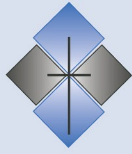

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>
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At the Eldercare Crossroads: Collaborative Responses to Aging in Male Religious Life

Dr. David Rohrer Budiash and Deacon Steven A. DeMartino

Male religious communities in the United States face significant challenges in providing adequate eldercare for their members due to a rapidly aging population and financial constraints. This article focuses on the deeper structural issues within communities that complicate this vital ministry rather than the more well-known issue of delivery of care. To navigate this complex and shifting landscape, leaders must recognize that the most effective, sustainable best practices are those developed through ongoing dialogue and collaborative initiatives.

Context of Eldercare for Male Religious

The Conference of Major Superiors of Men (CMSM) was established in 1956 by the Holy See as the common voice of male religious in the United States and the liaison to what is now the Dicastery for Institutes of Consecrated Life and Societies of Apostolic Life. CMSM serves two other important functions: advocating for the common needs of male religious, and helping to connect the communities in order to realize the importance of a collaborative approach to issues of common concern.

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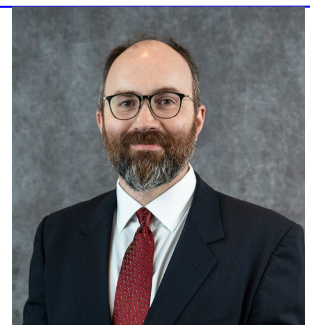

Deacon Steven A. DeMartino serves as Director of Safeguarding Initiatives for the Conference of Major Superiors of Men (CMSM), providing Major Superiors of Religious Communities with consultation, technical assistance, and continuing human formation. He also serves the United States Conference of Catholic Bishops (USCCB) as a consultant to the committee for Child and Youth Protection, as CMSM liaison to the CPCYP Secretariat, and as a member of the Charter Review Working Group.

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One common need is eldercare. Like women religious, the number of elder male religious and corresponding levels of infirmity in the United States are increasing. Statistics from the National Religious Retirement Office (NRRO) indicate that the average cost of care for this aging population is now at $56,000 per person, with higher levels of care, such as skilled nursing, now costing an average of $96,000 per person per year. With the dramatic aging of religious in the United States, NRRO estimates that fewer than 5% of the congregations that submitted data this year are adequately funded for retirement. Communities of male religious are part of these statistics.

Eldercare was identified as a top concern of male major superiors in a 2023 survey conducted by the Center for Applied Research in the Apostolate (CARA) on behalf of CMSM. In that survey, just under 70% of respondents said that the “aging of members” was among their top 5 concerns over the next five years. Unsurprisingly, 64% said that a lack of new vocations was also in their top five concerns, and 63% worried about excessive workloads. These three concerns are, of course, related, all stemming from the demographic shift that male religious communities share with women religious. While the average age of male religious hasn’t risen quite as quickly as that of women religious in the United States, nevertheless, the men’s communities face a significant aging population without a balancing number of new vocations. This has resulted in excessive workloads for many in leadership positions.

In light of this, two groups need to build their capacity for eldercare:

- care providers need support to provide quality and effective care, and collaborative relationships that can facilitate the delivery of care need to be developed;
- leaders need to improve their understanding of what must be done to care for their elder members and then allocate the appropriate financial and human resources to support this important ministry.

To help achieve this, CMSM has developed an Eldercare Summit with the goal of bringing decision makers together to learn about best practices and to make their decisions more responsive to the needs of their communities.

All photographs in this issue were taken at the 2025 Annual Assembly of the Conference of Major Superiors of Men. CMSM is the national organization representing leaders of Catholic religious institutes for men, monasteries, and societies of apostolic life in the United States. All photographs were used with permission of CMSM.

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Historical Perspective

For a good portion of the late 20th and early 21st centuries, most religious communities created their own independent eldercare systems. Some of these were licensed and some were unlicensed. As time passed, these systems became increasingly untenable due to both the expense and the administrative challenges associated with them, especially with locating component personnel to administer facilities as well as to deliver care.

As providers of eldercare for religious began to informally network, they realized that there were common challenges across communities and that talking about these challenges was a valuable resource in its own right that could lead to new ideas and resources. Dialogue begun by the simple sharing of stories increased the possibility of collaborative initiatives and moved communities out of their old, independently-run healthcare silos.

