Paper Work: Outline of an Institutional theory of Documents

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Abstract

Using data from ongoing field research in administrative healthcare, we outline an institutionalist view of standardized administrative documents or forms. Such forms must be analyzed at two levels. First, standardized forms constrain behavior through data fields and by demarcating areas for input of personal data and others for institutional annotation of user input by authorized institutional representatives. Second, standardized forms are sites for reproduction of structural roles and relations obtaining in the broader field. The application form for Medicaid benefits, for example, is structured around delimited data. In duly completing the form, users (the applicant, healthcare facility, and the Medicaid authorities) affirm and reproduce the (asymmetric) structural control relations that link them. An institutionalist analysis of standardized forms is sensitive to the domination of the *local* (the personal) by the *institutional* (the impersonal and bureaucratic), domination that is usually exercised in any bureaucracy through such documents. But additionally, an institutionalist view would be sensitive to the possibility of agency – that is, action by the users collectively to change the way such documents mediate between the local and the institutional in ways perceived as favoring the former, thus modifying the distribution of control relations in the field. Using field data, we report on such a change, identifying the central role played by new conceptions of *paperwork* and of *paper work* – collaborative work patterns whose object and medium is documentation – in effecting the change.

Introduction

At DOCAM '05, we presented a topological view of documents with particular reference to standardized administrative forms (Venkatesh, 2005). We develop the topological view more fully here to outline an institutional theory of such documents. Our research context now as before is the Medicaid/Chronic Care (also known as long term care) eligibility determination process; our analytic focus is on the benefits application (paper) form and supporting documentation. Applicants for benefits fill out the form and submit supporting evidence to verify their financial need for Medicaid/Chronic Care benefits (which falls under the umbrella of Medical Assistance under the federal public assistance programs), and it is on the basis of the application -- comprising the completed form and documents pertaining to the applicant's income and financial assets, such as bank statements and verification of financial investment and trust accounts – and an in-person, face-to-face certification interview (hereafter interview) with Medicaid staff that eligibility decisions are made. The Medicaid program, established under Title XIX of the United States Social Security Act in 1965, is intended to provide financial support to people whose income and resources fall below what they need for necessary medical care and services. It is a cooperative public assistance program at federal and state levels. The federal government shares program administration expenses with the states. In New York State – where the present research is ongoing – eligibility determination is made at the county level by the county Medicaid office, which is located in the county's Department of Social Services (DSS). The county administers the program under federal and state mandates.

US public assistance programs have been characterized as complex "rule-bound, paper-driven" bureaucracies (Lens & Pollack, 1999). Stemming from federal legislation in the 1970s, when "income maintenance" staff replaced social workers in evaluating eligibility, documents have increasingly moved center stage in the process of determining benefits eligibility under these programs. Where a social worker might have decided eligibility based on an individualized assessment of the applicant, income maintenance (hereafter IM) workers base their decisions strictly on standardized financial criteria. The shift to standard criteria from more personalized social casework-based assessment methods has meant eligibility verification now relies heavily on standardized administrative (usually paper) documentation: "Perhaps more than any other change, this increased reliance on documentation and verification (has) symbolized the system's metamorphosis from the personalized social casework-approach of the past to (the) modern welfare bureaucracy" (Lens and Pollack, 1999). This is certainly true of Medicaid/Chronic Care eligibility. IM workers review exhaustive income and financial resources verification going back three years before making an Approve/Deny decision; the application can be as much as six to nine inches thick. When a five-year lookback period becomes mandatory, as is expected, the applicant must gather, and the staff person must process an even larger volume of documentation en route to a decision. Referring to the complexity of verification rules and requirements, a recent report noted that "customers end up lost in the Medicaid maze…" (NYAHSA, 2003).

We start by describing the eligibility determination process for Medicaid/Chronic Care benefits before analyzing how the application form structures the process. Our ongoing field research on the eligibility process is briefly described. We present findings from our data analysis to show how parts of the process have been restructured by the facilities, with active guidance and support from the county Medicaid office, to enhance their sense of control over the constitution of the Applicant as an institutionally-valid category in the application. In understanding and explaining these changes and their effects, we outline a theoretical basis for conceptualizing *document* in a provocative new way.

Determining Medicaid/Chronic Care benefits eligibility

Medicaid offers two types of medical assistance: Community Medicaid and Medicaid/Chronic Care. The first covers citizens who need short-term care, while the latter covers persons requiring long-term care (over 100 days) at a nursing home or hospital (we refer to these as *facilities* hereafter). Medicaid /Chronic Care applicants are required to provide considerably more documentary verification than Community Medicaid applicants since they usually need more substantial financial assistance over a longer time span to cover their healthcare expenses. Our focus is on *Medicaid/Chronic Care*, which is abbreviated to *M/CC* in the rest of the paper.

M/CC eligibility determination starts and ends with the application. In most cases, the applicant is already in a facility when she, in consultation with or at the suggestion of the facility staff decides to apply for M/CC benefits. The staff person calls county Medicaid to schedule the interview. Meanwhile, the applicant works on the M/CC application form and supporting documents. The facility staff person may assist with this or assume the do it herself for the applicant. On the scheduled interview date the applicant or, as is more often the case, an authorized representative (established by the applicant on the basis of a power of attorney arrangement) appears for the interview, which takes place at county Medicaid's downtown offices. The applicant brings the application to the interview with her. Applicants are usually old and infirm and seldom attend the interview themselves. Hereafter, *applicant* refers to the representative.

A county Medicaid IM Worker starts the interview by reviewing the application. She may ask the applicant a few or many questions depending on how complete the application is. At the conclusion of the interview, which could last an hour or more, the worker writes up a pending letter listing missing documentation. The applicant has two to four weeks (extensions may be requested) to complete the application. When complete it is written up by the worker – where the decision on the application (Approve/Deny) and a narrative explaining the reasons for the decision are recorded. Medicaid can close a case pending for a long period of time for “failure to complete”. If approved, the applicant and facility receive a “budget letter” authorizing Medicaid billing. If denied, the applicant can appeal the decision before the county’s Fair Hearing (legal) department and await its verdict.

In the meantime, the facility continues to care for the applicant and expend its resources. It is in the facility’s interest to expedite eligibility so that “receivables” -- the cost of care already provided and ongoing -- may be recovered. If eligible, Medicaid coverage only goes back three months: the facility’s window for recovering expenses is limited to that time period. The facility must absorb any cost of receivables falling outside the recovery window. These expenses can run to hundreds or even thousands of dollars which, if not recovered or not recovered in a timely fashion, can significantly affect their cash flow. A county Medicaid official we will call HK noted:

> *“If we don’t process the application in a timely manner, they (nursing home) have a cash flow problem. If we can process applications in a more timely manner …we help the nursing homes with their cash flow because now they don’t have to borrow money to make pay roll…”.*

The M/CC application form

The M/CC benefits application form is actually a generic standardized form developed by New York State and used by several federal public assistance programs besides Medicaid in the state. The light green form is 16 pages long; the applicant fills out those items that pertain to the M/CC program (Community Medicaid uses a different, shorter form). The form, like standardized administrative forms generally, is structured around data fields: the applicant checks boxes as pertinent and, when required, writes out/types up free-form responses in strictly delimited areas on the form. Each page of the form marks off – with a “Do not write in shaded areas” – the institutional portion from the applicant’s personal information portion. The form’s institutional sections -- shaded dark green for contrast – are meant for annotations by the IM Worker during and after the interview (and for other authorized staff later on, down the road). These institutional annotations (codes) have no meaning in the absence of the applicant’s personal data, and the applicant’s data has no institutional validity without the codes. These codes are activated (D. Smith, 2005) when the form is duly completed. The codes specify the terms and conditions under which the applicant, over the course of the eligibility determination process, emerges as a more or less institutionally-valid category called *Applicant*. A duly completed application yields a bona fide claimant recognizable to Medicaid.

