Introduction

Locating Nursing Home Care Work

“Jason is helping me out, so he can hear all of this,” said Andy Fischer, the administrator of Rolling Hills Extended Care and Rehabilitation Center, a nonprofit and secular nursing home. Eli, a sick old man with shaggy white hair and thick glasses, pedaled his wheelchair until he came to a standstill in Andy’s doorway. Eli looked tired and somewhat disheveled, wearing an oversized red-and-black flannel shirt, gray cotton shorts, white socks pulled up toward his knees, and an old pair of loafers. His right arm was held in a sling that looked uncomfortable. Andy leaned forward in his office chair, elbows on his knees, and explained to Eli that his check for “room and board” had bounced for the fourth consecutive month. In his typically informal and homespun style, Andy asked Eli, “What’s going on dude?”

Eli was not sure. He knew he was “behind on the rent,” but did not know why; his daughter was supposed to pay the nursing home with his pension checks. She assumed control over his finances after he moved into Rolling Hills about a year earlier. Later, Andy wondered aloud to me whether Eli’s daughter took his money for herself, which he claimed happened more than occasionally. But during the meeting, Eli told Andy that his daughter had a doctorate in chemistry and “could buy you and me,” defending his daughter against the implication that she was pocketing his money. Andy too did not understand how Eli had been allowed to fall so far behind, and commented, “It’s clear you two aren’t on the same page.” Andy suggested that Eli make Rolling Hills his representative payee, which meant that the nursing home would receive his pension and Social Security checks directly, pay his “room and board,” then deposit what remained into a personal funds account. Eli agreed, or perhaps he acquiesced. Then, upon leaving, he turned to wheel out of Andy’s doorway and noticed his friend and co-resident nearby. He explained sarcastically, “I just got called to the principal’s office.” Andy closed the door. I told him that I felt bad for Eli. Andy squinted in disbelief and shook his head. “No,” he huffed, “you should feel bad for me. He hasn’t paid us in four months!” Yet a few minutes later, when Andy had cooled down a bit, he confided to me that he never wanted to pursue money from residents.
In fact, he explained that this was why he left the for-profit nursing home side of the industry for the nonprofit sector. Now, just a few years later, he found himself in the unenviable position of carrying out the same business practices he fled from, except this time it was as the administrator of a non-profit nursing home.

I met Andy for the first time on a chilly, sunny November afternoon in New England. Expecting my arrival, he greeted me warmly just inside the foyer of Rolling Hills, a two-story brick building with white columns that provided nursing home services for about 120 individuals, a bit more than the national average. He was tall, with reddish-blonde hair styled high to make him appear even taller. His size was matched by his demonstrative personality: outgoing, affable, and spontaneous. Initially, I sent him a letter to introduce myself and to outline my project. I followed up with a phone call a few days later. Looking back and considering how infrequently he sat at his desk, I am grateful and lucky he was there to answer the phone. I told him of my interest in understanding the role of emotions in nursing home care work. Throughout the eighteen months I spent conducting field research at Rolling Hills, and at the other nursing home researched for this book, Golden Bay, I continued to pursue the issue of emotions in nursing homes, but Andy led me to thinking about emotions within the context of the financial and regulatory structures that shape nursing home care work.

Andy told me that his time as the administrator at for-profit nursing homes led him to conclude that their day-to-day decision making was overly oriented toward cost-efficiency at the expense of resident quality of life. In fact, he was called to account for expenses that were over budget by as little as a few hundred dollars. Andy’s supervisor at his last for-profit facility, an investor-owned and nationally recognized for-profit corporation, was, in his words, “focused like a laser on the bottom line.” Andy was stunned when his supervisor required that he develop a plan to discharge a half-dozen Medicaid residents. Andy was told to replace them with individuals whose care would be more financially lucrative for the facility. Medicaid pays the lowest, less than individuals who pay for care from their savings and much less than people whose care is paid by Medicare. Medicare, although not designed to reimburse for nursing home care, will pay “skilled nursing facilities” such as nursing homes for up to one hundred days of physical, occupational, or speech rehabilitation, and at much higher rates than any other form of payment. The Medicaid residents were poor, or more likely became poor paying for nursing home care out of pocket. The nursing home was truly their home, and Andy did not want to discharge them. This, he claimed, was the moment
he decided to leave behind the for-profit nursing home sector and seek out work at a nonprofit.

