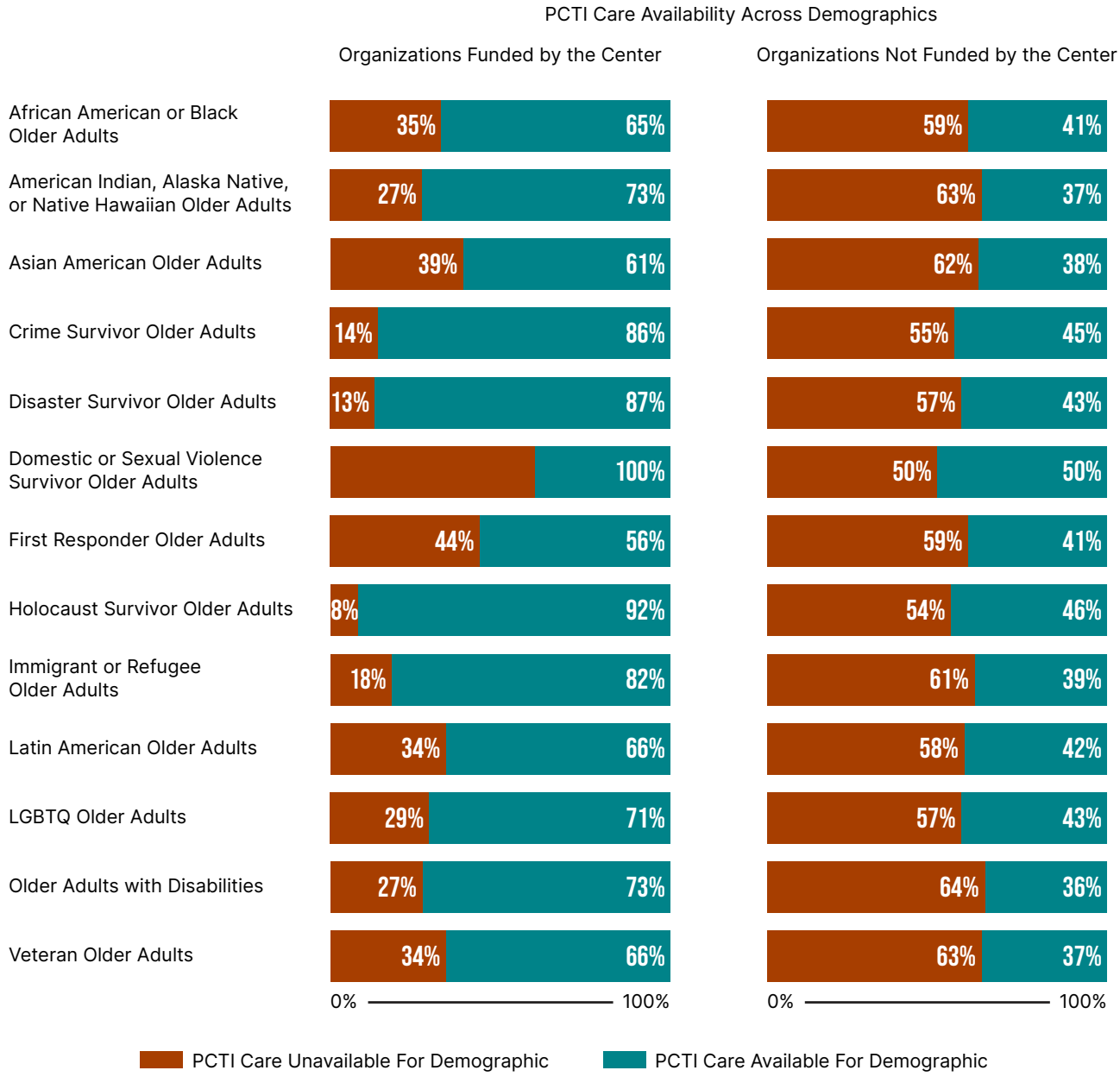
Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 68)

Similar to the subjective capacity ratings, both rates of PCTI care availability and capacity were higher for organizations funded by the Center than those organization that did not receive Center funding. While the variability of PCTI care availability and capacity remained, whether an organization is funded by the Center or not, the overall rates of PCTI care availability and capacity increased across all service groups with Center funding.

When compared to organizations not receiving Center funding, organizations receiving Center funding reported higher rates of PCTI care availability and capacity across all client demographics. Center funded organizations were not only associated with higher rates of PCTI care availability and capacity for Holocaust survivors (which was expected as this was the primary focus of the initial Center grant), but also with higher rates of PCTI care availability and capacity for African American or Black older adults; American Indian, Native Hawaiian, or Native Alaskan older adults; Asian American older adults; older adult crime survivors; older adults with disabilities; older adult disaster survivors; older adult survivors of sexual and domestic violence; family caregivers, older adult first responders; older adult immigrants and refugees; older Latin Americans; LGBTQ older adults; and older adult veterans.

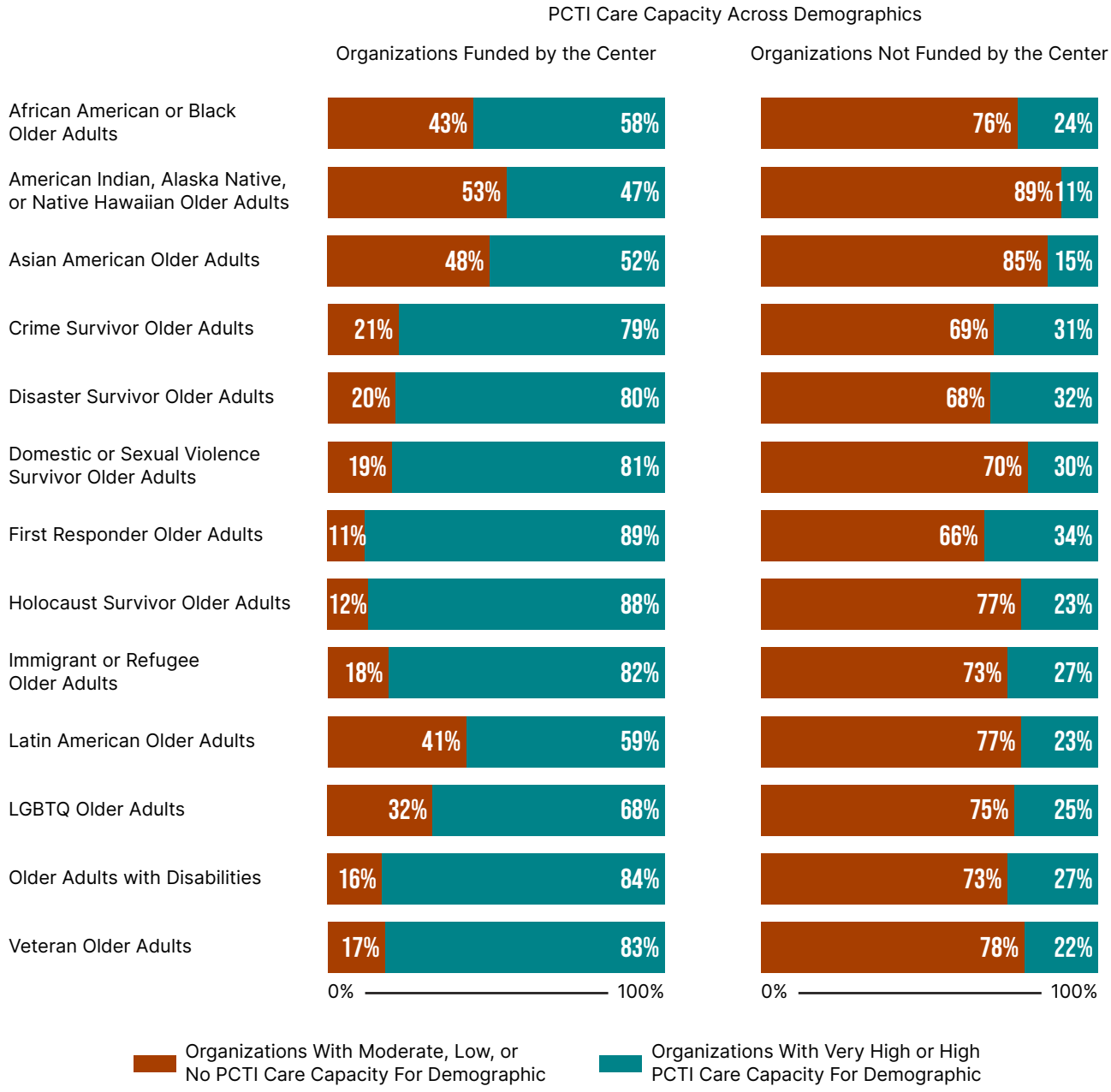
Figure 29. Subjective Organizational PCTI Care Availability Across Client Demographics by Center Funding



Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 69)

Figure 30. Subjective Organizational PCTI Care Capacity Across Client Demographics by Center Funding

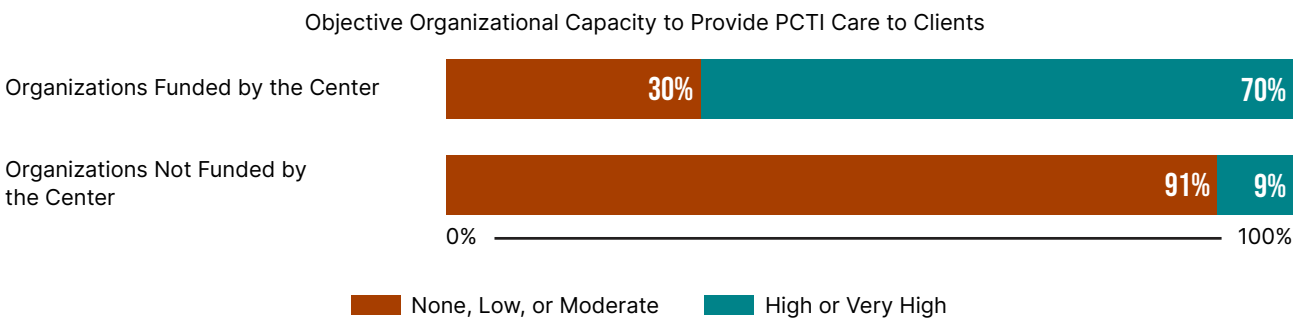


Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 70)

Additionally, organizations receiving Center funding showed higher rates of objective PCTI care capacity when compared to organizations that did not receive Center funding. Of those organizations receiving Center funding, 70% reported high or very high objective PCTI care capacity. This compares to 9% of organizations not funded by the Center who showed high or very high objective PCTI care capacity.