The form embeds topological relations in three ways. In the mathematical sense, it links county Medicaid, facility, applicant, and her attorney (if the applicant has retained an attorney's services). It is the eligibility determination process that actually links these points, activating the form's embedded topological relations through social practices, but it is only in the application that these relations and practices assume official standing in the eyes of Medicaid. The form, for example, devotes a section to *Medical Information* where the applicant may itemize medical expenses and designate the facility that should receive M/CC reimbursement. For its part, the facility must include in the application a document called the Release of Information and Authorization to Represent Resident to establish its provider--client relation with the applicant. Documents like these (we call such documents *front stage* documents, elaborated later) are referenced directly in the body of the application form and are a required part of the application.

In distributed computing/data processing terms, *topology* refers to the configuration of nodes (processing units) in a network and to distribution of processing responsibilities on the network. Nodes may be linked via an architecture of co-operative, distributed control, where each cooperating node has a high degree of autonomy over use of its computing capacity. This type of control architecture characterizes many peer-to-peer systems like the Internet. Alternatively, nodes may be linked via an hierarchical control architecture, where one node or set of nodes controls activities of the other nodes on the network. Such a scenario, where the nodes are not peers but are stratified into controlling and controlled entities, characterizes some older computer networks. Whether the regime is distributed or not, control relations are the result of design parameters in the architecture, which the nodes then implement through enabling protocols and algorithms.

For the social theorist Bourdieu (1998), *topology* refers to the distribution of power in a social structure. Social structure is defined as patterned relations among social positions (Porpora, 1989). The distribution of resources, power and life chances among incumbents of these positions -- people, groups, organizations – tends to be asymmetric, so that some positions have more power than others. Power manifests itself through control relations among incumbents: power-holders control the conduct of others from superior resource access (*resources* can mean material or cultural resources). Authority can be normative and/or statutory in its origin. Certain social *positions* (standing in for *nodes* linked in a network) may control the behavior of others in a social structure from authority derived under law or institutionalized practice, making for a field of practice characterized by "relations of domination" (Burawoy, 1998). This is culturally-sourced (structural) power. In such cases, the controlled voluntarily cooperate in the asymmetric power relation with the controller due to statutory provisions and/or historical precedence ("that's the way it's always been done"). For both controller and controlled, alternative relational patterns are often hard to imagine. Henceforth, after Bourdieu, by *topology* we refer to the prevailing structural distribution of control relations in a field of activity.

The application form embeds topological relations in all three senses of the term. As noted earlier, it links the nodes (minimally county Medicaid, applicant, and facility) "officially", that is through institutionally-valid roles: the applicant is recognized as the claimant, the facility as the provider, and county Medicaid as the claims appraiser and adjudicator. Control relations are asymmetric: under Medicaid law, claims processing occurs at the Medicaid office, and only the office has the authority to make Approve /Deny decisions. Applicant and facility initiate the eligibility process by scheduling the interview. Conventionally, once this step is taken, there is little interaction between applicant and facility, and facility and county Medicaid. The facility assumes that the applicant would show up for the interview with a duly completed application. In reality, though, the following scenarios play out often enough. In the first scenario the applicant, confused or fazed by Medicaid's complex verification requirements, just gives up and assembles an incomplete package for the interview. In the second scenario, in 25 per cent of the cases (Medicaid estimates), the applicant does not show up for the interview at all. In the first case, the facility comes to know just how incomplete the application is when they receive a copy of the pending letter. In the second case, the nursing home may not find out at all that the applicant was a "no-show" at the interview unless they followed up with county Medicaid. The facility's cash flow takes a hit because of delayed recovery of receivables (or outright loss if delay is longer than the permissible window due to a long pending list). In the second case, the nursing home has no hope of recovering expenses because the interview never occurred.

Medicaid & healthcare facilities: Us versus Them

The poor communication between county Medicaid and facilities is attributable to the historically adversarial relations that have existed in the field. Such relations issued from a particular conception of control (Fligstein, 1996). This refers to cultural agreements on how relations between nodes (or more, generally, actors) will be organized. Conceptions may favor distributed or centralized control, heterarchical or hierarchical architectures. Governance structures develop over time to institutionalize such conceptions, grounding them in a distinctive topology with the power to regulate constituents' social behavior.

For their part, governance structures acquire legitimacy within the field from the notions of control they embed in them. Both the topology and its cultural content persist through the routine actions they elicit from socialized actors in the field. This *structurational* view (Bourdieu, 1971; Giddens, 1984) explicates the relation of culture, structure and action: structure (or the topology) provides material and cultural resources to actors, enabling actions consistent with prevailing ideas of control. Actors who behave in compliant ways affirm the topology and abet its persistence, while also assuring and sustaining its cultural currency in the field (Somers, 1995).

HK, the county Medicaid official, characterized relations with facilities as "a Them and Us kind of thing" historically, and this stemmed from the belief that applicants were out to "scam" the system. In the mid-nineties, applications processing at the county Medicaid office had bogged down for a variety of systemic problems. Facilities were experiencing increased demand for their services even as their budgets, already shrinking, were subject to increasing pressure from delayed or denied Medicaid reimbursements. BA, president of TDNH (nursing home), observed:

> *"So what we have over the years…many nursing facilities have had issues as far as the Medicaid processing issues and the timeliness of that, so…there had been a number of meetings…with the county to try and look at, you know, how could we speed up the process of eligibility. Some providers had opted to-- actually have -- to pay for people to work at the county who only work on their specific accounts or applications. Some of us opted not to do that with the view that…one of the roles that the county is supposed to serve…is to process those applications."*

She characterized the county's solution to application processing delays as *"Well, you know, if you want to pay for somebody to work on your claims then you can do that but we don't have any money to do that. So I would say that wasn't a very helpful solution"*.

The *Us versus Them* mind-set that marked working relations up until the mid-nineties helped reinforce the asymmetric power relations between county Medicaid and facilities, relations institutionalized through statutory authority and historical precedence. In the structurational sense, the application form is the official site where this topology and its embedded conceptions of control are enacted every time an application is validly filled out and filed with county Medicaid for processing. As should be evident from BA's view above, strains in working relations worsened in the years preceding 1998 when facilities, frustrated by continuing cash flow problems, became more assertive and began pressing county Medicaid to reform the eligibility determination process, only to be met by county Medicaid asserting its super-ordinate position in the field.

