Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00047-34

Combined Assessment Program Review of the Robley Rex VA Medical Center Louisville, Kentucky

November 29, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
DoD	Department of Defense
EOC	environment of care
ER	emergency room
ESA	erythropoiesis stimulating agent
facility	Robley Rex VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
MH	mental health
MI	manufacturers' instructions
MPU	medical procedure unit
MRI	magnetic resonance imaging
NSQIP	National Surgical Quality Improvement Program
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RCA	root cause analysis
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Robley Rex VA Medical Center, Louisville, KY

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 13, 2010.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Medication Management
- Physician Credentialing and Privileging
- Reusable Medical Equipment
- Suicide Prevention Safety Plans

The facility's reported accomplishment was the assignment of a liaison at the Fort Knox, KY, military base to facilitate the transfer of health care for ill and injured service members from the Department of Defense to a VA facility.

Recommendations: We made recommendations in the following three activities:

Magnetic Resonance Imaging Safety: Provide designated staff with appropriate safety training, complete informed consents for high-risk patients, document results of patient safety screenings in medical records, and conduct a risk assessment of the area.

Quality Management: Follow the process outlined in local policy to evaluate and document adverse events, and review all required resuscitation event elements.

Environment of Care: Ensure staff designated as high risk for exposure to airborne pathogens receive annual respirator fit testing.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable corrective actions. We will follow up on the actions to ensure they are implemented.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Safety Prevention Plans

The review covered facility operations for FY 2009 and FY 2010 through September 13, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the VA Medical Center, Louisville, Kentucky,* Report No. 07-02271-20, November 6, 2007). The facility had corrected all findings.

During this review, we also presented crime awareness briefings for 166 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Health Care Liaison

A facility VA social worker is assigned to the Fort Knox, KY, military base to ensure that returning service members receive appropriate care and case management in a VA facility. The liaison's primary role is to facilitate the transfer of ill and injured service members from the DoD's 300-bed Warrior in Transition Unit to a VA. The liaison collaborates with DoD to ensure a seamless transition of care.

Results

Review Activities With Recommendations

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel.

The facility is in the process of remodeling the MRI area, and managers had implemented appropriate barriers to prevent unauthorized or accidental access. Patients in the magnet rooms were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and patients had access to a push-button call system while in the scanner. However, we identified the following areas that needed improvement.

MRI Safety Training. VA guidelines[1] require that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed training records and found that two of six MRI personnel and three of six non-MRI support personnel had not completed the required MRI safety training.

Informed Consent. VHA policy[2] requires that high-risk patients who have an MRI with contrast material sign an informed consent. We reviewed the medical records of 10 patients and did not find evidence of informed consent for the 2 high-risk patients.

Safety Screening. VA guidelines also require screening of patients undergoing MRI using a standard screening questionnaire. MRI technologists are required to review and sign the questionnaires and address any positive responses before a patient is scanned. MRI technologists reported screening all patients as required, and we witnessed technologists screening patients during our visit. However, technologists reported, and we confirmed, that they did not consistently document screening in the patient's medical record unless they identified a contraindication to the MRI.

Risk Assessment of the MRI Environment. The JC requires that managers conduct a risk assessment of the MRI environment. We did not find evidence that this was completed.

Recommendations

1. We recommended that personnel who have access to the MRI area complete the required MRI safety training.

2. We recommended that high-risk patients who have an MRI with contrast material sign an informed consent.

3. We recommended that MRI technologists document results of all patient MRI safety screenings.

4. We recommended that managers conduct a risk assessment of the MRI environment.

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of patient care and whether senior managers

[1] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.
[2] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.

actively supported the program's activities. We interviewed the facility's Director, the Chief of Staff, and selected QM staff. We evaluated plans, policies, PI data, and other relevant documents.

The QM program was generally effective in providing oversight of the facility's quality of care, and senior managers supported the program through participation in and evaluation of PI initiatives and through the allocation of resources to the program. However, we identified the following QM areas that needed improvement.

