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ENTRY-LEVEL SALARIES AND FRINGE BENEFITS OF HOSPITAL DIETITIANS IN THE MIDWEST

by

ROSEMARY N. RICH

B.A., Stephens College, 1971

A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Dietetics, Restaurant and Institutional Management

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1978

Approved by:

Helene G. Faden
Major Professor

ACKNOWLEDGEMENTS

Appreciation and thanks is expressed to Dr. Allene G. Vaden, Department of Dietetics, Restaurant and Institutional Management, Kansas State University, for her guidance, support and assistance throughout this project. Thanks also is expressed to Dr. Kathleen Newell, Department of Foods and Nutrition, and Dr. Faith Roach, Department of Dietetics, Restaurant and Institutional Management, for reviewing the manuscript and serving on the committee. Appreciation is expressed to Dr. Marion Spears, Professor and Head of Dietetics, Restaurant and Institutional Management for her assistance in reviewing the questionnaire.

Special thanks to my husband, Clarence, and my parents and sister, for their assistance. Also, thanks to friends in the department for their interest and encouragement.

Lastly, appreciation is extended to the hospital personnel directors who supplied data to make this project possible, and to Deanna Dieker, for technical assistance.

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INTRODUCTION

In an historical review of the dietetics profession, Hart (1) acknowledged a present increasing interest in nutrition and indicated that this trend has contributed to a positive employment outlook for dietitians. The American Dietetic Association (ADA) has indicated, however, that to maintain high standards and achieve the objectives of the profession, competent people must be attracted to and retained in the field. Essential requirements for recruitment include sound employment practices, salary commensurate with education and responsibilities, and good employment conditions (2).

Periodic studies have been made by government and private organizations regarding the status of persons engaged in the dietetics profession as Registered Dietitians (R.D.s). General information about the profession is provided semi-annually in occupational data published by the United States Department of Labor (3). The ADA periodically provides nationwide guidelines for dietitians with varying levels of experience and in different job classifications by issuing position papers on recommended salaries and employment practices for members (2,4,5).

Although the national indexes do provide the entry level R.D. with an indication of salary possibilities, they may or may not be representative of the geographic area in which the dietitian wishes to work, and thus may not be a realistic guide to use in a job search. Further, certain other factors such as the presence of a food management company may influence the proposed recommendations for salary.

The overall objective of this project was to determine typical salaries and fringe benefits offered to entry-level dietitians in hospitals of 200

beds or more in a six state Midwestern area. Related objectives were: (a) determination of salary trends in the profession by studying annual salaries offered entry-level R.D.s from 1972 to 1976, and (b) examination of typical salary increment amounts and frequency of increments during the first three years of employment. The existence of contracts with food management companies and the educational and professional background of Directors of Dietetics also were studied because of possible influences on employment of dietitians.

This project was conducted through the use of mailed questionnaires distributed to personnel directors of 100 randomly selected hospitals in the designated area. It was believed the personnel officers would have best access to the salary data sought. Hospitals included in the survey were at least 200 beds or more in size, and were further limited to those providing general short term care. Hospitals were selected from those which were members of the American Hospital Association, accredited by the Joint Commission on Accreditation of Hospitals, and classified as government-federal, government-non federal, non government-not for profit, osteopathic-for profit, osteopathic-not for profit, or investor owned. These criteria were established to insure some homogenity in the type of institution studied. Also, this definition includes the predominant number of hospitals in the United States and represents the type of institution most likely to employ several dietitians (6). The study was limited to hospitals because the majority of employed dietitians work in hospital dietetics (7).

The following definitions were used for the study:

entry-level Registered Dietitian
a person who has successfully completed requirements outlined by The American Dietetic Association and who has successfully completed the examination for registration, and has no more than six months professional work experience;

food contract company
  a company outside hospital jurisdiction which contracts with the hospital to provide specified dietary services, which may include employment of dietitians;

salary
  compensation represented by a dollar amount and representing pay for work on an hourly, weekly, monthly, or annual basis;

fringe benefits
  compensation offered other than salary.

This project should provide data to persons preparing to enter the profession of dietetics to enable them to formulate realistic goals regarding salary and benefits. Literature reviewed relevant to the study included current salaries, salary trends, fringe benefits, impact of food management companies, educational preparation of dietitians, and educational and professional backgrounds of directors of dietetics.

REVIEW OF LITERATURE

Salaries

Perhaps the most relevant salary indexes were those presented in a series of three position papers on recommended salaries and employment practices for members of The American Dietetic Association between 1974 and 1976 (2,4,5). These salary recommendations were based on: general salary trends in dietetics related to position responsibility and investment in professional preparation; salary trends in other occupations, especially those with similar education requirements and levels of responsibility; and broad trends in the general economy. Subsequent revisions were based on goals, trends, facts, and realistic expectations.

In the first position paper, published in 1974, an entry level dietitian was defined as: an ADA member; possessing a baccalaureate degree from an accredited college or university with a major in foods, nutrition, food service management, institutional management, or a related area, and having completed an approved internship, traineeship, or coordinated program, or an advanced degree and qualifying experience (Dietitian I); and successful completion of the registration examination (Dietitian II). The recommended annual salary for an entry-level position (Dietitian II) was $11,000 (2).

The second position paper, published in 1975, recommended an entry-level salary of $12,100 annually (4). This represented an increase of 10 per cent over the 1974 recommendation. The third position paper, published in 1976, recommended a salary of $12,500 (5). This represented an increase

over the 1975 recommendation of only 3.3 per cent. ADA acknowledged this slight increase was a more realistic goal in terms of achieving the recommended minimums in all regions. The ADA stated, however, that salaries of most members of the profession should be above the minimums. Further, ADA indicated that salaries of dietitians should increase at least as much as the increase for other health care occupations. In 1976, salaries for hospital-related jobs were increasing annually at a rate of 10 per cent. This compared favorably with the 7 per cent increase in the private non-farm sector, the 8.1 per cent increase in the non-farm business sector, and exceeded cost of living increases (8,9). Another possible explanation for the small increase in recommended minimum salaries for dietitians in 1976 was that wage gains generally were smaller than in previous years due to an economic recovery slowdown, and high unemployment causing increased job security pressures (8).