In summary, an institutional view of the application form starts with the conceptions (Fligstein, 1996) or beliefs that motivate topologies and imbue them with distinctive meaning and control distributions. The form is the visible part of the topology and of its cultural warrant, the site of its reproduction and enactment (reproduction by enactment). It is the form where the personal and the *local* (applicant data) is codified and rendered recognizable in *institutional* terms (D. Smith, 2005), and it is the only official site where this occurs in the eligibility process. Institutions exercise power via documents or texts (D. Smith, 2005). In the present case, the state department of health authorizes use of the generic form for M/CC applications in all counties statewide. As such, no one county can unilaterally effect changes to the form; all changes must be approved by the state. What is more easily altered at the county-level, it turns out, are the form's structural and cultural underpinnings. As they felt an increased pressure from facilities to address the mounting applications processing backlog, county Medicaid's top management realized they could modify the prevailing topology while staying within the bounds of Medicaid laws. These topological changes have since been implemented in the county. The county's authority over eligibility decisions has not changed, neither has the application form's physical characteristics and attributes. What has changed is the facilities' sense of control over the constitution of the Applicant in the application, in ways they believe have helped them in better managing their cash flow. Below, we analyze these topological changes initiated by the county under its M/CC Reform program in 1998.

A new topology: The Reforms of 1998 and structural change

This paper draws on data from an ongoing field research project involving the first and third authors. The research looks at the 1998 Reforms and their effects and includes four research sites: county Medicaid, three nursing homes (KTNH, TDNH and WENH) and a hospital (DHH). Research site and respondent names have been disguised in this paper to protect confidentiality. Since late 2005, when the research project commenced, we have conducted over 20 research interviews with county Medicaid and facility staff at different management levels. Additionally, we have also conducted research interviews with three sets of applicants. Observation of five eligibility interview sessions has been completed. Over one hundred pages of archival documentation have been collected from county Medicaid and participating facilities. In addition, we observed a pre-screening training session organized by the county at a facility and participated in and observed a "facility" meeting, which occurs bi-annually at the county Medicaid offices.

In 1997, the new county Medicaid Director convened a departmental task force to reform the M/CC eligibility determination process. The task force met for a year, and in 1998, its recommendations were implemented. One of these was to establish a separate M/CC unit within county DSS (hereafter the M/CC Unit is referred to as the *Unit*). The Unit would be within county Medicaid but administratively distinct from Community Medicaid. The Unit's IM workers would specialize in M/CC cases and would be trained to process such cases. The Unit would relate to facilities differently than had been the norm historically. The Director (the respondent we referred to as HK earlier) characterized the new thinking this way:

> *"I told the (M/CC) supervisor that we were going to "make friends with the nursing homes". It was a real foreign concept at that time…He looked at me and he said "We're going to do what?". "We are going to make them partners. We are going to make them partly responsible for helping us determine eligibility".*

She explained the idea of shared responsibility for eligibility:

> *"The more they (facilities) knew about Medicaid the better they were able to prepare their patients when they came to apply. That's the biggest thing. Medicaid is not the black hole (downtown). We know how to prepare you for the interview. We wanted to improve the lines of communication (with facilities). Why isn't this person eligible? We don't know and we don't just understand that (this was the way it was). It just improved communication 100%.*
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> *"The (new) M/CC Unit brought the facilities…to the table, passing on training about coverage codes, timelines, and documentation requirements. Prior to this the applicant just received a pending letter with items that needed to be submitted for eligibility determination. This new process allowed the facilities… knowledge of what their residents or patients needed to complete an application or renewal. This is what I have referred to as making the facilities and agencies our partner in the eligibility determination process".*
>
> *(Unit) staff actually go the facilities or agencies and do training on how to help a person apply for benefits…This was a new concept".*

The new conception of control initiated under the 1998 Reforms believed in making the healthcare facility a *partner* in assessing eligibility. For the facility, capitalizing on this arrangement meant periodically subjecting their in-house staff to pre-screening training provided by the Unit, making a preliminary assessment (called pre-screening) of the applicant's eligibility and actively assisting her with assembly of the application for the interview. Under the partnership arrangement, facility staff would be far more involved than before with the applicant over the entire eligibility process – from pre-screening and application assembly through the interview and post-interview pending period, disposal of the application and, in case of a denial, even through the Fair Hearing process (not all facilities support the applicant through all these stages, though). For the Unit's part, the new arrangement meant proactively passing on information and sharing "best practices" in formal (via the bi-annual facility meetings) and informal ways. BA, TDNH president, characterized the partnership thus: "*I think the partnership that has been helpful is the county has been very willing to talk about what the issues are, to give suggestions and recommendations that, you know, help the cause and so from that perspective I think definitely that it has been a partnership*".

The new "*Let's be friends*" thinking, which was a cultural change from the pre-1998 ethos, has been institutionalized through the formal pre-screening training and bi-annual meeting program. The Unit's designated trainer offers monthly training sessions at the Unit for facility staff (and others like attorneys) on the pre-screening process. In addition, facilities can request customized pre-screening training to address some of their specific problems, and the Unit's designated trainer provides the training at the facility. The bi-annual meetings serve as forums for the Unit to announce/explain upcoming Medicaid changes and update the facilities on changes at the Unit. They also serve less formally as forums for the Unit to share best practices and for facilities to network with each other -- share information, concerns and strategies. The training program and b-annual meetings are formal programs intended to institutionalize the new relational patterns between the Unit and facilities. These changes have been paralleled by analogous structural changes within the facilities as well, we show.

In 1972, the federal Department of Health, Education and Welfare mandated what has come to be known as "separation of services", "requiring states to have two separate and autonomous organizational units in their public welfare agencies…one unit would be responsible for income maintenance, the other for social service" (Courtney & Dworsky, 2003). The "separation of services" mandate was implemented and continues to this day at the county (and generally in New York State). As part of the 1998 Reforms, the county Medicaid task force proposed further specialization through a new IM job category, the *IM Specialist*, which was differentiated from the *IM Worker*. This distinction has been in effect since 1998 and is now part of the county's official civil service job specifications. IM workers make eligibility decisions for all federal public assistance programs except M/CC, which is solely the IM Specialist's responsibility. As the job title and the county's published specifications indicate, the IM Specialist job calls for more detailed knowledge of Medicaid Law and financial rules relative to the IM worker. Medicaid, with its already complex set of rules, has steadily become more complex still from new regulations and by applicants exploring strategies to qualify for M/CC by "impoverishing" themselves through estate planning, setting up of trusts and other complex financial arrangements. These trends have further increased federal and state requirements for verification via voluminous paper documentation required of the applicant. The IM Specialist must keep up with these changes and work through an increased level of complexity in determining the applicant's eligibility for M/CC benefits. It was in recognition of the ever-increasing complexity of M/CC eligibility determination that the new job category was created as part of the county Medicaid's 1998 Reforms. Hereafter, IM Specialist is referred to as *M/CC Specialist*.

