



Original Research

Are Productivity Goals in Rehabilitation Practice Associated With Unethical Behaviors?



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KEYWORDS

Efficiency;
Ethics;
Goals;
Rehabilitation

Abstract

Objectives: To evaluate the presence of productivity goals among licensed rehabilitation clinicians and their relationship with observed unethical behavior.

Design: Exploratory, cross-sectional survey.

Setting: Online.

Participants: Licensed physical therapy clinicians (N=3446).

Intervention: Not applicable.

Main Outcome Measure: Participants completed an electronic survey regarding use of clinical productivity goals. They rated the frequency in which they observed 6 unethical behaviors on a 7-point Likert scale in their practice setting from 1=never to 7=always. An overall observed unethical behavior score was calculated by summing these scales.

Results: The response rate was 12.8% (N=3446), with analyses showing low risk of nonresponse bias. Many respondents (73.9%) had a formal productivity goal. Most (89.4%) reported observing some form of unethical behavior, but many (68.6%) reported it occurred "rarely" or "never." Those in skilled nursing facility (SNF) settings reported higher frequencies of observance and were 4.1 times more likely to report more unethical behavior than the median compared with all other settings. A positive correlation existed between expected productivity rate and rate of unethical behaviors observed ($\rho=0.225$; $P<.0001$). Amounts of organizational emphases on ethical practice ($\rho=-0.509$; $P<.0001$) and evidence-based practice ($\rho=-0.492$; $P<.0001$) were negatively correlated with total observed unethical behavior.

Conclusions: Use of productivity goals in rehabilitation practice is significantly related with rate of unethical behavior observed. Frequency of observed unethical behavior in

List of abbreviations: EBP, evidence-based practice; PT, physical therapist; PTA, physical therapist assistant; SNF, skilled nursing facility. Disclosures: none.

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rehabilitation practice was very low overall. Organizational culture appears to be a greater predictor of observed unethical behavior than any individual clinician-related characteristics. The SNF setting displays the greatest areas of ethical concern.

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Rehabilitation clinicians may be confronted with ethical conflicts while balancing their responsibilities to their patients, organizations, and other stakeholders. The concept of ethics in rehabilitation practice can refer to a myriad of applications, ranging from the moral philosophy of Plato, to a personal set of principles that guide one's behavior. Behavioral science demonstrates that perception and resolution of ethical conflicts are influenced by individual, social, organizational, cultural, and religious factors.¹ Clinicians must weigh these influences when making decisions about allocation of resources, goal setting, discharge planning, patient autonomy, and end-of-life care, among others.²

Hammaker and Knadig³ report ethical decisions are necessary when there is potential detriment to individuals or the health care system or ethical norms or laws could be broken. Core ethical principles in health care include respect for autonomy, beneficence, nonmaleficence, and justice.⁴ Yet, many decisions facing the rehabilitation clinician involve consideration of these ethical principles through the lenses of multiple invested parties including the patient, their family, the health care organization, payer sources, and the health care system itself.

Unfortunately, the variety of considerations in the ethical decision-making process may create opportunities for clinicians to morally disengage by forming justifications to act in a normally unethical manner.⁵ Molinsky and Margoli⁶ presented the concept of "necessary evils" whereby ethical norms are sacrificed for what the individual deems to be a more important cause. This moral disengagement is significantly related to inclination to make unethical decisions.⁵ One major way this has been observed in many industries is with organizational productivity goals.⁷⁻⁹ Rehabilitation organizations often establish productivity standards whereby clinicians are expected to produce a given number of billable treatment units per unit of time worked.¹⁰ Historically, rehabilitation ethics research has largely ignored issues related to business economic factors, such as billing fraud and overuse of services.^{11,12} Yet, often the largest portion of ethical conflict in rehabilitation clinicians comes from health care reimbursement pressures and a corporate culture that expects financially driven treatment decisions.^{2,13}

To date, research regarding the effects of productivity goals in rehabilitation remains very limited. Studies in other industries demonstrated that goal setting often leads to unintentional increases in unethical behavior.⁷⁻⁹ Historically, use of rehabilitation has been highly influenced by financial incentives,¹⁴ with significant variances in factors unrelated to caseload, such as geographic location and payer source.¹⁵⁻¹⁸ Exploration of mediators of clinical

behavior in rehabilitation is valuable as health care payment models shift from quantity-based to quality-based reimbursement¹⁹ and autonomy is threatened for those with unexplained practice variance.²⁰ The objectives of the present study were to provide preliminary data of the prevalence and characteristics of productivity goals in physical therapy practices and identify their relationships to clinical behavior. These productivity goals are more commonly referred to as productivity "standards" in clinical practice. Thus, the terms "productivity goals" and "productivity standards" are often used interchangeably.