The small nonprofit company that owned Rolling Hills, he said, would never force him to discharge Medicaid residents, whose care generates much lower reimbursements than that of Medicare residents and residents who pay privately from their life savings. He regarded nursing home administration at Rolling Hills as an altogether different enterprise than what he had done at the for-profits. For one thing, he had greater discretion to make decisions based on what was best for the residents’ care. When he became the administrator at Rolling Hills, he replaced all the mattresses because they were outdated and potentially hazardous. The mattresses had springs inside that posed an unacceptably high risk of pressure ulcers, also known as “bedsores,” which are lesions caused by prolonged periods of unrelieved pressure on the body. Although they are preventable and treatable if caught early, they can quickly progress and become fatal, particularly among the elderly. State and federal regulators use the number of pressure ulcers acquired by residents as a key metric of nursing home quality. Replacing the mattresses was an expensive upgrade, which he pointed to as evidence that the facility was oriented toward good care, even though it cost a lot of money. In addition to the new mattresses, he bought new equipment, organized trainings, prioritized outreach to potential volunteer networks and local media, and worked to improve the organizational culture with a rhetoric of “teamwork,” the idea that everyone works together toward the common goal of quality care. He set the tone to his staff that the facility would do something different from—and for that matter better than—the for-profits that dominated the local market.

Rolling Hills engaged, initially, in various forms of altruistic and community-oriented activities, while Golden Bay Nursing and Rehabilitation Center, the other nursing home I researched for this book, operated from a corporate model premised on profitability and cost-efficiency. Golden Bay was part of an investor-owned, nationwide, for-profit chain that operated hundreds of health services organizations across the country. It aggressively expanded and purchased subsidiaries to vertically integrate rehabilitation therapy services and medical staffing agencies. Cynthia Rosen had been the administrator there for several years and was highly regarded by her immediate staff because she provided stable and consistent leadership. She was proud of the facility and boasted not only that it was profitable, but that it had become increasingly so in the years under her management. Cynthia had a calm, warm presence. She was friendly but spoke carefully and seemed to keep in the back of her mind that anything she said around me could be published. Smart and conscientious, she was recognized as a top administrator.
in the company perhaps because she closely monitored the financial indicators of the nursing home, especially the “case mix,” meaning the proportions of residents whose care was reimbursed by Medicare or paid privately out of pocket to balance against Medicaid residents. Medicaid reimburses nursing homes for care at rates that are often lower than the operational costs to house these individuals.

In my first meeting with Andy, I was convinced. The story he told was one I was ready to hear, a story about the superiority of nonprofits to proprietary nursing homes, of altruism and compassion to crass profit seeking. I still think this today, but, having spent considerable time in nursing homes, I now also realize that the story is much more complicated than Andy described. This book is about how Andy and Cynthia managed their nursing homes given the financial and regulatory demands of the nursing home industry, but it is about much more than that. It is about the complex minuet nursing home staff dance between a logic of care and a logic of cost. The structure of the nursing home industry imposes on care workers, constraining them into a range of behavior and thought patterns that objectify residents as embodiments of reimbursable activities. Given these unwanted constraints, staff turned to the emotional rewards of care work to make the labor bearable. Many of them told me they continued to work in nursing homes because they loved the residents and loved caring for people who needed them. The harsh structural constraints of these workplaces, providing low pay and minimal prestige, unenforced workplace protections, and almost no opportunities for meaningful career advancement, were enough to make many nursing home care workers move on for other work. Those who stayed were a kind of “prisoner of love,” as Paula England put it. Their love for residents was the main reason they continued to do nursing home care work, despite the otherwise unrewarding work environment.

Workers in the Nursing Home Industry

Nursing homes are typically composed of rigid vertical hierarchies in which floor staff do the direct face-to-face care work with residents and are paid on an hourly basis while salaried managers attend primarily to financial and regulatory matters. Part of the appeal of studying care work in nursing homes is that, with an average size of about one hundred beds, they are small enough to gain the perspectives of employees throughout the workplace yet large enough also to gain insights into how the rigid lines of authority and supervision structure the experience. The majority of workers in the “service theater,” to use Rachel Sherman’s phrase, are certified nursing assistants.
Of the 16 million workers in the health care sector, more than 1.5 million of them are certified nursing assistants, and this number is expected to grow by 20 percent between 2010 and 2020, making nursing assistants among the top twenty fastest growing occupations in the United States. Almost half of nursing assistants work in nursing homes, while the rest typically work in hospitals, clinics, or doctors’ offices. Many also work as home health aides. Nursing assistant is an entry-level position in health care that requires little training. In the state where this research was conducted, trainees were required to take a one-hundred-hour course and then pass a certification exam before they were allowed to work as a certified nursing assistant. Beyond that, nursing assistants face dim prospects for career advancement, and most tend to move laterally across nursing homes rather than vertically up the chain of command. The median wage for nursing assistants, according to the Bureau of Labor Statistics, is eleven dollars per hour (twenty-four thousand dollars annually), and moreover, they face unstable work schedules and difficult working conditions. They are at elevated risk for workplace injuries because they lift and turn residents frequently, making them particularly susceptible to lower back and wrist injuries. They are also exposed to infections, diseases, and physically, verbally, and sexually aggressive behavior from agitated residents. These are some of the reasons why the turnover rate among nursing assistants in nursing homes is extremely high.