Prior to 1998, at the three nursing homes included in the present study, social workers assisted their patients with the M/CC application. Post-1998, two of the three sites have followed the Unit's lead, relieving social workers of M/CC-related work and vesting this responsibility with specially-trained staff – hereafter referred to as the *M/CC staff person* -- located in the facility's admissions management function and reporting to the business office. Social workers, as part of their job responsibility for assuring welfare of patients overall, continue to identify and refer prospective applicants to the M/CC staff person. IB, TDNH social services director, described the new relations between her office (social services), admissions management in the business office, and the applicant thus:

> *Researcher: And those changes have been implemented? So is it MR______ and TD_______ that do the…*
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> *IB: Medicaid appointments. Where the social workers and case managers are key is post-admission not only where are they (the patient) in those first two weeks after admission but where are they three months down the line, six months…they are the eyes and ears to know where the person is in their stay here and whether or not they need to think about…other means of funding. So their (social workers) role is really one of tracking patients once they are here. Making the business office aware. Yeah this person came in with Medicare had insurance coverage and are telling us they have some private pay. But look Medicare is going to stop paying as of this date. Their job then is to go give the patient that Income/Asset Form… start the discussion about Medicaid (M/CC), make the appointment with MR_____, give MR______ the Income/Asset tracking form so he's got that knowledge when he sits down with the family.*

SM, KTNH president, described the since discredited “integrated services” arrangement – where his social worker staff assisted M/CC applicants -- as a “boondoggle”. He justified his decision in 1997-98 to separate services thus:

> *“Because then there isn’t this financial connection with someone looking to provide support service or counsel someone, you know. So we came to conclude we’d be better served, the residents would be better served, families would be better served, to have a specialist (specializing in M/CC applications). And that’s how that was born. It was born out of the dysfunction of the process and how it was becoming evermore complicated every year, you know. So I think we went through several years of a lot of frustration. A new social worker coming in, let’s say, having to be trained first off in the nuances about talking with people about grieving, about loss, you know, about medical care, oh by the way, how much income do you have? You know? Really, it is a misfit”.*

The third nursing home in our sample is in the process of changing from social workers to business office staff for M/CC work. The one hospital in the sample (DHH) has, for a number of years, used an M/CC staff person in its business office for this purpose.

At the two nursing homes and DHH where separation of services is in effect, the M/CC staff person reports to the facility’s business office. This reporting relationship is further tightened through document-enabled information handoffs to the M/CC staff person from the admissions staff early in the admissions process so that the facility, as part of its risk management strategy vis-à-vis cash flow, starts worrying about the patient’s healthcare costs and revenue recovery right at the very outset of, or close to, their admission to the facility. ML, the M/CC staff person at KTNH, explained:

> *(Researcher: Let’s say a patient picks your facility. They come in through the admissions office…)*
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> *ML: Which is my immediate supervisor…she is vice president of operations, community relations /admissions. And she’ll normally talk to them, do the new admission paperwork and discuss with them as far as insurance or whatever. Say a person is here (for) short-term rehab…and they have Medicare and they have a Medicare supplemental and they are in pretty good health. She is not going to bother having me talk to them…But say the person has no secondary insurance*

and they are here she's going to have them talk to me or if they are here on long-term placement she's going to have them talk to me."

TDNH's risk management strategy starts with screening nurses. In addition to screening prospective new patients at feeder hospitals on clinical criteria, TDNH's screening nurse's work with discharge planners at the hospital to collect preliminary financial data as well. BA, TDNH president, noted:

> *"… we had to train our people who are screeners at the hospital as far as, you know, gathering more information from the charts. So it's just trying to decrease our risk at this end". .*

BA elaborated on TDNH's risk management strategy:

> *"…there is more of a push to take people who are Medicaid pending, for example …so…in our situation we have taken some risks that have not proven to work out very well with people who it wasn't clearly determined as far as their Medicaid status. We took them and ended up with problems as far as whether they were actually eligible, whether we were getting all the information, whether assets had been transferred -- and we ended up with, you know, a non-payment. So I think some of the things that have happened to push people through the system faster have also resulted in issues in regards to payment."*

And again:

> *"I would say what we have done internally, having gone through some issues last year in terms of Medicaid processing is that we've slowed down our process to say,* ***we need much more financial information from the people before we admit them*** *(our emphasis".*

To avoid costly mistakes, TDNH had in the last six months (since November, 2005) adopted two new standardized administrative paper forms – the *Income/Asset Form* and the *Admissions Agreement* -- designed to capture "more financial information from the people before we admit them". In outlining an institutional theory of M/CC application form below, we use TDNH's use of the Income/Asset Form as to illustrate the changes – in internal relational structures, staff roles, procedures, and documents -- that have been effected by the facilities in line with the 1998 Reform aimed at streamlining eligibility. TDNH's Income/Asset Form was picked for illustrative purposes here because we believe it exemplifies the new partnership relation between the Unit and facilities while also enabling the tight coupling of TDNH's internal admissions process with the M/CC eligibility process.

Standardized administrative forms like the Income/Asset Form play a key role in risk management by helping TDNH coordinate distributed work in order to better calibrate the category called *Applicant* as it is documented in the application. The concern for risk management in patient admissions not only directly informs the M/CC staff person's role but is inspired directly by the documentation requirements of M/CC eligibility. The work of risk management at TDNH is best characterized as *paper work*: work conducted for paper (it is documentation work which produces documentation, that is p*aperwork*) mediated primarily through paper, linking one category of paper – which we term front stage, after Goffman (1959), as exemplified by the M/CC application form – with another – which we term backstage, as exemplified by the Income/Asset Form. Paper work is also relational work in the social sense, linking diverse actors, organizations and documents in an extended narrative which is more-or-less co-extensive with the eligibility process. At TDNH this linking occurs in two ways: asynchronously via documents (in linked sets of backstage --backstage, backstage --front stage, front stage --front stage documents) and synchronously through defined social spaces and temporal events we call *staging points* (a term that combines the dramaturgical idea of *stage* and that of *staging area* from the military). Individuals engaged in collaborative work come together asynchronously or synchronously, physically or virtually at stagings, which are organized around backstage and/or front stage documents. These stagings make up a spatially and temporally-linked narrative reaching back before admission to the facility and extending to the interview and even beyond. Collaborative actions at stagings are "objectified" (Ricoeur, 1971) in the documents they produce, documents that feed directly/indirectly into the application. The *content* of paper work, handed off from actor to actor through systematically linked documents at stagings, helps TDNH manage risk. The distinctive *form* of this paper work – its internal structure and scope, its procedures – is shaped by topological changes in the field post-1998.