Benefits

Fringe benefits for the American worker received attention as early as 1894, when the National Wallpaper Company and Wallpaper Craftsmen negotiated a guaranteed annual wage. The biggest expansion in the area of benefits began just prior to World War II however. Benefits over the period of 1929-67, adjusted for inflation, rose at a rate of 9.6 per cent annually, compared to a 3.9 per cent annual increase in wages and salaries (10). The chairman of the General Motors Corporation stated that during the period from 1959-69, fringe benefits, specifically pension and insurance costs, rose four times more than hourly wage costs (11). Currently, studies indicate that costs for fringe benefits average 25-35 per cent of a total payroll, although they are expected to increase. A panel of business experts surveyed by Gordon

and LeBleu (10), as well as a Mid West food company executive, estimated that by the mid-1980's costs of benefits will have increased to 50 per cent of total payroll costs (9).

The same panel of experts identified the impact of labor unions on increased fringe benefits for the worker, and indicated that benefits achieved by unions for union members often were then extended to salaried workers (9). This increase in benefits apparently reflected the wishes of workers generally. For example, a 1972 survey of middle managers showed that the respondents placed more emphasis on benefits and nonfinancial rewards than on salary alone because of tax benefits (12).

As discussed, labor unions have had an important impact on fringe benefits. Other forces which have had or are projected to have influences in the future include: increased leisure time, a higher level of affluence, increased medical advances, technological advances, competition among employers, innovations in the insurance industry, and increased pressure from minority groups (10).

Gordon and LeBleu (10) grouped benefits into four categories: (a) legally required - unemployment compensation, old age and health insurance; (b) hazard protection - pensions, life insurance, and termination pay; (c) pay for time not worked - sick leave, holidays, and vacations; and (d) miscellaneous - tuition refunds, savings plans, and profit sharing. A typical compensation plan was described by Scheible (13) as follows:

	%
pay for actual worked time	80.5
retirement, including Social Security	7.0
paid leave	5.6
insurance	4.7
other	2.2

Paid vacations were the most common fringe benefit, with an estimated 99 per cent of all employers providing this benefit in some manner (11). Insurance benefits were reported by Scheible (13) to have increased more than other benefits during the period since 1966. In surveys of food related industries, pension plans were identified as a rapidly increasing benefit (14,15). Less traditional benefits presently offered by some employers included free apartment furnishings and a paid day off for Christmas shopping (11).

Trends in benefits either presently underway or predicted for the near future included group legal and auto insurance, medical coverage to include dental, psychiatric, and prescription drug costs, day care centers, guaranteed annual minimum income, and flextime (9-11). Cost of living raises received attention in recent labor statistics reviews. The most frequently cited cost of living increase was 1 per cent compensation per 0.3 point increase in the Consumer Price Index (15).

The three position papers on recommended salaries and employment practices for members of the ADA also addressed fringe benefits for dietitians employed in various roles in the profession. Categories of benefits recommended by the ADA remained constant in all position papers; however, the 1976 discussion of benefits was more specific than in 1974. A comparison of the 1974 and 1976 recommendations appears in Table 1.

A general concensus of the business experts surveyed by Gordon and Le Bleu (10) was that benefits will gradually become integrated with compensation, social welfare, and other job related privileges. Trends such as a changing work force profile, increased leisure time, and insurance innovations were all indicated by the panel as contributing to rapid and expanding changes in benefit programs.

Table 1: Selected fringe benefits recommended by ADA in 1974 and 1976[1]

1974	1976
twelve days annual sick leave	same
group life insurance equal to annual salary	same
hospitalization and medical insurance paid by employer, providing usual and customary hospital and surgical charges plus major medical	same, plus provision of major medical for family. Attention was given to the increasing development of dental plans, and indication given that such a plan might soon be included in recommendations
policy governing vacation and holidays	same, recommending a good plan to provide four weeks and at least nine days respectively
plan for salary increments and advancement opportunities, with a minimum to maximum salary range for the same position of at least 25 per cent; annual review of compensation plans with minimum, maximum, and intermediate steps adjusted to keep up with trends in industry, the economy, and the profession	same, plus provision for an increase of salaries set in 1975 of 5 to 10 per cent to accommodate rises in the Consumer Price Index
retirement plans to supplement Social Security; tax sheltered annuity for persons in public or non profit employment	same
allowance for professional growth including attendance at professional meetings, academic study, and in-service programs	same, plus allowance for other continuing education
travel allowance	same, plus allowances to match increased costs.

[1]Source: (2,5)

Food Management Companies

Food management companies first appeared in hospitals about twenty years ago, and have grown slowly but steadily since that time. Although according to a historical review of management companies (16) there is no central information source for data regarding the numbers of hospitals using contract services, it was estimated in this review in 1971 that 10 per cent of all hospitals use services of management companies. The literature suggested that presently, hospitals with a capacity of 150 beds or more were more likely to utilize management company services (16,17).

Services provided by management companies vary with the needs of the hospital, but the most frequently reported arrangement involved the hospital paying a fixed fee per patient day in return for management services which included: food purchasing, preparation, and service; budget maintenance; hiring and supervision of employees; and all other functions necessary to satisfy patients' dietary needs (16,18).

A literature review reported mixed opinions on the benefits of management companies. A central theme promoted by those in favor of management companies was that they were able to provide foodservice specialists with access to resources that allowed for constant updating in the field. It was purported further that management companies freed dietitians of the operational aspects of foodservice and thus provided them with more time for patient contact (18,19).

With specific regard to dietitians, one food management executive reported strained relations with ADA (16). He contended that dietitians believe management companies pose a threat to job security and professional standing. Conversely, the executive stated that contract services in

reality expanded and upgraded dietitians' roles by relieving them of mundane duties, and by providing good management support.

Educational Trends

E. Grace McCullough, at the 1906 Lake Placid Conference on Home Economics, stated that "Today a successful dietitian must be an all-around woman with a technical training" (1). In the period since that time, training for dietitians has advanced rapidly to meet the demands of consumers, while striving to maintain high professional standards.