Adverse Event Disclosure. Local policy defines the process to evaluate adverse events for possible disclosure and the documentation requirements for actual disclosure. However, we found that staff did not follow the process as outlined. Staff identified 12 adverse patient events in the past 12 months but only considered disclosure for three cases. Staff determined that the three cases were appropriate for clinical disclosure; however, only one medical record contained any documentation related to the disclosure.

Review of Resuscitation and Its Outcomes. VHA policy[3] requires that facilities measure performance of relevant processes during resuscitation events. We found that the facility's analysis of resuscitation events did not include errors or deficiencies in technique or malfunctioning equipment.

Recommendations

5. We recommended that the facility follow the process outlined in local policy to evaluate and document adverse events.

6. We recommended that the facility review all required resuscitation event elements, including errors or deficiencies in technique and malfunctioning equipment.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.

We inspected the locked MH (7N), acute inpatient medicine/surgery (6S), intensive care (6N), medicine/hospice (5N), and medicine/telemetry (4N) units. We also inspected the ER and the medicine/urology outpatient units. The facility maintained a generally clean and safe environment. The IC program monitored data and appropriately reported that data to relevant committees. However, we identified the following area that needed improvement.

Respirator Fit Testing. OSHA requires that staff at risk for exposure to airborne pathogens, such as swine flu or tuberculosis, have annual respirator fit testing. We found that 158 (30 percent) of 530 employees—which included 24 (96 percent) of 25 ER employees—designated as Category I (high risk) by the facility had not received annual respirator fit testing.

Recommendation

7. We recommended that staff designated as high risk for exposure to airborne pathogens receive annual respirator fit testing.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's acute inpatient unit or ER to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA and The JC require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and

determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the specified timeframes. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients.

The facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive ESAs.[4] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Also the facility had pharmacy services available 24 hours a day, 7 days a week. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[5] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed the C&P files and profiles of 10 physicians who were granted either initial privileges or renewal of privileges within the past 12 months. We found that licenses were current and that primary source verification had been obtained. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements.

FPPE should be considered at the time of initial appointment or when new privileges are requested using objective criteria accepted by the practitioner. While it appeared that objective performance data was being collected on new providers and that that data was routinely reviewed and discussed in the relevant committees, there was no evidence of formal FPPEs for the two newly hired physicians. While we were onsite, program managers implemented a system to document that new providers were advised of, and agreed to, the performance data being applied. Therefore, we made no recommendation for this finding.

[4] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Meeting minutes consistently documented discussions of the physicians' credentials and compliance with continuing medical education requirements; however, the minutes did not reflect the specific performance data reviewed to support clinical competency for privileges. Clinical managers collected and reported an abundance of performance data, which was generally summarized in a single page format. While we were onsite, managers added a statement to the relevant committee minutes template to reflect the specific performance data reviewed as part of the clinical privileges approval process. We made no recommendations.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD, the MPU, and the OR. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. In addition, the facility had a process in place to track RME should a sterilization failure occur.

We reviewed the reprocessing SOPs for 10 pieces of RME and found them to be current and consistent with the MI. The SOPs were designed to also serve as the competency validation forms, decreasing the likelihood of clerical errors or clinical differences in forms. Employees were able to demonstrate the cleaning procedures in the SOPs. We reviewed the competency folders and training records of the employees who demonstrated the cleaning procedures and found that annual competencies and training were current and consistently documented. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior-oriented, identify warning signs preceding crisis, and include internal coping strategies. They should also identify when patients

should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.[6]

A previous OIG review of suicide prevention programs in VHA facilities[7] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide within the past 6 months. In four cases, clinicians made repeated but unsuccessful attempts to contact the patient and family to address the safety plan. In the remaining six cases, clinicians had developed timely safety plans that included appropriate elements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable corrective actions. (See Appendixes D and E, pages 13–16, for the full text of the Directors' comments.) We will follow up on the actions to ensure that they are implemented.

