Preventing Unnecessary or Avoidable Rehospitalizations by Utilizing Root Cause Analysis

Conn Foley, MD, FACP
Medical Director / Chief Medical Officer

Parker Jewish Institute for Health Care and Rehabilitation
READMISSIONS

Unnecessary - Avoidable

Why do they occur?

The usual answer is?
CIRCUMSTANCES BEYOND YOUR CONTROL
NEXT 2650 MILES
Readmissions: The Issue

- Cost of rehospitalization: $17B for Medicare
- 20% of MC hospital discharges readmit within 30 days
- 90% are unplanned
- Cause is likely a break in the clinical process
- Symptom of care fragmentation
- 20-40% are avoidable
  - for the elderly – traumatizing
- Momentum for change
- Legislation is in place
Hospital Readmission Reduction Program (HRRP)

- Penalizes hospitals with high readmission rates
- HRRP began in October 2012
- Payment reduction is based on an assessment of readmissions
  - 1% - 2013, 2% - 2014, **3% - 2015**
- Based on hospital’s **Inpatient Quality report (IQR)** for readmits
- Hospital **Inpatient Prospective Payment System (IPPS)**
  - reduction in payment: 2013 - 1%, 2014 - 2%
  - AMI, HF, PNA, COPD, hip/knee surgery α readmit measures

- What will hospitals do?
  - Match care needs to a SNF
  - SNF with lowest rehospitalization rates
KEEP CALM
IT'S NOT ROCKET SCIENCE
IT IS MUCH MORE CHALLENGING!
Leadership

- President and Chief Executive Officer
- Chair of Board of Trustees / Trustees
- Executive Vice President/COO
- Chief Financial Officer
- Medical Director
- Director Nursing / Quality Improvement
- Chairs of Clinical Departments
- Director Social Work
- Director Pharmacy
- Director Information Services
- Director Building Services
- VP Research
READMISSIONS ARE NOT ACCEPTABLE

LEADERSHIP

• ‘Vision’ - NO READMISSIONS (period !)
• Expected Demanded Required
• Facilitation
• Resources
• Planning
• Metrics
• Monitoring
• Follow-up - PERSONALLY by CEO
• On the Administrative Dashboard
Symptom of the problem. “The Weed - Readmits” above the surface

The word root, in root cause analysis, refers to the underlying causes, not the one cause.
A Readmission happens….

–now what?
NOT used to blame any one person or group.

When he got the wrong medication, no one would own up to it. They were real good at covering their own butts.
What is Root Cause Analysis (RCA)?

• The process used to identify the origin of a problem

• Uses a specific set of tools to determine:
  – What happened?
  – Why it happened?
  – How to prevent it from happening again
‘Pulling’ the RCA Community Team Together

• The RCA team is;
  – Cross-setting
  – Multidisciplinary
  – Inclusive of staff directly involved if possible
  – Includes Physicians
  – Has support of leadership
  – Everyone on the team is EQUAL

• Everyone leaves their badge outside of the room
“DON’T REINVENT THE WHEEL, JUST REALIGN IT.”

ANTHONY J. D’ANGELO

© Lifehack Quotes
Health Care Leader Action Guide to Reduce Avoidable Readmissions

January 2010
Reference from the:

American Medical Directors Association

Download FREE
Variety of Root Cause Analysis Tools

- Patient/family interviews
- Care coordinator interviews
- Medical record reviews
- Process mapping
- “5 Whys”
- Cause-and-effect diagrams
Intervention improves patient/staff activation and engagement — addresses four pillars: (personal health record, red flags, medication management, and follow-up)

Using RCA to Drive Intervention Selection

Patient factors

RCA Technique: **Interview** for all patients during one month who are currently in hospital for a 30-day readmission

Key Findings:
1. Patients/Staff did not understand and did not correctly take/administer medications
2. Patient condition worsened; unsure of what to do, so sent to ED

Intervention directly addresses root cause identified

Intervention improves patient/staff activation and engagement — addresses four pillars: (personal health record, red flags, medication management, and follow-up)

Intervention Selection: Care Transitions Intervention (CTI)
Process Mapping

- Clarify specific roles and contributions of those involved.