At the first meeting of The American Dietetic Association in 1918, special interest groups for student dietitians were designated which included Diet Therapy, Teaching, Social Welfare, and Administration. At that time, the Association recommended a four year college program to cover those areas. During the 1920's the Outline for Standard Course for Student Dietitians evolved, which among other things, stipulated that the training hospital dietitian be an ADA member, and that the student entering an internship have a bachelor's degree in foods and nutrition (1).

The 1930's saw an increasing need for dietitians, largely due to Title V of the Social Security Act of 1935, which allowed funds for positions in state and local health departments. Also during this period there was increased emphasis on graduate level education (20). The profession continued to evolve and revise, necessitated by increased knowledge, changes in the health care delivery concept, and more consumer input (1,21).

Various options are available to the entry-level dietitian seeking professional recognition through membership in The American Dietetic Association and registration. The most traditional option has been four years of undergraduate preparation to meet academic guidelines, followed by a one-year internship (22). The widespread acceptance of this option is

evidenced by the November 1976 data base analysis of the ADA; 82 per cent of the reporting members achieved membership through the "4+1" option (7). Traditionally the undergraduate program integrated clinical and didactic experience in nutrition, communication, conceptual thinking, research, and biological sciences, and prepared the entry-level dietitian with competencies to provide nutritional care under guidance of an experienced dietitian (23). Chase (24) pointed out the need for a balance between professional and liberal arts academic preparation in enabling the entry-level dietitian to handle day-to-day decisions. Minimum academic requirements are set forth by the ADA; students currently beginning preparation are guided by Plan IV, which includes basic education requirements in addition to training and specialization in general dietetics, management, clinical dietetics, or community nutrition (22,25).

In lieu of an internship, students may complete a traineeship following completion of the minimum academic requirements set forth by ADA. Approximately 4 per cent of ADA members represented in the 1976 data base analysis achieved membership by this option.

Coordinated undergraduate programs are an option whereby students can integrate clinical and didactic training in a four year program and enter directly into the profession without other qualifying experience. Wilson (22) acknowledged the shift from a traditional 4+1 program to the coordinated program as significant. Justification for the shift included a decrease in financial support and shifts in programs receiving financial assistance, as well as the belief that coordinated programs provide a more reality-based education. Approximately 2 per cent of the ADA members in the 1976 data base analysis achieved membership by a coordinated program; however, this type of program is relatively new, with the first graduates coming from Ohio State University in 1964.

Literature available on the education background of dietitians today was limited. Loyd sampled clinical, administrative, and generalist dietitians (26). Given a reporting group of 525, 420 dietitians (80 per cent) had attained bachelor's degrees, and 105 (20 per cent) had earned master's degrees. Most (N = 422) (80 per cent), had completed an internship as the route to professional qualification.

According to data available from the 1976 ADA data base analysis, 82 per cent of members reporting achieved membership via an internship; 2 per cent met requirements through a coordinated program; 4 per cent completed a traineeship. The remaining members meeting requirements through advanced degrees, professional practice, or other means (7).

A survey conducted in 1974 by Williams (17) provided data on hospital foodservice directors in Michigan. Approximately 54 per cent of directors surveyed were registered ADA members. Sixty-four per cent of the directors held bachelor's degrees, and 4 per cent had earned master's degrees. Directors were asked to indicate areas of professional specialization, and the most frequently reported areas were: general dietetics (28 per cent); hotel, restaurant, and institutional management (20 per cent); and administrative dietetics (12 per cent). One finding of that survey of particular interest was that dietetic specialization and professional affiliation, although still held in high regard, were viewed by directors as less important criteria than evidence of proven and/or potential effectiveness in managerial leadership.

With regard to trends in dietetic education, coordinated programs seem to be receiving growing attention because of their reality-oriented approach (1,22). Academic training beyond a bachelor's degree also received mention as a future trend because of the need to specialize to meet expanding needs (1,22,23). Hart (1) indicated a need for dietetic certification beyond registration in areas of specialization, with the dietitian establishing and self-pacing his or her own program of continuing education.

METHODOLOGY

To obtain information for this project, questionnaires were mailed to 100 personnel directors of hospitals of 200 or more beds in a six-state Midwestern region.

Selection of Hospitals

Target states chosen to survey were Kansas, Illinois, Iowa, Missouri, Nebraska, and Oklahoma. It was believed that hospitals located in these states would provide representative data for the practitioner wishing to locate in the midwest, or for the student completing dietetic training at a midwestern university who desired to remain in the area.

For selection of the sample for the survey, the American Hospital Association Guide to the Health Care Field (1976 Edition) was consulted, and a list compiled of the name and address of each hospital in each of the six states meeting these criteria: (1) 200 or more beds/bassinets in size; (2) a member of the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals; (3) hospitals offering general medical and surgical services; (4) hospitals offering short-term care; and (5) hospitals classified with regard to method of ownership or control as government-federal, government-non federal, non government-not for profit, osteopathic for profit, osteopathic not for profit, or investor owned.

The lists were arranged alphabetically according to state and each hospital assigned a number consecutively; there were 239 hospitals in the listing. A sample of 100 hospitals was selected by using a computer generated

list of random numbers. Table 2 lists the final sampling breakdown of hospitals by state.

Table 2: Number of hospitals selected by state for sampling

state	eligible hospitals	sample	% selected
Kansas	14	7	50
Iowa	28	13	46
Illinois	118	48	41
Missouri	44	15	34
Nebraska	16	8	50
Oklahoma	19	9	47
total	239	100	42

As stated previously, the survey was directed to the personnel director of each hospital. It was believed that this person had best access to records about the type of data sought. A cover letter, however, did request that the personnel director forward the questionnaire to the Director of Dietetics if the latter had access to the information.

Questionnaire Development

A mailed questionnaire was used to gather data (Appendix A). The twelve questions included in the instrument were formulated in a manner whereby direct and factual information could be reported to fulfill the objectives stated in the Introduction. Prior to mailing, the questionnaire was reviewed for appropriateness by two faculty members (both R.D.s) in the Department of Dietetics, Restaurant and Institutional Management at Kansas State University.

The construction format utilized for the majority of solicitations was a question; in some instances a statement was supplied and the respondent

asked to provide certain factual information. Structured responses were solicited. Fill-in, checklist, and categorical response formats were included.

