The Association of Community Cancer Centers
2009 Cancer Program Administrator Survey

In February and March 2009, ACCC encouraged cancer program administrators employed at ACCC-Member Cancer Programs to take an online survey. Slightly more than 19 percent (130 institutions) responded to ACCC's survey.

In Brief

The majority of the cancer program administrators remain happy in their positions. In fact, almost half report they are "very satisfied." Just 3 percent express dissatisfaction, a sharp decline from 16 percent expressing dissatisfaction in 2006. And they are staying at their jobs. More than half of respondents have been in their position for five or more years, and more than 70 percent report their future career goal is to continue employment as a full-time cancer program administrator. At the same time, new administrators are entering the field: About 12 percent have been in their administrator positions for less than one year, and another 17 percent have been in their positions for one to two years.

The average total salary is $121,458—up about 8 percent from $112,000 in 2006 and keeping up with inflation from fall 2006 to early 2009.

Who Are Our Cancer Program Administrators?

The position title "Cancer Program Administrator" is disappearing. Only 8 percent of respondents answered that their official title is, in fact, "Cancer Program Administrator" or "Cancer Service Line Administrator." Of the remaining 92 percent, most (67 percent) hold the title of executive director or director, including "Director, Oncology Services" or "Director, Cancer Services." Seventeen percent hold positions as managers ("Cancer Center Manager," for example). Six percent hold positions as vice presidents. The remainder indicate various titles, including coordinator.

Overall, cancer program administrators are highly credentialed. The majority of respondents (77 percent) have attained a master's degree or higher. Almost 39 percent hold an MBA or MHA. Forty-eight percent hold nursing degrees, with 14 percent holding an MSN.

Fourteen percent of respondents are oncology certified nurses, compared to the 16 percent of respondents in 2006. Six percent of respondents are Advanced Oncology Certified Nurses (AOCNs), close to the 7 percent reported in 2006. Other licensures and certifications include licensed radiologic technologist (6 percent).

Almost three-quarters of respondents are female.

The Economy

Sixty-four percent of respondents indicate that the economy is affecting their ability to access the capital needed to acquire new technologies or expand services. Of those respondents, 62 percent said upgrades to current radiation therapy equipment have been put on hold, including replacing outdated linear

accelerators and HDRs, upgrading IGRT and CT/Sim, or purchasing Rapid Arc, for example. Eight percent note that physical expansion plans have been put on hold, while 12 percent indicate that purchase of or upgrades to oncology-specific EMRs have been put on hold.

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, more than one in five (23 percent) report they are making upgrades to radiation oncology equipment and equipment for diagnostic imaging. A few report moving forward on facility expansion, including opening a new cancer center or building a new radiation oncology facility, although one respondent noted that expansion is taking place in phases instead of building out the entire project.

What Do They Think About Their Position?
The majority of respondents (71 percent) plan to continue in their positions as full-time cancer program administrators. This number is down from 2006 (82 percent). About 18 percent say they plan to move into other areas of hospital administration. A few professionals (2.5 percent) report plans to reenter clinical practice. Almost 17 percent indicate they would leave their positions, some retiring, others completing MHA or MBA programs.

Long-timers (five or more years) number about half (52 percent) of the total respondents. Still, new people are moving into the role of cancer program administrator: 12 percent have been in their position as administrator for less than one year, and another 17 percent have been in their position for one to two years. About 19 percent of respondents have held their position for three or four years.

Job satisfaction is high. The majority of respondents indicate they are not planning to change their positions and remain happy in their positions. Forty-eight percent report being "very satisfied" and 48 percent are "satisfied" with their jobs. Just 3 percent expressed "some dissatisfaction" with their position versus approximately 16 percent in 2006. No respondent expressed "very dissatisfied" with the job.

Where Do They Work?
Not surprisingly, the vast majority of ACCC-member cancer program administrators (96 percent) are employed by community-based cancer centers, followed by 4 percent university-based cancer programs, and just one NCI-designated center.

About 77 percent of the cancer program administrators work alongside a cancer program medical director compared with 75 percent in 2006.

The most popular way to fill the position of cancer program administrator is from within: About 54 percent report being on staff when they applied for the position or were approached by management. About 14 percent found their position through a recruiting firm; 13 percent were recruited from other institutions. Advertising—including the Internet—is how 9 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 (41 percent) responded that they "directly supervise" between 6 and 10 people. About 28 percent are responsible for the direct supervision of 11 to 20 staff. Other responses are as follows: 8 percent directly supervise 30 to 50 individuals; 13 percent directly supervise 3 to 5 individuals; 7 percent directly supervise 1 to 2 individuals and 3 percent directly supervise more than 50.

