The Association of Community Cancer Centers
2011 Cancer Program Administrator Survey

In April 2011, ACCC encouraged cancer program administrators employed at ACCC-Member Cancer Programs to take an online survey. One hundred and thirty administrators responded to ACCC's survey.

In Brief

Generally, cancer program administrators seem to be a happy group. Ninety-one percent report being "very satisfied" or "satisfied" with their jobs. And a majority of respondents (75 percent) plan to continue in their positions as full-time cancer program administrators. About 17 percent say they plan to move into other areas of hospital administration.

Although a majority of respondents report the economy is affecting their ability to access the capital needed to acquire new technologies or expand services, 64 percent report considering adding or upgrading their EHR system(s), and 56 percent have the funds and are considering adding/upgrading linear accelerators in 2011-2012.

The median annual total salary is $124,000, up about 8.5 percent from $114,000 in 2009. The average annual total salary is $133,794 up about 9 percent from $121,458 over the two years since the last survey.

Who Are Our Cancer Program Administrators?

The position title "Cancer Program Administrator" continues to become the exception rather than the rule. Only 9 percent of respondents answered that their official title is, in fact, "Cancer Program Administrator." Of the remaining 91 percent, most (54 percent) hold the title of director, including "Director, Oncology Services" or "Director, Cancer Services." Fifteen percent hold the title executive director or executive director, cancer services, while 9 percent hold the title administrative director. Seven percent hold positions as managers ("Cancer Center Manager," for example). Eight percent hold positions as vice presidents. The remainder indicate various titles, including supervisor and clinical service director.

Twenty-seven percent hold an MBA degree and 9 percent hold an MHA.

Forty-eight percent are RNs, with 18 percent holding an MSN. Thirty percent of respondents are oncology certified nurses, compared to the 14 percent of respondents in 2009. Eleven percent of respondents are Advanced Oncology Certified Nurses (AOCNs), compared to 6 percent in 2009.

Ten percent are fellows of the American College of Healthcare Executive, FACHE. Other licensures and certifications include licensed radiologic technologist (17 percent).

Almost 80 percent of respondents are female.

The Economy

Fifty-four percent of respondents indicate that the economy is affecting their ability to access the capital needed to acquire new technologies or expand services. (This is down from 64 percent in the 2009

survey.) Of those respondents, half said upgrades/purchase of linear accelerators have been put on hold. This percentage is down from 62 percent in the 2009 survey.

Twenty-five percent report delaying purchase of robotic surgical devices and Cyberknife, while 23 percent report delaying purchasing stereotactic radio-surgery equipment. Twenty-nine percent report that they are not able to upgrade or add electronic health record (EHR) systems at this time. Other reported technologies that have been put on hold: PET/CT tomotherapy, 19 percent, and XOFT brachytherapy, 15 percent.

All is not bad news, however. Although a majority of respondents report the economy is affecting their ability to access the capital needed to acquire new technologies or expand services, 64 percent report considering adding or upgrading their EHR system(s), and 56 percent have the funds and are considering adding/upgrading linear accelerators in 2011-2012. At least some are also considering adding PET/CT tomography (10 percent) and Cyberknife, robotic surgery, and XOFT brachytherapy (6 percent each.)

Almost 38 percent of respondents report working with their cancer program to acquire or bring oncology practice(s) in-house. Almost one in three responders chose to comment on this question. Some are looking to do a professional services agreement with private practice medical oncology groups. Many are in negotiations now to acquire medical oncology practices or have just started using the physician employment model and are still recruiting medical oncologists.

What Do They Think About Their Position?

Job satisfaction is high. Forty-three percent report being "very satisfied" and 48 percent are "satisfied" with their jobs. About 8 percent report some dissatisfaction. (Three percent expressed "some dissatisfaction" with their position in 2009.) About 2 percent said they were "very dissatisfied" with the job.

A majority of respondents (75 percent) plan to continue in their positions as full-time cancer program administrators. About 17 percent say they plan to move into other areas of hospital administration. The remainder indicate they would leave their positions, some retiring, others completing MHA or MBA programs.

Long-timers (five or more years) number 60 percent of the total respondents. Just 5 percent have been in the position less than one year. (In 2009 12 percent indicated they had been in the position less than one year.) New people are still moving into the role of cancer program administrator: 12 percent have been in their position as administrator for one to two years, and 23 percent have held their position for three or four years.

Where Do They Work?