Figure 31. Objective Organizational Capacity to Provide PCTI Care to Clients by Center Funding

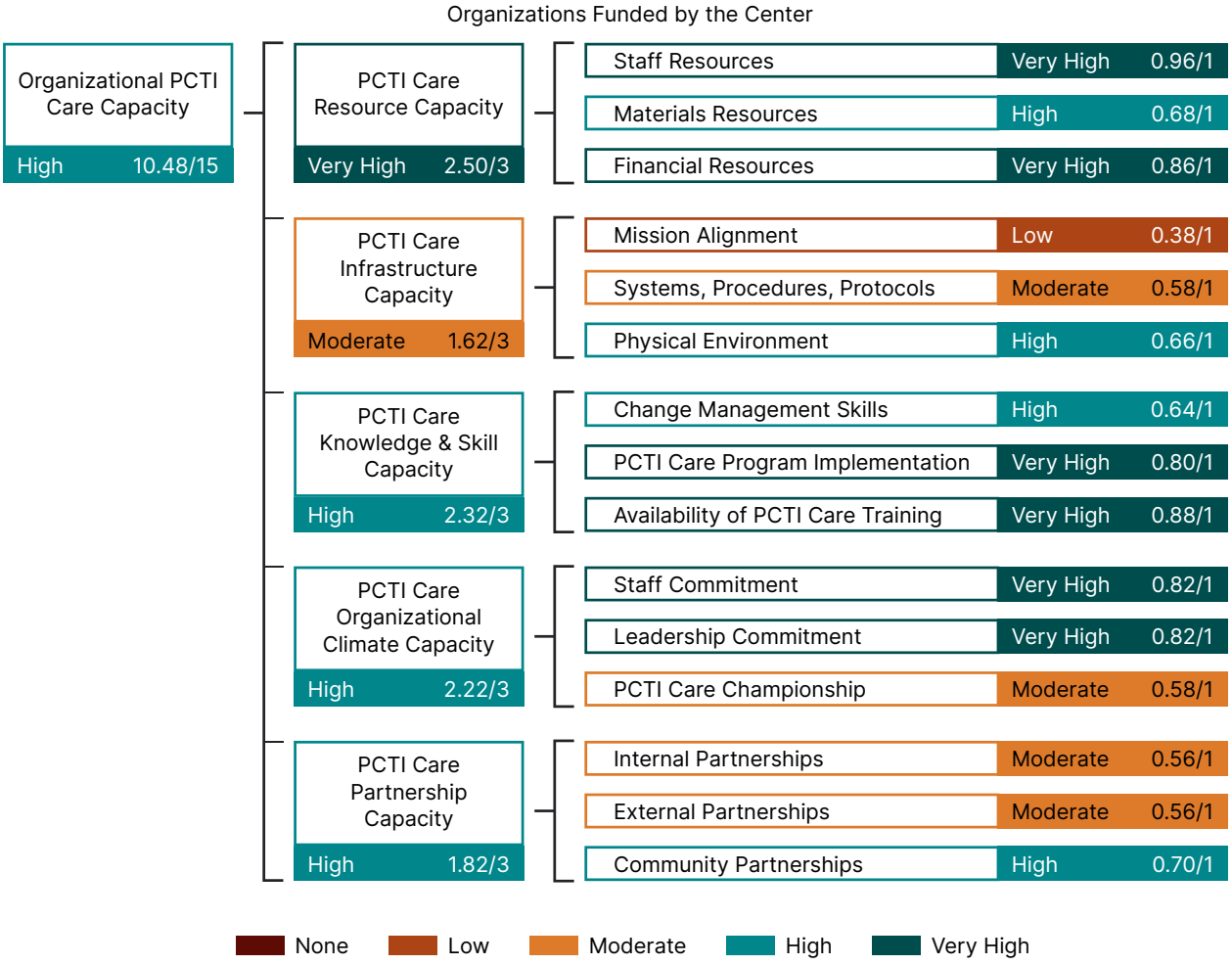


Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 71)

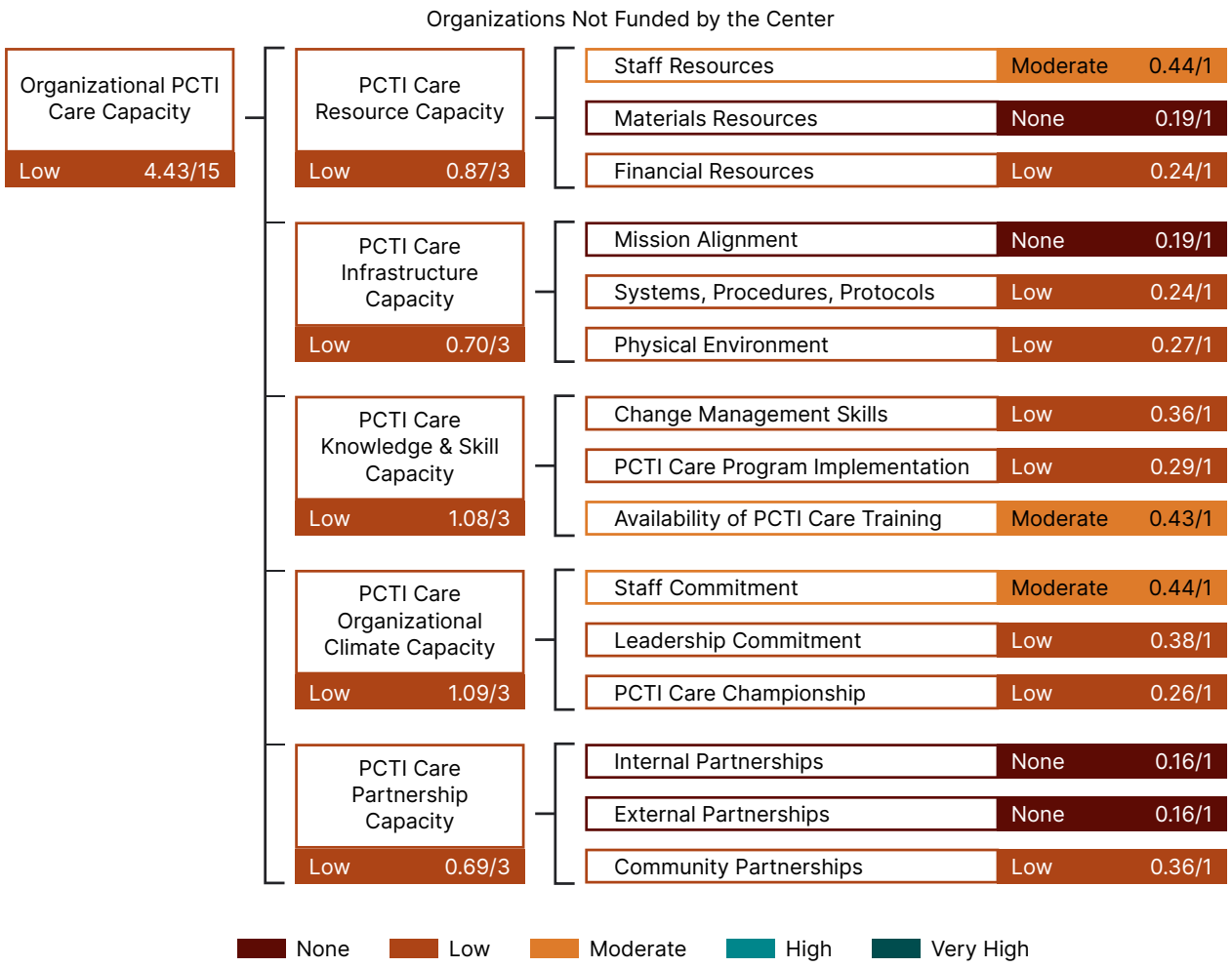
Organizations funded by the Center had an average rating of high capacity to provide PCTI care as the average sample score was 10.48 out of 15.00. This compares to a rating of low capacity to provide PCTI care and a score of 4.27 out of 15.00 for organizations not funded by the Center. In addition to increased performance for overall organizational PCTI care capacity, Center funding appears to have had a positive influence on PCTI capacity across each of the five capacity areas and 15 capacity indicators.

Figure 32. Objective Organizational PCTI Capacity Scores and Ratings by Center Funding (1)



(Appendix, Table 72)

Figure 32. Objective Organizational PCTI Capacity Scores and Ratings by Center Funding (2)

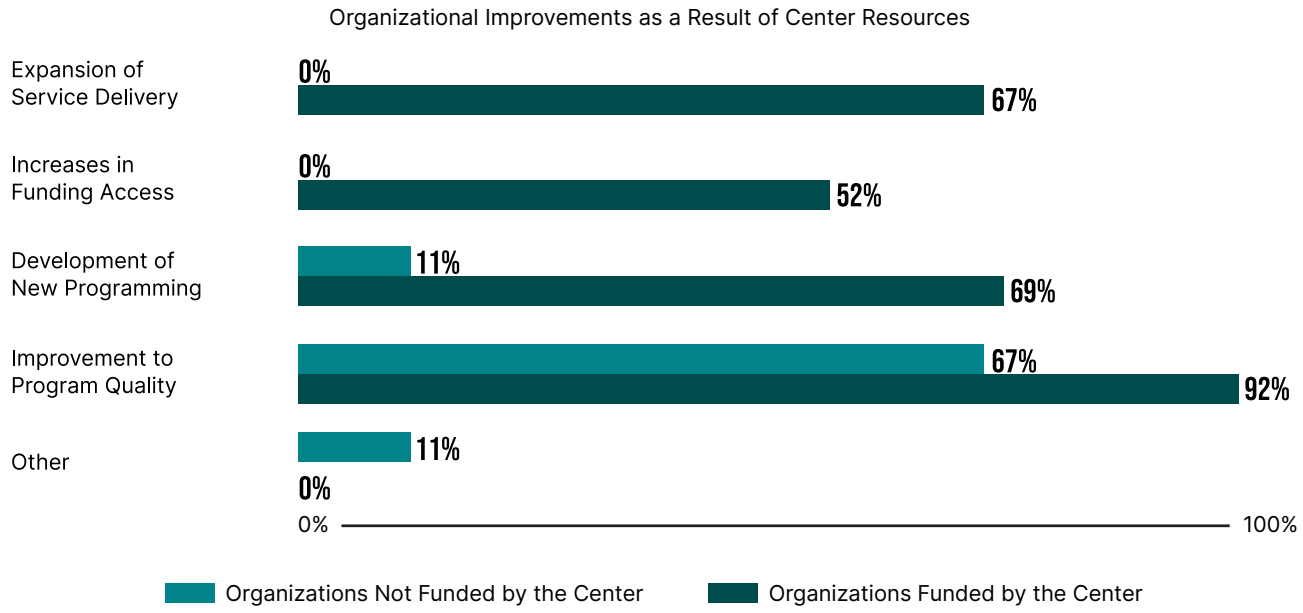


(Appendix, Table 72)

C. Center funding impacted Center resource effectiveness

Center resources had increased effectiveness among organizations funded by the Center when compared to organizations not funded by the Center. Of those organizations funded by the Center, 96% reported that Center resources resulted in positive changes to their organizations. Conversely, of those organizations not funded by the Center, 78% reported that Center resources resulted in positive changes to their organizations.