Distribution

Prior to mailing, each questionnaire was inconspicuously coded with a number corresponding to the hospital number on the final participant list. A cover letter was prepared to accompany the initial mailing of each questionnaire (Appendix B). That letter identified the researchers and objectives of the project. Also, the coding was explained and anonymity was assured. Self-addressed stamped envelopes were enclosed to enhance return of the questionnaires; the cover letter was kept brief and the questionnaire limited to only one page for the same reason. Also included in the initial mailing was a form to complete and return if the respondent wished a copy of the project's final results (Appendix B). It was hoped this offer to share results would encourage response.

Fifty responses resulted from the first mailing. A second mailing was done three weeks after the initial mailing. A second cover letter was prepared, again outlining the project and soliciting assistance (Appendix B). That mailing packet also included the cover letter, questionnaire coded as before, results request form, and a stamped addressed envelope. Twenty additional surveys were returned, or a total of seventy, representing a 70 per cent return. Final sample representation is illustrated in Table 3.

Analysis

Computer assistance was utilized to compile frequency distributions for all items except those that could not be coded easily for computer use (questions 10 e and f, 11, and 12). Data provided by the frequency

distributions also provided mean, median, and range information when appropriate. Data analyzed manually were tabulated and means, medians, and ranges were computed when possible.

Table 3: Responses to survey questionnaire

state	number of surveys sent	number of hospitals responding	% return
Illinois	48	28	58.3
Iowa	13	9	69.2
Kansas	7	7	100.0
Missouri	15	12	80.0
Nebraska	8	7	87.5
Oklahoma	9	7	77.7
total	100	70	70.0

RESULTS AND DISCUSSION

Data were examined according to the following categories: current salaries, salary trends, fringe benefits, impact of food contract companies, and education and professional background of dietitians.

General Information About Hospitals

Size and Type of Hospitals

Size of hospitals ranged from 196 to 1,222 total beds, and 10 to 79 total bassinets; the mean number of beds was 369. The mean number of bassinets, 27. When combined, the mean number of beds/bassinets was 378 (Table 4).

Table 4: Size of reporting hospitals

state	number of hospitals	combined number of beds/bassinets	
		mean	range
Illinois	28	387	212-1,301
Iowa	9	379	218- 781
Kansas	7	376	176- 623
Missouri	12	434	176- 700
Nebraska	7	304	204- 500
Oklahoma	7	393	190- 689

Hospitals classified as non-governmental, not for profit, represented 80 per cent of the sample. Government affiliated hospitals, both federal and non-federal, represented the second largest sampling, and only one investor-owned hospital was represented. No osteopathic hospitals responded (Table 5).

Table 5: Classification of hospitals

classification	N	%
government, federal	6	8.6
government, non-federal	7	10.0
non-government, not for profit	56	80.0
investor owned	1	1.4

Employment of Dietitians

Sixty-seven hospitals employed at least one full-time dietitian. The maximum number of full-time dietitians employed at one facility was twenty-eight, and the mean was 4.3.

Sixty-seven hospitals reported employing at least one R.D. in either a full or part-time capacity. The maximum number of full or part-time R.D.s employed in one facility was twenty-five. Twenty hospitals reported employing part-time dietitians. Numbers employed ranged from a minimum of one to a maximum of six part-time dietitians. In some instances, one part-time dietitian was the only dietitian employed; while in others, those persons augmented a sizeable staff of full-time dietitians. In at least one hospital, several part-time dietitians were on staff while no full-time dietitians were employed. Qualifications of staff dietitians and department directors appear in Table 6.

Table 6: Qualifications of staff dietitians and Directors of Dietetics

qualifications of dietitians	number of hospitals	qualification of directors		
		R.D.	ADA dietitian	foodservice director
all are R.D.s	50	25	11	14
R.D.s & non-R.D.s	19	10	1	7

Twenty hospitals (29 per cent) reported dietary departments managed by directors; thirty-seven hospitals (53.6 per cent) employed R.D.s to manage dietary departments; and twelve hospitals (17.4 per cent) employed administrative dietitians who were non-registered ADA members.

The majority of the directors (69.1 per cent) had earned Bachelor's degrees; sixteen directors (23.5 per cent) had Master's degrees; four directors (5.9 per cent) were high school graduates; and one director had earned an associate degree. The questionnaire did not ask for identification of the area in which the degree was earned.

Control and Direction of Department of Dietetics

Only eleven hospitals of those surveyed (15.9 per cent) indicated the Department of Dietetics was operated by a food management company. The proportion of management companies in the final representation (15.9 per cent) was higher than the estimated norm of 10 per cent in the total hospital population. It was felt this higher ratio occurred because the sample was limited to hospitals of 200 or more beds; the literature indicated, that hospitals of 150 beds or more are more inclined to utilize food management company services. Five of those hospitals were located in Illinois; two each in Iowa and Oklahoma and one each in Kansas and Nebraska.

Three reporting hospitals utilizing management company services had access to all information solicited by the questionnaire. Three facilities had no access to the information sought; and the remaining five hospitals were able to report only partial information.

In eight facilities, the management company had full responsibility for hiring dietitians. Two hospitals reported sharing hiring responsibilities with the management companies; and in one hospital the dietitians were hired by the hospital and maintained on the hospital's payroll, although the hospital did receive reimbursement for salaries from the management company.

Entry Level Salaries and Conditions of Employment

Entry-level Salaries

The mean salary offered to dietitians eligible for registration, but not yet R.D.s, was $10,793 annually (N=44 reporting hospitals). Minimum salary offered was $8,600, and maximum was $13,500. Mean, median, minimum, and maximum annual salaries are shown by state in Table 7.

Table 7: Entry level salaries of dietitians eligible for registration

state	annual salary mean	median	minimum	maximum	% of ADA recommendation[1]
Illinois	$11,180	$11,050	$ 9,500	$13,500	97.2
Iowa	10,689	11,067	9,100	11,523	92.9
Kansas	10,038	10,000	8,600	11,250	87.2
Missouri	10,802	10,895	9,303	11,882	93.9
Nebraska	10,857	11,377	8,856	11,820	94.4
Oklahoma	10,473	10,338	10,210	11,028	91.1
total	$10,793	$10,905	$ 8,600	$13,500	93.9

N = 44

[1]Represents percentage of the 1976 ADA recommendation of $11,500 for this position.