Not surprisingly, the vast majority of ACCC-member cancer program administrators (94 percent) are employed at community-based programs, followed by 4 percent at university-based cancer programs and about 3 percent at NCI-designated centers. Almost half have freestanding facilities. About 60 percent indicated their hospital is in a consortium or multihospital system. Just 9 percent work in for-profit institutions.

About half report that their facility is qualified for and receiving 340B drug discount pricing. For those not receiving 340B drug discount pricing, about one in four report they expect to receive it over the next year or two.

About 85 percent of the cancer program administrators work alongside a cancer program medical director compared with 77 percent in 2009.

The most popular way to fill the position of cancer program administrator is from within: About 48 percent report being on staff when they applied for the position or were approached by management. About 18 percent found their position through a recruiting firm; 14 percent were recruited from other institutions. Advertising—including the Internet—is how 11 percent of the cancer program administrators heard about their position. Others report using personal and professional referrals and networking opportunities, such as ACCC's online job offerings (www.accc-cancer.org), to procure their position.

Who Do They Supervise and Report To?
When asked about staff size, most cancer program administrators (42 percent) responded that they "directly supervise" between 11 and 30 people. About 36 percent are responsible for the direct supervision of 6 to 10 staff. Other responses are as follows: 8 percent directly supervise 31 to 50 individuals; 6 percent directly supervise more than 50; 5 percent directly supervise 3 to 5 individuals; and 4 percent directly supervise 1 to 2 individuals.

More than half of respondents (53 percent) indicate that they "indirectly supervise" more than 50 staff. The next most common answer (16 percent) was indirect supervision of between 30 and 50 staff. The remaining answers broke down as follows:

- 12 percent indirectly supervise from 11 to 20 people
- 7 percent indirectly supervise from 21 to 30 people
- 5 percent indirectly supervise from 3 to 5 people
- 4 percent indirectly supervise from 1 to 2 people
- 3 percent indirectly supervise from 6 to 10 people.

When asked to whom they report, 35 percent said that they report to a "vice president," including a vice president of medical affairs, vice president of patient care services, vice president administrative services, vice president of cancer services, vice president of operations, senior vice president, among others.

About 30 percent of the cancer program administrators report to a chief operating officer (COO), while 10 percent report to a chief executive officer (CEO) and 1 percent to a chief financial officer (CFO).

About 7 percent report to a medical director and 5 percent to a chief nursing officer (CNO). Others report to the director of oncology or director of the cancer center. Just 1 of 125 cancer program administrators specified they report to a Board of Directors and 2 to a manager.

What Do They Do?
Cancer program administrators have a busy workload, including financial, operational, management, and educational/professional and program development responsibilities.

Cancer program administrators devote extensive time and effort on three "primary" responsibilities—1) mentoring staff and subordinates to maximize their abilities; 2) assisting staff to understand and support organizational policies and objectives; and 3) conducting and documenting regular meetings with all department personnel. At the opposite end of the spectrum, administrators spend less time supervising additional services outside the cancer service line (such as bariatrics or wound care); applying for and managing grants; and managing clinical research. See Table 1 for a complete look at the primary responsibilities of the cancer program administrators.

Cancer program administrators rate their "educational/professional and program development" responsibilities slightly higher than those identified as operational or financial management responsibilities. The top three educational/professional and program development responsibilities are 1) developing and maintaining a strong relationship with physicians and identifying areas for business opportunity and support, 2) maintaining high quality image in all programs and services, and 3) evaluating existing services and identifying new program opportunities. These remain the same as in the 2009 survey. At the opposite end of the spectrum, cancer program administrators spend less time 1)

representing the department by participating in trade organizations and attending seminars and conferences, 2) developing and maintaining data on market-share costs, profitability, and competitor data, and 3) developing products or services to enhance market share within managed care organizations. See Table 2.

ACCC asked administrators to rate in importance their operational/management responsibilities. Developing an effective strategic plan, including ongoing goals and objectives to support the plan, remains the number one operational responsibility, just as in the 2009 survey. Next, in order of ranked importance are 2) implementing quality programs to reduce risk and promote quality care; 3) quantifying department efficiency and effectiveness through benchmarking and continuous quality improvement; and 4) actively supporting and participating in the hospital continuous quality improvement efforts. To view how cancer program administrators ranked all operational management responsibilities, see Table 3.

Financial responsibilities are rated nearly as important as operational responsibilities. The top two responses in this category are unchanged between the 2009 survey: 1) making continuous efforts to ensure cost-effective, efficient operations and 2) developing an annual operational budget and ensuring adherence to operating parameters. Providing timely and complete budget variance reports and completing justification for capital equipment, including pro forma and payback analysis, also rank high in importance. Table 4 shows how respondents ranked all financial responsibilities.