Our research hypotheses were as follows: (1) the frequency of observed unethical behaviors would differ by practice setting, (2) clinicians who practice in settings that have productivity standards would report higher rates of observed unethical behavior than those without productivity standards, (3) there would be a positive correlation between observed unethical behavior and productivity standard characteristics such as difficulty of achievement and rate of expected productivity, and (4) rate of observed unethical behavior would be negatively correlated with level of organizational emphasis on evidence-based practice (EBP) and ethical practice.

Methods

Survey development

We developed an electronic survey questionnaire using concepts from Kaptein's²¹ scale of unethical behavior in the workplace because it was systematically designed and tested. The unethical behaviors in our scale were modified to approximate those referenced by the American Occupational Therapy Association, the American Speech-Language-Hearing Association, and the American Physical Therapy Association in their Consensus Statement on Clinical Judgment in Health Care Settings.²² The survey was reviewed by 3 experts knowledgeable in survey methodology and with publication records. The survey was pilot tested for question clarity, readability, and ease of use with 7 faculty from the primary investigator's institution (appendix 1).

Each question appeared individually, and participants could respond to a maximum of 27 questions. The survey first presented demographic questions and asked participants whether their primary practice setting had a formal productivity standard. If the participant responded that they did have a productivity standard, they saw a series of questions regarding the characteristics of their standard and then proceeded to the final section. If they answered

that they did not have a productivity standard, they immediately advanced to the final section.

The final section of the survey consisted of six 7-point Likert scales requiring participants to rate the frequency with which they observed specific unethical behaviors in their primary practice setting from “never” to “always.” A 7-point scale was chosen because of evidence that they are more accurate than 5-point scales for electronically distributed surveys.²³ We used sample behaviors from the previously mentioned Consensus Statement on Clinical Judgment in Healthcare Settings²² to ensure applicability to the rehabilitation industry. To avoid biasing responses, questions regarding unethical behavior were not strictly defined. General terms such as “inappropriate” were used to describe each behavior, and sample behaviors provided in these questions were those that were explicitly illegal or fraudulent based on governmental regulations (see appendix 1). This method allowed us to remain consistent with Hammaker and Knadig’s³ definition of unethical behavior as that which violates societal ethical norms or the law. Additionally, this method was consistent with previously validated survey items.²¹

Survey dissemination

The local Institutional Review Board granted formal ethical approval to this research project. An e-mailing list was purchased for all physical therapists (PTs) and physical therapist assistants (PTAs) licensed in the State of Texas from the Executive Council of Physical Therapy and Occupational Therapy Examiners. We chose to survey a single state because of the availability of e-mail addresses for therapists licensed in Texas, allowing access to a large pool of clinicians. A link to the survey instrument was sent to 26,902 e-mail addresses. Any clinician was eligible that held a PT or PTA license in the state at the time the list was purchased in August 2017. Sample size calculation was based on previously published formulas for surveys.²⁴ Based on a confidence level of 95% and margin of error of 5%, the minimum sample required was 379 respondents. Respondents first read a description of the survey and had the opportunity to provide informed consent and access the survey. Surveys were completed anonymously via SurveyMonkey^a software. Reminder e-mails were sent out 2 times (2 weeks apart), and the survey was open from October through November 2017. There were no incentives offered for participation.