There have been a handful of exemplary ethnographies of nursing homes that have given voice to nursing assistants and sought to highlight the ways that they manage the strains of their work within the bureaucratic and hierarchical structure of nursing homes. As important as these studies have been, they have had the tendency to overlook all the other nursing home care workers. These individuals include dietary aides, activities assistants, rehabilitation aides, social workers, and maintenance staff. Less is known about these workers, but all of them are important to a functioning nursing home. This book integrates their experiences to provide a fuller portrait of nursing homes as workplaces.

The demographic characteristics of the floor staff in this study are largely consistent with the national picture of nursing home care workers. In 2004 the Centers for Disease Control and Prevention conducted their first nationally representative survey of certified nursing assistants who work in nursing homes as part of their National Nursing Home Survey. The survey found that 92 percent of nursing assistants are women, more than 80 percent are over the age of twenty-five, and almost 75 percent have a high school diploma or less education. Nationally, nursing assistants working in nursing homes are disproportionately black, representing 38 percent of all these workers. About
53 percent of nursing assistants are white. Due to the location of these nursing homes, almost all of the staff members and residents at Rolling Hills and Golden Bay were white. At the level of nursing assistants, Golden Bay had a bit more racial and ethnic diversity than Rolling Hills. A handful of Latinas worked at Golden Bay as nursing assistants. Golden Bay was located close enough to a town that had a large Latino/a population, while Rolling Hills was farther away and in a somewhat more rural area. Golden Bay recruited nursing assistants from the town, while Rolling Hills tended to hire staff from the white farming communities that surrounded the area. The differences in ethnic composition that existed between the two facilities did not extend above the nursing assistant level on the work hierarchy. In other words, Golden Bay had a handful of Latina nursing assistants, but nearly all others at both nursing homes were white.

The nursing department primarily comprises nursing assistants, but licensed practical nurses (LPNs) and registered nurses (RNs) also work on the nursing home floor. LPNs have less nursing education than RNs, but in nursing homes they often do the same work: they dispense medication to residents and monitor the nursing assistants. LPNs and RNs make up 13 percent and 8 percent, respectively, of the nursing home workforce. In total, 28 percent of LPNs and only 5 percent of nurses work in nursing homes; many nurses are likely lured away from nursing home care for jobs in hospitals that pay more and often entail more autonomy and better benefits. Like nursing assistants, LPN and RN occupations are expected to grow rapidly, between 20 and 25 percent over the next ten years according to the Bureau of Labor Statistics. The median annual salary of an LPN working in a nursing home is forty thousand dollars, much more than nursing assistants’ salaries but much less compared to RNs in nursing homes, who earn a median salary of fifty-seven thousand dollars. This is likely due to the fact that LPNs have fewer opportunities for career advancement compared to RNs. An RN must sign most state forms, limiting the possibility that LPNs will become managers.

Managers at Rolling Hills and Golden Bay were mostly women nurses, but the maintenance directors at both nursing homes were men. Andy, the administrator at Rolling Hills, was an outlier in a few respects, in that he was neither a woman nor a nurse. He started his career as a volunteer and eventually took college courses in health services that were designed to train students to become nursing home administrators. Andy’s supervisor also was a man, and both companies were run by men, so it is possible if not likely that Andy benefited from a “glass escalator” effect, whereby men quickly ascend organizational hierarchies in fields that are traditionally associated with women’s work.8
Health care is one of the fastest growing industries in the U.S. economy, and the Bureau of Labor Statistics projects that ten of the twenty fastest growing occupations over the next decade will be in the health care industry.\(^9\) As the baby boomer generation enters retirement and life expectancy lengths, the number of workers needed to provide long-term care will increase sharply. The number of people over the age of sixty-five is projected to double by 2030, but in terms of nursing home care, the larger issue may be that the number of individuals over the age of eighty-five, currently about five million, is expected to surge to twenty million by 2050.\(^{10}\) Individuals over age eighty-five are the most likely to require continuous care in institutional settings and currently make up more than half of the nursing home population. The demand for nursing assistants, home health care aids, physical and occupational therapists, and others who will provide care to the elderly will grow dramatically in the coming decades. These jobs cannot be outsourced to workers overseas.

Just as most studies of nursing home care work focus on the experience of nursing assistants at the bottom of the work hierarchy, studies that discuss management tend to focus narrowly on administrators and nursing directors. This book is more inclusive, incorporating the perspectives of reimbursement coordinators, financial managers, unit staff managers, and various other supervisors who are central organizational actors in nursing homes. Managers were typically RNs who had “paid their dues” working shifts on the nursing home floor before moving up to a salaried position with an office, removed from the daily grind of direct care work for a position centrally focused on reimbursement and regulatory matters.