More than half of respondents (53 percent) indicate that they "indirectly supervise" more than 50 staff. The next most common answer (15 percent) was indirect supervision of between 30 and 50 staff. The remaining answers broke down as follows:

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

When asked to whom they report, 45 percent said that they report to a "vice president," including a vice president of medical affairs, vice president of patient care services, vice president of professional services, vice president of operations, vice president of service line development, and vice president of clinical services, among others. About 22 percent of the cancer program administrators report to a chief operating officer (COO), while 9 percent report to a chief executive officer (CEO) or a chief financial officer (CFO). About 10 percent report to an administrator and 8 percent to a chief nursing officer (CNO). Four percent of respondents report to a medical director. Just 2 of 120 cancer program administrators specified they report to a Board of Directors or Managers.

What Do They Do?
Cancer program administrators have a busy workload, including financial, operational, management, and programmatic responsibilities.

Cancer program administrators rank their "programmatic" responsibilities higher than those identified as financial, "primary," or operational management responsibilities. The top three programmatic 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. 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 1.

Financial responsibilities are ranked second and nearly as important as programmatic responsibilities. The top two responses in this category are unchanged between the 2009 survey and the 2006 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 2 shows how respondents ranked all financial responsibilities.

Cancer program administrators devote extensive time and effort on two "primary" responsibilities—mentoring staff and subordinates to maximize their abilities and assisting staff to understand and support organizational policies and objectives. At the opposite end of the spectrum, administrators spend less time assuring that time and attendance records are completed and maintained accurately and assuring appropriate performance and documentation of new employee orientation, specific competencies, and in-service and outside education programs. These findings are similar to the 2006 survey. See Table 3 for a complete look at the primary responsibilities of the cancer program administrators.

ACCC asked administrators to rank 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 2006 survey. Next, in order of ranked importance are 2) implementing quality programs to reduce risk and promote quality care; 3) using the political and social network positively for the benefit of the department and organization; and 4) quantifying department efficiency and effectiveness through benchmarking and continuous quality improvement. To view how cancer program administrators ranked all operational management responsibilities, see Table 4.

TABLE 1. 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.	0.0%	6.2%	8.0%	24.8%	**61.1%**	**4.41**
Maintaining high quality and image in all programs and services.	0.0%	2.7%	11.5%	39.8%	**46.0%**	**4.29**
Evaluating existing services and identifying new program opportunities.	0.9%	6.3%	14.4%	**43.2%**	35.1%	**4.05**
Effectively implementing the plans.	4.4%	9.7%	14.2%	35.4%	**36.3%**	**3.89**
Developing effective strategic and marketing plans, along with action steps and implementation dates.	4.4%	10.6%	17.7%	31.9%	**35.4%**	**3.83**
Identifying new markets for program growth.	4.4%	10.6%	21.2%	30.1%	**33.6%**	**3.78**
Serving as a mentor to and promoting professional development of staff.	1.8%	4.5%	32.1%	**43.8%**	17.9%	**3.71**
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.)	7.1%	10.7%	23.2%	**30.4%**	28.6%	**3.63**
Ensuring personal professional growth and development.	1.8%	9.7%	31.0%	**41.6%**	15.9%	**3.60**
Learning about ACoS Cancer Program Accreditation guidelines.	11.0%	12.8%	23.9%	19.3%	**33.0%**	**3.50**
Developing products or services to enhance market share within managed care organizations.	10.6%	17.7%	**26.5%**	**26.5%**	18.6%	**3.25**
Developing and maintaining data on market share costs, profitability, and competitor data.	12.5%	17.9%	24.1%	**26.8%**	18.8%	**3.21**
Representing the department by participating in trade organizations and attending seminars and conferences.	13.3%	21.2%	**32.7%**	22.1%	10.6%	**2.96**

TABLE 2. Financial Management, Responsibility Rating						
	1/Low	**2**	**3**	**4**	**5/High**	**Rating Average**
Making continuous efforts to ensure cost-effective, efficient operations.	0.0%	5.4%	16.1%	33.0%	**45.5%**	**4.19**
Developing an annual operational budget and ensuring adherence to operating parameters.	2.7%	6.3%	18.8%	32.1%	**40.2%**	**4.01**
Providing timely and complete budget variance reports.	7.1%	8.0%	**30.4%**	29.5%	25.0%	**3.57**
Completing justification for capital equipment, including pro forma and payback analysis.	6.3%	12.5%	24.1%	**33.0%**	24.1%	**3.56**
Collaborating with Accounting, Managed Care, and Medical Records departments to oversee cancer service reimbursements from third-party payers and CMS.	12.6%	16.2%	**30.6%**	24.3%	16.2%	**3.15**
Assuring compliance with hospital policies and practices regarding vendor selection and acquisition and payment of supplies and services.	8.0%	**28.6%**	26.8%	**28.6%**	8.0%	**3.00**