Data analysis

Data were analyzed using IBM SPSS, version 24.0.^b Descriptive statistics were used to summarize the distribution, central tendency, and dispersion of responses. Chi-square analysis was used to evaluate the frequency of productivity standards among different practice settings. Because observed unethical behavior was measured on ordinal scales, primarily nonparametric analyses were used. The Kruskal-Wallis test was used to determine if the frequency of unethical behaviors differed among practice settings, with post hoc pairwise comparisons using the Dunn procedure with a Bonferroni correction for multiple

Table 1 Demographic data of survey respondents (N= 3446)

Characteristic	Count (%)
Sex	
Female	2431 (70.5)
Male	1015 (29.5)
Age \bar{X} (y), mean \pm SD	42.5 \pm 11.5
Time of practice (y), mean \pm \bar{X} SD	14.9 \pm 11.3
License type	
Physical therapist	2381 (69.1)
Physical therapist assistant	1065 (30.9)
Practice setting	
Acute care hospital	508 (14.7)
Subacute inpatient rehabilitation Hospital	191 (5.5)
Hospital-based outpatient clinic	499 (14.5)
Private outpatient clinic	610 (17.7)
Skilled nursing facility	795 (23.1)
Home health	603 (17.5)
School system	76 (2.2)
Other	164 (4.8)
Population of practice area	
Rural (<50,000)	970 (28.1)
Urban (\geq 50,000)	2476 (71.9)
Primary practice location	
Texas	3186 (92.5)
Outside of Texas	260 (7.5)
Have a formal productivity standard	
Yes	2548 (73.9)
No	898 (26.1)

comparisons. A binomial logistic regression was performed to determine the effect of practice setting on likelihood of observing higher than median unethical behavior. Spearman ρ was used to analyze the correlation of observed unethical behaviors with attributes of the clinicians’ organizations, their productivity standards, and demographics. Significance was set at $\alpha = .05$. Scores from the 6 unethical behavior questions were summed to provide a total observed unethical behavior variable ranging from 6, if they reported never observing any of the unethical behaviors, to 42, if they reported always observing all of the unethical behaviors.^{5,25,26} These items had a Cronbach α coefficient of .86, demonstrating good internal consistency. A Mann-Whitney test was used to examine the difference in total observed unethical behavior of clinicians with productivity standards vs those who did not have productivity standards. Lastly, a cumulative odds ordinal logistic regression with proportional odds was used to evaluate which organizational or productivity goal factors were significant predictors of unethical behavior. Factors chosen for analysis were based on previous research^{5,9,27,28} while ensuring to exclude independent variables that were highly correlated. Because of limitations of the statistical software, it was necessary to recode the total observed unethical behavior frequency scores into 7 ordinal levels for this analysis. The assumption of proportional odds was met, as assessed by a full likelihood ratio test comparing the fit of the proportional odds model to a model with varying location parameters.

Tests for multicollinearity indicated a very low level of multicollinearity present.

Results

A link to the web survey instrument was sent to the 26,902 physical therapy clinicians. Of these, 14,676 opened the e-mail invitation, and 4210 followed the link to the survey. Subjects were excluded from analysis if survey data were incomplete or missing, resulting in a total sample of 3446 respondents (response rate of 12.8% of invited; 23.5% of those who opened invitation). The respondents' mean age was 42.5±11.5 years (range, 21-75 years), and mean years of practice was 14.9±11.3 years (range, 0-41 years). Women made up a greater proportion of respondents (70.5%), and the ratio of PTs to PTAs was 2.2:1. The largest proportion of respondents worked in the skilled nursing facility (SNF) setting (23.1%), followed by private outpatient (17.7%). Most respondents (73.9%; n=2548) had a formal productivity goal set by their employer. Of those, 85.1% (n=2169) reported their productivity was measured as number of billable units produced per hour worked. Respondent demographic characteristics are shown in [table 1](#).

Observed unethical behavior

[Table 2](#) displays the percentage of clinicians in each setting who observed specific unethical behaviors (any score higher than "never"), along with the median score for each behavior. Most (89.4%; n=3080) respondents reported observing some form of unethical behavior in their clinical practice, although the majority (68.6%) responded that these occurred "rarely" or "never." The SNF setting reported both the highest prevalence of observed unethical behavior and the highest median score for the frequency of each behavior (see [table 2](#)). A Kruskal-Wallis test indicated the practice settings significantly differed in total observed unethical behaviors ($H[7]=506.58$; $P<.0001$). Follow-up pair-wise comparisons indicated that clinicians in the SNF setting observed significantly more unethical behaviors than clinicians in all other settings ($P<.0001$). Odds ratio testing revealed that clinicians in the SNF setting were 4.11 (95% CI, 3.45-4.91) times more likely to observe higher than the median total unethical behaviors than all other settings.

