Introduction

Annual turnover among direct service workers (DSW) in the nursing home industry is estimated at 71%¹ and costs nearly $4.1 billion annually.² High DSW turnover rates are also prevalent among providers of home health (25%)¹, mental health (30%)³ and developmental disabilities services (50%).⁴ However, to our knowledge, this study is the first to examine DSW turnover across provider types. The specific aims of this study were to:

1) Examine DSW turnover in four human service industries in Ohio: nursing homes (NH), home health (HH), mental health (MH) and developmental disabilities (DD) providers; and
2) Examine predictors of DSW turnover, including regional differences across Ohio.

Methods

Operational Definitions of DSWs: In NH, HH and DD providers, DSWs were defined as staff providing clients/residents with hands-on care such as bathing, dressing, and grooming. Other duties, depending on setting, include assisting with meals and housekeeping. In MH, the most comparable employee was the community psychiatric supportive treatment (CPST) worker. CPST workers provide services such as care coordination, mental health interventions, and help maintain an individual in the community by addressing barriers to independent living, education and employment.

Questionnaires: Since definitions of DSWs differed, two parallel provider surveys were developed for: 1) NH, HH and DD; and 2) MH providers. Both mailed (paper/pencil) and electronic (SurveyMonkey) versions were developed so providers could choose the method for completing the survey. Some providers also completed surveys via fax and by telephone.

Sampling: The sampling frame of all provider types that was developed included NH and HH provider lists downloaded from the www.Medicare.gov website; a list of MH providers obtained from the Ohio Department of Mental Health; and a DD list obtained from the Ohio Department of Developmental Disabilities (DODD). Independent providers were excluded from these lists since the focus of the study was on agencies. Subsequently, the four provider sampling lists were divided into the five major geographic regions of Ohio: Appalachia, Metropolitan, Rural, Small City and Suburban. Stratified random sampling procedures were used to draw the sample. Targeted respondents included management staff such as the Administrators/CEO and the Director of Human Resources. The survey was limited to one per provider; however, more than one administrative staff member could assist with completion of the survey.
Results

Providers Participating in the Survey by Type

<table>
<thead>
<tr>
<th>Region</th>
<th>NH</th>
<th>HH</th>
<th>MH</th>
<th>DD</th>
<th>Totals by Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appalachia</td>
<td>7</td>
<td>6</td>
<td>11</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Rural</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Small City</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Suburban</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Totals by Provider</td>
<td>32</td>
<td>31</td>
<td>42</td>
<td>32</td>
<td>137</td>
</tr>
</tbody>
</table>

A total of 137 providers completed the study. Responses were fairly evenly distributed among provider types and geographic regions.

Percent of Providers Reporting Services Performed by their DSWs

<table>
<thead>
<tr>
<th>Services</th>
<th>NH</th>
<th>HH</th>
<th>DD</th>
<th>MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>100</td>
<td>100</td>
<td>84</td>
<td>0</td>
</tr>
<tr>
<td>Toileting</td>
<td>100</td>
<td>90</td>
<td>84</td>
<td>0</td>
</tr>
<tr>
<td>Dressing</td>
<td>94</td>
<td>100</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Grooming</td>
<td>97</td>
<td>100</td>
<td>15</td>
<td>72</td>
</tr>
<tr>
<td>Feeding</td>
<td>100</td>
<td>77</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>50</td>
<td>81</td>
<td>88</td>
<td>15</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>50</td>
<td>81</td>
<td>84</td>
<td>20</td>
</tr>
<tr>
<td>Medication Reminders</td>
<td>50</td>
<td>65</td>
<td>88</td>
<td>61</td>
</tr>
<tr>
<td>Transportation</td>
<td>72</td>
<td>10</td>
<td>97</td>
<td>63</td>
</tr>
<tr>
<td>Case Management</td>
<td>47</td>
<td>19</td>
<td>9</td>
<td>95</td>
</tr>
<tr>
<td>Conducting Assessments</td>
<td>44</td>
<td>16</td>
<td>25</td>
<td>76</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>47</td>
<td>10</td>
<td>50</td>
<td>83</td>
</tr>
<tr>
<td>Development of Care Plans</td>
<td>56</td>
<td>26</td>
<td>53</td>
<td>83</td>
</tr>
<tr>
<td>Positive Behavior Support</td>
<td>69</td>
<td>48</td>
<td>81</td>
<td>90</td>
</tr>
</tbody>
</table>

DSWs primarily provide:
- NH - Activities of Daily Living (ADLs; coded red).
- HH - ADLs & Instrumental Activities of Daily Living (IADLs; coded green).
- DD – IADLs & ADLs.
- MH - Includes Case Management, Counseling, Care Planning (coded purple).
DSWs are Paid Low Wages

- The minimum hourly rate of pay is uniformly low, although MH is higher with a median of $12.
- The maximum hourly rate of pay was lowest for HH and DD and highest for MH providers.
- The average hourly rate of pay was statistically significantly different between: NH & DD; MH & HH; MH & DD.