Theoretical development

TDNH's admissions department modeled the Income/Asset Form directly on the Unit's Checklist of documents required to complete the application. The Form has been in use since late 2005. Upon admission based on the screening nurse's input, the admissions staff capture more detailed financial data from the new admit on the Income/Asset Form. If the patient has no insurance or limited insurance, admissions refer her directly to MR –

TDNH's M/CC staff person – along with the patient's Income/Asset Form. Not only is admissions gathering preliminary financial data pre-admission, they are capturing more detailed data upon admission (or sometime after) in accordance with the Unit's Checklist. Starting in 2004, TDNH's top managers met with the Unit's managers twice for advice as they searched for ways to better manage cash flow. The Income/Asset Form was inspired by these meetings. Assisting patients to complete the application in strict accordance with the Unit's own requirements for documentary evidence, TDNH's managers reasoned, would improve cash flow (and cut risk) by expediting M/CC reimbursements.

The Checklist is part of a file folder of 26 documents that the Unit's trainer (who is also an M/CC Specialist) distributes at pre-screening training sessions. The folder contains an application form, state-provided informational materials intended for facility M/CC staff persons and/or social workers and attorneys, and information sheets (like the Checklist), desk aids and "cheat-sheets" developed by the Unit to help facility staff help patients more effectively with the application. The folder directly structures the flow of the training session as the trainer systematically works through the contents, taking out a document and explaining its specific role in the eligibility process before proceeding to do the same with the next document in the packet. The session, which typically lasts around two hours, concludes when the trainer has worked through the entire folder. The session we attended for this research was requested by TDNH and occurred at the facility. The trainer kicked off the session with this comment:

> *"…that's why I am here today, to help you understand what it is that should be done in terms of pre-screening patients and getting them on their way in the process of applying for Medicaid. So we are going to go through this packet step by step and feel free to ask any questions you need to as we go through this".*

We refer to TDNH's Income/Asset Form and the Unit's pre-screening folder as examples of *backstage* documents, after Goffman (1959). Writing about human social behavior and "impression management" in terms of theatrical "performance", Goffman differentiated front stage behavior from backstage ones. Front stage, "actors are visible to the audience and have to stay in role. Backstage, actors can relax from their roles, step out of character, and work with their dramaturgical team mates to prepare for the front stage performance". (Friedman, 1996, p. 16). In the present case, *backstage* documents refer to paperwork that help prepare the applicant "for the front stage performance" – the interview. *Front stag*e documents refer to the paperwork – comprising the application form and supporting verification that Medicaid requires applicants to append to the form – which the M/CC Specialist reviews at the interview before making an eligibility decision. For Goffman, *front stage* and *backstage* refer to social roles that people assume with more-or-less formality and to their behavior in-role (front stage) and out-of-role (backstage). We use these terms to describe documents not human actors, because it is primarily in documents and through documents that the applicant's institutional role is defined and enacted for Medicaid. The application is both role (as defined by Medicaid) and performance, which occurs at the intersection of the institutionally-defined role and its locally-elaborated enactment by the applicant (as she is usually not physically present, the application is the applicant's primary surrogate at the interview; the representative is the supplemental). *Backstage* and *Front stage* in this case refer also to paper work: work done collaboratively with and for backstage and front stage paperwork. Front stage paper work by the M/CC Specialist entails judging the Applicant's role performance as enacted primarily through the application at the interview. Backstage paper work involves piecing together the enactment prior to the performance and occurs at the healthcare facility. We illustrate these ideas with reference to TDNH.

Paper work, and paperwork, together delineate a defined locus of activity – featuring three different combinations of actors and front stage/backstage documents -- bounded at the TDNH end by the nursing home intake (admissions) procedure and, at the Unit end, by the certification interview, which is an integral part of the M/CC intake process. The Income /Asset Form is only one of a set of documents – such as the Admissions Agreement and the Patient Review Instrument (PRI) -- that link the discharging hospital, the patient, and TDNH at or close to the TDNH intake point. Post-TDNH intake but prior to M/CC intake occurs the meeting between the patient and MR, TDNH's M/CC staff person. MR, at this meeting, reviews the patient's Income /Asset information and, in consultation with her, determines when an application should be submitted. The timing of the application can be a complex matter and takes into account the patient's financial resources, TDNH admit date, and Medicaid rules covering the permissible window for retrospective recovery of receivables by TDNH. If the decision is made to apply, MR starts a file on the patient, files the PRI in it, and pre-screens the patient at the meeting or soon thereafter, walking her through the Unit Checklist to get the application assembly process started. MR may fill out the application form himself at the meeting or may hand it to the patient to complete and return to him. He may personally call banks, the Internal Revenue Service (IRS) and investment accounts on the patient's behalf to gather the income, asset and tax data that Medicaid requires; alternatively, he may delegate this responsibility to the patient. Importantly, MR will call the Unit and schedule the certification interview.

We must elaborate on the idea of stagings before we proceed. Each of the three social interaction points in the above process -- TDNH intake, the patient - MR meeting, the interview -- is a staging point. We use *staging* here to refer to a defined social spaces and scheduled temporal events where documents are assembled for review and processing in "readiness for further movement and action" (Latham & Sassen, 2005). The TDNH intake process can be analyzed both as *staging space* (referring to a functional social space not a physical area) and *staging event*. Since 2005, TDNH has (re)conceptualized admissions as an extended staging space defined functionally around each incoming patient where the work of hospital discharge planners, TDNH screening nurses and admissions staff is coordinated asynchronously via documents -- documents such as the discharge planning paperwork and the PRI. This is a "defined" social space because TDNH recognizes it as such, naming the actors and official roles constituting the space and tightly coupling information handoffs in this space via standardized documents in order to better manage risk. TDNH sees admissions as a scheduled staging *event* as well – defined and purposed in the same way as staging space -- where screening nurse(s) and admissions staff meet synchronously with the patient, and where the patient's clinical data, including the PRI, is reviewed and her financial information, outlined earlier by the screening nurse(s), is elaborated on the Admissions Agreement and Income/Asset Form. When the work performed is asynchronous, stagings may be modeled as staging spaces; they are modeled as events when the work is synchronous. In either case, they function as social scaffolding enabling diverse actors to dovetail documenting activities centering on one object – the application.

The (face-to-face) meeting between the patient and MR is the second staging – a staging event -- en route to the interview (which is the third staging, also an event). MR usually already has the patient's PRI and Income/Asset Form prior to the meeting or may receive it at the meeting from the patient or TDNH admissions staff. At this meeting, MR, as noted, may initiate the application process, as part of which he would transfer, or direct applicant to transfer, information (recorded earlier) from the Income /Asset Form to the M/CC application form. The interview is the only *formal* stage where the applicant, in person, performs the institutional role of Applicant, but we see it as a staging event none-theless as it is not necessarily the *final* enactment. The application could be incomplete even at this late stage from the applicant waiting for required documentation from banks, for example. At the interview, the M/CC specialist may provide information to help the applicant complete the application. For example, at an interview we observed, the M/CC Specialist advised the WENH M/CC staff person, who was co-present with the applicant, on how to obtain the required "non-filing" verification from the IRS. The final enactment of the Applicant's role occurs when the application is complete, unfolding solely through the medium of the application within the confines of the M/CC Specialist's office.
The notion of staging helps clarify the notions of front stage and backstage documents. Nominally, front stage refers to the application, while backstage refers to forms such the Income/Asset Form and the Admissions Agreement. These documents have no standing