The mean salary offered entry-level ADA dietitians awaiting registration was 93.9 per cent of the 1976 ADA recommendation for this position (5). Means by state also were compared with the recommended minimum of $11,500 in Table 7. As reflected in Table 7, dietitians in Illinois most closely achieved the ADA recommendation. It was believed this was reflective of a higher degree of urbanization in that state and concomitant larger hospital size. Also, data may reflect a higher cost of living in that area, which would influence prevailing salary levels.

The mean annual salary offered to entry-level R.D.s was $11,343; the minimum was $9,744 and the maximum, $15,500 (Table 8).

Table 8: Annual salaries offered to entry-level R.D.s by state

state	mean	median	minimum	maximum	% of ADA recommendation[1]
Illinois	$11,924	$11,627	$10,400	$15,500	95.4
Iowa	10,909	10,962	10,239	11,523	87.3
Kansas	10,934	10,500	9,800	12,300	87.5
Missouri	11,131	11,294	9,744	11,882	89.1
Nebraska	10,966	11,377	9,600	11,820	87.7
Oklahoma	10,859	11,189	10,213	11,028	86.9
total	$11,343	$11,305	$ 9,744	$15,500	90.7

N = 60

[1]Represents percentage of the 1976 ADA recommendation of $12,500 for this position.

The mean annual salary offered to entry-level R.D.s was 90.7 per cent of the 1976 ADA recommendation of $12,500 (5). Data by state indicated a pattern somewhat similar to that for dietitians eligible, but not yet R.D.s, with salaries in Illinois being highest among those reported.

The mean salary offered the entry-level R.D. was $550 greater than that of the dietitian awaiting registration. Twenty-two hospitals (N=50) indicated a salary increment was given upon achieving R.D. status. Increments ranged from $212 to $2,500 annually. The mean annual increase reported was $867, which is less than the differential recommended by ADA of $1,000 annually between the classifications of entry-level ADA dietitian and R.D. The difference between the positions is that the R.D. has successfully completed the registration examination and has a commitment to maintain continuing education requirements in order to retain the R.D. status. Also, the R.D. may have a limited amount of work experience during the period between graduation from a program and writing the registration examination. Of the twenty-two hospitals which did indicate an increment, twelve of the

departments of dietetics were directed by R.D.s, two were directed by ADA dietitians, and eight were managed by foodservice directors.

A discrepancy was found between salaries offered entry-level R.D.s and dietitians who were hired while awaiting registration but who later achieved R.D. status. In six hospitals where a salary increment was granted after successful completion of the registration exam, the increase did not result in a salary level equivalent to that offered an entry-level R.D.: the differences ranged from $260 to $2,000 annually. Of those six hospitals, four were managed by R.D.s, one was managed by an ADA dietitian, and one was managed by a foodservice director.

Four hospitals indicated they would not hire a dietitian awaiting registration and, although not reported, perhaps this is a view shared by other personnel directors. This was reinforced by data from sixteen hospitals reporting salaries for R.D.s but not for dietitians awaiting registration. Of those sixteen hospitals reporting no salaries for dietitians eligible for registration, Directors of Dietetics in seven were foodservice directors, in five were R.D.s, and in four were ADA dietitians.

Salary Increments

Participants were also surveyed to determine the frequency of salary increments offered entry-level dietitians during the first three years of employment. With sixty hospitals reporting, 48 per cent indicated annual increments were granted. The second most frequent increase plan was based on increments after the first six months, and annually thereafter on the date of employment (Table 9).

Table 9: Frequency of salary increments during first three years of employment

frequency	number of hospitals	%
annually	29	48.4
six months, annually/date of hire	19	31.6
six months	3	5.0
merit	3	5.0
other	6	10.0

Typical salaries for the entry-level dietitian after one, two, and three years of employment were determined, based on typical salaries offered entry-level R.D.s at the time of this survey, and the frequency and amounts of salary increments. Mean salary after one year was $12,282; after two years, $12,877; and after three years, $13,459 (Table 10).

Table 10: Annual salaries projected after one, two, and three years of employment for the entry-level R.D.

time period	range	median	mean
one year	$9,700-$18,328	$11,956	$12,282
two years	9,800- 21,179	12,463	12,877
three years	9,900- 24,474	12,948	13,459

N = 44

The average annual salary increment expressed as a percentage figure was 4.2 per cent. Reported increment amounts ranged from 0.7 to 9.0 per cent annually, with the median increment being 4.0 per cent.

With regard to salary increments following probation or during subsequent employment, the ADA made no specific recommendation in the 1976 position paper. However, the recommendation was made that there be some type of defined plan for salary increment.

Salary Trends

Salary trends were viewed by examining annual salaries offered entry-level dietitians in the years 1972 to 1976. Data were available from thirty-two hospitals. Average annual salaries for that time span, along with typical annual increment amounts expressed as percentages, are shown in Table 11.

Table 11: Annual salaries and percentage increments for entry-level dietitians

year	mean	median	range	% increase
1972	$ 9,241	$ 9,093	$7,800-$11,394	
1973	9,396	9,494	7,104- 11,670	1.7
1974	10,188	10,112	7,822- 12,078	8.4
1975	10,750	10,536	8,856- 13,044	5.5
1976	11,725	11,211	8,856- 13,156	9.1

N = 32

In viewing salary trends from 1972 to 1976, only the 9.1 per cent increase in 1976 was near the 10 per cent annual increase recommended by ADA. The 9.1 per cent increase was good in view of the economy's overall small wage gains in 1975 to 1976, attributed to general economic recovery slowdown. The sharp increase in 1974 wages (8.4 per cent) may have been reflective of the termination of the Economic Stabilization Program (8).

Probationary Periods

Sixty-one hospitals (87.1 per cent, N=65), reported that entry-level dietitians were subject to a probation period upon initial employment. The most frequently reported probation term was three months (42.9 per cent); a six month period was reported in 30 per cent of the hospitals. A one year probation period was reported in 8.6 per cent of the hospitals. A few had only a two month probation.