Figure 33. Center Resources and Organizational Change by Center Funding

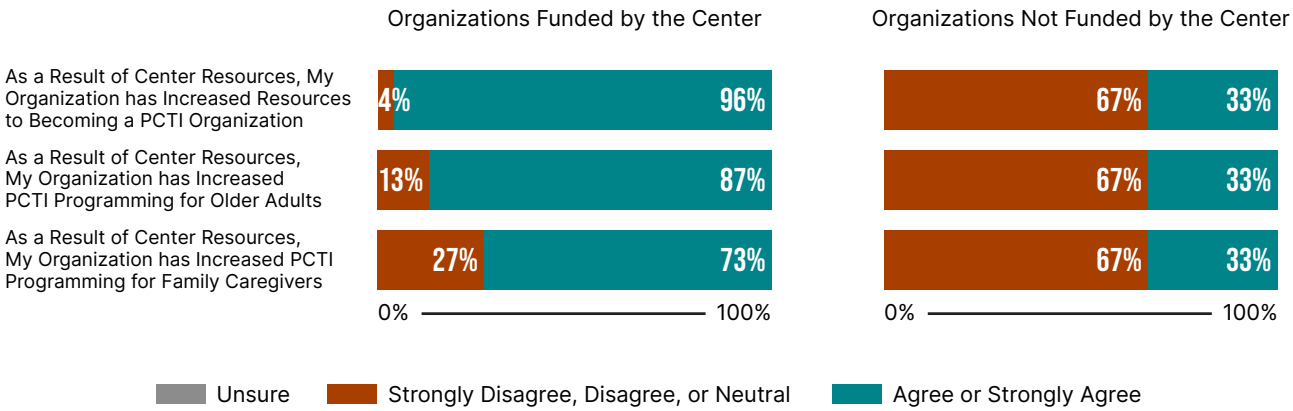


Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 73)

Similarly, of those organizations funded by the Center, 98% organizations agreed or strongly agreed that Center resources resulted in improvements to at least one area of their organization's PCTI care implementation. Conversely, for those organizations not funded by the Center, 44% agreed or strongly agreed that Center resources resulted in improvements to at least one area of their organization's PCTI care implementation.

Figure 34. Center Resources and Changes in Implementation of PCTI Care by Center Funding



Organizations unsure of funding status are grouped with those organizations not funded by Center.

(Appendix, Table 74 and 75)

4 IMPLICATIONS

IMPLICATIONS

The findings of the National Survey show the exciting growth of PCTI care among aging services providers. By the time of this study in 2021, 72% of respondents noted that their organization was aware of PCTI care and 30% of respondents objectively demonstrated high or very high organizational capacity to provide PCTI care to clients. These statistics, as well as all others in this report, demonstrate the rapid expansion and recognition of the PCTI care approach.

However, there remain significant gaps in PCTI care. Of survey respondents, 28% reported that their organization was not aware of PCTI care, and 70% objectively demonstrated moderate, low, or no capacity to provide PCTI care to their clients. These statistics reveal that not only are few organizations able to provide PCTI care for their clients, but also that many clients relying on these organizations for critical supports and services are going without PCTI care – care that can greatly improve client outcomes. While PCTI care has grown dramatically over the last five years, there remains significant progress to ensure that all those who would benefit from this type of care are able to receive it.

Incorporating PCTI care among aging services providers is no small task. While there may be momentum building behind PCTI care, deepening the capacity and understanding of organizations to implement PCTI care requires a shift in the way organizations operate – shifting the culture of aging services to be person-centered and trauma-informed. This shift requires advocacy, dedication, diligence, and information. The survey not only revealed the growth of PCTI care, and the work that remains, but also uncovered trends that can inform future work in PCTI care improvements. These trends enable PCTI care practitioners – whether policy writers, grant makers, or aging service providers – to infuse PCTI care more effectively in their work.

4.1 AWARENESS OF AGING, TRAUMA, AND PCTI CARE

Awareness of PCTI care is not the same as knowledge of aging and trauma.

As PCTI care awareness grows, it is important to delineate what it is and what it is not. While PCTI care awareness can often be conflated with an organization's familiarity with the topics of aging and trauma, the survey demonstrated that these concepts are not the same. An organization's awareness of PCTI care may not be reflective of their understanding of aging and trauma. Conversely, an organization's understanding of aging and trauma should not be mistaken for their awareness of the PCTI care approach. While efforts to increase PCTI care awareness and understanding of aging and trauma may be complementary and mutually

reinforcing, they are not interchangeable. Educational materials about the topics of aging and trauma would need to include explanation of how the PCTI care model meets the needs of this vulnerable population.

Service to vulnerable populations may not translate to organizational PCTI care awareness or understanding of aging and trauma.

An organization's prior service to vulnerable client populations does not necessarily translate to an organization's awareness of PCTI care or understanding of aging and trauma. Although some organizations benefit from their history of service, the survey revealed that for most organizations, there is a limited relationship between service to older adults with a history of trauma and their family caregivers, and rates of PCTI care awareness and understanding of aging and trauma. Service to vulnerable populations should not be viewed as an indicator of the organization's PCTI care awareness or understanding of aging and trauma. Rather, service to vulnerable populations should be viewed as an asset for any organization interested in the PCTI care approach and its application to older adult care.

4.2 CAPACITY TO PROVIDE PCTI CARE

Awareness of PCTI care is not the same as organizational PCTI care capacity.

An organization's awareness of PCTI care should not be conflated with an organization's capacity to provide PCTI care. Being aware of PCTI care is relatively simple task – it involves learning about the PCTI care model from peer organizations, conferences, grant applications, and so on. PCTI care awareness does not require much work, commitment, or intention on the part of organizations. However, developing PCTI care capacity requires an organization to undergo structural and cultural changes as it shifts resources and modifies practices to prioritize PCTI principles. PCTI care awareness is the start of the longer journey of an organization in developing its PCTI care capacity. Practitioners charged with increasing organizational PCTI care capacity should venture beyond increasing organization's recognition of the term. Instead, practitioners should advocate, prioritize, and dive into the challenging and dynamic work of increasing organizational PCTI care capacity.

Organizations tend to overestimate their capacity for PCTI care.

Just as PCTI care awareness is growing, so is the capacity of organizations to provide PCTI care. As rates of PCTI care capacity increase among aging services organizations, it is important to grow our understanding of what it means for an organization to have PCTI care capacity. In the survey, this was assessed in two primary ways – subjectively and objectively. The relationship between subjective and objective PCTI care capacity points towards the possibility that organizations are overestimating their PCTI care capacity. Organizations with high PCTI care capacity showed a clear understanding of this capacity as rates of subjective and objective PCTI care capacity are similar. However, organizations with low PCTI care capacity tended to

overestimate their organization's ability to provide PCTI care to clients. The overestimation may be a result of viewing PCTI care capacity too simplistically. Organizations may be viewing capacity as having PCTI-infused programming or availability of PCTI staff training.

However, as outlined earlier, PCTI care capacity is more than infusing PCTI care into one organizational initiative or time-bound activity. Organizational PCTI care capacity requires PCTI care principles to be infused throughout an entire organization. This means having material, fiscal, and staffing resources assigned to building and supporting PCTI care. It also means establishing, revising, or instituting policies, procedures, and priorities that center PCTI care within the organization's work. PCTI care capacity also requires both practical experience in PCTI care programming, as well as the knowledge of how to manage organizational change. Part and parcel to this organizational change and sustained PCTI care capacity is the demonstrated commitment of organizational leadership and staff to integrate PCTI principles into their work. And finally, PCTI care capacity requires an organization to establish and maintain partnerships across departments, organizations, and communities to better provide a holistic network of care. Thus, PCTI care may be a lot broader and deeper that most organizations realize.

The divergence in these statistics is an important one for practitioners. There is an opportunity to improve both metrics of subjective and objective PCTI care capacity, with special focus on objective PCTI care capacity. Capacity building initiatives can introduce organizations to the depth of the PCTI care practice and the meaning of the five areas of organizational capacity. Practitioners can also direct explicit attention to building capacity across all areas of organizational capacity. Finally, attention can be focused on bridging the gap between an organization's technical abilities and perceived ability to act as this will help the organization understand areas of strength and further improvement.

PCTI care is not evenly distributed between older adults with a history of trauma and their family caregivers.

The National Survey revealed that organizations reflect differently about their PCTI care abilities for older adults with a history of trauma and their family caregivers. Survey respondents tended to estimate higher capacity to provide PCTI care for older adults with a history of trauma than for family caregivers of those older adults. These statistics reveal the significant gap in PCTI care for family caregivers and that PCTI care for family caregivers of older adults with a history of trauma may be lagging.

As previously explained, these statistics also share a relationship. Most of those organizations with high or very high PCTI care capacity to serve family caregivers estimated similar levels of capacity to serve older adults with a history of trauma. However, not all organizations that expressed a high or very ability to provide PCTI care to older adults with a history of trauma estimated similar levels of capacity for caring for their family caregivers. The dynamics hint at the idea that PCTI care capacity for older adults may be developed first and then extended to family caregivers through PCTI care services and supports. Nonetheless, this gap in estimated PCTI care capacity leaves many family caregivers without the critical approaches that can

improve their ability to care for their loved one, as well as improve their own well-being, health outcomes, and quality of life.

This gap between estimated PCTI care capacity for older adults and for their family caregivers should be a key focus area for practitioners. Whether through advocacy, policy, grant making, or service provision, the provision of PCTI care to family caregivers must be prioritized. Capacity building initiatives can focus on demonstrating how PCTI care can be provided to family caregiver and can raise awareness of the integral role of family caregivers in providing PCTI care to their loved one.

PCTI care availability and capacity is not distributed evenly among older adults.

Respondent organizations reported disparities in PCTI care availability and capacity based on client demographics. Not all organizations are providing PCTI care equally and equitably across client groups, and thus not all clients are able to access the same levels of PCTI care. For example, organizations reported the highest PCTI care availability and capacity to serve Holocaust survivors and older adult survivors of domestic and sexual violence. Organizations reported the lowest PCTI care availability and capacity for American Indian, Native Hawaiian, or Alaska Native, Asian American, Latin American, and veteran older adults.

The disparity in service delivery based on client demographics is not new as it has been documented in studies on healthcare and human service disparities (McDaniel et al., 2017). Disparities in care have been shown across a wide variety of topics including client access to services and care, quality of care received, and client social and health outcomes. The survey showed that these disparities extend to PCTI care. While PCTI care can often be seen as a method of overcoming client outcome disparities, the PCTI care approach itself is not evenly distributed among organizations and client groups.

The disparity in PCTI care availability and capacity based on client demographic may be a result of various factors. For example, service organizations may share a limited understanding of the prevalence, appearance, and influence of trauma on diverse client demographics. Thus, organizations may feel that certain client demographics could benefit more or less from the PCTI care approach. Additionally, the disparity could reflect uneven resources made available to organizations. Organizations serving particular client demographics may have fewer resources to direct to PCTI care capacity building initiatives. Finally, disparities in PCTI care availability and capacity based on client demographic could mirror disparities in care elsewhere in the healthcare and human services system.