The Research

The data gathered for this book are the result of eighteen months of fieldwork at two nursing homes and sixty-five interviews with their staff members. I gained access to Rolling Hills Extended Care and Rehabilitation in November 2006. Located on a hilly side street near a highway, it was separated from the street by about a hundred yards of grass and light forest. The facility was housed in a several-decades-old brick building shaped like a T. Just inside was a big, octagonal foyer leading to the front hallway. The carpeted, wallpapered halls were often decorated to reflect an upcoming holiday, especially in December, when the staff invited residents and their families to decorate the large plastic Christmas tree and place Hanukkah decorations. There were small couches and chairs that friends and family used to chat with their loved ones away from the noise and energy on the units. The company newsletter
and a calendar with upcoming events sat atop a small, round wooden table in the center of the room. In the corner, on a smaller wooden table, lay the results from the most recent inspection by the Department of Public Health, which by law must be easily accessible to the public. After passing through the entryway, managers’ offices lined the front hallway that led to the facility’s main thoroughfare. The dining room, activities office, and rehabilitation gym were located off this central artery that connected the units. The locked doors to the dementia unit were at one end, while the subacute rehabilitation unit was at the other end. The residents on the long-term care unit lived upstairs. The floors throughout the facility were carpeted with a pattern designed to hide stains, and the walls were either painted or wallpapered and had large wooden handrails to assist residents in case they lost their balance. The hallways were spacious and easily fit two wheelchairs across. The doors to residents’ rooms often remained open throughout the day, as residents were lined up, sitting in their wheelchairs, gathered around the nursing stations in the middle of the units.

A few months after I started collecting data at the nonprofit Rolling Hills, Andy helped me gain access to Golden Bay Nursing and Rehabilitation Center, which was part of a large, national for-profit chain of health care facilities. He knew Cynthia, the administrator, through professional networks and called her on my behalf. Several days later I spoke to her by phone and we set up a meeting. When we met, she kindly agreed to allow me one month of participant observation and then she would determine how much more time, if any, I could spend at the facility. We never had that meeting. She later explained that she let me stay because I did not interfere with the work being done in the nursing home.

Golden Bay was built around the same time as Rolling Hills and had a very similar look and layout. Its parking lot and brick building were set away from the road by about a hundred yards of grass and a handful of maple trees. A receptionist monitored the large white doors and greeted all visitors, who had to sign in before they were permitted to proceed. The small foyer of the facility had a gently worn love seat, a few stately chairs, and a large vase filled with fake flowers sitting atop a table. A rarely played baby grand piano sat along the wall. After signing in with the receptionist, visitors walked through another large white door to the front hallway, which, like at Rolling Hills, was where most of the managers’ offices were located. Golden Bay looked very similar to Rolling Hills on the outside but inside seemed a bit more worn and darker. Doors to both residents’ rooms and staff offices were more likely to be closed at Golden Bay than at Rolling Hills. About a month after I arrived at Golden Bay, I was offered a small desk and chair in
the facility’s reimbursement office, which I accepted, and it served as something of a home base.

On most days at Golden Bay, a long table with candy and baked goods for sale stood in the middle of the central hallway. Two residents spent their day “working” at the tabletop store and chatting with people. The building’s layout was essentially the same as Rolling Hills’, except for the rehabilitation gym. It was roughly twice the size of the one at Rolling Hills. It also had more modern equipment and staff. This allowed Golden Bay to generate more revenue from Medicare, which reimburses nursing homes for up to one hundred days of rehabilitative care (after a three-night qualifying hospital stay) at rates that often exceed five hundred dollars per day, much more than Medicaid reimbursements, which are typically under two hundred dollars per day for as long as the individual resides. In addition to the rehabilitation gym, the activities room, the dining room, a hairdresser, a small store run by activities assistants, and a small library were connected to Golden Bay’s central hallway.

Both nursing homes had three nursing units: a subacute rehabilitation unit for individuals who had been discharged recently from a hospital and were at the nursing home to gain strength and recover abilities that would allow them to go home, a long-term care unit for people who could no longer live independently safely, and a locked unit for people with severe dementia. The rehabilitation unit had by far the fastest pace and had the highest resident turnover, as individuals often started in a wheelchair, then regained enough strength to walk with the assistance of a cane or walker, and then finally regained enough abilities to leave the nursing home and return to their place of residence. This unit had quite a bit of foot traffic; family members, physicians, psychiatrists, and physical, occupational, and speech therapists were there every day. This unit was also the most important financially, as the high-reimbursement Medicare residents were housed there. It stood in striking contrast to the dementia unit, which had the slowest pace and the most stable daily routine. It had very few visitors and felt self-contained compared to the others. Almost all of the individuals living on this unit were on Medicaid, typically after “spending down” their accumulated life savings paying for the nursing home out of pocket. On the long-term care unit, residents had stable daily routines, but the pace on the unit was more active than that on the dementia unit and there were more visitors. Residents on the long-term care unit may have had some symptoms of dementia but required assistance with daily activities that they could not easily do themselves.