Types of Benefits (%) Offered to DSWs Vary by Provider

- Paid Vacations, Paid Holidays Off, & Paid Sick Leave for DSW: Overall, more NH, MH & HH offer these benefits compared to DD providers.
- Career Ladder Programs: Overall, less than half of the providers offer such programs, with HH ranking the lowest.
- Partly Paid Health Insurance: Overall, 3/4 of providers offer this.
- Fully Paid Health Insurance: Overall, only 10% of providers offer this (although some providers may offer both fully & partly paid health insurance).
Similar Rate of DSW Turnover in 2011 across Providers

- Overall, the mean DSW turnover rate for providers was 30%.
- Turnover ranged widely among providers (0-100%).
- Twenty percent of providers had no DSW turnover in 2011. These tended to be smaller organizations with fewer DSWs.
- There was no statistically significant difference among provider types.

Statistically Significant Predictors of DSW Turnover

Among all providers (had and did not have turnover), the following were predictors of turnover:
- Regional differences: Metropolitan & Appalachian* had higher turnover than Suburban regions.
- Maximum Hourly Wages: Lower maximum hourly wages had higher turnover rates.
- Years in Service*: Fewer years of being in operation had higher turnover rates.

Among providers that reported they had DSW turnover, in addition to maximum hourly wages* and years in service, two perceived causes of turnover by management were predictors of turnover:
- Unsuitable fit for DSW position.
- DSWs finding the work to be too emotionally exhausting.

Practice and Policy Recommendations

Improving wages, particularly maximum wages a DSW can receive

It is important to increase the maximum wages that DSWs receive so they have an incentive to continue working. Other studies have demonstrated that low wages are linked to alarming rates of DSW turnover, particularly because such workers are primarily women from low-income families.\(^2,5,6,7\) Studies have also demonstrated that higher pay levels and benefits are related to DSW retention.\(^7,8\)

*Approached statistical significance at ≤ .10; all other statistical significance levels reported were <.05.
Focus on improving DSW retention, particularly in Ohio’s Metropolitan and Appalachian Regions

In metropolitan regions, human services providers are likely to compete with the retail and food industries to attract those seeking entry-level positions. In Appalachian regions, although there may be less competition for low-paying jobs, the travel time and distance between the DSW's home and the location of the provider or client’s home could be barriers to retention. Thus, providing better wages and benefits to workers in these regions is likely to attract and improve DSW retention, especially in light of the availability of other similar-paying, less physically and emotionally stressful jobs.

Create a repository of evidence-based programs that have reduced DSW turnover and disseminate the findings

Given that DSW turnover in our study ranged from 0 to 100%, with 20% of providers reporting no DSW turnover in 2011, it is important that best practices incorporated by providers with little or no turnover in Ohio and across the nation are documented and disseminated widely to all providers. Policy makers could fund researchers and/or academicians to: 1) conduct literature reviews and develop a series of white papers and videos to examine industry best practices and evidence-based programs that have led/are likely to lead to a reduction in DSW turnover; 2) examine the extent to which such programs are relevant to the four provider types included in our study; 3) implement selected programs to examine their success rate in reducing turnover; and 4) support other avenues for disseminating the white papers/videos, such as sponsoring statewide seminars, webinars and conferences focused on evidence-based programs and industry best practices. Dissemination could include the extent to which turnover is impacted by practices such as: increased wages; improved hiring practices such as behavioral interviewing, skills assessment and customized orientation to avoid hiring workers who are unsuitable for the DSW position; implementation of Employee Assistance Programs and counselors to reduce job stress and the emotional demands of the job, and improving work-life balance; and the implementation of career lattice and ladder programs.

Reward providers with a higher reimbursement rate for low DSW turnover

Policy makers could reward providers who use evidence-based programs to reduce their DSW turnover rates. In Ohio, the NH industry is already participating in a Pay-for-Performance system, in which DSW retention is one of the quality incentives for increased reimbursement. This system could be expanded to other human services sectors such as DD, MH and HH. The rate of reimbursement should be adequate to attract and encourage provider participation in such quality improvement programs.
References


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