Productivity standards

[Table 3](#) contains reported productivity standards by clinical practice setting, displayed as the percentage of worked time that clinicians were expected to produce billable units. Responses are ranked by percentiles. A chi-square test compared the frequency counts in each practice setting of those who reported having productivity standards. Prevalence of having a productivity standard differed significantly by practice setting ($\chi^2[7]=634.76$; $P<.0001$), with clinicians working in SNFs reporting the greatest prevalence of productivity standards (97.1%), and those working in school systems reporting the lowest prevalence (13.2%).

A Spearman ρ correlation coefficient was calculated to determine whether a relationship existed between the clinician's expected productivity rate and the rate of

Table 2 Percentage of clinicians who observed specific unethical behavior by setting

Behavior	Acute Care Hospital (n = 508)	Subacute IRF (n = 191)	Hospital-Based OP (n = 499)	Private OP (n = 610)	SNF (n = 795)	HH (n = 603)	School (n = 76)	Other (n = 164)	Total (N = 3446)
Placing patients on caseload who do not meet skilled criteria, % (median)	81.3 (2)	81.2 (2)	62.1 (2)	62.8 (2)	86.3 (3)	76.9 (2)	63.2 (2)	72.6 (2)	74.8 (2)
Discharging patients inappropriately, % (median)	79.7 (2)	84.3 (3)	71.9 (2)	70.0 (2)	88.3 (3)	78.8 (2)	51.3 (2)	78.7 (2)	78.3 (2)
Inappropriate frequency, intensity or duration of services, % (median)	66.7 (2)	71.7 (2)	44.1 (1)	50.5 (2)	86.5 (4)	65.3 (2)	56.6 (2)	64.0 (2)	64.8 (2)
Counting treatment time that is not permitted by payer sources, % (median)	53.7 (2)	61.3 (2)	42.9 (1)	39.7 (1)	75.6 (3)	39.8 (1)	23.7 (1)	46.3 (1)	51.7 (2)
Falsifying or changing documentation, % (median)	31.5 (1)	26.2 (1)	20.0 (1)	23.9 (1)	51.4 (2)	22.6 (1)	18.4 (1)	30.5 (1)	30.9 (1)
Allowing an employee to perform task outside scope of practice, % (median)	25.8 (1)	23.6 (1)	20.6 (1)	31.6 (1)	33.7 (1)	14.1 (1)	10.5 (1)	31.1 (1)	25.7 (1)

NOTE. Median observed behavior score: 1 = never, 2 = rarely, 3 = occasionally, 4 = sometimes, 5 = frequently, 6 = usually, 7 = always. Abbreviations: HH, home health; IRF, inpatient rehabilitation facility; OP, outpatient.

Table 3 Reported productivity standard expectations by setting

Expectation	Acute Care Hospital (n=396)	Subacute IRF (n=135)	Hospital-Based OP Clinic (n=300)	Private OP Clinic (n=226)	Skilled Nursing Facility (n=754)	Home Health (n=239)	School System (n=4)	Other (n=80)
25th percentile	65.0	75.0	75.0	75.0	87.0	80.0	65.0	75.0
50th percentile (median)	75.0	80.0	80.0	85.0	90.0	90.0	82.5	80.0
75th percentile	83.0	86.0	90.0	90.0	93.0	96.0	96.25	90.0
Mean ± SD	74.5±13.8	80.4±9.7	80.2±14.4	83.6±14.2	89.7±5.5	86.5±13.4	81.3±16.5	79.4±13.8

NOTE. Data represent expected percentage of worked time that produced billable units. Abbreviations: HH, home health; IRF, inpatient rehabilitation facility; OP, outpatient.