Overcoming disparities in PCTI care should be a primary focus of practitioners as doing so could improve service access, service quality, and client outcomes. PCTI care disparities can be addressed by educating aging services providers on the applicability of the PCTI care model to the needs of diverse client demographics. The PCTI care model can also be adapted to fit the language and cultures of demographic groups. Moreover, additional resources can be directed to support and develop PCTI care capacity in organizations serving diverse client demographics. These resources can help tailor the PCTI care model for the unique needs and strengths of an organization and its community. Finally, improvements in healthcare

and human service equity throughout aging services organizations would support equity in PCTI care availability and capacity.

4.3 BENEFIT OF PROVIDING PCTI CARE

The benefits of PCTI care are increasingly understood.

As the PCTI care model spreads and builds momentum, organizations increasingly recognize the multitude of benefits this approach can have on client outcomes and organizational operations. Survey respondents reported that PCTI care resulted in improved client empowerment, understanding, safety, relationships, feedback, decision-making, peer support, mental health, well-being, service access, physical health, and socialization. Respondents also noted that PCTI care supported their organization by improving service delivery, providing a structured work approach, furthering staff knowledge, and contributing to organizational sustainability. Additionally, respondents noted that PCTI care improved service to family caregivers and engaged family caregivers in better service delivery for their loved ones.

The view of PCTI care as beneficial to clients as well as organizations is a perspective that makes it easier for organizational leadership to adopt PCTI care. Implementing PCTI care into an organization's structure and culture is not an easy process. It requires the dedication of resources, buy-in of leadership, training of staff, updates to programming, and more. Thus, to be implemented into the fabric of an organization, PCTI care needs to be seen not only as a benefit to clients but also as a benefit for the organization itself. When an organization views PCTI care as contributing to sustainability, improving services, and providing a structured work approach in addition to improving client experiences and outcomes, organizations may have an easier time growing their PCTI care capacity.

The number of sources of Information about PCTI care are growing.

The Center and ACL are no longer the only advocates and teachers of PCTI care; there are many organizations, policies, and practices that promote the recognition and implementation of the PCTI care model. This growth in the number of PCTI care learning sources shows the spread of the PCTI care model throughout aging services organizations. Since the term was coined by ACL, defined by JFNA, and codified in the reauthorization of the Older Americans Act, many more organizations are aware of and are sharing information about the PCTI care approach. For example, organizations funded and trained through the Center's ACL grant have creating PCTI care training materials, trained other organizations in PCTI care, and raised awareness of the PCTI care approach in their community. The more organizations and learning sources are available, the more likely an organization is to encounter the concept of PCTI care. And the more organizations are aware and engaging in PCTI care, the more likely other organizations are to adopt PCTI

care as the normative standard for client care. Additionally, the more learning sources are available, the more partners an organization will have to rely on to deepen their PCTI care knowledge and capacity.

This variety is important to remember when implementing PCTI care awareness activities. PCTI care learning does not have to come exclusively from formal regulations or leadership mandates. Rather, PCTI care awareness can emerge simultaneously from a variety of sources including staff learning and experience. This variety demonstrates that if raising awareness about PCTI care is the goal, there are many ways of getting there. For organizations that need a hard push, formal regulation could help. For organizations nested in close-nit professional fields, peer organizations and professional colleagues may share the PCTI care approach. For organizations that support continued professional education, conferences, webinars, and trainings could be a method of learning PCTI care.

4.4 IMPACT OF CENTER ACTIVITIES

Center funding impacts PCTI care awareness and capacity.

While there is a great deal of work ahead for aging services organizations, there is one factor that appears to have a significant effect on organizational PCTI care awareness and capacity – Center funding. The survey revealed that organizations that received funding from the Center fared better across all variables of PCTI care awareness and capacity when compared to organizations that did not receive Center funding. Out of all organizational characteristics – including organization location, sector, size, religious affiliation, service type, and service demographics – Center funding had the most significant influence on an organization's awareness of and capacity to practice PCTI care. While the variability of PCTI care availability and capacity remain, organizations funded by the Center showed increased ability to provide PCTI care across all client demographics.

Implementing PCTI care throughout an organization may require overcoming informational and capacity barriers. These are barriers which Center funding aims to address. Firstly, through the Center grant, organizations increase their familiarity with the PCTI care model as well as their understanding of the topics of aging and trauma. This is done through the technical assistance, the request for proposal process, webinars, and a host of online and print materials. For example, organizations receiving Center funding have access to articles, factsheets, webinars, and training workshops relevant to their work. While these resources are made freely available to the public, the survey revealed that most organizations using these resources also receive Center funding. As shown through the findings of the National Survey, the resources provided by the Center improve organizations' understanding of aging and trauma, trauma triggers, and PCTI care. The Center resources also improve PCTI care implementation and make a positive impact on an organization's performance.

Secondly, Center funding is often used to support organizational PCTI care capacity building. Center funding can be used to build PCTI care resources, infrastructure, knowledge and skill, organizational climate, and partnerships. For example, Center funding can be used to supplement staffing costs, finance program activities, and purchase equipment to develop and implement PCTI programming. Funding may also be used to infuse PCTI care principles throughout an organization's policies and protocols. Center funding is often used to afford PCTI care training and skill development for staff, board members, and volunteers. Furthermore, organizations receiving Center funding become part of a cohort. The Center promotes cohort learning so that funding recipients can partner with and learn from peer organizations that are also integrating PCTI care into their organization's operations. Finally, through applying for, accepting, and implementing the Center grant, organization leadership and staff make a commitment to implementing the PCTI care approach.

If the goal is to improve aging services organizations' understanding and ability to provide PCTI care, then providing dedicated funding for this endeavor is likely to yield positive results. Additionally, incorporating a PCTI lens and requirements for PCTI care into the granting process can be a catalyst for change. While organizations may have the inherent interest in this PCTI care model, some organizations face informational and resource limitations. By dedicating funding and support explicitly to PCTI care improvements, practitioners can overcome these challenges. Dedicated PCTI care funding can also help organizations prioritize PCTI care improvements among various competing initiatives. Dedicating funding for PCTI care among underserved client demographics can improve the equity of PCTI care availability and capacity.

5 RECOMMENDATIONS

RECOMMENDATIONS

Although the field of PCTI care has grown tremendously over the past five years, there remains a sizeable gap in PCTI care awareness and capacity among aging service providers. This gap denotes that there is significant work ahead of the network of aging services organization to improve access and quality of PCTI care. As most older adults and their family caregivers have a history of trauma, providing quality PCTI care is imperative. Based on the National Survey findings, the Center makes the following recommendations for aging services professionals working on policy, advocacy, grant making, and service delivery. The network of aging service organizations should:

1. Raise awareness and understanding about topics of aging and trauma. Increase the understanding of aging services practitioners on the topics of aging and trauma so that aging services organizations have a broader and deeper understanding of the role of trauma in the aging process of their clients. This can be done by adding the topics of aging and trauma into, for example, dental, legal, social service, or business administration curricula or continuing professional education.

2. Raise awareness and understanding of the PCTI care approach. Leverage diverse learning sources to increase awareness of the PCTI care model so that that aging services organizations have a deeper understanding of its relevance and the application of PCTI care for older adults with a history of trauma and their family caregivers.

3. Deepen organizational capacity to provide PCTI care. Increase the understanding of aging services professionals of PCTI care capacity. Engage in organizational PCTI care capacity building efforts, so that organizations can provide PCTI care to all clients through all services.

4. Acknowledge and overcome disparities in PCTI care. Work to address disparities in PCTI care by acknowledging that PCTI care availability and capacity is unevenly distributed based on client demographic groups and between older adults with a history of trauma and their family caregivers. Broaden the understanding that all clients can benefit from PCTI care and direct resources to overcome disparities in care with flexibility and cultural competency.

5. Provide dedicated resources for PCTI care. Proactively dedicate resources for PCTI care capacity building so that organizations have dedicated funding, infrastructure, knowledge and skill, partnerships, and organizational climate to infuse the PCTI care model and principles throughout all areas of their organizations.

By implementing these recommendations, we can ensure that more older adults with a history of trauma can age in place with safety and dignity. We can ensure that family caregivers of older adults with a history of trauma receive the same level of care and are best positioned to help their loved one.

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7 APPENDIX

7.1 SURVEY TOOL

National Survey A Survey of Person-Centered, Trauma-Informed Care for Older Adults with a History and Their Family Caregivers	Title
Thank you for participating in the National Survey on person-centered, trauma-informed (PCTI) care for older adults with a history of trauma and their family caregivers. This survey is conducted by The Jewish Federations of North America (JFNA) Center on Aging and Trauma as part of a grant by the United States Department of Health and Human Services, Administration for Community Living/Administration on Aging. The purpose of this survey is to understand the implementation o`f PCTI care among organizations providing care to older adults and family caregivers. PCTI care is a holistic approach to service provision that infuses knowledge about trauma into organizational programs and policies to promote the health and well-being of clients, staff, and volunteers. Regardless of your level of familiarity with Person-Centered, Trauma-Informed care, we encourage you to take this survey and complete it to the best of your knowledge. As an organization serving older adults and family caregivers, you have key insights into the care of older populations and your responses will help advance and expand the field of aging services. The survey should take approximately 15 minutes to complete. The findings will be used in program reports and other materials, but your answers will be anonymous and presented in aggregate form. We ask that only one survey is submitted from each organization, so please make every effort to coordinate with your colleagues to reduce duplication. Only organizations in the United States should complete this survey. Please do not put your name or the name of your organization on the survey. To complete this survey in more than one sitting, please use the 'save' button at the bottom of the page and click the link in your email to return to the survey. Note, to use the 'Save' feature you will need to enter your email address and create a new password. If you have any questions about this survey, please contact Carmel Rabin, Project Manager for Research and Evaluation at the Center on Aging and Trauma (direct email provided). Thank you for helping us advance the field of PCTI care!	Instructions

Organization Information	Section Title
1A. In what city is your organization located? *	Short, open-ended text question
1B. In what state is your organization located? *	Single-choice drop-down question of U.S. states and territories
2. Which category best describes your organization? * ◯ Adult Day Care ◯ Adult Protective Services ◯ Area/State Agency on Aging ◯ Home Care/Home Health Agency ◯ Hospice ◯ Hospital ◯ Legal Services Provider ◯ Meals Program ◯ Mental Health Clinic/Agency ◯ Nursing Home ◯ Residential Care Facility/Assisted Living ◯ Senior Center ◯ Senior Housing ◯ Social Service Agency ◯ Transportation Provider ◯ Veterans Affairs Facility ◯ Victim Services Program ◯ Other If 'Other' please specify:	Single-choice question
3. Which category best describes your organization? * ◯ National ◯ Regional ◯ Local ◯ Other If 'Other' please specify:	Single-choice question