- Observe discharge and admission processes directly, interview process owners, map the processes.

- Elicit staff and community partner perceptions about where communication issues and gaps may occur.
Root Cause Analysis: The 5 Whys?

Why is Jefferson Memorial Crumbling?
- Frequent Washings

Why are frequent washings needed?
- Bird Droppings

Why are there so many bird droppings?
- Many Spiders to Eat

Why are there so many spiders for birds to eat?
- Many Midge for Spiders to Eat

Why are there so many midges?
- Midges are attracted to the lights that turn on at dusk. Turn on lights 1-hour later to break causal chain.
“5 Whys”

• Start asking why readmissions occur and record the answer.
• If the answer does not directly identify the root cause of your readmissions problem, ask why again and record the answer.
• Continue this process until your team agrees the problem’s root cause has been identified.
"5 Whys"

Why are so many patients with heart failure readmitted?
   Because they do not understand or remember the red flags related to their condition after discharge.

Why do they not understand the red flags?
   They do not have the correct documentation or reminder systems in place.

Why do they not have the proper documentation or reminders?
   They did not receive a Personal Health Record (PHR) or a red flag magnet with documentation of these red flags upon discharge.

Why did they not receive the PHR or magnet?
   Distribution of these materials is not part of the current discharge process.
Cause-and-Effect (Fishbone) Diagram

- Equipment
- Process
- People

- Materials
- Environment
- Management

Problem
Cause-and-Effect Diagram (Fishbone Diagram)

• Visually illustrates potential causes of high readmissions
Process Improvement Plan

Identify a manageable change based on the outcome of root cause analysis. What will we do/change to address the root of the problem?

1. Brainstorm all potential solutions before rejecting any ideas. The purpose is to generate ideas; all contributions should be considered. Use this space for brainstorming:

___________________________________________________________________

2. Identify criteria that will guide the selection of solutions to the problem, such as:

☐ Cost
☐ Value
☐ Potential benefits to organization, patients or staff
☐ Ease of implementation

_____________________________________________________________________

3. Evaluate a few of the solutions listed above. Don’t be afraid to combine ideas! As a team, agree on the best solutions to test.

☐ An agreement is when each team member can “live with” the solution, even if it’s not his/her favorite.

_____________________________________________________________________

4. Write the consensus decision about each process change or improvement to make:

_____________________________________________________________________
Morning Report

• All key staff attend
• 24 hour nursing report – all units
• AOD report daily – available on e-mail from prior pm
• ‘Hot Line’ Calls - 24 hour administrator response
• FOLLOW-UP: reports (from previous days)
• Special Issues (transfers, deaths, infections, falls, caregiver challenges, emergency problems, and weather issues)
• Administrative updates
• TARGET POTENTIAL TRANSFERS - PLAN
Education and Training

- All Staff
- Education Grants from DOH
  - CNA to LPN
  - LPN to RN
  - Retention of Staff, reduce turnover
- ‘INTERACT’ - change: early recognition and act
- Floor Nurse
- Charge Nurse
- Nurse Supervisor / Manager
- Directors
INTERACT

INTERACT II
Interventions to Reduce Acute Care Transfers

INTERACT NY
Interventions to Reduce Preventable Acute Care Transfers

Working Together to Improve Care, Communication, and Continuity for our Residents
GNYHA-CCLC

PRESSURE ULCER IMPROVEMENT

INTERACT NY
Interventions to Reduce Preventable Acute Care Transfers

THE COLORS OF SAFETY
ACROSS THE CONTINUUM OF CARE

<table>
<thead>
<tr>
<th>Alert Condition</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Not Resuscitate (DNR)</td>
<td>Purple</td>
</tr>
<tr>
<td>Allergies</td>
<td>Red</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>Yellow</td>
</tr>
</tbody>
</table>

CCITI NY
CONTINUUM OF CARE IMPROVEMENT THROUGH INFORMATION NEW YORK

TRANSITIONS IN CARE
know-it-all™

BEFORE YOU CALL
Data Collection System

know-it-all™
WHEN YOU'RE CALLED
Diagnosing System

Essential clinical data collection:
A GUIDE FOR NURSES ON REPORTING
CHANGE OF CONDITION