TABLE 1. Primary Tasks, Responsibility Rating

	1/Low	2	3	4	5/High	Rating Average
Mentoring staff and subordinates to maximize their abilities.	0.9%	6.9%	25.0%	**37.1%**	30.2%	**3.89**
Assisting the staff to understand and support organizational policies and objectives.	1.7%	9.6%	**34.8%**	**34.8%**	19.1%	**3.60**
Conducting and documenting regular departmental meetings with all department personnel for proper communication.	9.4%	17.1%	23.1%	**29.1%**	21.4%	**3.36**
Ensuring awareness of and adherence to hospital-wide and departmental policies.	4.3%	**30.8%**	**30.8%**	19.7%	14.5%	**3.09**
Performing personnel tasks, including hiring, counseling, promoting, and disciplining staff as appropriate.	12.7%	21.2%	**28.8%**	26.3%	11.0%	**3.02**
Ensuring appropriate staffing based on work load and staff competency.	21.4%	**26.5%**	**26.5%**	13.7%	12.0%	**2.68**
Assuring appropriate performance and documentation of new employee orientation, as well as assuring specific competencies within in-service educational programs and outside educational programs.	18.6%	**39.8**	25.4%	13.6%	2.5%	**2.42**
Playing an active role in fundraising or philanthrophy.	28.2%	**29.1%**	26.5%	12.0%	4.3%	**2.35**
Assuring time and attendance records are completed accurately and maintained.	**38.8%**	24.1%	18.1%	12.1%	6.9%	**2.24**

TABLE 1. Primary Tasks, Responsibility Rating						
Managing clinical research.	**39.3%**	29.1%	14.5%	12.0%	5.1%	**2.15**
Applying for and managing grants.	**53.0%**	20.9%	13.9%	10.4%	1.7%	**1.87**
Supervising additional services outside the cancer service line, such as bariatrics or wound care.	**67.0%**	7.8%	7.0%	11.3%	7.0%	**1.83**

TABLE 2. Programmatic/Educational/Professional and Program Development, Responsibility Rating						
	1/Low	2	3	4	5/High	Rating Average
Developing and maintaining a strong relationship with the physicians and identifying areas for business opportunity and support.	0.8%	1.7%	6.7%	31.1%	**59.7%**	**4.47**
Maintaining high quality and image in all programs and services.	0.0%	1.7%	12.6%	39.5%	**46.2%**	**4.30**
Evaluating existing services and identifying new program opportunities	0.0%	5.0%	26.1%	21.0%	**47.9%**	**4.12**
Identifying new markets for program growth.	4.2%	10.2%	15.3%	28.0%	**42.4%**	**3.94**
Developing effective strategic and marketing plans, along with action steps and implementation dates.	2.5%	10.1%	20.2%	31.9%	**35.3%**	**3.87**
Effectively implementing strategic and marketing plans.	1.7%	10.9%	23.5%	28.6%	**35.3%**	**3.85**
Serving as a mentor and promoting professional development to staff.	1.7%	8.4%	26.1%	31.9%	**31.9%**	**3.84**
Learning about ACoS Cancer Program Accreditation guidelines.	8.5%	11.0%	22.9%	26.3%	**31.4%**	**3.61**
Collaborating with other hospital departments to further develop the oncology product line (for example, radiology to upgrade equipment; nursing in regards to inpatient care, nuclear medicine for radiopharmaceuticals, etc.)	6.7%	14.3%	17.6%	**36.1%**	25.2%	**3.59**
Ensuring personal professional growth and development.	1.7%	15.3%	**30.5%**	29.7%	22.9%	**3.57**
Developing products or services to enhance market share within managed care organizations.	12.0%	18.8%	18.8%	24.8%	**25.6%**	**3.33**
Developing and maintaining data on market share costs, profitability, and competitor data.	13.8%	19.0%	**27.6%**	19.8%	19.8%	**3.13**
Representing the department by participating in trade organizations and attending seminars and conferences.	15.1%	23.5%	**31.1%**	19.3%	10.9%	**2.87**