4. Which category best describes your organization? * ◯ Non-profit ◯ For-profit ◯ Other If 'Other' please specify:	Single-choice question
5. Is your organization religiously affiliated? * ◯ Yes ◯ No	Single-choice question
5A. Which religious affiliation best describes your organization? * ◯ Buddhist ◯ Christian ◯ Hindu ◯ Indigenous ◯ Islamic ◯ Jewish ◯ Other If 'Other' please specify:	Single-choice question, conditionally linked to question 5
6. Which of the following older adult populations does your organization serve? (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 ☐ First Responder older adults ☐ Holocaust survivors ☐ Immigrant or refugee older adults ☐ Latin American older adults ☐ LGBTQ older adults ☐ Older adult crime survivors ☐ Older adult disaster survivors ☐ Older adult domestic or sexual violence survivors ☐ Older adults with disabilities ☐ Veteran older adults ☐ None ☐ Other If 'Other' please specify:	Multiple-choice question

7. How many full-time employees does your organization have? * ◯ Under 100 ◯ Between 100 and 500 ◯ Between 500 and 1,000 ◯ Over 1,000	Single-choice question
8. What is your position at the organization? * ◯ Executive Staff/Senior Management ◯ Project Director/Program Manager ◯ Direct Service Provider ◯ Other If 'Other' please specify:	Single-choice question
9. Does your organization receive any funding from Medicaid? * ◯ Yes ◯ No ◯ I Don't Know	Single-choice question
10. Does your organization receive any funding from the United States Department of Veteran Affairs? * ◯ Yes ◯ No ◯ I Don't Know	Single-choice question
11. Has your organization received grant funding from The JFNA Center on Aging and Trauma (formerly the Center for Advancing Holocaust Survivor Care)?* ◯ Yes ◯ No ◯ I Don't Know	Single-choice question
Person-Centered, Trauma-Informed Care, Aging, and Trauma	Section Title
12. To the best of your knowledge, please describe your organization's understanding of how previous trauma can affect older adults as they age. * ◯ None ◯ Low ◯ Medium ◯ High ◯ Very High ◯ I Don't Know	Single-choice question
13. To the best of your knowledge, before receiving this survey, was your organization aware of the concept of Person-Centered, Trauma-Informed care?* ◯ Yes ◯ No ◯ I Don't Know *Person-centered, trauma-informed (PCTI) care is a holistic approach to service provision that infuses knowledge about trauma into organizational programs and policies to promote the health and well-being of clients, staff, and volunteers.*	Single-choice question

13A. To the best of your knowledge, how would you describe your organization's capacity to provide Person-Centered, Trauma-Informed care to OLDER ADULTS with a history of trauma? * ◯ None ◯ Low ◯ Medium ◯ High ◯ Very High ◯ I Don't Know	Single-choice question
13B. To the best of your knowledge, how would you describe your organization's capacity to provide Person-Centered, Trauma-Informed care to FAMILY CAREGIVERS of older adults with a history of trauma? * ◯ None ◯ Low ◯ Medium ◯ High ◯ Very High ◯ I Don't Know	Single-choice question
13C. Thinking about your organization's practice of person-centered, trauma-informed (PCTI) care, which of the following statements are true? (Select all that apply) * ☐ My organization has invested fiscal resources to provide PCTI care. (e.g., financial assets, in-kind contributions) ☐ My organization has invested staffing resources to provide PCTI care. (e.g., number, general skill level, time availability of staff) ☐ My organization has invested material resources to provide PCTI care. (e.g., facilities, equipment, technology) ☐ My organization has written goals establishing PCTI care as an essential part of the organizational mission. (e.g., mission statement, organizational objectives or values) ☐ My organization has systems, procedures, and protocols for providing PCTI care. (e.g., operational policies or guidelines) ☐ My organization has offices and other spaces that are PCTI. (e.g., spaces are designed to be welcoming and promote a sense of safety, community, and connection) ☐ My organization staff have the technical ability to lead organizational change to provide PCTI care. (e.g., change management skills of leadership, communication, strategic vision, etc.) ☐ My organization trains staff on PCTI care. (e.g., onboarding or continuing education on PCTI care) ☐ My organization implements PCTI programs and services. (e.g., PCTI cognitive therapy, socialization activities, client intakes, etc.)	Multiple-choice question

☐ My organization's leadership have demonstrated commitment to provide PCTI care. (e.g., leadership practice, express priority, and encourage PCTI care) ☐ My organization's staff have demonstrated commitment to provide PCTI care. (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 PCTI care. (e.g., PCTI working group or officer) ☐ My organization has internal partnerships to support provision of PCTI care. (e.g., cross-departmental, or cross-functional partnerships). ☐ My organization has external partnerships to support provision of PCTI care. (e.g., partnerships with other organizations serving trauma-affected older adult populations) ☐ My organization has community partnerships to support provision of PCTI care. (e.g., partnerships with trauma-affected older adult populations in community) ☐ Other If 'Other' please specify:	Multiple-choice question
13D. For which of the following older adult populations does you organization provide Person-Centered, Trauma-Informed care? (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 ☐ First Responder older adults ☐ Holocaust survivors ☐ Immigrant or refugee older adults ☐ Latin American older adults ☐ LGBTQ older adults ☐ Older adult crime survivors ☐ Older adult disaster survivors ☐ Older adult domestic or sexual violence survivors ☐ Older adults with disabilities ☐ Veteran older adults ☐ None ☐ Other If 'Other', please specify:	Multiple-choice question

13E. To the best of your knowledge, please complete the following table about your organization's CAPACITY TO PROVIDE Person-Centered, Trauma-Informed care to each of the populations indicated. *

	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	○	○	○	○	○	○
First Responder older adults	○	○	○	○	○	○
Holocaust survivors	○	○	○	○	○	○
Immigrant or refugee older adults	○	○	○	○	○	○
Latin American older adults	○	○	○	○	○	○
LGBTQ older adults	○	○	○	○	○	○
Older adult crime survivors	○	○	○	○	○	○
Older adult disaster survivors	○	○	○	○	○	○
Older adult domestic or sexual violence survivors	○	○	○	○	○	○
Older adults with disabilities	○	○	○	○	○	○
Veteran older adults	○	○	○	○	○	○
Other	○	○	○	○	○	○
If 'Other' please specify:						

Single-select, Likert question set

13F. Overall, how would you say that providing Person-Centered, Trauma-Informed care impacts the older adults and family caregivers you serve?

Long, open-ended text question

13G. Please elaborate on where your organization first leaned about the concept of Person-Centered, Trauma-Informed care.	Long, open-ended text question
JFNA Center on Aging and Trauma	Section Title
14. Has your organization used resources provided by The JFNA Center on Aging and Trauma (formerly The JFNA Center for Advancing Holocaust Survivor Care)? This includes webinars, conference presentations, website, or other resources. * ◯ Yes ◯ No ◯ I Don't Know	Single-choice question

14A. Please indicate how much you agree or disagree with the following statements. As a result of JFNA resources, my organization... *

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
...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 clients and how we can avoid them.	◯	◯	◯	◯	◯
...has a better understanding of how to provide PCTI care.	◯	◯	◯	◯	◯
...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.	◯	◯	◯	◯	◯

Single-select, Likert question set, conditionally linked to question 14

14B. Has your organization made any of the following changes as a result of participating in JFNA's webinars, conference presentations, or resources? (Select all that apply) * ☐ 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. ☐ No changes have been made to the organization ☐ Other If 'Other' please specify:	Multiple-choice question, conditionally linked to question 14
Thank you for your participation! If you would like to save your responses and complete the survey later, please click the 'Save' button below, enter your email address, and create a new password. If you have additional feedback you would like to share or would like to collaborate on topics of aging and trauma, please email us at Aging@JewishFederations.org and check out our website www.AgingAndTrauma.org. Once you have completed your survey, please click 'Submit' below.	Closing Comments
Print Save Submit	**Submission buttons**

An asterisk (*) denotes a required question

7.2 TABLES

Table 35. Geographic Distribution of National Survey Data	
Respondent Organization Location by State and City	**Number of Responses**
Alabama	**1**
Alabaster	1
Arizona	**2**
Sells	1
St. Michaels	1
California	**12**
Encinitas	1
Grass Valley	1
Long Beach	1
Los Angeles	3
Los Gatos	1
San Diego	3
Santa Maria	1
Walnut Creek	1
Colorado	**6**
Denver	2
Fort Collins	2
Greeley	2
Connecticut	**5**
Groton	1
New Haven	1
West Hartford	1
Woodbridge	1
Unknown	1
Delaware	**2**
Wilmington	1
Unknown	1
District of Columbia	**2**
Washington	2

Florida	**15**
Boca Raton	1
Clearwater	1
Davie	2
Jacksonville	2
Miami	2
Pompano Beach	1
Riverview	1
Sarasota	2
West Palm Beach	2
Unknown	1
Georgia	**2**
Rome	1
Atlanta	1
Hawaii	**2**
Wailuku	1
Honolulu	1
Idaho	**1**
Boise	1
Illinois	**10**
Chicago	6
Evanston	1
Lombard	1
Matteson	1
Northfield	1
Indiana	**5**
Indianapolis	2
Madison	1
South Bend	2
Kansas	**1**
Kansas City	1
Kentucky	**7**
Bowling Green	1
Elizabethtown	1
Lexington	1
Louisville	2
Maysville	1
Owensboro	1
Maine	**1**
Damariscotta	1

Maryland	**4**
Baltimore	1
Columbia	1
Rockville	1
Unknown	1
Massachusetts	**5**
Boston	2
Framingham	1
Lawrence	1
Waltham	1
Michigan	**9**
Alma	1
Ann Arbor	1
L'Anse	1
Mt. Clemens	1
Muskegon	1
Sterling Heights	1
Sturgis	1
West Bloomfield	2
Minnesota	**1**
Minneapolis	1
Missouri	**1**
Branson	1
Nebraska	**1**
Omaha	1
Nevada	**1**
Pahrump	1
New Jersey	**10**
Asbury Park	1
Camden	1
Cherry Hill	1
Elizabeth	2
Florham Park	1
Jersey City	2
Margate City	1
Whippany	1

New York	**28**
Albion	1
Akwesasne	1
Auburn	1
Brooklyn	5
Lyons	1
Montour Falls	1
New York City	12
Richmond Hill	1
Rochester	2
Spring Valley	1
Queens	2
North Carolina	**7**
Charlotte	1
Raleigh	2
Wilmington	3
Winston-Salem	1
Ohio	**7**
Cincinnati	4
Cleveland	2
Springdale	1
Oklahoma	**2**
Anadarko	1
Oklahoma City	1
Oregon	**2**
Portland	2
Pennsylvania	**8**
Camp Hill	2
Harrisburg	1
Oakmont	1
Philadelphia	1
Pittsburgh	2
Pottsville	1
Puerto Rico	**1**
San Juan	1
Rhode Island	**3**
Cranston	1
Pawtucket	1
Providence	1