My fieldwork allowed me to gain access to the character and contours of work from many angles. I conducted participant observation between two
and four days a week, usually in four-hour stretches. Typically, I arrived in
the morning before the daily managers meeting and left sometime in the
afternoon after lunch. After a few months I began to observe evening shifts
to get a sense of temporal variation, but I usually visited during the day so I
could attend meetings. In the summer of 2007 I increased the extent of my
fieldwork and began to conduct interviews with staff. In the fall of 2007, I
scaled my observations back to presummer levels and conducted interviews
up until fieldwork concluded in the spring of 2008. I spent time observing in
and around nursing stations and shadowing nursing assistants and licensed
nursing staff, and I occasionally lent a hand with serving meals or escorting
residents to activities, to the rehabilitation gym, and to meals in the main
hall. I helped out informally as a volunteer activities assistant. I often spent
several consecutive hours on the units to get a good sense of the pace of
the daily routine. To hear informal conversation between staff, I observed
in break rooms and at holiday parties and other staff functions, and I spent
time having lunch or loitering outside at the “butt hut” with staff on smok-
ing breaks. I routinely observed staff meetings, including the daily managers
meetings, nursing reports, care plan meetings, Medicare meetings, employee
retention committee meetings, and staff trainings. In addition, I had innum-
erable conversations with various individuals in the organizations, from
the maintenance staff to the activities aides, physical, occupational, and
speech therapy staff, dietary aides, residents, and visitors. I recorded my
observations in detailed field notes written soon after I left the facility. To
recall events accurately, I jotted down quotes or keywords in unobtrusive
spots and expanded on them at the end of each day.

Approximately six months after I began fieldwork at Rolling Hills I
conducted the first of sixty-five staff interviews. I asked everyone I inter-
viewed a core set of questions, although the interviews varied according
to my observations and were tailored to each individual, occupation, and
organization. I interviewed staff members throughout the organizational
chain, including certified nursing assistants, LPNs, RNs, physical ther-
apists, occupational therapists, speech therapists, social workers, activities
assistants, unit managers, directors of nursing, and the administrators.
Please see Table I.1 for a list of key staff members who appear in the book
and Figure I.1 for a flow chart of the organizational structure of the nurs-
ing homes. Conducting interviews in the middle stage of my fieldwork
allowed for time to build rapport with staff members and to gain knowl-
dge of particular events that I wanted to learn more about. I asked staff
members about their daily job tasks, their work history, the emotional
attachments they had with residents (or not), how the documentation and
### Table I.1. Key Staff Members

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<tr>
<th>Rolling Hills (Nonprofit)</th>
<th>Golden Bay (For-Profit)</th>
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<tbody>
<tr>
<td><strong>Staff</strong></td>
<td><strong>Job Title</strong></td>
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<tr>
<td>Managers</td>
<td>Managers</td>
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<tr>
<td>Mike</td>
<td>Regional Administrator</td>
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<td>Andy</td>
<td>Administrator</td>
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<tr>
<td>Joanne</td>
<td>Director of Nursing</td>
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<tr>
<td>Nancy</td>
<td>Staff Development Coordinator Medicaid Reimbursement Coordinator</td>
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<tr>
<td>Victoria</td>
<td>Medicaid Reimbursement Coordinator</td>
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<tr>
<td>Beverley</td>
<td>Admissions Coordinator</td>
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<tr>
<td>Flo</td>
<td>Dietary Manager</td>
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<tr>
<td>Dawn</td>
<td>Subacute Rehabilitation Unit Manager Medicare Reimbursement Coordinator</td>
</tr>
<tr>
<td>Carol</td>
<td>Medicare Reimbursement Coordinator</td>
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<tr>
<td>Jamie</td>
<td>Social Services Director</td>
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<tr>
<td>Liz</td>
<td>Activities Manager</td>
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<td>Tina</td>
<td>Scheduler</td>
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<th>Floor Staff</th>
<th>Floor Staff</th>
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<td>Stephanie</td>
<td>Nurse</td>
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<tr>
<td>Caryn</td>
<td>Nurse</td>
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<tr>
<td>Cindy</td>
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<td>Maria</td>
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<td>Bonnie</td>
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<td>Daphne</td>
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<td>Caroline</td>
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<td>Angela</td>
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<td>Alice</td>
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<td>Diane</td>
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<td>Rebecca</td>
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<td>Jamie</td>
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<td>Randi</td>
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<tr>
<td>Marlene</td>
<td>Activities Assistant</td>
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<tr>
<td>Dotty</td>
<td>Activities Assistant</td>
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reimbursement process shaped their work, the problems and challenges they faced on the job, and what it felt like to care for people who often died in their care. The individuals I interviewed ranged in age from their early twenties to their mid-seventies, and given the substantial differences in pay between floor staff and managers, there was a fair degree of class variation. Other staff demographics were fairly consistent with the makeup of the residents. Most residents were white elderly women, whereas the floor staff at Rolling Hills tended to be white women in their thirties or forties and at Golden Bay mostly white women, with some Latinas, in their twenties or thirties.