with Medicaid, which only recognizes front stage documents as institutionally-valid. But staging spaces and events elide the nominal distinction, so that front stage and backstage documents could be equally implicated in the work that is performed at stagings. In fact, this blurring of categorical distinctions is an integral part of a deliberate strategy designed by facilities (with active guidance and help from the Unit) to calibrate the application as well as possible to Medicaid requirements in order to expedite reimbursement and better manage cash flow. It is only since 1998 that the category of backstage documentation has gained currency at the Unit and at the facilities, as referring to a paperwork corpus which is tied directly and unambiguously to the application. Prior to that, applicant obtained an application form from the county or the facility, filled it out, assembled the documents and submitted the application to the county. Whatever supplemental paperwork the Unit and the facility may have used in the process did not constitute the distinctive corpus of resources they do today. Post-1998, as part of its program to streamline overall eligibility process, the Unit has developed supplemental – or backstage – documentation for its own use internally as well as for training and informing the facilities to fulfill their new role as partners in eligibility determination. The facilities have done likewise, as exemplified by TDNH's Income /Asset Form. But not all facilities in our sample recognize the need for such resources in the same way. WENH, for instance, uses a standardized form to collect preliminary financial data from incoming patients, but this information, unlike at TDNH (or KTNH) is not tied in systematically or directly to the work of WENH's M/CC staff persons, whose administrative location is in the social services office. As such, the form does not qualify as a backstage document in our strict definition of the term, as referring to documents that link in a systematic and direct way to front stage documents. The form, at present, is merely one of a nebulous set that have no defined inter-relationships in the application process as practiced by WENH. It is the mode of use that qualifies documents as front stage and backstage.

The file folder that structures the pre-screening training session contains, along with the Checklist and other backstage documents, the application form. The application form -- a front stage document – is included in the folder for instructional purposes. At the session we attended, the Unit's trainer prefaced her systematic ("piece by piece"*)* walk-through of the application form thus:

> *"The better job you (TDNH's M/CC staff person and social service staff, who were attendees) do with this form going over it piece by piece with the family (and) the better job they do the easier the initial interview process and understanding of the documentation that we get will be. Okay?*

The form, in other words, was being used here as a backstage document to better prepare facility staff (and through them the applicant) for completing a valid application. The pre-screening training sessions, as well as the bi-annual meetings hosted by the Unit, are also staging events as they are designed to serve as social spaces for "a coordination of views, visualizations and narrations" (Latham & Sassen, 2005) across the Unit and the facilities. Front stage documents can change identity and become backstage documents depending on their use at stagings. At the interview, for instance, the application form is a front stage document; at pre-screening training it is not. Documents cannot be stagings themselves; they merely provide structures that must be "activated" (D. Smith, 2005) at stagings through social relations and practices before they can have social effects, and they may be activated as front stage and/or backstage documentation (within limits, however: while front stage documents can be and are used as backstage resources, the reverse cannot occur: no backstage document by itself has any official standing under Medicaid). The categorization of *front stage* and *backstage* would be recognizable to the Unit and the facilities. After all, the pre-screening training centers on preparing facilities to file the necessary front stage documentation for eligibility determination. Backstage documents in the file folder, in the words of the trainer, is "stuff we stuff it (application package) with before we send it to you" to assist facilities with the application process. TDNH created the Income/Asset Form (among others) to serve as a backstage resource for use with the very same process. Although *front stage* and *backstage* refer to distinct classes of documents, both the Unit and the facilities recognize the benefit of eliding this distinction (within above limits). It is the institutionalization of this recognition by both sides (though not evenly at all facilities) that helps differentiate pre-1998 practices from practices since the Reforms of 1998.

One further point must be noted. Stagings are intentional structural affordances, created not opportunistic social spaces or occasions. In the TDNH case, the first two (of the three stagings) are the result of formal measures instituted by the facility to better manage risk: the design of the Income/Asset Form, designation of MR as the M/CC staff person, and design of the internal process linking the form and MR at the second staging. These first two stagings were shaped also by the structural changes instituted by the Unit in 1998 in its relations with facilities, as exemplified by the pre-screening training and the bi-annual meeting program: recall that the Income/Asset Form was a result of TDNH meeting with the Unit and was directly modeled on the Unit Checklist). In 2004, the Unit incorporated another structural change intended to further streamline eligibility process: Internet video (certification) interviewing, which enables virtual staging.

Conventional practice requires that the applicant show up in person for the interview, which takes place at the Unit's downtown offices. Applicants are usually old and infirm, which is why representatives often represent them at the interview. In 2000-2001 the Unit secured permission from the state to trial Internet video interviewing. The applicant is interviewed live at the facility over the Internet by the M/CC Specialist, who sits in the Unit's downtown offices. The trial proved successful. In 2004, the Unit started offering video interviewing as an alternative to the in-person interview. Three facilities in our sample now offer residents the video interview option; three more facilities, including TDNH, plan to offer it at some point in the future.

Video interviewing has changed the work of M/CC Specialists and facility M/CC staff. We focus on just one of these changes here. Facility staff do not usually accompany the applicant to the interview. This was not feasible as each visit could take up to three hours out of the worker's work day, when she is physically away from her desk: half hour drive time each way to and from downtown, and an hour for the interview. With the interview now occurring at the facility, it is far more convenient for her to attend the interview with the applicant. We use the term virtual staging to characterize the new social space created by the video interview, where applicant and the staff person are co -present at the facility and are linked synchronously with the M/CC Specialist over the Internet for the duration of the interview. This is a new social space created by video because, in the conventional interview, synchronous three-way linking was uncommon: usually, the applicant attended interview and later advised the staff person on what occurred, or, alternatively, the staff person followed up with the applicant and M/CC Specialist to find out how the interview went. Field notes from a video interview session one of us observed illustrate how virtual staging affords a new relational space for synchronous collaborative work. Participants at the session, which lasted ten minutes, were the facility M/CC staff person (here identified as HN), a mother and her middle-aged son representing his father, who was the applicant. As per protocol established by the Unit, EM the M/CC Specialist initiated the session by dialing in from her downtown office.

> EM starts by asking about Patient Review Instrument (PRI). HN answers. HN asks EM about applicant's social security identification cards. Son answers. HN explains question to the mother. EM inquires about a "discrepancy" regarding applicant's assets. Son clarifies.
>
> EM asks for applicant's gross pension verification; the son makes notes. EM asks about applicant's checking/savings account documentation for the last three years. Any opening/closing of such accounts in the past three years? Any life insurance? Any bank withdrawals/deposits of $500? Son seeks clarification of questions; HN explains. Son consults the mother before answering EM's last question.

> EM asks whether applicant has a burial account. Son does not understand; HN translates. EM asks about applicant's Income Tax refund and Internal Revenue Service "non-filing" form. HN asks EM how she could get the "non-filing" form. EM answers. EM asks for copy of applicant's Medicare cards, and the son makes notes. EM lists the documents still needed ("pending') to complete application; son makes notes. Session concludes.