3.70

TABLE 3. Operational Management, Responsibility Rating						
	1/Low	2	3	4	5/High	Rating Average
Developing strategic plan and ongoing goals and objectives to support the plan.	2.5%	1.7%	9.2%	26.1%	**60.5%**	**4.40**
Implementing quality program to reduce risk and promote quality.	0.8%	3.4%	27.1%	**34.7%**	33.9%	**3.97**
Quantifying department efficiency and effectiveness through benchmarking and continuous quality improvement.	2.5%	6.7%	25.2%	**35.3%**	30.3%	**3.84**
Actively supporting and participating in the hospital continuous quality improvement efforts.	5.9%	7.6%	28.0%	**30.5%**	28.0%	**3.67**
Developing a comprehensive quality assurance plan.	4.3%	12.9%	22.4%	**37.9%**	22.4%	**3.61**
Assessing, recommending, and/or implementing new technologies.	5.1%	15.3%	25.4%	**31.4%**	22.9%	**3.52**
Using the political and social network positively for the benefit of the department and organization.	10.2%	11.0%	22.9%	**29.7%**	26.3%	**3.51**
Ensuring departmental compliance with all provisions of JCAHO, Title 22, and other pertinent regulatory requirements	6.7%	16.0%	26.9%	**30.3%**	20.2%	**3.41**
Assessing, recommending, and/or implementing electronic health record systems.	16.9%	16.9%	**26.3%**	24.6%	15.3%	**3.04**
Addressing outside complaints about employee or department performance and promoting "service recovery."	19.5%	**27.1%**	20.3%	17.8%	15.3%	**2.82**
Ensuring that supplies, equipment, and staffing needed by the departments are available.	21.0%	**28.6%**	22.7%	19.3%	8.4%	**2.66**

TABLE 3. Operational Management, Responsibility Rating						
Ensuring proper maintenance of the environment and equipment. Coordinating with housekeeping and engineering to ensure proper maintenance and cleaning.	20.2%	**33.6%**	26.9%	13.4%	5.9%	**2.51**

TABLE 4. Financial Management, Responsibility Rating						
	1/Low	2	3	4	5/High	Rating Average
Making continuous efforts to ensure cost-effective, efficient operations.	1.7%	4.2%	17.6%	38.7%	**37.8%**	**4.07**
Developing an annual operational budget and ensuring adherence to operating parameters.	3.4%	8.4%	11.8%	37.0%	**39.5%**	**4.01**
Completing justification for capital equipment, including pro forma and payback analysis.	5.9%	10.1%	26.1%	28.6%	**29.4%**	**3.66**
Providing timely and complete budget variance reports.	6.7%	12.6%	**28.6%**	27.7%	24.4%	**3.50**
Collaborating with Accounting, Managed Care, and Medical Records departments to oversee cancer service reimbursements from third-party payers and CMS.	9.3%	18.6%	**30.5%**	28.0%	13.6%	**3.18**
Assuring compliance with hospital policies and practices regarding vendor selection and acquisition and payment of supplies and services.	19.3%	21.0%	**27.7%**	22.7%	9.2%	**2.82**

What Is Their Compensation?

Cancer program administrators indicate having base salaries ranging from a low of $39,260 to a high of $269,000. The median annual base salary is $117,000 up from $110,000 in 2009—about a 6 percent increase over two years. The average annual base salary is $122,226, up from $115,865 in 2009, also up about 6 percent over the two years. A detailed analysis of base salaries is provided in Table 5.

TABLE 5. Annual 2010 Base Salary for Cancer Program Administrators

Salary Range	Percentage of Cancer Program Administrators in This Range	Average Salary	Median Salary
$25,000-$49,999	1%	$39,260	$39,260
$50,000-$59,999	3%	$50,666	$50,000
$60,000-$69,999	3%	$64,375	$64,250
$70,000-$79,999	4%	$72,805	$74,000
$80,000-$89,999	3%	$85,333	$85,000
$90,000-$99,999	13%	$94,953	$95,500
$100,000-$109,999	16%	$103,833	$104,000
$110,000-119,999	8%	$112,991	$111,000
$120,000-$129,999	11%	$123,923	$124,000
$130,000-$139,999	7%	$132,286	$130,571
$140,000-$149,999	9%	$142,956	$143,520
$150,000-$159,999	2%	$153,000	$153,000
$160,000-$169,999	9%	$163,114	$165,000
$170,000-$179,999	3%	$172,600	$170,000
$180,000-199,999	2%	$184,333	$185,000
$200,000-$300,000	4%	$217,200	$208,000

When asked about *total* annual salary (includes all sources), cancer program administrators provided answers ranging from a low of $50,000 to a high of $308,000. The median annual total salary is $124,000, up about 8.5 percent from $114,000 in 2009. The average annual total salary is $133,794 up about 9 percent from $121,458 over the two years since the last survey.