In addition to the observations and staff interviews, I collected financial records, brochures, advertisements, various internal documents, and other forms of material culture produced by both nursing homes. These documents are useful inasmuch as they reveal the kind of image the facilities tried to propagate about themselves. They were key parts of the narratives that each facility crafted about what they believed about themselves and what they aspired to be. I also utilized data collected by state and federal regulatory agencies. These agencies, primarily the Centers for Medicare and
Medicaid Services (CMS) and the state Department of Public Health, routinely collect data on the characteristics of nursing home populations and the performance of the facilities. I used these data to check or clarify claims made by the nursing home managers and, where I could, examine how far and wide the findings of this study generalize to nursing homes across the country. Combining these sources of data—field observations, documents, and interviews—allowed me to triangulate sources and strengthen the evidentiary base of the research.11

I utilized multiple layers of camouflage to protect the confidentiality of the participants in this study. I have changed the names of all study participants and the organizations. I also am vague about certain details that could have provided even more context and detail but would have opened the possibility that the individuals or the nursing homes could be identified. Last, I have altered certain details about people and the nursing homes that are not critical to the arguments but do provide context, such as the physical appearance of the participants and of the nursing homes.

Nursing Home Care Work

Medicaid and Medicare pay nursing homes on a fee-for-service basis, meaning the more services they provide and bill for, the more reimbursement money they receive. The Patient Protection and Affordable Care Act makes some changes to the reimbursement system that will encourage health services organizations to increase the value instead of the volume of services provided. For example, CMS now imposes financial penalties on the 25 percent of hospitals that have the highest rates of hospital-acquired conditions such as infections and bedsores. But those changes apply much more to hospitals than they do to nursing homes. What remains is a nursing home industry, like the larger health care system it is a piece of, that is deeply driven by profit and incentivized to provide more care, even though more care is not necessarily better care.12 The profitability of nursing home care relies, to a great extent, on doing a lot of work on residents. The fee-for-service model of reimbursement to nursing homes means that nursing homes get reimbursed more when residents are more dependent on staff for everyday activities like getting dressed and eating. This lucrative payment model has helped to generate a system in which presently more than two-thirds of the nation’s sixteen thousand nursing homes operate as for-profit facilities and more than half are part of a multifacility chain. About one-quarter are nonprofit, and the rest are publicly owned and operated.13 Private equity groups have noticed the opportunities for quick profits, buying up nursing homes, often
with complex management structures that obscure ultimate responsibility for residents’ care and safety.\textsuperscript{14}

Yet the big story about health care over the past couple of decades has not been so much about the rise of the for-profit sector (although that is certainly an important story) but more about nonprofits coming to act like for-profits—about the successful imposition of a “market regime” on a sector of the economy that had previously been shielded from such pressures. As Paul Starr wrote in his landmark study \textit{The Social Transformation of American Medicine}, “The organizational culture of medicine used to be dominated by the ideals of professionalism and voluntarism, which softened the underlying acquisitive activity.”\textsuperscript{15} But that is no longer the case. Medical payment and regulatory systems are, self-consciously, policy instruments meant to encourage some activities and discourage others. There is plenty of evidence that reimbursement incentives do shape the behavior of health services organizations, but with very little sense of the processes by which these broad policy contexts are expressed in everyday practices. The stories in the pages that follow show in vivid detail how the reimbursement and regulatory frameworks shape nursing home care work, and how workers use emotional labor as a resource to construct a sense of dignity and meaning within the structural constraints of the workplaces.

Nursing home care work is a prototypical example of what sociologist Everett Hughes termed “dirty work.” In this formulation, particular forms of labor are physically, socially, or morally devalued as disgusting, demeaning, and properly conducted out of the public eye.\textsuperscript{16} Dirty work is delegated to groups who labor on society’s behalf, doing necessary work that is then devalued and disowned by the society that has mandated such work be done. Although managers are to some extent shielded due to their status,\textsuperscript{17} nursing home care work is stigmatized as something that nobody would seem to do willingly. Nursing assistants come to personify a set of repulsive tasks. Although nursing home care work includes food preparation, doing laundry, organizing activities, and completing paperwork, it is largely associated with the daily tasks done by nursing assistants such as assisting elderly individuals who have difficulty controlling their bowels or require help with bathing, dressing, and other routine daily activities that are necessary to live independently. In occupations such as these that are stigmatized and socially undesirable, workers tend to imbue work with meaning in a way that transcends the sum of its parts.\textsuperscript{18} They also tend to have particularly strong and widely shared beliefs, values, and norms that mitigate the stigma of dirty work, although high turnover among the floor staff weakens the shared organizational culture compared to those of low turnover occupations.\textsuperscript{19} The daily
tasks of the job and the interactions staff have with coworkers, supervisors, residents, and family members are the raw materials workers use to make meaning out of their work.

Care work is more than a set of instrumental acts required to maintain the physical well-being of another individual. It is also an ethic comprising genuine concern, affection, emotions, and attentiveness to meeting the needs of a vulnerable person or group of people. Nursing assistants and other floor staff draw from this broader conception of care, for residents but also about residents, to construct dignity in their dirty work. Care work has an emotional component that cannot be adequately captured or regulated by markets. It transcends a simple market exchange precisely because emotions permeate the relationship between the care provider and the care’s recipient.