Pre-1998, the social space of M/CC eligibility determination was structured rigidly in an institutionally-determined topology characterized by centralized control. The application form was the site for the enactment of prescribed social roles and relations by the nodes in the topology: the "text", when properly activated, reproduced these roles and relations. Virtual staging events afford a new space where the dramaturgical metaphor is inverted: relations produce "text" – referring to the constitution of the Applicant in the application. This new relational space can subtly alter the prevailing topology by affording facilities a sense of increased control over "textual constitution" (D. Smith, 2005) of the Applicant. Enactment of roles in this virtual space continues to be structured by the application form along institutionalized lines: notice that the M/CC Specialist leads the session, initiating it and signaling its termination. Also, she is the one asking questions, the other participants respond to her questions. The form also structures the activity: EM's questions generally follow the sequence of data fields as they occur on the physical form. But notice how the synchronicity of question/answer/clarification afforded by virtual staging, which brings together actors who posses diverse pieces of information in a shared, interactive space, helps improve the calibration of the Applicant as constituted through text at the interview. The PRI, for example, is exchanged between discharging hospital and admitting facility: the facility's M/CC staff person gets the PRI from the facility's admissions office along with the other new patient paperwork. The applicant is unlikely to have the PRI or even know what it stands for. Conversely, the M/CC staff person is unlikely to know details of the applicant's financial transactions. In fact, as evident from above, not even the son nor the mother had information on the M/CC Specialist's questions on bank accounts and life insurance (the M/CC Specialist ended up including this information in the list of pending documentation she handed the son for follow up at the end of the session). On the M/CC Specialist's third question, the son consulted with the mother before answering it.

Without the synchronicity of relations and activity afforded by video, information gaps surfacing at the interview would mean a longer list of pending documentation before the application is deemed complete by Medicaid. A longer pending list can delay the receipt of Medicaid reimbursement by the facility, occasioning or exacerbating cash flow issues.

To summarize, stagings – spaces as well as events, physical as well as virtual -- share at least three characteristics:

- Coordination of documentation work across stagings occurs through linking actors and/or documents. Stagings serve as relational scaffolding that helps coordinate documenting activities by actors dispersed across space and time around the same object – the application.

- Documents (front stage, backstage) "mediate" and "anchor" stagings (D. Smith, 2005), and stagings are intended to produce documentation. Paperwork is both medium and object of paper work.

- Documentation work at staging is structured by the application form and occurs with direct, explicit and exclusive reference to it. In this sense, paperwork (front stage, back stage) defines the *referential* bound of the social space within which paper work occurs (see Ricoeur, 1971).

Not all facilities in our sample use stagings in the same way. At TDNH, MR gets a referral from admissions (first staging), walks the applicant through pre-screening (at second staging), but does not attend the interview (third staging) with applicant. On the other hand ML, the M/CC staff person at KTNH, works closely with the applicant right from the point of referral from admissions all the way through, staying "on the case" through the interview and pending period until the application is approved. She is the active linking element and works directly with linking documents: she fills out the M/CC application form for the applicant (unless they wish to do it themselves), assembles the required documents, and attends the interview (face-to-face and video) along with the applicant. We identified three stagings at TDNH, each involving a different combination of actors and relying primarily on linking documents. KTNH views application-related activity from the point of referral to post-interview as one unitary staging, relying on one actor – ML – to personally inter-link the different phases of the activity. Why does KTNH do it this way? ML believes she has greater control over eligibility, and cash flow, this way; this way she knows exactly "what's going on"[1]:

[1] With virtual staging, ML could exercise control more conveniently than with the face-to-face interview: she could participate in the interview without leaving her office. Furthermore, video interviews tend to be briefer. The longest of the five video interview sessions we observed lasted 22 minutes; face-to-face interviews, according to estimates from the M/CC Unit and facilities, can last up to an hour.

Researcher: SM (KTNH President) talked about the sense of control from you doing all of this.

ML:We know what's going on. Yeah. Because if this is all left on its own, it wouldn't all come together, I can tell you this right now, it would not all come together and we'd have all these straggling pieces all over the place like people getting denied for failure to complete the application or after they are approved they didn't pay their monthly income because no one explained it to them right at the get go, or the husband and wife cases they didn't realize exactly what they had to transfer out of the name and it had to be done and they had to show proof to Medicaid or those types of things. We'd get hit financially if we didn't follow through on all these…it's a lot cheaper say for us to spend a few little extra hours doing these things and not take thousands of dollars of a financial hit".

In light of the above, we take *document* broadly to refer to the defined relational space in which documentation occurs, and includes both documents that mediate relations and are products of relations. *Document* refers to *paper work* as well as *paperwork*. The term has been used in similarly broad terms to refer to "traces of human activity" (Buckland, 1997; Olsen, Lund & Hartvigsen, n.d.). Action itself is sometimes characterized as text: "action itself, action as meaningful, may become an object of science…through … objectification similar to the fixation which occurs in writing" (Ricoeur, 1971, 538). Our expanded view of document offers a perspective on text – standardized administrative forms in particular – and on text-mediated practices that is similar to both but with important qualifications. First, texts like standardized administrative forms are designed to document activity and also to structure activity. Second, if action is text, how might we bound it so as to render it suitable for social scientific analysis? We suggest starting with interlocking documents (front stage, backstage) intended to objectify actions in consistent ways.

Human activity becomes an "object of science" when it shows persistent patterns that can be analyzed and modeled (see Ricoeur, 1971). Pre-1998, eligibility-related activity lacked consistency. The reforms of 1998 sought to pattern this activity by improving consistency through role-specialization at the Unit: henceforth, eligibility decisions were to be made by specialized staff (M/CC Specialists). Facilities too suffered (some continue to suffer) from inconsistencies in the way they worked with residents applying for M/CC benefits. BA, president of TDNH, described her problem this way:

"…people who were showing up down at the county (for the interview) that didn't have all the information and so we weren't doing something right at our end… case managers or social workers…were telling patients what to do as far as what information they needed and perhaps didn't have a clear enough process to say, well, why don't you get this information together and then go to MR (TDNH's M/CC staff person) so we have a check to make sure and then go down (to the county). So they were making their appointment showing up didn't have all their information and so, we were unaware of that.

To improve consistency in the way they channeled their residents through the application process, TDNH, in consultation with M/CC Unit, made two structural changes. The first was to designate MR as the single gatekeeper or "check" point for all residents applying for M/CC benefits: all residents were routed through MR. The second change, mimicking the Unit's move to role specialization, was to have MR specialize in M/CC work. Two of the other three facilities in this research have implemented similar changes internally and the fourth, DHH, has been doing it this way for a while.