Essential clinical data exchange:
A GUIDE FOR ATTENDING PRACTITIONERS
ON CHANGE OF CONDITION
Hospitals Need to Address Root Causes of Readmits If Possible

- Treat + Address Root Causes
- Hospital
- Home + PCP
- Long Term Care
- Home Health
- Rehab

© 2011, 2012 Center for Healthcare Quality and Payment Reform, Network for Regional Healthcare Improvement
WHO IS ACCOUNTABLE

- Hospital?
- PCP?
- Home Health?
- Rehab?
- LTC Facility?
- Patient/Family?

Which readmissions are they each taking accountability for?
Hospital Collaboration

• Joint Planning Meetings:
  – Process Improvement Coordinating Group (PICG) at hospital

• Emergency Department:
  – ‘Avoid admission’ – MAJOR ISSUE. Clinical Decision Unit (CDU)
  – Educate / persuade the patient / family to return to and remain at SNF

• Radiology:
  – Expedite studies and return patient to SNF

• Hospitalists:
  – Communicate with SNF at time of SNF transfer
  – ‘Warm Hand Off’
  – Educate / persuade patient / family to remain at SNF
  – Evaluate in ED and return patient to SNF
  – IMPACT, BOOST, RED
Hospital Coordination

• Blood transfusion - Amb Chemo Tx (ACT) unit
• Gastrostomy change
• Imaging: CT / MRI / Ultrasound
• I.V. access - e.g.: PICC, midlines
  – Avoid line infections
• EMS: return to transferring hospital
• Consultants and Inter-institutional Guidelines
• Emergency Department - Clinical Decision Unit
• Care Coaches – Care Coordinators
• Home Care - no readmissions to hospital
• MDs - joint appointments
A Truly Comprehensive Solution
Physician Involvement

- Recruitment
- Vision and Goals
- Education – on-sight at participating facilities
- Performance evaluation – measures / metrics
- Weekly Medical Staff Meeting
  - Education
  - Transfers
  - Morbidity and Mortality
  - Critical Values
  - Negative Outcomes
  - Medical Record Review – internal / external
  - Root Cause Analysis
  - Medico-legal
Consultants / ED Staff

• Goals and Responsibilities
  – in the SNF
  – in MD’s office
  – studies in MD’s office
  – Do Not Admit / Do Not Hospitalize (DNH)
• Education – what the SNF can do - provided on-site
• Timeliness
• Follow-up post hospitalization
• Documentation
• Monitoring of Performance
• Managing Costs and Care
• Risk Management
• Reimbursement – facilitate for the MD
• Speak to patient / family – Goals of Care
Medication Reconciliation

and what about COMPLIANCE?
Medications

• Medication Reconciliation
• Medication Reduction - a Quality Initiative
• Medication Regimen Review - includes EVP
• Formulary to match that of referring hospitals
• Obtain Rx from hospital
• Rigorous formulary review
• P&T Committee
• Omnicell – medication dispensing at night
• EMR

• Patient and Family Education
Anticipatory Management
(Plan Ahead to avoid readmission)

Colon Cancer

- age 87
- inoperable
- multiple severe co-morbidities
  - end stage cardiac failure
  - advanced dementia

The hospital D/C plan is: ‘transfer to Parker for rehab’.

What can we anticipate?
Anticipatory Management

Colon Cancer — ‘conservative’ management

Hemorrhage:
  blood transfusion
  bleed to death in Nursing Home!

Infection:
  Tylenol, cooling, sedation, morphine, antibiotic - which, how long, how often?

Dehydration - Vomiting - Diarrhea
  fluids? None?
  by mouth
  Nasogastric
  IV
  other?
  clysis

Obstruction:
  surgery
  stent
Anticipatory Management

Colon Cancer — ‘conservative’ management

Jaundice:
what management?

Perforation:
only pain Rx?

Metastases:
nerve block, radiation, chemotherapy?

Death:
where - at non-hospital facility?
at home

Advance Directives?