[6] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[7] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Facility Profile[8]		
Type of Organization	Tertiary	
Complexity Level	1c	
VISN	9	
CBOCs	Ft Knox, KY New Albany, IN Shively, KY Dupont, KY Newburg, KY Grayson County, KY Scott County, IN Carroll, KY	
Veteran Population in Catchment Area	156,617	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	116	
• **CLC/Nursing Home Care Unit**	0	
• **Other**	0	
Medical School Affiliation(s)	University of Louisville	
• **Number of Residents**	102.8	
	Current FY (through June 30, 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	283.2	255.4
• **Medical Care Expenditures**	217	198.8
Total Medical Care FTE	1,635.78	1,580.07
Workload:		
• **Number of Station Level Unique Patients**	42,090	43,371
• **Inpatient Days of Care:**		
o **Acute Care**	21,441	29,960
o **CLC/Nursing Home Care Unit**	0	0
Hospital Discharges	3,783	5,194
Total Average Daily Census (including all bed types)	78.5	82.2
Cumulative Occupancy Rate	74.09%	76.4%
Outpatient Visits	386,348	484,324

[8] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Complete peer reviews are in accordance with VHA policy.	Data is collected and trended in a rolling 12-month graph. Data is presented on a monthly basis to the Peer Review Committee.	Y	N
2. Complete RCAs in accordance with VHA policy.	All RCAs have been completed within timeframes since January 2008.	Y	N
3. Ensure operative and other invasive procedure review includes all elements required by The JC. • Discuss discrepancies between pre- and post-operative diagnosis. • Review NSQIP surgical data.	The Out of OR Invasive Procedures Committee, the Surgical Quality Committee, and the Tissue Committee all meet monthly and discuss the pre- and post-operative diagnosis discrepancies. NSQIP data is reviewed monthly at the Surgical Quality Committee.	Y	N
EOC			
1. Comply with National Patient Safety Alert, Bed Rail Entrapment, issued July 2001.	All beds are compliant with the National Patient Safety Alert.	Y	N

VHA Satisfaction Surveys

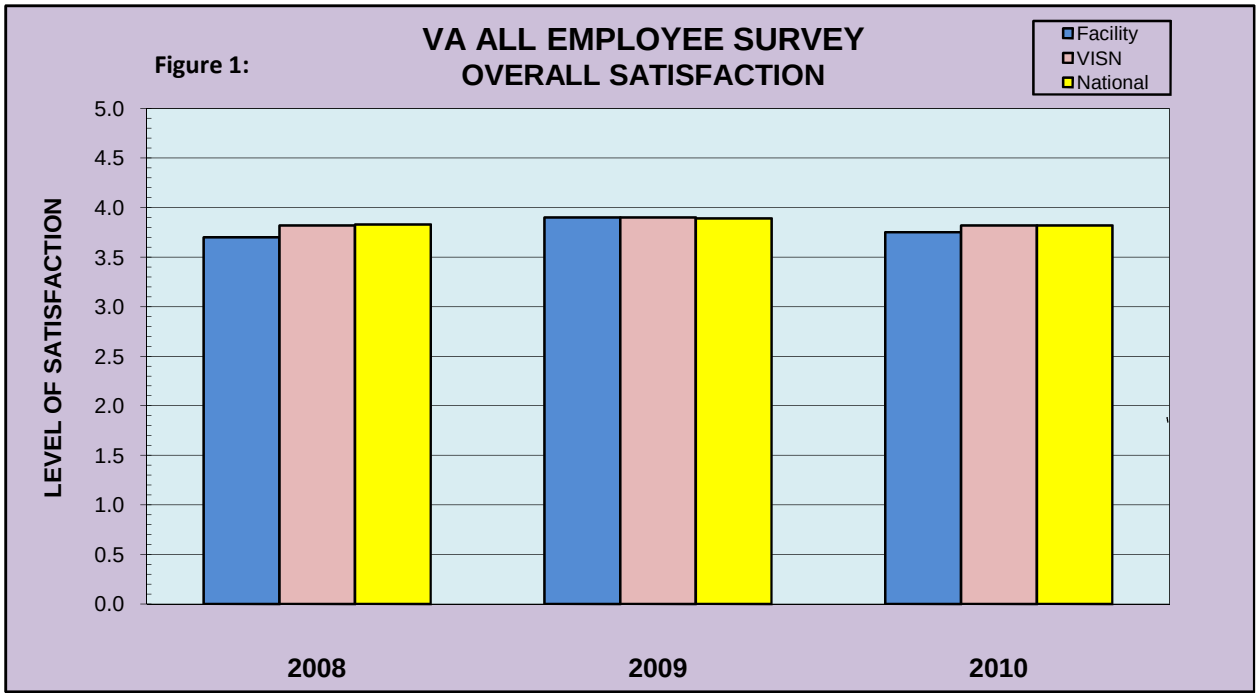
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	63.19	54.27	69.2	62.6	59.3	56.6
VISN	62.62	49.17	62.2	61.2	55.5	56.5
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[9] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.59	10.5	18.89	20.09	18.39	13.41
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[9] CHF is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 4, 2010