Texas	**12**
Austin	1
Dallas	1
Fort Worth	1
Houston	2
Lubbock	1
Plano	1
San Antonio	4
Sherman	1
Utah	**1**
Salt Lake City	1
Virginia	**7**
Alexandria	1
Charlottesville	1
Chester	1
Fairfax	2
Norfolk	1
Roanoke	1
Washington	**5**
Aberdeen	1
Bellevue	1
Olympia	1
Spokane	2
Wisconsin	**5**
Grafton	1
Keshena	1
Madison	1
Manitowoc	1
Milwaukee	1
Total Responses	**195**
Unique States	37
Unique Cities *	132

**Does not include count of unknown cities*

Table 36. Service Area Distribution of National Survey Data		
Organization Service Area	**Percentage of Sample**	**Number of Responses**
Local	63.08%	123
Regional	21.03%	41
National	10.26%	20
Statewide	3.59%	7
Other	2.05%	4
Total	**100%**	**195**

Table 37. Sector Distribution of National Survey Data		
Organization Sector	**Percentage of Sample**	**Number of Responses**
Non-Profit	87.18%	170
Government	6.67%	13
For-Profit	5.13%	10
Other	1.03%	2
Total	**100%**	**195**

Table 38. Staff Size Distribution of National Survey Data		
Organization Staff Size	**Percentage of Sample**	**Number of Responses**
Less than 100 Staff	64.62%	126
100-500 Staff	23.59%	46
500-1,000 Staff	6.15%	12
More than 1,000 Staff	5.64%	11
Total	**100%**	**195**

Table 39. Religious Affiliation Distribution of National Survey Data		
Organization Religious Affiliation	**Percentage of Sample**	**Number of Responses**
Jewish	23.08%	45
Christian	9.23%	18
Not Religiously Affiliated	66.67%	130
Other	1.03%	2
Total	**100%**	**195**

Table 40. Service Type Distribution of National Survey Data		
Organization Service Type	**Percentage of Sample**	**Number of Responses**
Adult Day Care	1.03%	2
Adult Protective and/or Victim Services	2.05%	4
Advocacy Organization	2.05%	4
Area/State Agency on Aging	12.82%	25
Association or Society	1.54%	3
Caregiver Program	1.03%	2
Center for Independent Living	0.51%	1
Emergency Responders	1.03%	2
Foundation/Philanthropy/Charitable Trust	1.03%	2
Health Plan	1.03%	2
Home Care/Home Health Agency	3.59%	7
Hospital	3.08%	6
Legal Services Provider	1.54%	3
Meals Program	1.03%	2
Mental Health Clinic/Agency	3.59%	7
Nursing Home	4.62%	9
Residential Services and Supports	6.67%	13
Senior Center	3.08%	6
Social Service Agency	41.03%	80
Transportation Provider	0.51%	1
Other	7.18%	14
Total	**100%**	**195**

Table 41. Service Demographic Distribution of National Survey Data		
Organization Service Demographics	**Percentage of Sample**	**Number of Responses**
African American or Black Older Adults	69.74%	136
American Indian, Alaska Native, or Native Hawaiian Older Adults	43.59%	85
Asian American Older Adults	57.95%	113
Crime Survivor Older Adults	33.33%	65
Disaster Survivor Older Adults	34.87%	68
Domestic or Sexual Violence Survivor Older Adults	44.10%	86
Family Caregivers of Older Adults	65.64%	128
First Responder Older Adults	19.49%	38
Holocaust Survivor Older Adults	54.87%	107
Immigrant or Refugee Older Adults	57.95%	113
Latin American Older Adults	54.87%	107
LGBTQ Older Adults	62.56%	122
Older Adults with Disabilities	72.31%	141
Veteran Older Adults	61.03%	119
None	1.54%	3
Other	6.15%	12
Total	**N/A**	**195**

Table 42. Funding Source Distribution of National Survey Data		
Organization Funding Source	**Percentage of Sample**	**Number of Responses**
Jewish Federations of North America	27.69%	54
Medicaid	41.54%	81
U.S. Department of Veteran Affairs	8.72%	17

Table 43. Organizational Awareness of PCTICare Prior to National Survey		
Organization Awareness of PCTI Care Prior to Survey	**Percentage of Sample**	**Number of Responses**
Organizations Aware of PCTI Care	72.31%	141
Organizations Unaware of PCTI Care	15.38%	30
Organizations Unsure of PCTI Care Awareness	12.31%	24
Total	**100%**	**195**

Table 44. Organizational Knowledge of Aging and Trauma		
Organizational Knowledge of Aging and Trauma	**Percentage of Sample**	**Number of Responses**
Very High	30.26%	59
High	28.21%	55
Moderate	25.64%	50
Low	13.85%	27
None	0.00%	0
Unsure	2.05%	0
Total	**100%**	**195**

Table 45. Organizational Knowledge of Aging and Trauma by Organizational PCTI Care Awareness				
Organizational Knowledge of Aging	**Organizations Unaware or Unsure of Awareness of PCTI Care**		**Organizations Aware of PCTI Care**	
	Percentage of Sample	**Number of Responses**	**Percentage of Sample**	**Number of Responses**
Very High	22.22%	12	33.33%	47
High	09.26%	5	35.46%	50
Moderate	35.19%	19	21.99%	31
Low	27.78%	15	8.51%	12
None	0.00%	0	0.00%	0
Unsure	5.56%	3	0.71%	1
Total	**100%**	**54**	**100%**	**141**

Table 46. Organizational PCTI Care Awareness by Organizational Knowledge of Aging and Trauma				
Organizational Knowledge of Aging	**Organizations with Moderate, Low, or No Knowledge of Aging and Trauma***		**Organizations with High or Very High Knowledge of Aging and Trauma**	
	Percentage of Sample	**Number of Responses**	**Percentage of Sample**	**Number of Responses**
Organizations Aware of PCTI Care	54.32%	44	85.09%	97
Organizations Unaware of PCTI Care	25.93%	21	7.89%	9
Organizations Unsure of PCTI Care Awareness	19.75%	16	7.02%	8
Total	**100%**	**81**	**100%**	**114**

**Organizations unsure of their knowledge of aging and trauma are included in the category of organizations with moderate, low, or no knowledge on the topic*

Table 47. Organizational PCTI Care Awareness by Demographics of Clients Served

Organization Service Demographics	Organizational Awareness of PCTI Care (Percentage of Sample)			Number of Responses
	Unsure	Unaware	Aware	
African American or Black Older Adults	10.29%	15.44%	74.26%	136
American Indian, Alaska Native, or Native Hawaiian Older Adults	15.29%	17.65%	67.06%	85
Asian American Older Adults	9.73%	15.93%	74.34%	113
Crime Survivor Older Adults	7.69%	12.31%	80.00%	65
Disaster Survivor Older Adults	8.82%	13.24%	77.94%	68
Domestic or Sexual Violence Survivor Older Adults	8.14%	13.95%	77.91%	86
Family Caregivers of Older Adults	7.81%	17.97%	74.22%	128
First Responder Older Adults	10.53%	18.42%	71.05%	38
Holocaust Survivor Older Adults	5.61%	9.35%	85.05%	107
Immigrant or Refugee Older Adults	6.19%	14.16%	79.65%	113
Latin American Older Adults	8.41%	18.69%	72.90%	107
LGBTQ Older Adults	9.02%	13.93%	77.05%	122
Older Adults with Disabilities	10.64%	17.02%	72.34%	141
Veteran Older Adults	10.92%	16.81%	72.27%	119
None	0.00%	0.00%	100.00%	3
Other	16.67%	0.00%	83.33%	12

Table 48. Organizational Knowledge of Aging and Trauma by Demographics of Clients Served

Organization Service Demographics	Organizational Knowledge of Aging and Trauma (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
African American or Black Older Adults	2.21%	0.00%	16.91%	23.53%	30.88%	26.47%	136
American Indian, Alaska Native, or Native Hawaiian Older Adults	2.35%	0.00%	23.53%	22.35%	30.59%	21.18%	85
Asian American Older Adults	1.77%	0.00%	17.70%	23.89%	34.51%	22.12%	113
Crime Survivor Older Adults	1.54%	0.00%	21.54%	20.00%	32.31%	24.62%	65
Disaster Survivor Older Adults	1.47%	0.00%	20.59%	19.12%	35.29%	23.53%	68
Domestic or Sexual Violence Survivor Older Adults	1.16%	0.00%	18.60%	20.93%	31.40%	27.91%	86
Family Caregivers of Older Adults	2.34%	0.00%	16.41%	22.66%	31.25%	27.34%	128
First Responder Older Adults	2.63%	0.00%	21.05%	21.05%	31.58%	23.68%	38
Holocaust Survivor Older Adults	0.93%	0.00%	11.21%	19.63%	37.38%	30.84%	107
Immigrant or Refugee Older Adults	0.88%	0.00%	14.16%	23.01%	35.40%	26.55%	113
Latin American Older Adults	2.80%	0.00%	19.63%	22.43%	32.71%	22.43%	107
LGBTQ Older Adults	1.64%	0.00%	17.21%	25.41%	34.43%	21.31%	122
Older Adults with Disabilities	2.13%	0.00%	15.60%	24.11%	29.79%	28.37%	141
Veteran Older Adults	2.52%	0.00%	18.49%	22.69%	30.25%	26.05%	119
None	0.00%	0.00%	66.67%	0.00%	33.33%	0.00%	3
Other	0.00%	0.00%	0.00%	33.33%	25.00%	41.67%	12

Table 49. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma		
Subjective Organizational Capacity to Provide PCTI care to Older Adults	**Percentage of Sample**	**Number of Responses**
Very High	22.70%	32
High	31.91%	45
Moderate	28.37%	40
Low	10.64%	15
None	4.26%	6
Unsure	2.13%	3
Total	**100%**	**141**

Table 50. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers		
Subjective Organizational Capacity to Provide PCTI care to Family Caregivers	**Percentage of Sample**	**Number of Responses**
Very High	14.18%	20
High	29.08%	41
Moderate	27.66%	39
Low	16.31%	23
None	9.93%	14
Unsure	2.84%	4
Total	**100%**	**141**

Table 68. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Center Funding

Organization Service Demographics	Organizational PCTI Care Availability (Percentage of Sample)		Number of Responses
	PCTI Care Unavailable for Demographic	PCTI Care Available for Demographic	
African American or Black Older Adults	52.21%	47.79%	136
American Indian, Alaska Native, or Native Hawaiian Older Adults	56.47%	43.53%	85
Asian American Older Adults	55.75%	44.25%	113
Crime Survivor Older Adults	46.15%	53.85%	65
Disaster Survivor Older Adults	47.06%	52.94%	68
Domestic or Sexual Violence Survivor Older Adults	34.88%	65.12%	86
First Responder Older Adults	55.26%	44.74%	38
Holocaust Survivor Older Adults	31.78%	68.22%	107
Immigrant or Refugee Older Adults	46.90%	53.10%	113
Latin American Older Adults	51.40%	48.60%	107
LGBTQ Older Adults	49.18%	50.82%	122
Older Adults with Disabilities	54.61%	45.39%	141
Veteran Older Adults	56.30%	43.70%	119