Post-1998, relations between the M/CC Unit and facilities have also been restructured in light of the "Let's be friends" thinking, resulting in a new topology. Although the Unit is still the only node on the topology authorized to process applications and make eligibility determinations, facilities now feel they can have more direct control over those decisions by working closely with the applicant and the Unit in the application's formative stages. Facilities see the topology as less asymmetric than it was prior to 1998. The Reforms and aftermath changed the topology by redistributing controls in subtle but significant ways. The new topology is being institutionalized – rendered reproducible through consistent everyday action – in mutually-reinforcing ways through new relational structures within and between the Unit and the facilities, new staff roles and work processes, and backstage documents. These changes are intended both by the Unit and facilities to *objectify* or fix action (Ricoeur, 1971) – action that occurs in relation to the application -- in a consistent pattern across situations and persons. Backstage documents are a key to objectification.

We use *institutionalization* and *objectification* interchangeably. Institutionalization is occurring through objectification so as to establish certain activity patterns as meaningful across the extended activity space and actively abet its persistence by patterning behavior consistent with this understanding. The present case offers a basis for a stringent version of Ricoeur's (1971) characterization of activity itself as text. We start not with actions but with documents designed to objectify actions. These (backstage) texts can be described as “interlocking” (D. Smith, 2005) in that they are cross-referenced directly (Income/Asset Form is tied into the application) and indirectly (this particular tie in is modeled on the Checklist). The actors themselves see backstage documents as inter-locking resources for patterning action. Considered as a set, backstage documents are a critical element in a set of elements – which includes structures, procedures, and roles – that have been instituted by the Unit and facilities stemming from a more-or-less shared definition of the extended application process as an object of reflexive analysis and reform. These structures, roles and procedures have been developed to work with interlocking documents, which infuse and mediate the extended process end-to-end. Constitutive activity is linked up as well as patterned at staging spaces and events by combinations of front stage and backstage texts. The entire extended process is motivated by a singular document-centered goal: to better calibrate, to more consistently calibrate, the textual constitution of the Applicant in order to streamline eligibility. It is in the specific context of the M/CC application process that we characterize *document* in this dual way: both as paper work and paperwork. The latter, to the extent it comprises documents that are interlocking in referential terms, we believe offers a theoretical basis for bounding the scope of the former for empirical analysis.

Is there value in characterizing *document* in these terms? We address this question in the concluding section below.

Conclusion: Structure, Agency and the Social Life of Documents

Documents are social things (Brown & Duguid, 1996; also Lund, cited in Olsen et al., 2000) because they mediate social relations and even entire “social worlds” (Brown & Duguid, 1996). This is an important insight but one that has not generated the volume of social scientific inquiry it deserves. Cultural products have an “expressive dimension” (Wuthnow, 1992) to the extent they catalyze and structure social relations, acquire their meaning and identity in and through relations, and are more-or-less durable containers of the outcomes of relations: they are both objects and social performances at the same time, *paperwork* as well as *paper work*. Cultural objects such as texts, including standardized administrative forms, cannot be fully understood only in terms of their internal structure or content; their expressive dimension must be analyzed as it can modify and reinterpret their manifest content in significant ways (Brown & Duguid, 1996; Wuthnow, 1992).

Dorothy Smith’s provocative work (2005) analyzes the implications of this insight – that documents are social things – in reference to standardized administrative documents. For Smith, texts are vehicles of domination of the “local” – the idiosyncratic particularities of social lives – by the “institutional” (bureaucratic structures). Texts are the crucial means by which the local is constituted and forced to fit institutional categories; in this process, the particularities of the local become stylized and abstract, thereby losing their humanity and existential pathos. Institutional domination works through "ruling relations", which are exercised mainly through texts:

> "It is the replicability of texts that substructs the ruling relations; replicability is the condition of their existence. The capacity to coordinate people's doings translocally depends on the ability of the text. Texts suture modes of social action organized extralocally to local actualities…" (p. 166).

Administrative documents like forms tend to be standardized and hence are replicable, which also means that the institutional actions they regulate are also reproduced across persons and situations: such texts operate trans-individually and trans-locally (or trans-situationally) to objectify actions, thus constraining the local in patterned ways. Decisions that directly affect the local are taken under institutional aegis, with stylized input at best by the local. This activity of Procrustean force-fitting of the local by the institutional occurs through text-centered events Smith calls "processing interchanges":

> "At each processing interchange, a text enters and is processed. It may then be passed on as modified or checked, or a new text built from the resources of the original is produced and passed on. The individual whose case is organized in this process has been constituted textually" (p. 171).

Smith's (2005) "institutional ethnography" says something important about the social life of documents, in particular their ability to constrain and control social relations (see also Brown & Duguid, 1996). Smith gets considerable analytical leverage from this point of view, which is structuralist in its concern. The institutional viewpoint of documents that we have outlined here is certainly sensitive to a structuralist view of social structure. Our characterization of the application form as embedded in an asymmetric control topology recognizes both that (a) Medicaid, as institution, exercises "ruling relations" over the textual constitution of the applicant, and (b) the basis of such relations lies in the social distribution of power. However, an institutional view must also afford the possibility of agency, but Smith does not accommodate this possibility in her view of texts.

Institutionalist theorizing recognizes that social actors are capable of contentious (or agentic) action, action that is opposed to prevailing institutionalized regimes (McAdam, 2003). The nature of agency and the particular attributes of agentic action will depend on the historical moment of contention. Depending on the social conditions, effective agents calibrate the target of their contention and the scope of the change they seek (Emirbayer & Mische, 1998). Medicaid is a federal program under the administrative charge of the states, and the relevant bureaucratic structures and practices are highly institutionalized and heavily regulated features of the landscape of public welfare in the US. As such, they are not easily changed. The scope of change that county Medicaid authorities could hope to effect in 1998 was limited by definition. Nonetheless, the Reforms dating to that year, designed and implemented with some input from the facilities, did manage to change the process sufficiently to increase perceived control by facilities over eligibility decisions. The facilities too acted like agents to change their internal structures and practices toward the same end. The text in this case – the M/CC application form -- has not changed in any way as a result of these actions, which is to say the textual constitution of the applicant continues to be institutionally-determined. But facilities' control over the calibration of the applicant's textual constitution has changed in ways many of them view as favorable and empowering.

Our idea of staging spaces and events offers an important contrast to D. Smith's (2005) notion of processing interchange. Both are characterized as structural affordances, not opportunistic social encounters. A processing exchange pits the local and the institutional in a stage determined by the latter. Stagings, on the other hand, are spaces and events for coordinated activity by diverse actors, and the stage in this case is the result of consensual action by facilities and the Unit explicitly to aid in the constitution of the local. Support by the institutional entity at stagings can be direct, as in virtual staging, through county-enabled video interviewing. It can be indirect, through, for example the Checklist. Administrative processes may in general be, and often are, created to favor the institutional, and Smith's focus on the institutional is valid and valuable. But empirically and theoretically, as well as morally, the possibility of agency must be acknowledged. An expanded view of document as encompassing not only paperwork but also paper work allows a nuanced institutionalist appreciation of the social life of such documents. If documents are seen not merely as embedding structures but as themselves embedded in larger topologies, interesting dialectical tensions can surface between the two levels. Changes to these larger structures can change the way text-embedded structures intersect the local, as we showed.

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11500 words approx.

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