TABLE 3. Primary Tasks, Responsibility Rating						
	1/Low	**2**	**3**	**4**	**5/High**	**Rating Average**
Mentoring staff and subordinates to maximize their abilities.	2.7%	6.3%	34.8%	**38.4%**	17.9%	**3.63**
Assisting the staff to understand and support organizational policies and objectives.	1.8%	12.4%	**38.9%**	30.1%	16.8%	**3.48**
Conducting and documenting regular departmental meetings with all department personnel for proper communication.	12.5%	14.3%	**33.0%**	27.7%	12.5%	**3.13**
Ensuring awareness of and adherence to hospital-wide and departmental policies.	8.0%	32.7%	**33.6%**	20.4%	5.3%	**2.82**
Performing personnel tasks, including hiring, counseling, promoting, and disciplining staff as appropriate.	15.9%	29.2%	**30.1%**	15.0%	9.7%	**2.73**
Ensuring appropriate staffing based on work load and staff competency.	18.6%	**28.3%**	**28.3%**	15.0%	9.7%	**2.69**
Assuring appropriate performance and documentation of new employee orientation, specific competencies in-service education programs, and outside educational programs.	28.6%	**38.4%**	18.8%	12.5%	1.8%	**2.21**
Assuring time and attendance records are completed accurately and maintained.	**42.2%**	26.6%	18.3%	9.2%	3.7%	**2.06**

TABLE 4. 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.	0.9%	5.4%	9.0%	32.4%	**52.3%**	**4.30**
Implementing quality program to reduce risk and promote quality.	1.8%	5.4%	23.4%	**39.6%**	29.7%	**3.90**
Using the political and social network positively for the benefit of the department and organization.	3.6%	11.6%	14.3%	**36.6%**	33.9%	**3.86**
Quantifying department efficiency and effectiveness through benchmarking and continuous quality improvement.	1.8%	8.9%	21.4%	**42.0%**	25.9%	**3.81**
Actively supporting and participating in the hospital continuous quality improvement efforts.	3.6%	8.9%	29.5%	**36.6%**	21.4%	**3.63**
Assessing, recommending, and/or implementing new technologies.	3.6%	11.8%	28.2%	**37.3%**	19.1%	**3.56**
Ensuring departmental compliance with all provisions of JCAHO, Title 22, and other pertinent regulatory requirements.	8.1%	8.1%	27.0%	**34.2%**	22.5%	**3.55**
Developing a comprehensive quality assurance plan.	3.6%	15.2%	25.9%	**33.9%**	21.4%	**3.54**
Addressing outside complaints about employee or department performance and promoting "service recovery."	18.0%	**24.3%**	23.4%	21.6%	12.6%	**2.86**
Ensuring that supplies, equipment, and staffing needed by the departments are available.	20.5%	24.1%	**36.6%**	16.1%	2.7%	**2.56**
Ensuring proper maintenance of the environment and equipment. Coordinating with housekeeping and engineering to ensure proper maintenance and cleaning.	30.4%	25.9%	**33.0%**	8.9%	1.8%	**2.26**

What Is Their Compensation?

Cancer program administrators indicate having base salaries ranging from a low of $39,000 to a high of $465,000. (These low and high salaries were excluded from the median and average calculations and the table, since they were well outside the range of the other salaries.) The median annual base salary is $110,000—up from $101,000 in 2006. The average annual base salary is $115,865—up from $105,000 in the 2006 survey. A detailed analysis of base salaries is provided in Table 5.

TABLE 5. Annual 2009 Base Salary for Cancer Program Administrators

Salary Range	Percentage of Cancer Program Administrators in This Range	Average Salary	Median Salary
$50,000-$59,999	1%	$50,000	$50,000
$60,000-$69,999	1%	$64,000	$64,000
$70,000-$79,999	6%	$75,167	$75,000
$80,000-$89,999	8%	$83,444	$85,000
$90,000-$99,999	11%	$93,216	$92,000
$100,000-$109,999	22%	$103,900	$105,000
$110,000-119,999	14%	$112,933	$111,000
$120,000-$129,999	12%	$123,667	$124,000
$130,000-$139,999	7%	$135,157	$135,000
$140,000-$149,999	5%	$141,600	$140,000
$150,000-$159,999	3%	$153,333	$152,000
$160,000-$169,999	3%	$163,000	$163,000
$170,000-$179,999	3%	$173,000	$172,000
$180,000-199,999	1%	$190,000	$190,000
$200,000-$300,000	3%	$241,000	$256,000

When asked about *total* annual salary (includes all sources), cancer program administrators provided answers ranging from a low of $39,000 to a high of $465,000. (Again, the low and the high salaries were not included in the median and average calculations.) The median salary is $114,000—up about 6.2 percent from $107,000 in 2006. The average total salary is $121,458—up about 8 percent from $112,000 in 2006 and keeping up with inflation from fall 2006 to early 2009.