This new collaboration was best expressed by the Tri-State Committee, originally created by Deacon Don Quigley and Brother Wayne Fitzpatrick, MM. The group was largely comprised of coordinators of care centers located in the New York, New Jersey, and Connecticut areas. They met to share stories, learn best practices in caring for elder diocesan clergy and religious, support one another, and help each other solve problems, especially around access to care. The explicit goals were learning, support, and collaboration.

One of the challenges of this early collaboration was that decision makers were not present, which hindered planning efforts and efforts of collaboration across religious communities. Consequently, there was a growing awareness of the need to explicitly involve leaders and decision makers in the dialogue.

Thus, the Eldercare Summit was born as an offshoot of the Tri-State Committee. The original team that created the Eldercare Summit included Deacon Steven DeMartino, Brother Stephen Olert, FSC, Brother Dan O'Riordan, FMS, and Brother Wayne Fitzpatrick, MM. The Summit was initially still primarily focused in the New York, New Jersey, and Connecticut areas.

The Eldercare Summit invited leaders and decision makers into the dialogue around eldercare needs. This helped to educate, build awareness, and grasp what resources were needed to deliver quality eldercare. With leaders in the room, collaboration and implementation of new ideas became much more feasible to implement.

After four Eldercare Summits, it became clear that leaders from all jurisdictions could benefit from being part of this dialogue. CMSM thus agreed to host the Eldercare Summit so as to invite all major superiors into this dialogue on eldercare.

When this occurred, it shifted the Eldercare Summit from a regional conversation to a national one. In the

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last six years that CMSM has coordinated the Eldercare Summit, we have helped our members address a series of issues, including the spirituality of aging, funding opportunities with partners like NRRO and Support Our Aging Religious (SOAR), person centered care, as well as eligibility for and accessing of benefits, among other topics. In addition, CMSM has focused on eldercare in other programs, including training at the CMSM New Leader Workshop and a CMSM Pre-Assembly workshop dedicated to eldercare in 2025.

Needs and Challenges

Significant needs and challenges still remain in the area of eldercare of male religious communities. We have chosen to focus on three areas:

- Needs and challenges in care;
- Community challenges;
- Leadership challenges.

Needs and Challenges in Care

For those communities that have dedicated, licensed facilities for their eldercare needs, difficulties arise when that model no longer fits the needs of the community. A facility with space to accommodate 40 men may now only need to serve 20. The financial cost of maintaining the facility is often significant.

In many cases, licensed facilities were built with a certain population in mind, but that cohort and those perceived needs may no longer exist, or will shortly cease to exist. In these cases, communities have to go back and reconsider their eldercare planning, projecting their new needs over the next 10-15 years and creating a series of realistic goals that will ensure their members receive the care they need at the time they need it.

A related issue is the ability of the community to provide members who are able to administer such a facility. Traditionally, there has been an infirmarian or eldercare coordinator appointed from the community's members. However, as communities age and younger members take on multiple roles, it can be difficult to find someone with enough time and capability to manage an eldercare facility. When this happens, a competent lay professional is usually hired, but this brings its own challenges. In addition to a salary commensurate with credentials, it is of utmost importance to ensure that the staff person understands the charism and way of life of the community. Beyond physical care, pastoral needs of members must remain a priority.

Another consideration is the model of care that undergirds the organization of services in the facility. Historically, a purely medical model of care has dominated our health systems. Medical models include the necessary biomedical professionalism around medications, compliance with local and na-

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tional laws, enrollment in insurance, legal paperwork, and so on.

Instead, an approach of person-centered care seems a better fit with Catholic entities and religious life care facilities especially. While ensuring that medical needs are met, this model of care incorporates the voice of the person receiving the care, taking into consideration a delivery of care that prioritizes holistic wellbeing. The personal dignity of the member as a Catholic religious remains paramount.

Despite being discussed at the Eldercare Summit and by experts such as Sr. Peter Lillian di Maria, O. Carm., of the Avila Institute, many communities still struggle to escape the medical model of eldercare and implement a person-centered approach that is more congruent with religious life.