The findings from the 2004 National Nursing Home Survey seem to validate the centrality of emotional attachments in paid care work. The survey asked a nationally representative sample of nursing assistants working in nursing homes about a range of work-related issues. When asked to choose from a list of reasons for staying at their current position, 99 percent of nursing assistants said they “enjoyed caring for others” and 97 percent responded “this kind of work feels good.” As far as the next most common answers, 76 percent said they stayed at the job for coworkers, 69 percent said it was the flexible schedule, and 68 percent said they liked the location of the facility. Fewer than half said they stayed at the job because of the good pay and career advancement, and 35 percent reported they stayed for the benefits package.

Nursing home care workers have emotional attachments to the individuals they provide care to, even as those emotions are constrained by structural characteristics of long-term care. Care work is devalued socially and materially because it is presumed to be a part of women’s natural instinct to care for others. It is something that women are seemingly supposed to do, with or without monetary remuneration. These assumptions about the value of care work, and the public policies that support them, bring personal notions of care into the public world of work. For example, nursing home staff often relate to residents as fictive kin, or “like family.” Nursing home staff use the familial metaphors and rely on their own personal experiences with death to mentally process the strains of caring for dying people at their jobs. The fictive kin relationship between staff and residents extends also to the families of residents, as each desire and appreciate close relationships with each other.

Yet given the vertical hierarchy of nursing homes, perhaps it is not surprising that managers encourage staff to think of residents like family only
to turn around and use those emotional ties to exploit these wage workers. That is one way that the business of nursing homes undermines the social and emotional components of care work, even though emotional attachments between staff and residents are associated with higher work satisfaction and better health outcomes. For example, Timothy Diamond’s *Making Gray Gold*, a vivid ethnographic portrait of nursing homes, examined how the profit motive undermined opportunities for emotional closeness between staff and residents. Diamond’s findings foreshadowed the takeover of long-term care by large for-profit corporations that have institutionalized chronic understaffing and work overload, at a huge cost to staff and residents. As Francesca Cancian argued, “Organizations undermine care work by maximizing profits, creating hierarchical systems of authority that give little power to care workers, enforcing rigid procedures and rules, and promoting a system of values, incentives, and training that recognizes only medical knowledge.”

Emotions may be devalued in organizations, but they remain a central component of nursing home care work. Arlie Hochschild’s *The Managed Heart: Commercialization of Human Feeling* is perhaps the most important contemporary analysis of emotions in the context of work. Hochschild showed how workers who provide a direct service to customers, a large and expanding sector of the workforce, align their inner emotions and outer displays of emotions (facial expressions, bodily gestures, etc.) with a set of rules, or norms, that are managed by organizations and driven by a logic of capitalist accumulation. Matching our emotions with what is expected and acceptable given the social context is a part of daily life. Some emotion work happens effortlessly; in most settings, people know how they are expected to emote and do so accordingly without awareness of the normative expectations. However, the alignment of our emotions to the organizational boundaries of permissible and prohibited emotions, as often occurs in the context of work, represents a new form of labor exploitation that Hochschild called “emotional labor.” Emotional labor happens when employees calibrate their inner emotions and outer displays of emotion with the “feeling rules” and “display rules” of a workplace. These rules are enforced by supervisors and occur within an institutional context that sets expectations over how workers are supposed to feel on the job. Emotional labor advances organizational goals at the expense of workers, who risk alienation from self when they repeatedly experience emotions that are not honestly felt. Hochschild combined the diverse perspectives of Erving Goffman, Charles Darwin, Sigmund Freud, and Karl Marx to argue that that emotional labor constitutes a form of labor exploitation unique to service work. When I began my field research,
I expected that managers would shape the emotional labor of workers in a manner broadly consistent with Hochschild’s model. The boundaries that marked permissible and prohibited emotions would be clearly delineated and workers would be held accountable to those standards. I also expected a more tightly controlled emotional culture at the for-profit Golden Bay compared to the nonprofit Rolling Hills, given the fact that the construction of a positive, caring culture is a key dimension of competition among nursing homes. But that is not what I found. As I spent time with workers on the floor of the nursing home, it became increasingly clear that emotions were considerably more self-directed and useful for workers as they endured and even constructed a dignified view of their work and their reasons for staying on the job. A number of researchers, building off of Hochschild’s foundation, have also shown the limits to the extent that organizations can control workers’ emotional labor.

The emotional labor that workers used, as a skill to build relationships that felt authentic and meaningful, is clearly an important part of nursing home care work. People from all walks of life struggle within the structural limitations of their workplaces to construct a sense of dignity at work. Dignity is part of Enlightenment-era beliefs of individual autonomy, self-determination, reason, and virtue. It entails the ability to establish and maintain a fundamental feeling of self-worth and a self-evaluation of the worthiness and esteem inherent to a given behavior. This book highlights the role of emotions in the process of constructing dignity. Workers produced emotions, sometimes in ways consistent with organizational demands and sometimes not, but they consistently found in their emotions a resource to manage the strains of their work lives. They used emotions as rhetorical resources to cast their work, and their selves, in a positive light, reclaimed from the stigma of dirty work.