Approximately one-half (N=30) of the hospitals indicated a salary increase after successful completion of a probation period, while twenty-eight indicated no increment was granted. Based on hospitals granting raises, $40 was the mean monthly increment offered, with the range of increments being $16 to $121 monthly. In hospitals granting raises after probation, the departments of dietetics were managed by R.D.s in seventeen, by foodservice directors in eight, and by ADA dietitians in five.

The 1976 ADA position paper made no recommendation regarding probation for newly employed dietitians. However, the three month probation period reported most frequently seems to be a typical and reasonable length of time during which to become familiar with job functions.

Fringe Benefits

Partial or complete data regarding fringe benefits offered entry-level dietitians were available from sixty-four hospitals.

Paid Leave Time

Paid Vacation. The mean number of days of paid vacation granted annually was 12.3 days. The minimum number of days reported was ten, and the maximum, twenty-five. The mean of 12.3 days was much less than the four weeks recommended by ADA as a good plan (5), but appeared realistic in terms of an entry-level position. Perhaps dietitians with more lengthy employment at an institution would more closely achieve the four week goal; however, since this study focused only on entry-level positions, these data were not requested.

Sick Leave. The average number of days of sick leave granted annually was 12.0 days. The minimum sick leave granted annually was six days, and the maximum was twenty-one (Table 12). The average of twelve days annually

equaled that recommended by the ADA in the 1976 position paper. The ADA recommended that sick leave be cumulative to sixty days, but information about accumulative sick leave policy was not requested in the survey.

Table 12: Days of sick leave granted annually

number of days	reporting hospitals	%
15 or more	4	6.7
13	8	13.5
12	40	67.8
10	4	6.8
6-9	3	5.1

Paid Holidays. The average number of paid holidays annually was 7.7; the minimum was six; and the maximum, fourteen days. That average was slightly lower than the ADA recommendation of at least nine days.

Insurance Benefits

Life Insurance. Full employer payment of employee life insurance was reported by forty-six of fifty-eight hospitals providing data; seven (12.1 per cent) indicated employer-employee sharing of costs; and five (8.6 per cent) indicated complete employee payment. Limited available data indicated that hospital-paid policies were in varying amounts, including policies of value equal to annual salary, one-half annual salary, $10,000, and $5,000. In instances where costs were shared, hospital payment of one-third and employee payment of two-thirds was most frequent, with equal division also a pattern.

The high percentage of support for this benefit was encouraging. However, from the limited number of hospitals that indicated the value of

these policies, only one provided a policy equal to annual salary as recommended by ADA.

Health Insurance. All reporting hospitals indicated health insurance was available; over 50 per cent provided fully paid insurance, and the remainder shared costs with the employee. Data on the types of plans provided in relation to the costs to the employee are shown in Table 13.

Table 13: Relative contributions of hospitals and employees to health insurance costs

contribution		reporting hospitals	
hospital %	employee %	number	%
100	0	30	55.6
75 or more	25 or less	8	14.8
less than 75	more than 25	16	29.6

The ADA recommended that hospitalization and medical insurance be paid by the employer. Further, the ADA recommended provision of coverage for the employee and family. Family coverage was indicated in only eleven responses; however, data on coverage for dependents was not specifically solicited.

Other Benefits

Medical Services. Almost two-thirds of the reporting hospitals indicated varying types of medical services were provided as employee benefits; twenty-one did not respond. Six hospitals indicated no services were available except those covered under health insurance policies. Services provided were varied; for example, emergency room discounts, provided by eight hospitals, ranged from 25 to 100 per cent. General employee discounts,

provided by five hospitals, ranged from 20 to 50 per cent; pharmacy discounts were reported by two hospitals (20 per cent and cost plus 10 per cent respectively). Outpatient benefits included services free of charge at one hospital, services available at a 25 per cent discount at two hospitals, and a $250 allowance annually to be applied toward outpatient fees at another hospital. Annual physical examinations were provided by eight hospitals.

In addition to the above, three hospitals provided annual blood tests and chest x-rays. Two hospitals provided annual tuberculosis tests, urinalysis, and pre-employment physical examinations as benefits; employee clinics, annual blood pressure tests, annual serology tests, and $100 to help defray costs were reported by single hospitals as benefits for employees.

From the sampling, a wide range of medical benefits were available to employees, ranging from traditional yearly testing to preventive clinics. It seems that these types of services could be a very attractive fringe benefit in light of increasing consumer interest in maintaining good health.

Retirement Benefits. From the total sample of seventy, fifty-five hospitals (78.6 per cent) indicated some form of retirement benefits; thirteen hospitals (18.6 per cent) did not respond, and two hospitals (2.8 per cent) indicated no retirement benefits were available to employees.

Twenty-one hospitals indicated noncontributory retirement plans. Values of these plans varied; e.g., one plan equaled 1 per cent of the employee's annual salary, while a second plan was equivalent to 5 to 6 per cent of an annual salary. Also, several types of contributory plans were reported.

Four hospitals indicated participation in local, state, or federal government programs. Three hospitals indicated profit sharing was available, and four hospitals provided undefined pension plans for employees.

Yields of plans also varied. Three hospitals based returns on an employees highest three years of salary plus number of years of service. In four

hospitals, yield was equivalent to from 4 to 7 per cent of average annual income.

Plans were fully vested after ten years in six facilities, and after five years in two facilities. One hospital reported benefits available after one year's employment.

Travel Allowance. Thirty of the fifty-three hospitals reporting indicated that some form of travel allowance for continuing education purposes was provided. Nine hospitals indicated that reimbursement varied with each specific situation. Four hospitals indicated that total reimbursement was provided for travel costs incurred in connection with continuing eduation. Seven hospitals provided travel allowance on a mileage basis. Five allowed 15¢ per mile, one allowed 14¢ per mile, and one allowed 13¢ per mile. One hospital provided funds to attend one workshop annually. Nine hospitals indicated an annual sum provided to cover continuing education costs, ranging from $35 to $300 annually. Twenty-three hospitals provided no allowance for continuing education.