More than half (57 percent) of the administrators report that they receive additional compensation in the form of incentives and bonuses, similar to 2006. Bonus amounts vary from $350 to $40,000. (A $110,000 bonus is not included in the analysis.) The median bonus is $8,000 (vs. $10,000 in 2006) and the average bonus is $10,299 (vs. $10,940 in 2006). Some administrators said their bonus was tied to a percentage of their salary. Since we are not able to correlate these percentages with their salary, however, these individuals are not counted in the analysis or in Table 6, which shows the total incentive or bonus compensation paid to cancer program administrators last year.

TABLE 6. Total Incentive or Bonus Compensation

Bonus Range	Percentage of Cancer Program Administrators in This Range	Average Bonus	Median Bonus
$325-$2,499	9%	$1,438	$1,500
$2,500-$4,999	16%	$3,500	$4,000
$5,000-$9,999	33%	$6,780	$7,000
$10,000-$14,999	25%	$11,318	$11,000
$15,000-$19,999	4%	$15,500	$15,500
$20,000-$24,999	2%	$20,000	$20,000
$25,000-29,999	4%	$25,500	$25,500
$30,000-$34,999	2%	$30,000	$30,000
$35,000-$39,999	2%	$35,000	$35,000
$40,000	2%	$40,000	$40,000

Twenty-six percent of respondents said that their incentives and bonuses are based on the overall financial performance of the organization, down from 38 percent in 2006. About 15 percent report that bonuses and incentives are based on attaining or completing developed objectives. Just 3 percent of administrators report that their bonuses and incentives are given at the discretion of their superiors (vs. 11 percent in 2006). Eight percent report that bonuses and incentives are tied to the overall financial performance of the cancer service line. More than 49 percent of respondents indicate that a combination of these factors as well as customer satisfaction are an important basis for their bonus.

Profile

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

- No inpatient beds 6%
- 1-99 inpatient beds 1%
- 100-199 inpatient beds 18%
- 200-399 inpatient beds 36%
- 400-599 inpatient beds 25%
- 600-999 inpatient beds 12%
- 1,000+ inpatient beds 2%

With regard to the size of the community and primary market, only 5 percent of the hospitals serve a population of less than 50,000, while about 12 percent serve a population of more than 1 million. Other responses include:

- 28% serve a population of between 100,000 and 249,000
- 19% serve a population of between 50,000 and 99,999
- 19% serve a population of between 250,000 and 499,000
- 17% serve a population of between 500,000 and 1 million

More than one in three (37 percent) have freestanding facilities.

The mean number of new analytic cancer patients is 871 and the average is 664.

A big change from the 2006 survey is that 54 percent of respondents indicate their hospital is in a consortium or multi-hospital system. In 2006, just 5 percent of respondents indicated their hospital as in a consortium or multi-hospital system (7 percent in 2005). (The full significance of this finding is unclear, particularly since the survey did not define “consortium”.)

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

About 32 percent of cancer program administrators said that their institution faces competition from 5 or more other hospitals. Seven 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 7%
- One 13%
- Two 25%
- Three 14%
- Four 9%
- Five or more 32%

The majority (57 percent) of administrators report that all cancer services are hospital-based. The remainder (43 percent) responded that not all of their services are hospital-based.

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)	9%
Mid-Atlantic (DE,DC, MD, NJ, NY, PA)	16%
Central (IL, IN, KY, MI, MN, OH, WV, WI)	23%
Southern (AL, FL, GA, MS, NC, SC, TN, VA)	27%
Mid-West (CO, IA, KS, MO, MT, NE, ND, SD, WY)	10%
Southwest (AR, LA, NM, OK, TX)	2%
Western (AK, AZ, CA, HI, ID, NV, OR, UT, WA)	12%
Virgin Islands	1%

2009 may be a year of economic distress for many Americans. Cancer program administrators, too, face a challenge: keeping their cancer service lines financially viable while still offering the best care to their patients.