APSHO Oncology/Hematology Advanced Practitioner Compensation Survey

WENDY VOGEL,[1] MSN, FNP, AOCNP®, FAPO, YI LISA HWA,[2] APRN, DNP, CNP, FAPO, LISA KOTTSCHADE,[2] APRN, MSN, CNP, FAPO, and MEGAN MAY,[3] PharmD, BCOP, FAPO, FHOPA

From [1]Advanced Practitioner Society for Hematology and Oncology, Newtown, Pennsylvania; [2]Mayo Clinic, Rochester, Minnesota; [3]Baptist Health Lexington, Lexington, Kentucky

Authors' disclosures of conflicts of interest are found at the end of this article.

Correspondence to: Wendy H. Vogel, MSN, FNP, AOCNP®, FAPO, Advanced Practitioner Society for Hematology and Oncology, 140 Terry Dr., Suite 103, Newtown, PA 18940
E-mail: wendy.vogel@broadcastmed.com

https://doi.org/10.6004/jadpro.2023.14.7.15

Abstract

The Advanced Practitioner Society for Hematology and Oncology (APSHO) launched its first oncology and hematology advanced practitioner (AP) compensation survey in 2022. This 74-question survey surveyed nurse practitioners, pharmacists, physician assistants, clinical nurse specialists, and advanced practice nurses in oncology, investigating all aspects of compensation structure, including salary, on-call payments, incentive structures where applicable, and consulting rates to work with industry partners. Data also include a concerning rate of AP burnout and intent to alter current work status by leaving the practice, leaving the specialty, reducing work hours, or leaving health care all together. Results from this survey may be beneficial in the recruitment, retention, and promotion of the AP in hematology and oncology.

In 2022, the Advanced Practitioner Society for Hematology and Oncology (APSHO) launched its first oncology and hematology advanced practitioner (AP) compensation survey. Advanced practitioners include nurse practitioners, pharmacists, physician assistants, clinical nurse specialists, and advanced practice nurses. This 74-question survey investigated all aspects of compensation structure, including salary, on-call payments, incentive structures where applicable, and consulting rates to work with industry partners. Key findings from the survey are discussed in this article with recommendations for best practices to compensate and retain qualified oncology APs.

NEED/RATIONALE

Oncology and hematology APs possess specialized skills and knowledge acquired through extensive education, training, and experience. These professionals often work in niche areas where their expertise is in high demand, and their contributions significantly impact the healthcare fields they serve.

J Adv Pract Oncol 2023;14(Suppl 3):49–56

It is often difficult to translate general compensation surveys into meaningful data that assists oncology/hematology APs in negotiating equitable and competitive compensation packages that recognize the AP's worth in the oncology/hematology field. A compensation survey can promote transparency and identify potential pay disparities within a profession. A professional society is an ideal conduit for conducting a compensation survey due to the unique connectivity to a wide range of health-care institutions, clinics, and practices within the oncology/hematology field. APSHO understands the expertise of and critical role these professionals play in the field of cancer care and is able to examine the data for compensation trends while considering factors such as geographic location, years of experience, and other demographic information. Data gathered by the professional society may be used to advocate for policy changes at both organizational and governmental levels. It can also provide information on the challenges faced by oncology/hematology APs and assist the development of strategies to address these challenges.

A compensation survey conducted by a professional society may offer valuable insights to employers as well, allowing institutions to compare their compensation structures with industry standards and ensuring they remain competitive in attracting and retaining the top talent within this specialized field. Employers are able to make informed decisions about compensation and benefits that ultimately contribute to the overall satisfaction and retention of oncology/hematology APs.

The stability and growth of the AP workforce is essential to meet the increasing numbers and needs of oncology/hematology patients. As noted in other parts of this supplemental issue, the application of adequate metrics in AP practice evaluation has been inconsistent at best, and this shortcoming has likely contributed to undervaluing the financial worth of the AP. This, in turn, contributes to burnout when individuals feel overworked, underappreciated, emotionally exhausted, and disengaged. Adequate compensation demonstrates that the organization values its employees. When employees receive fair compensation for their work, they feel valued, motivated, and an increased sense of satisfaction, thus reducing the likelihood of burnout.