Table 52. Subjective Organizational PCTI Care Capacity Across Client Demographics			
Organization Service Demographics	**Organizational PCTI Care Capacity (Percentage of Sample)**		**Number of Responses**
	Moderate, Low, or No PCTI Care Capacity for Demographic	**High or Very High PCTI Care Capacity for Demographic**	
African American or Black Older Adults	66.18%	33.82%	136
American Indian, Alaska Native, or Native Hawaiian Older Adults	82.35%	17.65%	85
Asian American Older Adults	75.22%	24.78%	113
Crime Survivor Older Adults	58.46%	41.54%	65
Disaster Survivor Older Adults	57.35%	42.65%	68
Domestic or Sexual Violence Survivor Older Adults	54.65%	45.35%	86
First Responder Older Adults	52.63%	47.37%	38
Holocaust Survivor Older Adults	45.79%	54.21%	107
Immigrant or Refugee Older Adults	54.87%	45.13%	113
Latin American Older Adults	67.29%	32.71%	107
LGBTQ Older Adults	63.11%	36.89%	122
Older Adults with Disabilities	58.16%	41.84%	141
Veteran Older Adults	63.03%	36.97%	119

**Organizations unsure of their PCTI care capacity are included in the category of organizations with moderate, low, or no PCTI care capacity*

Table 53. Objective Organizational Capacity To Provide PCTI Care To Clients		
Objective Organizational Capacity to Provide PCTI care to Clients	**Percentage of Sample**	**Number of Responses**
Very High	16.31%	23
High	14.18%	20
Moderate	17.73%	25
Low	20.57%	29
None	31.21%	44
Total	**100%**	**141**

Table 54. Objective Organizational Capacity Scores and Ratings Across Capacity Categories and Indicators

Capacity Area and Indicator	Organizational PCTI Care Capacity Score	Organizational PCTI Care Capacity Rating
Resource Capacity	**1.45/3**	**Moderate**
Staff Resources	0.62/1	High
Material Resources	0.36/1	Low
Financial Resources	0.46/1	Moderate
Infrastructure Capacity	**1.03/3**	**Low**
Mission Alignment	0.26/1	Low
Systems, Procedures, Protocols	0.36/1	Low
Physical Environment	0.41/1	Moderate
Knowledge & Skill Capacity	**1.52/3**	**Moderate**
Change Management Skills	0.46/1	Moderate
PCTI Program Implementation	0.47/1	Moderate
Availability of PCTI Training	0.59/1	Moderate
Organization Climate Capacity	**1.49/3**	**Moderate**
Staff Commitment	0.57/1	Moderate
Leadership Commitment	0.54/1	Moderate
PCTI Care Championship	0.38/1	Low
Partnership Capacity	**1.09/3**	**Low**
Internal Partnership	0.30/1	Low
External Partnership	0.30/1	Low
Community Partnership	0.48/1	Moderate
Overall PCTI Care Capacity	**6.57/15**	**Moderate**

Rating Scale for Overall Capacity Score:	*Rating Scale for Capacity Categories:*	*Rating Scale for Capacity Indicators:*
12.00 – 15.00 Very High	*2.40 – 3.00 Very High*	*0.80 – 1.00 Very High*
9.00 – 11.99 High	*1.80 – 2.39 High*	*0.60 – 0.79 High*
6.00 – 8.99 Moderate	*1.20 – 1.79 Moderate*	*0.40 – 0.59 Moderate*
3.00 – 5.99 Low	*0.60 – 1.99 Low*	*0.20 – 0.39 Low*
0.00 – 2.99 None	*0.00 – 0.59 None*	*0.00 – 0.19 None*

Table 55. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a history of Trauma

	Organizational Capacity to Provide PCTI Care to Family Caregivers (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Organizations with very high subjective capacity to provide PCTI care to older adults	0.00%	6.25%	0.00%	6.25%	28.13%	59.38%	32
Organizations with high subjective capacity to provide PCTI care to older adults	4.44%	2.22%	4.44%	20.00%	66.67%	2.22%	45
Organizations with moderate subjective capacity to provide PCTI care to older adults	0.00%	5.00%	22.50%	70.00%	2.50%	0.00%	40
Organizations with low subjective capacity to provide PCTI care to older adults	0.00%	20.00%	80.00%	0.00%	0.00%	0.00%	15
Organizations with no subjective capacity to provide PCTI care to older adults	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	6
Organizations unsure of their subjective capacity to provide PCTI care to older adults	66.67%	0.00%	0.00%	0.00%	33.33%	0.00%	3
All organizations	**2.84%**	**9.93%**	**16.31%**	**27.66%**	**29.08%**	**14.18%**	**141**

Table 56. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Subjective Organizational Capacity to Provide PCTI Care To Family Caregivers

	Organizational Capacity to Provide PCTI Care to Older Adults (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Organizations with very high subjective capacity to provide PCTI care to family caregivers	0.00%	0.00%	0.00%	0.00%	5.00%	95.00%	20
Organizations with high subjective capacity to provide PCTI care to family caregivers	2.44%	0.00%	0.00%	2.44%	73.17%	21.95%	41
Organizations with moderate subjective capacity to provide PCTI care to family caregivers	0.00%	0.00%	0.00%	71.79%	23.08%	5.13%	39
Organizations with low subjective capacity to provide PCTI care to family caregivers	0.00%	0.00%	52.17%	39.13%	8.70%	0.00%	23
Organizations with no subjective capacity to provide PCTI care to family caregivers	0.00%	42.86%	21.43%	14.29%	7.14%	14.29%	14
Organizations unsure of their subjective capacity to provide PCTI care to family caregivers	50.00%	0.00%	0.00%	0.00%	50.00%	0.00%	4
All organizations	**2.13%**	**4.26%**	**10.64%**	**28.37%**	**31.91%**	**22.70%**	**141**

Table 57. High or Very High Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Objective Organizational PCTI Care Capacity

	Organizations with High or Very High Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Objective Organizational PCTI Care Capacity	0.00%	7.79%	18.18%	20.78%	23.38%	29.87%	77

Table 58. High or Very High Subjective Organizational Capacity to Provide PCTI Care To Family Caregivers by Objective Organizational PCTI Care Capacity

	Organizations with High or Very High Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Objective Organizational PCTI Care Capacity	0.00%	9.84%	13.11%	18.03%	24.59%	34.43%	61

Table 59. High or Very High Objective Organizational Capacity to Provide PCTI Care to Clients by Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma and Family Caregivers

	High or Very High Objective Organizational Capacity to Provide PCTI Care to Clients (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma	0.00%	0.00%	0.00%	4.65%	41.86%	53.49%	43
Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers	0.00%	0.00%	0.00%	16.28%	41.86%	41.86%	43

Table 60. Perceived Benefit of PCTI Care Use		
Perceived Organizational Benefit of PCTI Care Use	**Percentage of Sample**	**Number of Responses**
Improvements to the Client Experience	**69.23%**	**54**
Improved Client Empowerment	26.92%	21
Improved Understanding of Client	23.08%	18
Improved Safety	17.95%	14
Improved Relationships	16.67%	13
Improved Client Feedback	12.82%	10
Improved Decision-Making	10.26%	8
Improved Client Peer Support	1.28%	1
Improvements to the Organization	**61.54%**	**48**
Improved Service Delivery	41.02%	32
Structured Work Approach	25.64%	20
Improved Staff Knowledge	25.64%	20
Organizational Sustainability	2.56%	2
Improvements to Client Outcomes	**26.92%**	**21**
Improved Client Mental Health Impact	17.94%	14
Improved Client Well-Being	12.82%	10
Improved Client Service Access Impact	5.13%	4
Improved Client Physical Health Impact	2.56%	2
Improved Client Socialization Impact	2.56%	2
Total	**NA**	**78**

Table 61. Origin of Organizational PCTI Care Awareness		
PCTI Care Awareness Origin	**Percentage of Sample**	**Number of Responses**
External Knowledge Source	**80.73%**	**88**
Peer Organizations	51.38%	56
Professional Education	38.53%	42
Grant Awards	23.85%	26
Scholarships & Literature	11.93%	13
Executive Leadership	10.09%	11
Professional Network	7.34%	8
Formal Regulations	4.59%	5
Client Benefit	0.92%	1
Internal Knowledge Source	**35.78%**	**39**
Organizational Practice	24.77%	27
Staff Knowledge	13.76%	15
Internal & External Knowledge Source	**19.27%**	**21**
Total	**NA**	**109**

Table 62. Center Resources and Changes in Understanding of Aging, Trauma, and PCTI Care

	Changes in Understanding of Aging, Trauma, and PCTI Care as a Result of Center Resources (Percentage of Sample)						Number of Responses
	Unsure	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
As a Result of Center Resources, My Organization's Understanding of Aging and Trauma has Increased	0.00%	0.00%	0.00%	1.64%	29.51%	68.85%	61
As a Result of Center Resources, My Organization's Understanding of Trauma Triggers has Increased	0.00%	0.00%	0.00%	3.28%	31.15%	65.57%	61
As a Result of Center Resources, My Organization's Understanding of PCTI Care has Increased	0.00%	0.00%	0.00%	5.00%	31.67%	63.33%	60

Table 63. Center Resources and Changes in Implementation of PCTI Care

	Changes in PCTI Care Implementation as a Result of Center Resources (Percentage of Sample)						Number of Responses
	Unsure	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
As a Result of Center Resources, My Organization has Increased Resources to Becoming a PCTI Organization	0.00%	0.00%	3.28%	9.84%	29.51%	57.38%	61
As a Result of Center Resources, My Organization has Increased PCTI Programming for Older Adults	0.00%	0.00%	4.92%	16.39%	22.95%	55.74%	61
As a Result of Center Resources, My Organization has Increased PCTI Programming for Family Caregivers	0.00%	0.00%	8.20%	24.59%	27.87%	39.34%	61

Table 64. Center Resources and Organizational Change

Organizational Changes as a Result of Center Resources	Percentage of Sample	Number of Responses
Expansion of Service Delivery	57.38%	35
Increases in Funding Access	44.26%	27
Development of New Programming	60.66%	37
Improvement to Program Quality	88.52%	54
Other	1.64%	1
None	0.00%	0
Total	**NA**	**61**

Table 65. Organizational PCTI Care Awareness by Center Funding				
Organization Awareness of PCTI Care Prior to Survey	**Organizations Funded by the Center**		**Organizations Not Funded by the Center***	
	Percentage of Sample	**Number of Responses**	**Percentage of Sample**	**Number of Responses**
Organizations Aware of PCTI Care	92.59%	50	64.54%	91
Organizations Unaware of PCTI Care	3.70%	2	19.86%	28
Organizations Unsure of PCTI Care Awareness	3.70%	2	15.60%	22
Total	**100%**	**54**	**100%**	**141**