Do Not Hospitalize (DNH)
Advance Care Planning (ACP)

- Early: On-Site Nurse at transferring facility
- Reason for admission: Subacute rehab/LTC/Palliative
- Don’t admit a patient for whom you cannot provide care
- On day of admission – family available?
- Health Care Proxy – goals of care?
- Surrogate and Living Will
- Documentation - MOLST
- Ethics review committee
- In-house Palliative/Hospice
- Who should complete the ACP documents?
When should it be completed?

By whom should it be completed?
Behavior Management

- Team Care Planning
- Comprehensive Assessment
- ‘Psych’ Rounds
- Medication Reduction
- Psychologists
- Therapeutic recreation
- Volunteers
- Non-pharmacologic interventions
- Environmental accommodations
- Caregivers education - participation
- Restraint-free
- Elopement
  - wander guard, TV monitoring
  - security
- ‘Meal at Night’ - ‘Midnight Snack’ program
Areas of Special Focus

- Pressure Ulcers Prevention
- Wound Care Management
- Fall Prevention
- Heart Failure Management
- Diabetes Management
- Infection Control/Prevention
- Infection Management
- Antibiotic Stewardship
- Dehydration
- Fever
- Delirium
- Anticoagulant Management
Special In-Facility Programs

• Evercare/Optum (Medicare + choice/Advantage)
  • Medicare LTC risk (hospitalization = $ loss)

• ‘Breath for Life’ - Pulmonary Care – 3d/wk

• Dialysis

• Hospice: in-house

• Medical Director / Associate: called for every potential transfer – 24hr / 7d
Is this an unusual Nursing Home or Hospital Transfer?
The Transfer Summary!
Consider this ....

If the transfer process did not work well, in the past, with ‘pen and paper’ --- and with reasonable administrative and senior clinical involvement and oversight --- why will the process work now - electronically?
Electronic Medical Record

- Interoperable
- Easily Accessible
- Secure
- ‘Sunrise’ EMR at NSLIJ
- Remote Access Portal
- Core Lab at NSLIJ
- LIPIX, the Long Island RHIO
- HEALTHIX - lipix + nyclix
- CCITIny (GNYHA)
- SigmaCare
Physicians must document communication, related to continuity of care, in the EMR, identifying the physician with whom they had contact.
<table>
<thead>
<tr>
<th>ID</th>
<th>Unit</th>
<th>Rm</th>
<th>Ins</th>
<th>Patient</th>
<th>Adm From</th>
<th>Date From</th>
<th>D/C Date</th>
<th>#Days</th>
<th>Day</th>
<th>Time</th>
<th>MD</th>
<th>Order</th>
<th>Tran To</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>50024</td>
<td>4NW</td>
<td>413</td>
<td>Aetna</td>
<td>LU</td>
<td>1/7/15</td>
<td>2/2/15</td>
<td>26</td>
<td>Mon</td>
<td>10:10</td>
<td>AM</td>
<td>Anand</td>
<td>Yes</td>
<td>LIJ</td>
<td>New Onset R Hemiparesis</td>
</tr>
<tr>
<td>49020</td>
<td>7S</td>
<td>734</td>
<td>PMCA ID</td>
<td>NSUH/Mann</td>
<td>7/1/14</td>
<td>2/2/15</td>
<td>215</td>
<td>Mon</td>
<td>9:19</td>
<td>PM</td>
<td>Gazis</td>
<td>Yes</td>
<td>LIJ</td>
<td>Possible Bronchitis; R/O PNA</td>
</tr>
<tr>
<td>49854</td>
<td>4NE</td>
<td>411</td>
<td>MCRE</td>
<td>NSUH/Mann</td>
<td>12/2/14</td>
<td>2/4/15</td>
<td>64</td>
<td>Wed</td>
<td>5:00</td>
<td>AM</td>
<td>Anand</td>
<td>Yes</td>
<td>NSUH/Mann</td>
<td>Chest Pain; R/O MI</td>
</tr>
<tr>
<td>49914</td>
<td>5N</td>
<td>501</td>
<td>CareCaid</td>
<td>LIJ</td>
<td>12/15/14</td>
<td>2/4/15</td>
<td>51</td>
<td>Wed</td>
<td>8:50</td>
<td>AM</td>
<td>Anand</td>
<td>Yes</td>
<td>LIJ</td>
<td>Acute Respiratory Distress due to PNA &amp; UTI, Pt expired - ER</td>
</tr>
<tr>
<td>50076</td>
<td>4NW</td>
<td>408</td>
<td>HIP/VIP</td>
<td>LIJ</td>
<td>1/16/15</td>
<td>2/3/15</td>
<td>18</td>
<td>Tue</td>
<td>5:30</td>
<td>AM</td>
<td>Anand</td>
<td>Yes</td>
<td>LIJ</td>
<td>Lethargy; Unresponsive to Staff</td>
</tr>
<tr>
<td>50186</td>
<td>4S</td>
<td>436</td>
<td>MCRE</td>
<td>NSUH/Plain</td>
<td>2/6/15</td>
<td>2/7/15</td>
<td>1</td>
<td>Sat</td>
<td>6:06</td>
<td>AM</td>
<td>Adeyemo</td>
<td>Yes</td>
<td>LIJ</td>
<td>Unresponsive; Cardiac Arrest; Expired</td>
</tr>
<tr>
<td>49670</td>
<td>5N</td>
<td>527</td>
<td>MCA ID</td>
<td>LIJ</td>
<td>2/5/15</td>
<td>2/7/15</td>
<td>2</td>
<td>Sat</td>
<td>1:50</td>
<td>PM</td>
<td>Adeyemo</td>
<td>Yes</td>
<td>LIJ</td>
<td>SOB; Tachycardia</td>
</tr>
<tr>
<td>49885</td>
<td>5N</td>
<td>524</td>
<td>MCA ID</td>
<td>LIJ</td>
<td>12/8/14</td>
<td>2/8/15</td>
<td>62</td>
<td>Sat</td>
<td>5:45</td>
<td>PM</td>
<td>Kleymenova</td>
<td>Yes</td>
<td>LIJ</td>
<td>Unresponsive</td>
</tr>
</tbody>
</table>