Although the travel allowances reported in some cases were substantial or covered total costs, the large number which did not provide this benefit may be cause for concern. Continuing education is of vital importance to the dietitian in order to maintain professional standards and keep abreast of the dynamic field. If an employer does not assist the entry-level dietitian defray costs for continuing eduation, it might prove difficult for these new professionals in the field to maintain current knowledge of trends in dietetics.

Payment of Professional Dues. Payment of professional dues was not an available fringe benefit in most (80.4 per cent) hospitals providing data for this question. Seven hospitals (12.5 per cent) indicated this benefit was offered; and four hospitals (7.1 per cent) indicated partial payment.

Three institutions limited payment to membership in one organization and a fourth facility paid dues of the department director only. Thus, payment of dues was not indicated to be a typical benefit in the survey area; however, ADA does not recommend payment of professional dues by the employer.

Meals and Other Benefits. Meals during working hours were not included as a fringe benefit in forty-three of fifty-five reporting hospitals. Of the twelve hospitals which did provide this benefit, eight (14.5 per cent) provided one meal daily, frequently at cost or discounts ranging from 25 to 50 per cent, and one institution provided a $1.50 per day allowance for meals. Four hospitals (7.3 per cent) provided two or more meals daily.

When asked to describe other employee fringe benefits not otherwise covered by the questionnaire, seven hospitals responded. Five of the seven hospitals indicated tuition reimbursement was an available benefit. This was encouraging as it seems to favor continuing education for the dietitian. One institution indicated a tax-sheltered annuity; ADA recommended this for persons in public or nonprofit employment, and these types of facilities constituted the majority in this survey. However, these were not data specifically asked for by the questionnaire, and perhaps other hospitals may provide these benefits. Three hospitals provided paid leave for a family death and two hospitals provided jury duty compensations. Single hospitals provided weekend wage differential, a salary continuation program, and a matching savings plan as benefits.

SUMMARY

The primary objective of this project was to determine typical salaries and fringe benefits offered entry-level dietitians by hospitals of 200 beds or more in six Midwestern states. Salary trends from 1972 to 1976 and salary increment amounts and frequencies also were studied.

Questionnaires were mailed to personnel directors of 100 randomly selected hospitals offering general short-term care. Seventy questionnaires were returned (70.0 per cent) as a result of an initial and follow-up mailing. Complete or partial information from all questionnaires was used in data analysis.

Registered Dietitians functioned as Directors of Dietetics in the majority of reporting hospitals. Over two-thirds of the directors had earned bachelor's degrees. The typical number of dietitians employed was 4.3.

Eleven of the reporting hospitals utilized management company services. In eight of these hospitals, the company had responsibility for the hiring of dietitians.

The typical salary offered dietitians awaiting registration was $10,793 annually which represented 93.9 per cent of the ADA recommendation for this position. This contrasted with $11,343, the mean salary offered entry-level R.D.s, which represented 90.7 per cent of the ADA recommendation. About one-half of the reporting hospitals indicated a salary increment for a dietitian upon achieving registration; $867 annually was the mean increase. However, several personnel directors indicated they would not employ dietitians awaiting registration.

Entry-level dietitians were subject to a three-month probation period most frequently. About one-half of the hospitals granted salary increments

upon successful probation completion; $40 monthly was the mean increment granted.

Also an annual salary increment was the most common salary adjustment reported. The increments averaged 4.2 per cent annually. Increments after six months of experience and annually thereafter was the second most frequently used increment plan. Examination of salaries from 1972 to 1976 indicated sporadic increases: the lowest increase was 1.7 per cent in 1973, and the greatest increase was 9.1 per cent in 1976. Given the period from 1972 through 1976, salaries in 1976 showed the greatest increase over previous years (9.1 per cent).

The mean number of paid vacation days was 12.3 days annually; sick leave averaged twelve days annually; and annual paid holidays 7.7 days. Health insurance, medical services, retirement benefits of varying types, and life insurance were available in most hospitals. About half of the hospitals provided some travel funds for continuing education. Free or reduced price meals while on duty and payment of professional dues were benefits not widely available.

This project studied several areas of concern for the entry-level dietitian including salary, increments, fringe benefits, and probation period. An on-going study regarding salaries and fringe benefits conducted regularly could assure current data for the beginning practitioner. This type of on-going project seems vital to the validity of salary and benefit data because many factors may cause fluctuations, including the overall economic picture, number of dietitians entering practice annually, or changes in the health care field. Also, since the mean salaries were lower than ADA recommendations, it seems that hospital administrators should be made aware of the results so that salary practices may be reviewed and revised as needed in order to bring salaries into concurrence with established professional

recommendations. The periodic position papers published by ADA should have wide distribution to hospital administrators and other potential employers of dietitians as well.

In-depth study of Directors of Dietetics could prove beneficial as only the level of education and professional achievement of directors was considered within the scope of this study. Because directors take an active part in hiring dietitians and establishing employment guidelines, a more definitive examination would be valuable. Similar examination of food management companies would be interesting, as overall objectives and employment practices of these organizations may differ from those of hospitals.

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APPENDIXES

APPENDIX A

QUESTIONNAIRE

KSU KANSAS STATE UNIVERSITY

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

SALARY STUDY: THE ENTRY-LEVEL DIETITIAN

Please answer each question so that data will be complete. Do not sign or otherwise indicate the name of your hospital: simply place the completed questionnaire in the enclosed postage paid envelope and return it to me. Prompt return will be greatly appreciated. Thank you.

1. In what state is your hospital located?

_____

2. Size of hospital
   beds _____
   bassinets _____

3. Classification of hospital:

(1) gov't., federal _____
(2) gov't., non federal _____
(3) non gov't., not for profit _____
(4) osteopathic, for profit _____
(5) osteopathic, not for profit _____
(6) investor owned _____

4.a. Does your hospital operate the Department of Dietetics?

(1) Yes _____
(2) No, operated by a food contract company _____

b. If a food management company operates the department, who employs the dietitians?