METHODS

The sampling frame for this survey was pulled from the APSHO member database, which includes contact information from nurse practitioners, physician assistants, pharmacists, and advanced practice nurses. The resulting database contained 3,480 records.

The survey was distributed online only. 3,480 individuals were sent a link to the online survey in email invitations that were sent at least weekly from June 16, 2022, through September 22, 2022. Other recruitment efforts included announcements at APSHO committee meetings, APSHO events, and APSHO website postings. Respondents had the opportunity to enter a drawing for a prize upon completion. All data was self-reported and anonymous.

RESULTS

Demographics

There were 3,480 invitations for the compensation survey. The overall response rate was 26.4%, or 922 responses. The number of APs who completed the compensation survey and were eligible to be included in the analysis was 816 (23.4%).

Eligible survey participants were oncology/hematology APs working at least 32 hours per week in a nonindustry role and based in the United States. Among the 816 AP respondents from 46 different states, 541 (66.3%) were nurse practitioners, 199 (24.4%) were physician assistants, 35 (4.3%) were in leadership/administration positions, 17 (2.1%) were pharmacists, and 24 (2.9%) were clinical nurse specialists and advanced practice nurses. A majority of APs held a master's degree or higher (master's, 81.5%%; doctorate, 16%).

The AP respondents were predominantly female (92.4%). The median age was 42 years, and 531 (65%) APs were ages 32 to 51 years. The distribution of race/ethnicity was Caucasian/White (79%), followed by Asian (8.5%), Hispanic/Latino (4.5%), Black/African-American (4.1%), Native Hawaiian/Other Pacific Islander (0.6%), American Indian/First Nations (0.5%), other (0.4%), Alaskan Native (0.1%), Middle Eastern/North African 0.1%), and preferred not to disclose (2.2%).

In regard to geographic location, 43% of survey participants were located in the South. Twenty percent of participants were located in the Northeast, 19% in the West, and 18% in the Midwest.

The level of oncology/hematology experience was split between the APs, with 53% having 10 years of experience or fewer and 47.1% with more than 10 years of experience. Of the respondents, over half work in the outpatient setting (64.6%), followed by inpatient (23.9%), surgery (4.1%), radiation (3.1%), urgent care (3%), and other settings (1.4%). There was a similar split between APs working at a community-based office (27.2%), comprehensive cancer center (27.5%), and academic/university setting (24.5%). The remaining respondents work at a community-based hospital, government/VA, medical center, biotech company, or within the research setting. The majority of APs have been with the same employer for 6 to 10 years (25.4%).

When evaluating the responsibilities of APs, they reported typically not covering on-call (71.9%), with 10.5% of APs sometimes taking call and 7.1% regularly managing on-call. The roles specifically with nurse practitioners, physician assistants, leadership/administration, clinical nurse specialists, and advanced practice nurses included reviewing scan results (68.9%), chemotherapy education appointment (55.3%), clinical trial appointments (49.4%), new patient appointments (45.3%), consenting patients for clinical trials (22.1%), and genetic counseling (14.7%). Pharmacists reported being involved in guideline/protocol development (82.4%), patient chemotherapy education (82.4%), participating in clinic specialty activities (76.5%), chemotherapy order verification (47.1%), hazardous drug sterile compounding (41.2%), and dispensing investigational agents (29.4%).

Compensation: Base Salary

The survey asked APs to report their compensation and include the following information: (1) base annual salary or hourly pay, (2) bonus (yearly/sign-on/relocation), (3) student loan repayment, (4) tuition reimbursement, (5) ownership of shares in practice, and (6) additional funding support. The survey data were analyzed and filtered by gender, education, job title, practice type/setting, race/ethnicity, specialty certification, state of license, birth year, and years of clinical experience. The comparisons of annual base salary and hourly rate based on education, gender, race/ethnicity, clinical experience, and practice setting are summarized in Table 1.