**DATA CAPTURE**

Transfer Summary From 02/02/15 through 02/08/2015

- **Unit Performance**
- **Calculate 30 day**
- **MD Performance**
- **For Root Cause Analysis**
Quality Control Chart for 2010 - 2011

Total Transfers per Month (Subacute + LTC)

C. Foley, M.D.
Quality Control Chart for Jan 2013 - Dec 2013

30 Day Readmits per Month (Subact + LTC)

#Transfers/Bedholds per Month

Month

UCL = 32.28
UWL = 27.96
Mean = 19.33
LWL = 10.70
LCL = 6.39

C. Foley, M.D.
Quality Control Chart for Jan 2014 - Sept 2014

30 Day Readmits per Month (Subact + LTC)

UCL=28.90
UWL=24.87
Mean=16.80
LWL=8.73
LCL=4.70

2014 Month
Quality Control Chart for Jan 2013 - Sept 2014

30 Day Readmits per Month (Subact + LTC)

# Transfers/Bedholds per Month

C. Foley, M.D.
Distribution (%) of Transfers by Reason/Diagnosis

- Respiratory
- Cardiac
- Sepsis
- Misc.
- GI Bleeding
- Fall
- Neurological
- Anemia
- Mental Status
- Abdominal
- Infection
- Renal/Urinary
- Unresponsive
- Electrolyte Imb.
- Circulatory
- Fever
- Bleeding
- Lethargy

Qtr. 1 | Qtr. 2 | Qtr. 3 | Qtr. 4
---|---|---|---

Percentages shown for each reason/diagnosis across quarters.
## Distribution (%) of Transfers by Day of Week