A final issue is with men who are on safety plans but now need care in their elder years. As this cohort grows, it has become very challenging to find facilities that are willing to care for them. This issue will require deeper dialogue and collaboration across communities for an adequate solution to be developed.

Community Challenges

A first challenge in this area is to find eldercare that understands, respects, and cares for the charism and way of life of religious. Catholic facilities are often better at this, but a community may not have one nearby and would prefer not to have community members live at a great distance from the rest of the community. Collaborating with other communities, either to utilize already established facilities that have space, or working together to create a wing or space for elder religious, is essential in meeting this need.

A second community challenge that needs more attention is aging in place. Anecdotally, male reli-

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gious have a strong preference to age in place. This raises challenges along two fronts. Despite his preference, it may be best for both the man and the community to have the member receive a higher level of care. If a community does not have a policy in place that has clear benchmarks for when to transition to a different level of care, these conversations can become fraught for both the senior member and the leaders of the community, sometimes devolving to negotiations tinged with fighting and acrimony.

Additionally, even when a senior member is still capable of aging in place, there can be strains on the community. Questions arise. Who will help coordinate care and resources? Is there enough money to update the facility so members can get to the refectory, chapel, and out to their various appointments? Can a community realistically take on the responsibility of helping someone age in place with the various other ministries and commitments it has? Answers are rarely simple.

Finally, an increasing eldercare population often means that functionally, many lay staff members access areas previously restricted for use only by members. This is both a cultural challenge and a safeguarding challenge. Whereas community used to be demarcated by specific boundaries, those have now become porous. This affects the quality of community life. Safeguarding challenges can result,

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especially if there is a member on a safety plan with whom staff have to interact.

Leadership Challenges

As persons in leadership change with each election, there is a tremendous fund of knowledge that must be learned in the transition. With the rising percentage of aging members, it is essential that new leaders spend time learning about things such as end of life directives and powers of attorney, enrollment in entitlements for their community members, and how to find needed funding for eldercare projects.

Larger communities with dedicated facilities for eldercare will require their community's leaders to have a good sense of organizational issues related to senior care. Providing eldercare remains very expensive. Yet, the organizational culture of many communities, along with the desires of individual religious, often leans toward retaining their own eldercare facilities regardless of the cost. A leader has to manage the fiscal responsibility of balancing the community's budget as well as helping the community to transition, when appropriate, from a longstanding preference for care to something more sustainable.

As the level of care increases in a community, it becomes necessary to recruit, train, and retain competent and dedicated staff. This can be time consuming and expensive, requiring significant resources. Because of the professional nature of the field of health care, it may be wise to utilize executive search firms, especially when hiring management personnel.

Finally, leaders may be faced with the decision to utilize non-licensed settings. While this may have some appeal, especially for men who want to age in place, these settings can tend to reduce accountability and ultimately can increase costs. Again, this poses the possibility of difficult deliberations with members.

Collaboration & Conclusion

The primary theme, both in the history recounted as well as in the current challenges, is that collaboration is often the best way forward. If a community finds that its facility is now too large, collaboration with other communities who need more care offers a possible, though legally complicated, solution. For those who wish to age in place, the sharing of job descriptions for staff, best practices in renovation of facilities, and ideas on how to appropriately care for elders without sacrificing ministry are all helpful.

Although the needs and challenges discussed are significant and coming to an inflection point as the large cohort of religious reach the age where significant eldercare is needed, we believe that collaborative initiatives can minimize these challenges, and remain one of the best ways for male religious to meet their eldercare needs at this time.

In recent decades, male religious communities have made significant strides in acknowledging and addressing the growing need for eldercare. However, the work is far from over, and the structural challenges surrounding funding, facility management, levels of care, and maintaining a person-centered approach require deeper engagement. The eldercare landscape is shifting rapidly, marked by demographic changes and financial pressures, mandating that dialogue be consistent and ongoing.

CMSM is committed to providing a platform for leaders of male religious communities and care providers to maintain this vital dialogue and collaboratively develop the best, most sustainable practices for caring for their elder members.

Our 2026 series featuring key national organizations for religious continues this quarter with a piece from CMSM, which does so much to assist men's communities with eldercare issues. We are grateful to Dr. Budiash and Deacon DeMartino for their insights.

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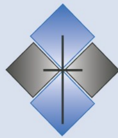

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