The majority of survey respondents (89%) reported that they receive an annual salary. Only 7.2% APs were paid by an hourly rate. Overall, respondents earned an average of $129,299 base salary each year. Compensation was highest in California ($172,119), Alaska ($168,000), and Hawaii ($154,172), and lowest in Mississippi ($90,000), Alabama ($102,200), and Nebraska ($102,953).

When examined by role, APs in administration and leadership roles had the highest pay ($166,429), followed by pharmacists ($142,328), physician assistants ($131,354), nurse practitioners ($125,998), and advanced practice nurses and clinical nurse specialists ($123,078). Doctorate-prepared APs reported a higher annual salary ($136,175) compared with those holding a master's degree ($128,741). The average salary for APs working in surgery was $142,500 compared with $130,00 for APs in the medical settings. The annual base salary was similar for inpatient and outpatient APs; however, most AP respondents (65%) in this survey practiced in outpatient clinics. Advanced practitioners employed in academic and comprehensive cancer centers earned approximately $8,000 per year more than APs working in community oncology settings ($132,764 vs. $124,621).

Compensation rates increased with years of oncology experience. Interestingly, while there was a positive correlation between compensation and years of all advanced practice clinical experience (not just oncology experience) for the initial 5 to 10 years, this association plateaued from 11 to 20 years. However, those with more than 20 years of advanced practice experience were compensated higher.

Male APs earned nearly $7,500 more each year than female AP counterparts. While the gender pay gap remained universal as in many other occupations, the survey reported that racial and ethnic minorities were not compensated at a lower rate in AP practice. The average annual base salaries for Caucasian and non-White APs were $128,380 and $134,271, respectively. Table 2 shows

Table 1. Advanced Practitioner Compensation Comparisons Among Variables

Variables		Average annual base salary
Job title	Total (*n* = 816)	$129,299
	Nurse practitioner (*n* = 541)	$125,998
	Physician assistant (*n* = 199)	$131,354
	Leadership/Administration (*n* = 35)	$166,429
	Pharmacist (*n* = 17)	$142,328
	CNS and advanced nurse (*n* = 24)	$123,078
Gender	Female (*n* = 754)	$128,741
	Male (*n* = 54)	$136,175
	Other (*n* = 8)	$136,750
Race/ Ethnicity	Caucasian/White (*n* = 670)	$128,380
	Non-Caucasian/White (*n* = 152)	$134,235
	Prefer not to disclose (*n* = 19)	$131,154
Clinical experience	0–5 years (*n* = 164)	$114,890
	6–10 years (*n* = 193)	$127,910
	11–15 years (*n* = 133)	$130,445
	16–20 years (*n* = 110)	$130,519
	> 20 years (*n* = 216)	$140,424
Oncology experience	0–5 years (*n* = 211)	$119,398
	6–10 years (*n* = 221)	$128,372
	11–15 years (*n* = 146)	$130,758
	16–20 years (*n* = 78)	$133,337
	> 20 years (*n* = 160)	$140,745
Practice settings	Outpatient (*n* = 700)	$128,544
	Inpatient (*n* = 259)	$129,419
	Radiation (*n* = 34)	$130,466
	Surgery (*n* = 44)	$141,319
	Urgent care (*n* = 32)	$142,500
Practice type	Academic/University (*n* = 200)	$132,403
	Comprehensive cancer center (*n* = 224)	$133,067
	Medical center (*n* = 78)	$126,817
	Community-based facility (*n* = 293)	$124,621

Note. CNS = clinical nurse specialist.

compensation by race/ethnicity. When examining compensation by race/ethnicity and a master's degree, American Indian and Caucasian APs had the lowest compensation. However, with a doctorate, Caucasian and Asian APs had the lowest compensation (Table 3).