<table>
<thead>
<tr>
<th>Day</th>
<th>Qtr. 1</th>
<th>Qtr. 2</th>
<th>Qtr. 3</th>
<th>Qtr. 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>9.5</td>
<td>12.0</td>
<td>8.1</td>
<td>13.6</td>
<td>10.8</td>
</tr>
<tr>
<td>Monday</td>
<td>16.2</td>
<td>20.0</td>
<td>15.3</td>
<td>17.4</td>
<td>17.3</td>
</tr>
<tr>
<td>Tuesday</td>
<td>18.2</td>
<td>11.3</td>
<td>13.7</td>
<td>16.7</td>
<td>15.0</td>
</tr>
<tr>
<td>Wednesday</td>
<td>13.5</td>
<td>17.3</td>
<td>12.9</td>
<td>12.9</td>
<td>14.3</td>
</tr>
<tr>
<td>Thursday</td>
<td>18.9</td>
<td>14.7</td>
<td>17.7</td>
<td>10.6</td>
<td>15.5</td>
</tr>
<tr>
<td>Friday</td>
<td>10.8</td>
<td>15.3</td>
<td>17.7</td>
<td>16.7</td>
<td>15.0</td>
</tr>
<tr>
<td>Saturday</td>
<td>12.8</td>
<td>9.3</td>
<td>14.5</td>
<td>12.1</td>
<td>12.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Distribution (%) of Transfers by Nursing Unit

<table>
<thead>
<tr>
<th>Unit</th>
<th>Qtr. 1</th>
<th>Qtr. 2</th>
<th>Qtr. 3</th>
<th>Qtr. 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2N</td>
<td>-</td>
<td>-</td>
<td>2.4</td>
<td>6.1</td>
<td>2.0</td>
</tr>
<tr>
<td>3NE</td>
<td>17.6</td>
<td>16.7</td>
<td>17.7</td>
<td>18.9</td>
<td>17.7</td>
</tr>
<tr>
<td>3NW</td>
<td>11.5</td>
<td>10.0</td>
<td>3.2</td>
<td>-</td>
<td>6.5</td>
</tr>
<tr>
<td>3SE</td>
<td>6.8</td>
<td>7.3</td>
<td>5.6</td>
<td>8.3</td>
<td>7.0</td>
</tr>
<tr>
<td>3SW</td>
<td>5.4</td>
<td>5.3</td>
<td>6.5</td>
<td>5.3</td>
<td>5.6</td>
</tr>
<tr>
<td>4NE</td>
<td>8.8</td>
<td>4.7</td>
<td>5.6</td>
<td>10.6</td>
<td>7.4</td>
</tr>
<tr>
<td>4NW</td>
<td>12.2</td>
<td>8.7</td>
<td>10.5</td>
<td>12.1</td>
<td>10.8</td>
</tr>
<tr>
<td>4S</td>
<td>12.8</td>
<td>15.3</td>
<td>13.7</td>
<td>9.1</td>
<td>12.8</td>
</tr>
<tr>
<td>5N</td>
<td>3.4</td>
<td>5.3</td>
<td>4.0</td>
<td>4.5</td>
<td>4.3</td>
</tr>
<tr>
<td>5S</td>
<td>2.7</td>
<td>6.0</td>
<td>8.1</td>
<td>3.0</td>
<td>4.9</td>
</tr>
<tr>
<td>6N</td>
<td>2.0</td>
<td>4.0</td>
<td>1.6</td>
<td>2.3</td>
<td>2.5</td>
</tr>
<tr>
<td>6S</td>
<td>8.1</td>
<td>6.0</td>
<td>8.1</td>
<td>10.6</td>
<td>8.1</td>
</tr>
<tr>
<td>7N</td>
<td>0.7</td>
<td>4.7</td>
<td>1.6</td>
<td>1.5</td>
<td>2.2</td>
</tr>
<tr>
<td>7S</td>
<td>3.4</td>
<td>2.0</td>
<td>6.5</td>
<td>0.8</td>
<td>3.1</td>
</tr>
<tr>
<td>8N</td>
<td>4.1</td>
<td>1.3</td>
<td>3.2</td>
<td>5.3</td>
<td>3.4</td>
</tr>
<tr>
<td>8S</td>
<td>0.7</td>
<td>2.7</td>
<td>1.6</td>
<td>1.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Root Cause Implementation

Summary

• Vision
• Expected Demanded Required
• Facilitation
• Resources
• Education
• Monitoring
• Metrics
• Follow-up
• Recognition
Time must be dedicated for discussion, planning, implementation and oversight.
Senior Management must give Direction, Support and Follow-up! - the rest will fall into place.
“Dr. Foley, may I be excused? My brain is full.”