In 2011, more than half (55 percent) earned $120,000 or more.

A detailed analysis of total annual salaries is provided in Table 6.

TABLE 6. 2011 Total Annual Salary for Cancer Program Administrators

Salary Range	Percentage of Cancer Program Administrators in This Range	Average Salary	Median Salary
$50,000-$59,999	2%	$50,000	$50,000
$60,000-$69,999	3%	$62,833	$62,000
$70,000-$79,999	4%	$75,205	$75,025
$80,000-$89,999	3%	$85,666	$87,000
$90,000-$99,999	8%	$96,844	$97,500
$100,000-$109,999	16%	$104,047	$104,350
$110,000-119,999	12%	$113,869	$115,000
$120,000-$129,999	8%	$123,333	$124,000
$130,000-$139,999	8%	$133,671	$133,150
$140,000-$149,999	10%	$143,454	$144,000
$150,000-$159,999	2%	$152,500	$152,500
$160,000-$169,999	8%	$162,944	$160,000
$170,000-$179,999	3%	$176,750	$176,500
$180,000-$189,999	4%	$186,400	$187,000

$190,000-$200,000	3%	$192,667	$193,000
$200,000-249,999	6%	$221,285	$220,000
More than $249,999	3%	$285,000	$297,000

Two-thirds (67 percent) of the administrators report that they receive additional compensation in the form of incentives and bonuses, up from 57 percent in 2009. Thirty-five percent of administrators said their bonus was tied to the overall financial performance of the organization, while 17 percent said their bonus was based on objectives they developed. While just 5 percent indicated their bonus was tied solely to the overall financial performance of the oncology product line, 38 percent of respondents indicate that a combination of factors (overall financial performance of the organization, personal objectives, overall financial performance of the organization and/or the oncology product line) as well as customer satisfaction are an important basis for their bonus.

TABLE 6. Total Incentive or Bonus Compensation

Bonus Range	Percentage of Cancer Program Administrators in This Range
Up tp $1,000	2%
$1,001-$5,000	23%
$5,001-$7,500	17%
$7,501-$10,000	11%
$10,001-$15,000	21%
$15,001-$20,000	12%
More than $20,000	13%

Where Do They Work?

Cancer program administrators reported their average bed size for their institutions:

- No inpatient beds 9%
- 1-49 inpatient beds 0%
- 50-99 inpatient beds 6%
- 100-199 inpatient beds 9%
- 200-399 inpatient beds 36%
- 400-599 inpatient beds 27%
- 600-999 inpatient beds 9%
- 1,000+ inpatient beds 3%

With regard to the size of the community and primary market, only 4 percent of the hospitals serve a population of less than 50,000, while about 11 percent serve a population of more than 1 million. Other responses include:

- 13% serve a population of between 50,000 and 99,999
- 25% serve a population of between 100,000 and 249,000
- 23% serve a population of between 250,000 and 499,000
- 25% serve a population of between 500,000 and 1 million

Most see 500 or more new analytic cancer patients annually:

- 51-100 2%
- 101-300 9%
- 301-500 11%
- 501-1,000 29%
- 1,001 – 1,500 18%
- 1,501-2,000 17%
- More than 2,000 15%

Fifty-nine percent of respondents indicate their hospital is in a consortium or multi-hospital system, up slightly from 54 percent in 2009.

Ninety-three percent of the cancer program administrators said their hospital was not-for-profit.

About 30 percent of cancer program administrators said that their institution faces competition from 5 or more other hospitals. Five percent of respondents indicate that their institution does not compete with any other hospitals. Here is the breakdown for "How many hospitals do you compete with?"

- None 5%
- One 9%
- Two 16%
- Three 24%
- Four 15%
- Five or more 30%

The majority (52 percent) of administrators report that all cancer services are hospital-based. And 47 percent report they have freestanding facilities.

Survey respondents represent states from across the country. (Table 7).

Table 7. Geographic Distribution of Respondents

Geographic Region	Percentage of Survey Respondents
Northeast (CT, ME, MA, NH, RI, VT)	8%
Mid-Atlantic (DE,DC, MD, NJ, NY, PA)	16%
Central (IL, IN, KY, MI, MN, OH, WV, WI)	25%
Southern (AL, FL, GA, MS, NC, SC, TN, VA)	24%
Mid-West (CO, IA, KS, MO, MT, NE, ND, SD, WY)	9%
Southwest (AR, LA, NM, OK, TX)	6%
Western (AK, AZ, CA, HI, ID, NV, OR, UT, WA)	12%