Compensation: Bonus

Advanced practitioners were asked to indicate if they received additional compensation from their employers beyond their base salaries. Most APs (95%) were employed and only 1.2% of respondents claimed to own or had ownership in shares in the practice. Nearly 30% of APs did not receive a bonus in the last calendar year. Bonuses were awarded based on the performance of practice (16.7%), holiday gifts (15.5%), individual performance (15.4%), and productivity (11.5%). The most common bonus value received was $5,001 to $10,000 (12.9%) and $10,001 to $20,000 (7%). Less than 5% of APs reported a bonus of greater than $20,000. Only 11.5% of APs were compensated with a sign-on bonus, ranging from $1,500 to $40,000, and approximately 5% were offered up to $26,000 as a relocation bonus for their current job.

Compensation: Paid Time Off

Paid time off was structured into the following types: one allotment to include vacation, holiday, and sick day (45%), separate vacation, holiday, and sick day (30.7%), grouped vacation and sick days but separate holidays (22.9%), or unlimited for flex time off with no set allotment (1.3%). The most common paid time off per year structures were 21 to 25 days (13.6%), 26 to 30 days (12.7%), and 16 to 20 days (11.2%). Less than 13% of APs had separate paid parental leave, ranging between 1 to 5 days and more than 80 days. Approximately 50% of APs were provided with paid bereavement leave and mostly for 1 to 5 days (45.1%).

Compensation: Retirement Benefits

We asked APs to identify the most accurate description of retirement benefits provided by their primary employers. Most APs (85.8%) did not participate in a profit-sharing plan at their organization. The majority of APs (89.4%) received their retirement benefits through 401(k)/403(b) contributed and/or matched by the employers.

Table 2. Compensation by Race/Ethnicity

Race/Ethnicity	Total respondents (*n*)	Compensation
Native Hawaiian/Pacific Islander	5	160,200
Hispanic/Latino	38	134,036
Middle Eastern or North African	1	134,000
Asian	72	133,321
American Indian/First Nations	4	132,701
Black/African American	35	132,200
Caucasian/White	670	128,380

They reported that their employers matched their 401(k)/403(b) contribution for up to 3% (32.4%), 3 to 7% (27.6%), more than 7% (8.9%), or contributed a set amount to their 401(k)/403(b) plan (10%). Fewer institutions (10.5%) offered a pension plan to APs.

Compensation: Insurance

Advanced practitioners were surveyed about the insurance coverages provided by their employers. The majority of APs (78.8%) reported that their employers provide full professional liability insurance. Most APs received coverage from their employers for individual health (69.4%), family health (55.2%), dental (61.3%), disability (51.9%), and term life (51.5%) insurance.

Compensation: Funding to Support Professional Development

Over 60% of APs reported that their employers provide 1 to 5 paid days and $1,000 to $3,000 funding each year to support their continuing medical education (CME) activities. Advanced practitioners were able to allocate their CME funds to reimburse other activities such as subscription to academic journals (34.3%), professional society membership fees (42%), and professional leadership development (33.5%). While fewer APs utilized the CME funding to pay for their state licensing (15.3%) and Drug Enforcement Administration (DEA) registration (10.3%) fees, many institutions provided full coverage for state license (55.1%) and DEA registration (65.3%). About 50% of respondents had tuition reimbursement, while 18% of APs did not know if this was included in their compensation benefits. Less than 10% of APs received student loan repayment. Over 50% of APs reported that their employers did not provide separate funding support for current technology.