observed unethical behavior. There was a statistically significant, but weak, positive correlation ($\rho=0.225$; 95% CI, 0.185-0.264; $P<.0001$), indicating that as productivity expectations increased, the rate of observed unethical behavior increased. More than half (53.3%; $n=1357$) of respondents felt their organization’s productivity goals were “difficult” or “very difficult” to meet (fig 1). Additionally, 60.2% ($n=1535$) of respondents felt their productivity standards were “high” or “much too high.” Most (83.4%; $n=2125$) reported productivity standards influenced their clinical decision-making. Yet, over half (54.5%; $n=1388$) reported they never participated in determining their productivity goal (fig 2). Clinicians with productivity standards displayed significantly higher median total observed unethical behavior scores (median, 12) than clinicians who did not have formal productivity standards (median, 10), $U=842,109.5$; $P<.0001$). However, the effect size was small ($r=0.201$; 95% CI, 0.169-0.232).

Relationships to unethical behavior

Spearman correlations were performed to identify relationships between the clinicians’ total observed unethical behavior and variables related to their demographics, qualities of the productivity standards, and characteristics of organizational culture (table 4). Multiple weak correlations were recorded between these variables and the clinicians’ total observed unethical behavior. A fair, positive relationship was noted between clinicians’ total observed unethical behavior and 2 variables: perceived inappropriateness of the productivity goal ($\rho=0.420$; 95% CI, 0.388-0.451; $P<.0001$) and level of difficulty in meeting the productivity goal ($\rho=0.375$; 95% CI, 0.342-0.407; $P<.0001$). Additionally, the emphasis the organization placed on ethical practice ($\rho=-0.509$; 95% CI, 0.480-0.537; $P<.0001$) and evidence-based practice ($\rho=-0.492$; 95% CI, 0.463-0.520; $P<.0001$)

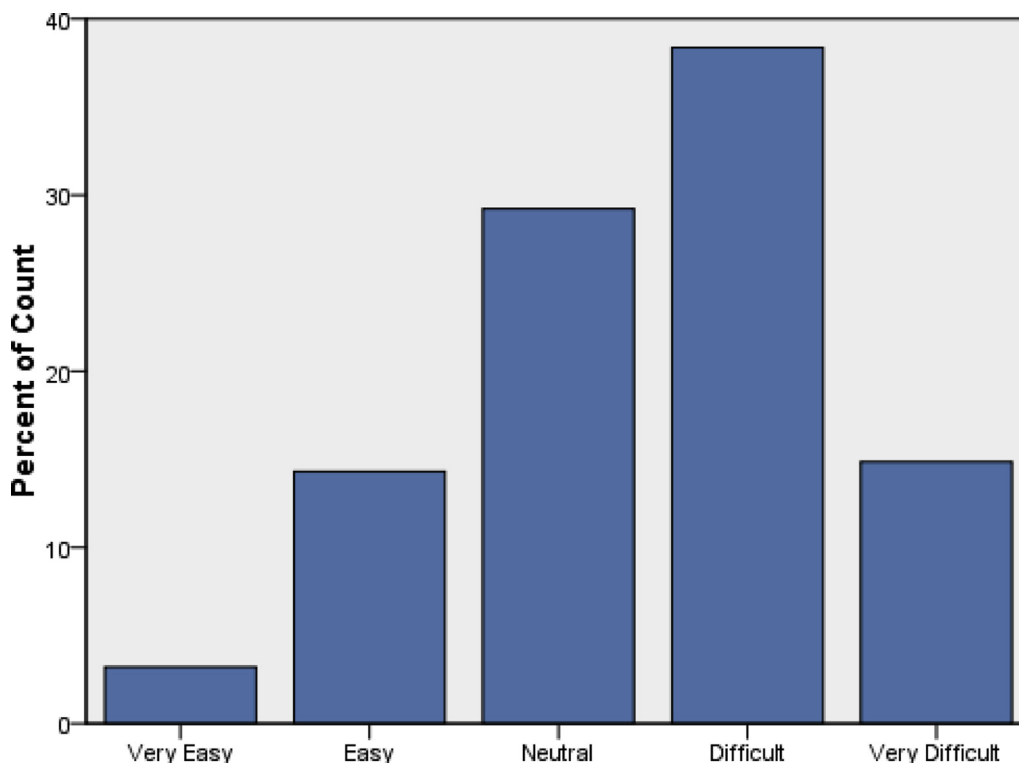


Fig 1 Perceived difficulty of current productivity standard.