(1) hospital employs all (yes or no) _____
(2) hospital employs (indicate no.) _____
(3) food contract company employs all (yes or no) _____
(4) food contract company employs (indicate no.) _____

5.a. Qualifications of the present Director of Dietetics:

(1) Food Service Director _____
(2) Administrative Dietitian, R.D. _____
(3) Administrative Dietitian, ADA member _____
(4) Administrative Dietitian, non ADA member _____

b. Educational background (indicate highest degree):

(1) Ph.D. _____
(2) Master's Degree _____
(3) Bachelor's Degree _____
(4) Associate Degree _____
(5) High School Diploma _____

6.a. How many dietitians are on your staff?

(1) full time (30 or more hours per week) _____
(2) part time (less than 30 hours per week) _____

b. How many are Registered Dietitians? _____

7. Indicate the current salary offered to entry level dietitians <u>awaiting registration</u> who are seeking <u>full time employment</u>. An entry level dietitian is defined as a person with six months or less professional work experience.

$ _____ /yr.

8.a. Is there a salary increase upon achieving an R.D. status?

(1) Yes _____
(2) No _____

b. If the answer above was yes, in what amount?

$ _____ /yr.

9. Please indicate the typical salary offered entry level <u>Registered Dietitians</u> seeking <u>full time employment</u>.

$ _____ /yr.

-OVER-

10.a. Is there a probationary period for newly employed dietitians?

(1) Yes _____
(2) No _____

b. If yes, state length _____

c. Is there a salary increment after the probationary period?

(1) Yes _____
(2) No _____

d. If yes, how much $ _____ /mo.

e. In the first three years of employment, how frequent are salary increments for entry level dietitians?

_____

f. In what amounts? $ _____

(Indicate whether annual or monthly.)

11. If the data are available, please indicate annual salary range, excluding all fringe benefits, offered to entry level dietitians seeking full time employment within the past five years.

	annual salary range
(1) 1972	$ _____
(2) 1973	$ _____
(3) 1974	$ _____
(4) 1975	$ _____
(5) 1976	$ _____

12. If data are available, please indicate compensation in the form of fringe benefits offered to entry level Registered Dietitians:

a. paid vacation
   # of days per year _____
b. sick leave
   # of days per year _____
c. paid holidays
   # of days per year _____
d. health insurance
   hospital contribution _____
   individual contribution _____
   (indicate $ or %)
e. life insurance
   hospital contribution _____
   individual contribution _____
   (indicate $ or %)
f. travel allowance for
   continuing education $ _____
   (approximate $ per year)
g. meals (# per day) _____
h. medical services provided _____
   (briefly describe)

i. retirement benefits _____
   (briefly describe)

j. payment of professional dues _____
k. other (please specify)

PLEASE RETURN AS SOON AS POSSIBLE IN THE ENCLOSED, STAMPED ENVELOPE.

APPENDIX B

CORRESPONDENCE

KANSAS STATE UNIVERSITY

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

March 25, 1977

Dear Hospital Personnel Director:

In the Department of Dietetics, Restaurant and Institutional Management at Kansas State University, we are currently seeking information regarding salary and fringe benefits offered to entry level Registered Dietitians. We feel this information will help us in counseling and guidance of students in the dietetics program here at K-State by providing current data for graduates to formulate reasonable and timely salary expectations.

As a hospital personnel director, we hope you can provide valuable input into this project because of your access to the type of data that will be the basis of our results. If this information could be secured more easily through the Department of Dietetics, would you please forward the questionnaire to the Director of that department?

The questionnaire enclosed is being mailed to personnel directors of hospitals accredited by the JCAH and holding AHA membership; we are surveying hospitals offering general, short term care, with two-hundred or more beds/bassinets. The scope of our project includes hospitals in Kansas, Missouri, Oklahoma, Nebraska, Iowa, and Illinois.

It would be greatly appreciated if you would complete the questionnaire and return it in the enclosed envelope at an early date. Please be assured that individual hospital anonymity will be maintained and results reported only in aggregate form for each state and the six state area. If you wish to receive a copy of the results, please return the enclosed form.

Thank you.

Sincerely,

Rosemary N. Rich
Graduate Teaching Assistant

Research Team:

Rosemary N. Rich
Graduate Teaching Assistant

Allene G. Vaden, Ph.D., R.D.
Assistant Professor,
Department of Dietetics, Restaurant
and Institutional Management

APPENDIX B

Please Mail a Copy of Project Results To:

(Name) _____

(Title) _____

(Hospital) _____

(Address) _____

(City, State) _____

KANSAS STATE UNIVERSITY

Department of Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521

April 19, 1977

Dear Hospital Personnel Director:

We need your assistance in compiling data for a project that has been undertaken at Kansas State University.

In March, we mailed you a questionnaire regarding salary benefit opportunities for the entry-level registered dietitian in a selected Midwestern area. Because our target samples were chosen randomly from hospitals having two-hundred beds or more, and further limited by location within a six state area, we are hoping for good response in order to have complete data in reporting results.

In the event you did not receive the first mailing, let me briefly restate the objective. We are seeking information about salary and benefits offered to entry-level dietitians in order that students graduating from the dietetics program here can be competently counseled on this important aspect of employment. We feel it will offer the student seeking employment in the Midwest realistic data on which to base expectations.

Included you will find a copy of the questionnaire: it has been coded for follow-up purposes only. Please be assured that all reported data will remain confidential, and final information presented as averages only.

It would be greatly appreciated if you would fill out the questionnaire and return it as early as possible in the enclosed envelope. Your response is needed for complete and valid project results. Thank you.

Sincerely,

Rosemary N. Rich
Graduate Teaching Assistant

Research Team:

Rosemary N. Rich
Graduate Teaching Assistant

Allene G. Vaden, Ph.D., R.D.
Assistant Professor,
Department of Dietetics, Restaurant and Institutional Management

ENTRY-LEVEL SALARIES AND FRINGE BENEFITS OF HOSPITAL DIETITIANS IN THE MIDWEST

by

ROSEMARY N. RICH

B.A., Stephens College, 1971

AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Dietetics, Restaurant and Institutional Management

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1978

ABSTRACT

The primary objective of this project was to determine typical salaries and fringe benefits offered entry-level dietitians by hospitals of 200 beds or more in six Midwestern states. Salary trends from 1972 to 1976 and salary increment amounts and frequencies also were studied.

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