Burnout

The survey presented a scale of 1 to 5, with 1 being the lowest and 5 being the highest level of burnout, and asked APs rate their level of burnout. Most respondents had burnout levels ranging from 2 to 4 (1 [9.6%], 2 [20.1%], 3 [31.3%], 4 [21.7%], and 5 [7.4%]). Female APs were more likely than their male colleagues to experience burnout score ≥ 3 (61.9% vs. 40.8%, respectively). A high burnout score (≥ 3) was most prevalent among pharmacists (76.4%), followed by APs in administration/leadership roles (71.4%), NPs (61.8%), PAs

Table 3. Compensation by Race/Ethnicity and Highest Level of Education

Race/Ethnicity	Compensation with master's degree	Compensation with doctorate
Native Hawaiian/Pacific Islander	$160,200 (*n* = 5)	N/A
Asian	$132,825 (*n* = 60)	$128,333 (*n* = 8)
Hispanic/Latino	$130,225 (*n* = 27)	$142,250 (*n* = 9)
Black/African American	$129,553 (*n* = 26)	$133,783 (*n* = 8)
Caucasian/White	$127,496 (*n* = 552)	$131,733 (*n* = 105)
American Indian/First Nations	$111,000 (*n* = 1)	$143,551 (*n* = 3)

(54.8%), and clinical nurse specialists and advanced practice nurses (45.8%). Advanced practitioners working in inpatient settings reported similarly high burnout scores (≥ 3) to APs in outpatient settings (61.8% vs. 59.7%). There was no association between years of clinical practice and burnout, as more experienced APs faced a similar level of burnout as newly graduated APs (Figure 1). Almost 40% of APs were considering a change to their work status either by leaving current practice (14.4%), leaving the oncology/hematology specialty (3.2%), leaving health care (4.6%), or reducing work hours (16.7%).

STUDY LIMITATIONS

The APSHO compensation survey was designed as a national survey and may not reflect all local or regional compensation practices. Further, the number of respondents within certain professional categories was quite low, limiting the generalizability of the data. The overall survey response rate may have been influenced by the number of requests to complete surveys during the data collection period, which was during the COVID-19 public health emergency, along with the increased burdens and stress upon APs. Geographic location may also confound the results, as 43% of respondents were located in the southern United States. The number of participants of non-Caucasian/White background may be too small to draw a generalized conclusion. All information was self-reported and may be associated with response bias factors. While attempts were made to eliminate bias through questionnaire design, self-reported data is always associated with a certain level of response bias based on factors such as social desirability and differences in question interpretation.

DISCUSSION AND IMPLICATIONS

Cancer care in the US has improved considerably in the past 20 years. Patients are living longer thanks to a better understanding of the disease process, advances in available treatments, and more services addressing survivorship issues. However, this growth in the number of cancer survivors and projected shortage of physicians has led to a demand for more health-care provid-