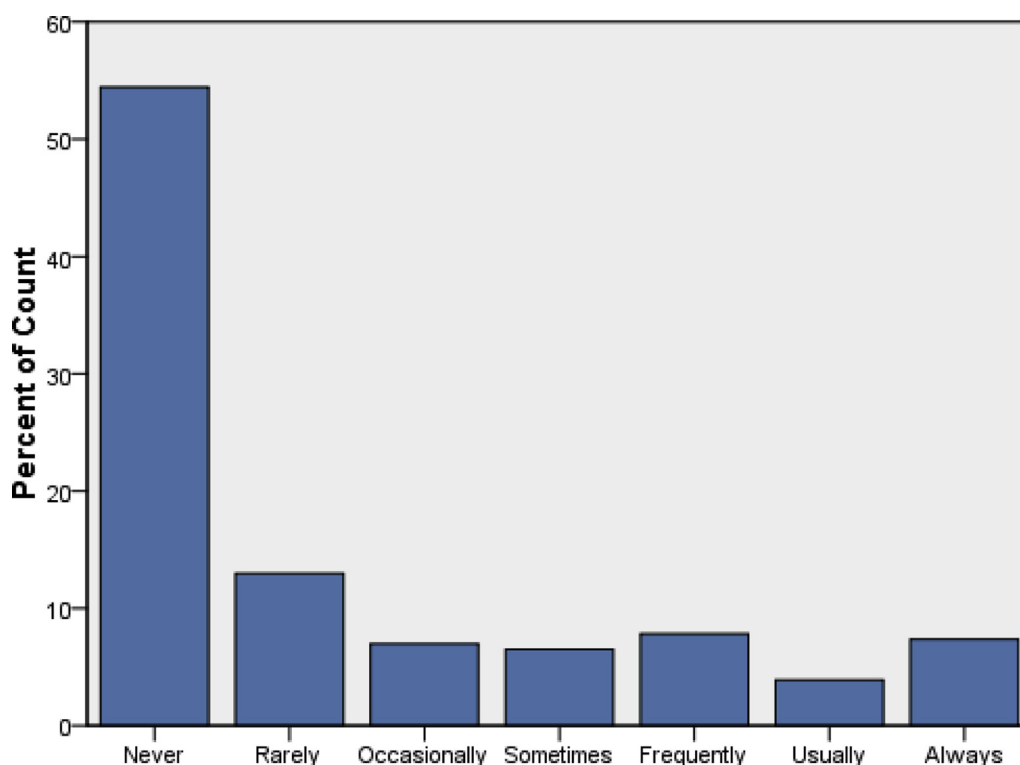


Fig 2 Frequency of participation in productivity standard setting.

were moderately negatively correlated with total observed unethical behavior.

Table 5 demonstrates the odds of high observed unethical behavior in those whose organization emphasized EBP much less than productivity was 6.01 (95% CI, 4.03-8.95) times that of those whose organization emphasized EBP much more than productivity. Similarly, those in organizations that emphasized ethical treatment much less than productivity were 3.39 (95% CI, 2.33-4.93) times more likely to report high observed unethical behavior than those in organizations that emphasized ethical treatment much more than productivity. Interestingly, those not primarily practicing in hospital-based outpatient settings were 2.51 (95% CI, 1.60-3.94) time more likely to report high observed unethical behavior than those practicing in hospital-based outpatient settings.

Table 4 Correlations between variables and total observed unethical behavior score

Variable	<i>r</i>
Age	-0.082*
Years of practice	-0.108*
Difficulty meeting productivity standard	0.375*
Appropriateness of productivity standard	0.420*
Productivity standard influence on decision-making	0.456*
Participation in productivity standard setting	-0.192*
Organizational emphasis on ethics	-0.509*
Organizational emphasis on EBP	-0.492*
Expected productivity percentage	0.225*

* $P < .0001$.

Discussion

To our knowledge, this is the first study to evaluate the relationships between productivity standard characteristics and unethical behaviors in rehabilitation practice. Regression analysis suggests that organizational ethical culture may be key in predicting physical therapists' unethical behavior. Additionally, use of productivity goals was associated with increased observed unethical behavior.