Outline of the Book

The book opens with a careful look at how reimbursement and regulatory structures shape nursing home care. Chapter 1 focuses on how staff managed Medicaid reimbursement, the largest contributor to nursing home revenues. The reimbursement system incentivizes the dependence and incapacity of residents, rather than encouraging independence and restorative care. In other words, Medicaid payment formulas promote the functional dependence of residents upon staff. The chapter details how nursing home staff tried to game the system without crossing the fraud line and the emotional conflict managers felt as this process unfolded. Chapter 2 examines...
the behind-the-scenes preparation by nursing homes for the annual health and safety inspection, the key tool used by CMS to monitor regulatory compliance. The inspections force nursing homes to maintain a baseline of safety for residents’ health, but they also normalize structural problems such as chronic understaffing and work overload. Each nursing assistant was assigned to care for ten residents at the same time. Each nurse had twenty residents. These staffing ratios are consistent with the industry standard and were not considered problematic during the inspections, even though they caused a lot of problems for nursing assistants who struggled to do all the work that needed to get done without cutting corners here and there.

The first two chapters reveal the set of constraints and pressures that nursing home managers face from the reimbursement and regulatory structures. They were compelled to treat care work as a series of instrumental, reimbursable acts in a system that does not provide enough resources. Nursing home residents became the embodiment of those reimbursable acts. Chapter 3 builds on this analysis by showing how these constraints generated conflict between floor staff and managers, given the steep workplace hierarchies. The structural context of nursing home care work pulled floor workers and managers toward different sets of priorities; indeed, they often seemed to work in entirely different social worlds. The concerns of the floor staff were pulled down to residents’ daily needs while managers’ interests were pulled up to the reimbursement and regulatory procedures, leading to different orientations and routine conflict toward the documentation that was critical for reimbursement and regulatory compliance.

Building off of this structural context, chapter 4 examines the consequences of practicing nursing home care in a way that is misaligned with the constraints of the reimbursement system. While the for-profit Golden Bay won awards for their solid financial performance, the nonprofit Rolling Hills edged to the brink of financial ruin. Rolling Hills’ “first-come, first-served” admission policy, which did not discriminate against Medicaid recipients—a key component of their nonprofit, altruistic orientation—caused a severe revenue crisis and ultimately led to Andy’s termination. The story I tell here is not simply about Andy’s personal failure, although it is surely that. It is also a story about the failure of nonprofit idealism and, more generally, about the failure of American social policy to develop an alternative to profit-driven nursing home care. It is, in this sense, a story about how and why nonprofits come to behave like for-profits but also about what is lost in that process. Chapter 5 extends the analysis in chapter 4, tracing the effects of the revenue crisis at Rolling Hills to their dietary department, including forced cuts to the budget for food and
meal service. This chapter documents how the budgetary austerity directly harmed residents’ quality of life and the morale of Rolling Hills’ work force.

Given the structural context that constrains nursing home care, reducing care to a series of instrumental acts and turning residents into an embodiment of reimbursable activities, workers turned to matters they could seemingly control to make the work bearable. They concentrated on their caring, emotional attachments with residents. Chapter 6 shows how nursing home care workers used emotional labor as a skill, a symbolic resource, to enhance and provide a sense of dignity at work. At the same time, they used emotional labor to control unwanted resident behaviors. The chapter also shows how these processes sometimes broke down into unresolved conflict. Chapter 7 builds on this analysis by examining how nursing home care workers made attributions of agency or the lack of agency about residents in order to make sense of, and cope with, residents’ behavior.

The concluding chapter 8 brings together the central themes of the book by connecting the experience of nursing home care workers to the experience of residents. The reimbursement and regulatory systems focus on a very narrow range of care that undermines residents’ quality of life and staff morale in some really critical ways. The burgeoning “culture change movement” aims to improve the physical, social, and emotional environment of nursing homes, but there will be no significant cultural change without major structural changes. The United States faces a huge challenge in terms of how we are going to care for the aged over the next thirty years. We know that the number of people who will need long-term care is going to rise dramatically, as the baby boomers retire and life expectancy increases. Yet we have done very little to prepare for the increasing need for long-term care. We also know that there is going to be a steep increase in the number of people who will be working in occupations that take care of the elderly. Yet we have also done very little to make these jobs more attractive to people who might be good at nursing home care work but stay away because of the low pay and low prestige of these jobs. The fates of the individuals who need long-term care services and the people who provide those services are deeply connected. Both have suffered from neglect, and now is the time to illuminate the structures that shape those fates, before it is too late to do anything but cope in a broken, overwhelmed system.