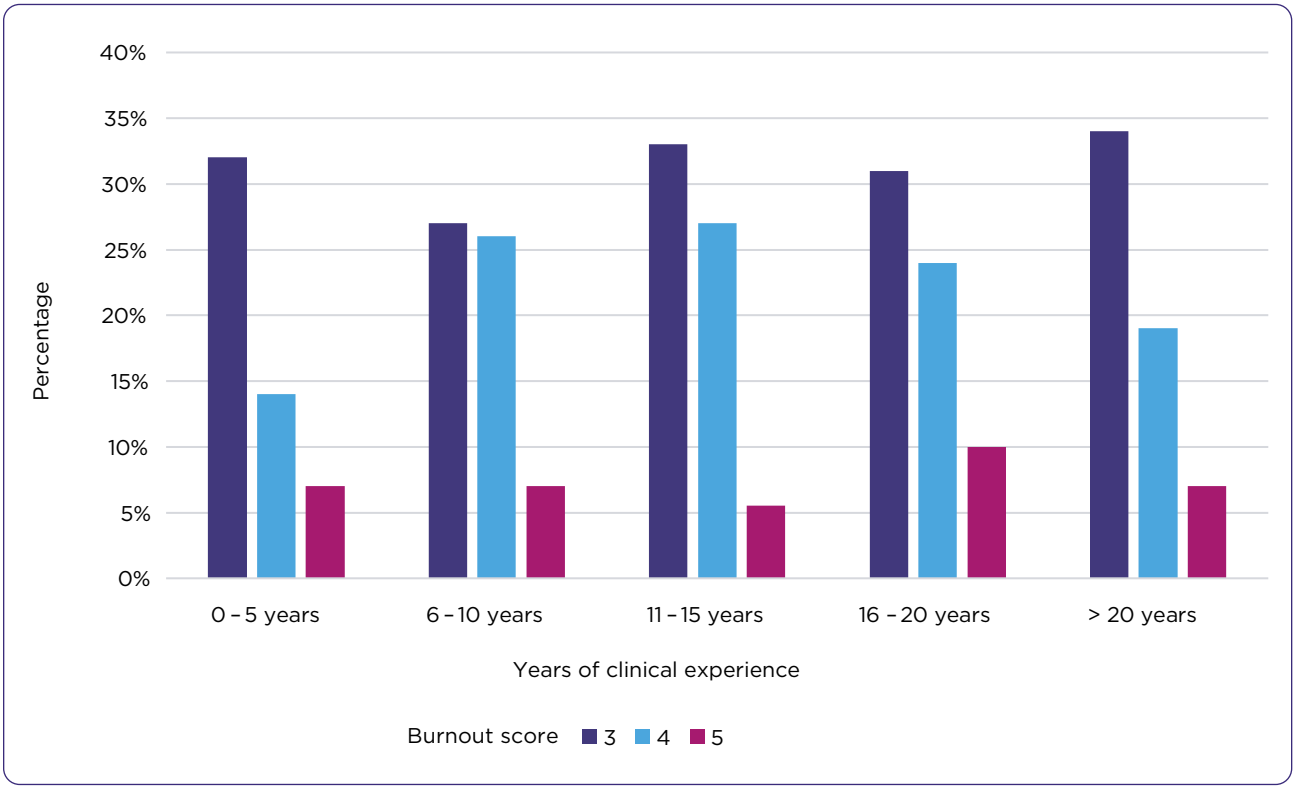

Figure 1. Reported burnout scores for advanced practitioners by years of clinical experience.

ers to care for this patient population. Advanced practitioners who specialize in oncology/hematology can improve access to care and the quality of care provided.

Given the unique skills that oncology/hematology APs possess, it was APSHO's goal to explore compensation among this group of subspecialized APs. The survey was launched to the entire APSHO membership. Approximately 26% of members responded. The representation was fairly evenly distributed across APs in community (27.2%), comprehensive cancer (27.5%), and academic practices (24.5%). Years of experience was also fairly well divided between those who had been practicing for fewer than or more than 10 years. Over half of the participants stated that they were practicing in an outpatient environment.

As expected, there was a correlation between compensation and years of total clinical experience. Interestingly, this association was flat between years 11 to 20. This is concerning, as it appears that years of service/experience are not acknowledged in this period, which may have implications in terms of retention. However, when considering oncology-specific years of experience, years of experience did correlate with higher compensation.

Consistent with other fields, there is a gender gap in compensation, with males making almost $7,500 more per year than females. The female-to-male earnings ratio was 94.5%. This gender gap is less than statistics given by the Bureau of Labor Statistics (2023), which noted the female-to-male earnings ratio to be 81.1% (all men and women, in all occupations, aged 16 and over, in the first quarter of 2023). A study by Smith and Jacobson (2016) noted similar findings from an American Academy of Physician Associates survey.