Studies have found that rehabilitation clinicians tend not to adhere to EBP because it differs from their typical work operations^{15,29,30} despite evidence that doing so improves treatment efficiency.³¹ Additionally, Locke and Latham³² reported ethical behavior increases when employees are told to focus on ethical task performance. We found that lack of organizational emphases on EBP and ethical practice were the best predictors of unethical behavior. Only 38.9% of physical therapy clinicians reported a workplace culture that emphasized ethics compared with 66% of those in industries responding to the National Business Ethics Survey.³³

Barsky²⁷ argued that when actions are determined to be "business decisions," or that usual ethics do not apply, the ethical decision-making process is never started. Clinicians justify overuse of rehabilitation services by portraying it as meeting their patients' desires or sustaining their own livelihoods. These "moral reconstructions" of negative behavior to worthy causes are the strongest contributors to engaging in detrimental activities.³⁴ In American health care, services are often provided first and paid for much later. Additionally, insurance coverage allows patients to pay a fraction of the cost of care. As a result, consumers and clinicians are often disconnected from negative consequences of treatment overuse.³⁵ Moreover, individuals are

Table 5 Ordinal regression analysis on predictors of high unethical behavior

Variable	Odds Ratio (95% CI)	P Value
Employer emphasis on productivity over ethics	3.39 (2.33-4.93)	<.0001
Employer emphasis on productivity over EBP	6.01 (4.03-8.95)	<.0001
Expected productivity rate	1.01 (1.00-1.01)	.1022
Difficulty in meeting productivity goal	.64 (0.35-1.20)	.1631
Appropriateness of productivity goal	2.41 (0.54-10.75)	.2484
Other than acute setting*	1.34 (0.87-2.07)	.1822
Other than subacute IRF setting*	1.07 (0.65-1.76)	.8044
Other than private OP setting*	1.54 (0.97-2.45)	.0679
Other than hospital OP setting*	2.51 (1.60-3.94)	.0001
Other than SNF setting*	.84 (0.55-1.27)	.4068
Other than home health setting*	1.50 (0.94-2.37)	.0866

Abbreviations: IRF, inpatient rehabilitation facility; OP, outpatient.

* Reference group included those whose primary practice was in the setting of interest.

more likely to disregard ethical controls when they feel their actions are determined by external circumstances beyond their control.²⁷ Our study found the majority of clinicians did not have any input in the creation of productivity standards.

Because we invited the entire population of licensed clinicians in 1 state to participate, we believe our response rate is sufficient to draw reasonable conclusions based on the data. Studies have shown that response-rate-induced bias poses little threat to the validity of such surveys, even with response rates <10%.^{36,37} To identify possible nonresponse bias, we used common methods³⁸ of comparing item responses of early and late respondents as well as the demographics of those who responded to unethical behavior items vs those who did not. We found no statistically significant differences in the responses nor demographics of these groups, indicating low risk of nonresponse bias. Additionally, validity of our findings is enhanced by the representativeness of our sample. Our sample's sex proportion matched published³⁹ descriptions of practice in Texas, and the proportion of PTs to PTAs in our study was identical to the proportions of those licensed in the United States.⁴⁰ Additionally, our response rate fell within the typical range of business ethics surveys.^{41,42}

Implications for practice

Intervention at the organizational level is recommended because multiple studies, including our own, have found that organizational culture is the top antecedent to unethical behavior and is also the most easily changeable component.^{43,44} Research demonstrates the importance of surveying employees to determine the ethical climate of the organization and making organizational behavioral norms prominent and well-defined.⁴⁵ Use of productivity standards measured solely by the quantity of billable units is not advised. We recommend that clinicians are involved in the setting of productivity standards.

Study limitations

There are several limitations of this study. Motivation to participate may differentiate our sample from the larger

population of clinicians. Sensitivity-induced participation bias often exists in surveys that ask participants to report on unethical behavior. Generally, proxy-report surveys of unethical behavior have problems of underreporting.⁴⁶ Additionally, because of the sensitive nature of questions, social desirability bias may be present. Survey respondents may underreport unethical behavior in order to defend the reputation of their organization or profession.⁴⁶ However, our chosen method of asking about the behaviors observed, rather than participated in, has been shown to be the best for controlling this form of bias.⁴⁷ Additionally, because of the low response rate, we acknowledge there may be some risk of nonresponse bias that cannot be measured directly.