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **CAP Review of the Robley Rex VA Medical Center, Louisville, KY**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Robley Rex VA Medical Center, Louisville, Kentucky, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Tammy Williams, RN, Continuous Readiness Coordinator at 615-695-2143 or Pamela R. Kelly, Staff Assistant to the Network Director at 615-695-2205 or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 1, 2010

From: Director, Robley Rex VA Medical Center (603/00)

Subject: **CAP Review of the Robley Rex VA Medical Center, Louisville, KY.**

To: Director, VA Mid South Healthcare Network (10N9)

1. We appreciate the opportunity to review the draft report of the CAP review completed September 13–16, 2010 for the Robley Rex VA Medical Center in Louisville, KY.

2. Attached you will find comments and actions for each finding. Several of the cited areas were resolved during the time of the audit.

3. We would like to extend our appreciation to the entire OIG CAP Team who was consultative, professional and provided excellent feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality care we provide to our veterans every day.

(original signed by:)

Wayne L. Pfeffer, MHSA, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that personnel who have access to the MRI area complete the required MRI safety training.

Concur

Target date for completion: Completed

The staff members with access to the MRI area have been trained. All new employees are being trained in New Employee Orientation. Refresher training has been incorporated into the annual training modules for all medical center staff members.

Recommendation 2. We recommended that high-risk patients who have an MRI with contrast material sign an informed consent.

Concur

Target date for completion: Completed

The Medical Center Memorandum has been modified to reflect VHA guidelines that all high-risk patients have a completed consent prior to the procedure being conducted. The Computerized Patient Record System (CPRS) template has been modified to reflect this change and it is now part of the checklist before patients enter the MRI area.

Recommendation 3. We recommended that MRI technologists document results of all patient MRI safety screenings.

Concur

Target date for completion: Completed

Staff now use a tool to document MRI safety screening. This tool is scanned in CPRS upon completion to meet this expectation. Documentation compliance is monitored and staff members can verbalize this process.

Recommendation 4. We recommended that managers conduct a risk assessment of the MRI environment.

Concur

Target date for completion: Completed

The MRI environmental risk assessments have been completed and reviewed in the MRI Safety Committee and submitted to the Environment of Care Committee.

Recommendation 5. We recommended that the facility follow the process outlined in local policy to evaluate and document adverse events.

Concur

Target date for completion: Completed

The facility Risk Manager and Patient Safety Manager have collaborated to develop a tool to track adverse events and consideration for institutional and clinical disclosures as well as the documentation of such. This information is regularly presented to the Quality Executive Board for their review.

Recommendation 6. We recommended that the facility review all required resuscitation event elements, including errors or deficiencies in technique and malfunctioning equipment.

Concur

Target date for completion: Completed

The Medical Center Memorandum has been aligned with the national directive and the process has changed to ensure all resuscitation event elements, including errors or deficiencies in technique and malfunctioning equipment are tracked and trended. This information is presented to the Quality Executive Board for their review, at least quarterly.

Recommendation 7. We recommended that staff designated as high risk for exposure to airborne pathogens receive annual respirator fit testing.

Concur

Target date for completion: Completed

The Respiratory Protection Program Medical Center Memorandum has been updated to ensure that staff designated as high-risk for exposure to airborne pathogens receive annual respirator fit testing. The high-risk staff members have been categorized to ensure fit testing is done on those at higher risk than others. Fit testing has been completed for those considered high-risk. A process is now in place to provide training during orientation for new employees before they become part of the annual schedule of fit testing.

OIG Contact and Staff Acknowledgments

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