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 66. Organizational Knowledge of Aging and Trauma by Center Funding							
Funding Status	**Organizational Knowledge of Aging and Trauma (Percentage of Sample)**						**Number of Responses**
	Unsure	**None**	**Low**	**Moderate**	**High**	**Very High**	
Organizations Funded by the Center	0.00%	0.00%	1.85%	11.11%	40.74%	46.30%	54
Organizations Not Funded by the Center*	2.84%	0.00%	18.44%	31.21%	23.40%	24.11%	141

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 67. Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma by Center Funding							
Funding Status	**Subjective Organizational Capacity to Provide PCTI Care to Older Adults with a History of Trauma (Percentage of Sample)**						**Number of Responses**
	Unsure	**None**	**Low**	**Moderate**	**High**	**Very High**	
Organizations Funded by the Center	2.00%	2.00%	2.00%	8.00%	40.00%	46.00%	54
Organizations Not Funded by the Center*	2.20%	5.49%	15.38%	39.56%	27.47%	9.89%	141

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 68. Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers by Center Funding

Funding Status	Subjective Organizational Capacity to Provide PCTI Care to Family Caregivers (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Organizations Funded by the Center	4.00%	2.00%	4.00%	18.00%	42.00%	30.00%	54
Organizations Not Funded by the Center*	2.20%	14.29%	23.08%	32.97%	21.98%	5.49%	141

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 69. Subjective Organizational PCTI Care Availability Across Client Demographics by Center Funding

Organization Service Demographics	Organizations Funded by the Center			Organizations Not Funded by the Center*		
	PCTI Care Unavailable for Demographic	PCTI Care Available for Demographic	Number of Responses	PCTI Care Unavailable for Demographic	PCTI Care Available for Demographic	Number of Responses
African American or Black Older Adults	35.00%	65.00%	40	59.37%	40.63%	96
American Indian, Alaska Native, or Native Hawaiian Older Adults	26.67%	73.33%	15	62.86%	37.14%	70
Asian American Older Adults	38.71%	61.29%	31	62.20%	37.80%	82
Crime Survivor Older Adults	14.29%	85.71%	14	54.90%	45.10%	51
Disaster Survivor Older Adults	13.33%	86.67%	15	56.60%	43.40%	53
Domestic or Sexual Violence Survivor Older Adults	0.00%	100.00%	26	50.00%	50.00%	60

First Responder Older Adults	44.44%	55.56%	9	58.62%	41.38%	29
Holocaust Survivor Older Adults	7.84%	92.16%	51	53.57%	46.43%	56
Immigrant or Refugee Older Adults	18.42%	81.58%	38	61.33%	38.67%	75
Latin American Older Adults	34.48%	65.52%	29	57.69%	42.31%	78
LGBTQ Older Adults	29.41%	70.59%	34	56.82%	43.18%	88
Older Adults with Disabilities	27.03%	72.97%	37	64.42%	35.58%	104
Veteran Older Adults	34.48%	65.52%	29	63.33%	36.67%	90
Total	**NA**	**NA**	**54**	**NA**	**NA**	**141**

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 70. Subjective Organizational PCTI Care Capacity Across Client Demographics by Center Funding

Organization Service Demographics	Organizations Funded by the Center			Organizations Not Funded by the Center*		
	Moderate, Low, or No PCTI Care Capacity for Demographic	Very High or High PCTI Care Capacity for Demographic	Number of Responses	Moderate, Low, or No PCTI Care Capacity for Demographic	Very High or High PCTI Care Capacity for Demographic	Number of Responses
African American or Black Older Adults	42.50%	57.50%	40	76.04%	23.96%	96
American Indian, Alaska Native, or Native Hawaiian Older Adults	53.33%	46.67%	15	88.57%	11.43%	70
Asian American Older Adults	48.39%	51.61%	31	85.37%	14.63%	82
Crime Survivor Older Adults	21.43%	78.57%	14	68.63%	31.37%	51

Disaster Survivor Older Adults	20.00%	80.00%	15	67.92%	32.08%	53
Domestic or Sexual Violence Survivor Older Adults	19.23%	80.77%	26	70.00%	30.00%	60
First Responder Older Adults	11.11%	88.89%	9	65.52%	34.48%	29
Holocaust Survivor Older Adults	11.76%	88.24%	51	76.79%	23.21%	56
Immigrant or Refugee Older Adults	18.42%	81.58%	38	73.33%	26.67%	75
Latin American Older Adults	41.38%	58.62%	29	76.92%	23.08%	78
LGBTQ Older Adults	32.35%	67.65%	34	75.00%	25.00%	88
Older Adults with Disabilities	16.22%	83.78%	37	73.08%	26.92%	104
Veteran Older Adults	17.24%	82.76%	29	77.78%	22.22%	90
Total	**NA**	**NA**	**54**	**NA**	**NA**	**141**

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 71. Objective Organizational Capacity to Provide PCTI Care to Clients by Center Funding

Funding Status	Objective Organizational Capacity to Provide PCTI Care to Clients (Percentage of Sample)						Number of Responses
	Unsure	None	Low	Moderate	High	Very High	
Organizations Funded by the Center	0.00%	4.00%	14.00%	12.00%	34.00%	36.00%	50
Organizations Not Funded by the Center*	0.00%	46.15%	24.18%	20.88%	3.30%	5.49%	91

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 72. Objective Organizational PCTI Capacity Scores and Ratings by Center Funding

Capacity Area and Indicator	Organizations Funded by the Center		Organizations Not Funded by the Center*	
	Organizational PCTI Care Capacity Score	Organizational PCTI Care Capacity Rating	Organizational PCTI Care Capacity Score	Organizational PCTI Care Capacity Rating
Resource Capacity	**2.50/3**	**Very High**	**0.87/3**	**Low**
Staff Resources	0.96/1	Very High	0.44/1	Moderate
Material Resources	0.68/1	High	0.19/1	None
Financial Resources	0.86/1	Very High	0.24/1	Low
Infrastructure Capacity	**1.62/3**	**Moderate**	**0.70/3**	**Low**
Mission Alignment	0.38/1	Low	0.19/1	None
Systems, Procedures, Protocols	0.58/1	Moderate	0.24/1	Low
Physical Environment	0.66/1	High	0.27/1	Low
Knowledge & Skill Capacity	**2.32/3**	**High**	**1.08/3**	**Low**
Change Management Skills	0.64/1	High	0.36/1	Low
PCTI Program Implementation	0.80/1	Very High	0.29/1	Low
Availability of PCTI Training	0.88/1	Very High	0.43/1	Moderate
Organization Climate Capacity	**2.22/3**	**High**	**1.09/3**	**Low**
Staff Commitment	0.82/1	Very High	0.44/1	Moderate
Leadership Commitment	0.82/1	Very High	0.38/1	Low
PCTI Care Championship	0.58/1	Moderate	0.26/1	Low
Partnership Capacity	**1.82/3**	**High**	**0.69/3**	**Low**
Internal Partnership	0.56/1	Moderate	0.16/1	None
External Partnership	0.56/1	Moderate	0.16/1	None
Community Partnership	0.70/1	High	0.36/1	Low
Overall PCTI Care Capacity	**10.48/15**	**High**	**4.43/15**	**Low**

Rating Scale for Overall Capacity Score:	*Rating Scale for Capacity Categories:*	*Rating Scale for Capacity Indicators:*
12.00 – 15.00 Very High	*2.40 – 3.00 Very High*	*0.80 – 1.00 Very High*
9.00 – 11.99 High	*1.80 – 2.39 High*	*0.60 – 0.79 High*
6.00 – 8.99 Moderate	*1.20 – 1.79 Moderate*	*0.40 – 0.59 Moderate*
3.00 – 5.99 Low	*0.60 – 1.99 Low*	*0.20 – 0.39 Low*
0.00 – 2.99 None	*0.00 – 0.59 None*	*0.00 – 0.19 None*

Table 73. Center Resources and Organizational Change by Center Funding				
Organizational Changes as a Result of Center Resources	**Organizations Funded by the Center**		**Organizations Not Funded by the Center**	
	Percentage of Sample	**Number of Responses**	**Percentage of Sample**	**Number of Responses**
Expansion of Service Delivery	67.31%	35	0.00%	0
Increases in Funding Access	51.92%	27	0.00%	0
Development of New Programming	69.23%	36	11.11%	1
Improvement to Program Quality	92.31%	48	66.67%	6
Other	0.00%	0	11.11%	1
None	0.00%	0	0.00%	0
Total	**NA**	**52**	**NA**	**9**

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 74. Center Resources and Changes in Understanding of Aging, Trauma, and PCTI Care by Center Funding							
Funding Status	**Changes in Understanding of Aging, Trauma, and PCTI Care as a Result of Center Resources (Percentage of Sample)**						**Number of Responses**
	Unsure	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	
As a Result of Center Resources, My Organization's Understanding of Aging and Trauma has Increased							
Organizations Funded by the Center	0.00%	0.00%	0.00%	1.92%	25.00%	73.08%	52
Organizations Not Funded by the Center*	0.00%	0.00%	0.00%	0.00%	55.56%	44.44%	9
As a Result of Center Resources, My Organization's Understanding of Trauma Triggers has Increased							
Organizations Funded by the Center	0.00%	0.00%	0.00%	3.85%	25.00%	71.15%	52
Organizations Not Funded by the Center*	0.00%	0.00%	0.00%	0.00%	66.67%	33.33%	9
As a Result of Center Resources, My Organization's Understanding of PCTI Care has Increased							
Organizations Funded by the Center	0.00%	0.00%	0.00%	1.96%	29.41%	68.63%	51
Organizations Not Funded by the Center*	0.00%	0.00%	0.00%	22.22%	44.44%	33.33%	9

**Organizations not funded by the Center includes organizations unsure of funding status.*

Table 75. Center Resources and Changes in Implementation of PCTI Care by Center Funding							
Funding Status	**Changes in PCTI Care Implementation as a Result of Center Resources (Percentage of Sample)**						**Number of Responses**
	Unsure	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	
As a Result of Center Resources, My Organization has Increased Resources to Becoming a PCTI Organization							
Organizations Funded by the Center	0.00%	0.00%	0.00%	3.85%	28.85%	67.31%	52
Organizations Not Funded by the Center*	0.00%	0.00%	22.22%	44.44%	33.33%	0.00%	9
As a Result of Center Resources, My Organization has Increased PCTI Programming for Older Adults							
Organizations Funded by the Center	0.00%	0.00%	1.92%	11.54%	23.08%	63.46%	52
Organizations Not Funded by the Center*	0.00%	0.00%	22.22%	44.44%	22.22%	11.11%	9
As a Result of Center Resources, My Organization has Increased PCTI Programming for Family Caregivers							
Organizations Funded by the Center	0.00%	0.00%	3.85%	23.08%	28.85%	44.23%	52
Organizations Not Funded by the Center*	0.00%	0.00%	33.33%	33.33%	22.22%	11.11%	9

**Organizations not funded by the Center includes organizations unsure of funding status.*

CENTER ON **HOLOCAUST SURVIVOR** CARE

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