Conclusion

Overall frequency of observed unethical behaviors in rehabilitation practice was very low. Organizational cultures that emphasize productivity achievement over ethical and EBP were primary predictors of unethical behavior. Additionally, use of productivity goals was associated with increased unethical behavior. These associations are consistent with previous studies of the effect of productivity goals on unethical behavior in the workplace.^{8,9,27,28,48} The results should be used in continuing research on individual and organizational factors that foster ethical practice and encourage value-based health care reimbursement in the United States.

Suppliers

- SurveyMonkey.
- SPSS, version 24.0; IBM.

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Appendix 1. Survey Instrument

Sex: Female Male

Age: _____

License type: Physical Therapist Physical Therapist Assistant

Years in Clinical Practice: _____

Primary Practice Setting (choose one):

Acute care hospital Subacute inpatient rehabilitation hospital Health system or hospital-based outpatient clinic Private outpatient office/clinic Skilled nursing facility/extended care facility Home health School system Other _____

Is your primary practice setting located in the state of Texas?

Yes No

What is the population of the area in which your primary practice setting is located?

<50,000 ≥50,000

Section 1

Do you have a formal productivity standard or goal set by your primary employer?

Yes No

If you answered no, please skip ahead to the Section 2

Do you have a formal productivity percentage goal set by your employer?

Yes No

If "No", how is your productivity measured? (If not applicable, leave blank)

If "Yes", what percentage productivity is expected of you by your employer? _____

On what frequency of measurement is your productivity expectation based?

Per day
 Per week
 Per pay period
 Per month
 Other _____

In general, how difficult is it for you to meet this productivity standard?

Very Easy Easy Neutral Difficult
 Very Difficult

How appropriate do you feel your organization's productivity standards are?

Much too low Low Just right High
 Much too high

In general, how much does your pursuit of the productivity standard influence your clinical decision-making?

Not at all influential Slightly influential
 Somewhat influential Very influential
 Extremely influential

Are rewards (financial bonus, promotion, or other incentives) tied to achievement of your productivity standards?

Yes No

Are there negative consequences (poor performance review, written warning) tied to failure to achieve your productivity standards?

Yes No

How much do you participate in determining your current productivity standard goal?

Never Rarely Occasionally Sometimes Frequently Usually Always

How much does your primary employer emphasize ethical behavior versus achieving productivity goals?

Much less Somewhat less About the same Somewhat more Much more

How much does your primary employer emphasize evidence-based treatment versus achieving productivity goals?

Much less Somewhat less About the same Somewhat more Much more

Section 2

Please rate to what degree you have observed the following behaviors in your primary practice setting:

a. Placing patients on caseload who do not meet skilled care criteria (eg, Therapy is not medically necessary or does not require the skills of a licensed therapist)

Never Rarely Occasionally Sometimes Frequently Usually Always

b. Discharging patients inappropriately (eg, early or delayed discharge)

Never Rarely Occasionally Sometimes Frequently Usually Always

c. Providing inappropriate frequency, intensity or duration of services (eg, requiring all patients to be seen 3×/wk for at least 1 hour regardless of severity, or requiring use of all approved visits per episode)

Never Rarely Occasionally Sometimes Frequently Usually Always

d. Counting time as treatment that is not permitted by Medicare or other payers as treatment (eg, rest time or time spent traveling to the patient's room)

Never Rarely Occasionally Sometimes Frequently Usually Always

e. Falsifying or changing documentation to misrepresent time spent or services delivered (eg, documenting treatment provided in a group of patients as 1-on-1 treatment; adding a few minutes to treatment time solely to bill an additional unit)

Never Rarely Occasionally Sometimes Frequently Usually Always

f. Allowing an employee to perform a task outside their scope of practice (eg, unlicensed aide instructs patient in billable therapeutic exercise while the therapist works with another patient; PTA makes the discharge decision for a patient)

Never Rarely Occasionally Sometimes Frequently Usually Always

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