There was a compensation discrepancy amongst racial and ethnic minorities. When examining compensation based on race/ethnicity (Table 2), non-White APs consistently had higher compensation than Caucasian/White APs. When data were examined by years of experience and by the highest level of education, this remained true. Upon literature review, Frogner & Schwartz (2021) noted that for APs in all areas of health care (pharmacists were not included), Asian/Pacific Islander APs had the highest compensation rates, followed by American Indian/Alaska Native, Non-Hispanic, White, Hispanic, Black, and multiracial APs, respectively. They postulated that the compensation gap between the groups was explained by measured factors such as the distribution of Hispanic practitioners and potentially advancing age of Black practitioners in this study. The Bureau of Labor Statistics (2023) data indicate that Asian practitioners earned the highest median weekly earnings, followed by White, Black, and Hispanic practitioners, respectively. The compensation comparison among differing ethnic and racial groups within oncology/hematology AP field merits future research.

More than 60% of APs reported a range of 1 to 5 CME days and $1,000 to $3,000 in funding. While some APs were required to use their CME funds to pay for their licensures (including DEA licensure), the vast majority (up to 65%) of licensures were paid by the employer.

Finally, the issue of burnout was addressed. The survey assessed burnout on a scale of 1 to 5, with 5 being high burnout. Almost two thirds of those surveyed reported burnout levels ≥ 3, with females (61.9%) 1.5 more times likely to report this score than their male counterparts (40.8%). In a specialty with a heavy emotional burden by the nature of the patients who are treated, this is quite concerning. Interestingly, there was no correlation between level of burnout and years of experience. Perhaps most alarming is that approximately 40% of the APs surveyed reported the desire to significantly alter their work status either through leaving their practice, leaving the specialty, reducing their hours, or leaving health care altogether.

Results from this survey are both informative and thought provoking as we continue to seek ways to avert a health care crisis in this country as well as continue to promote the role of the AP in hematology and oncology. Future studies should include additional data related to direct work environment, including hours worked, support staff available, average patient load, and patient acuity. The data contained here should also be used to address, develop, and implement strategies to help prevent burnout, as well as allow APs to benchmark their compensation packages when seeking and negotiating terms of employment.

SUMMARY

APSHO firmly believes in fostering fairness, trust, inclusivity, and equality within the oncology/hematology field and notes that transparency in compensation information is lacking in health care, and not just in the hematology/oncology advanced practice field. Studies have shown that compensation transparency can reduce the gender pay gap, increase pay equity and employee satisfaction, and improve performance (Benneden et al., 2022; Oblog & Zenger, 2022). Compensation transparency is defined as the practice of openly displaying employee salary information to existing employees, candidates, owners, regulators, or the public. Transparency in compensation empowers APs to make informed decisions about their career paths and enables them to negotiate for fairer remuneration. It also acts as a powerful tool for addressing discrimination, as it exposes any potential biases and ensures that everyone is fairly rewarded based on their skills and performance.

It is worth noting that while adequate compensation is crucial, it must be accompanied by other supportive measures such as a healthy work environment, realistic workloads, opportunities for growth and development, and recognition programs to effectively combat burnout. ●

Disclosure

The authors have no conflicts of interest to disclose.

References

Bennedsen, M., Simintzi, E., Tsoutsoura, M., & Wolfenzon, D. (2022). Do firms respond to gender pay gap transparency? *The Journal of Finance, 77*(4), 2051–2091. https://doi.org/10.1111/jofi.13136

Bureau of Labor Statistics. (2023). Usual weekly earnings of wage and salary workers second quarter. https://www.bls.gov/news.release/pdf/wkyeng.pdf .

Frogner, B. K., & Schwartz, M. (2021). Examining wage disparities by race and ethnicity of health care workers. *Medical Care, 59*(Suppl 5), S471–S478. https://doi.org/10.1097/MLR.0000000000001613

Obloj, T., & Zenger, T. (2022). The influence of pay transparency on (gender) inequity, inequality and the performance basis of pay. *Nature Human Behaviour, 6*(5), 646–655. https://doi.org/10.1038/s41562-022-01288-9

Smith, D. T., & Jacobson, C. K. (2016). Racial and gender disparities in the physician assistant profession. *Health Services Research, 51*(3), 892–909. https://doi.org/10.1111/1475-6773.12358