Strong Medicine Interview with Rob Osgood, 16 May 2014

[00:00:00]

Q: OK, this is Alyssa Botelho, on May 16, 2014. I am here with Rob Osgood at Tufts Medical Center for the Strong Medicine Oral History Project. Do I have your permission to record this interview?

A: Yes, Ma'am.

Q: OK, so if you could, begin by just kind of talking about where you're from and sort of where you got your training and how you got to Tufts, and your title and position here.

A: Sure. So first of all, thank you for being here and thank you for having me, it's really a pleasure, and it's actually an honor to be part of this project. I think this is tremendous, so thank you, I really appreciate it.

So, my name is Rob Osgood. I'm the emergency management director for Tufts Medical Center, and I oversee all the disaster planning mitigation response and recovery here at the medical center. I am from Revere, Massachusetts, which is just over the bridge, so part of my accent. I may drop a couple of *rs* here and there during the course of the interview, and so I apologize in advance. I was educated in East Boston, so in many ways, I'm a product of the city,

but I'm also a product of this medical center.

I started working here as a teenager and I started working as a patient sitter, which essentially would be somebody who was combative as a patient goes and you would sit in the room with them and make sure they didn't pull on their Ivs or cause any harm to staff or themselves, and basically they said, if you can survive eight hours with that patient in a room alone, we can send nursing staff in. So that was my first job here at the medical center. Then, I became a transporter, then I became a tech in the ED, then I supervised the techs in the ED, and I also worked in EMS. So, that is really sort of my background and how I started in emergency preparedness, was working here in the emergency department. So in many ways, I actually grew up here in the emergency department, considering I started here very young, so a lot of the staff we're really very, very close, and I think that actually helps a lot during days like we saw last year.

Q: Great. What does a typical day look like for you?

A: One of the great things about my typical day is that it's nothing but typical. I'd love to tell you that I come in at nine and punch in and go to work and it's always the same and I leave at five, but that's not the case at all.

Every day is actually very, very different, and that's one of the luxuries that I have in this role, is that it's so dynamic and so fluid.

Some days we're working on our evacuation plan, and the next day, we could be working on our Code Pink, or missing child plan, and one day, we could be working on emergency communications, and the next day, we're talking about mass casualty planning. So that's really what's so great and neat about my role, is really, anything that threatens to disrupt the "normal" operations of the medical center is when me and my partner kind of kick into gear, and that's what's so extraordinarily interesting about it, is every day, there's really a new opportunity or initiative that we're involved in to keep staff and patients safe.

Q: About how many staff do you oversee, and what kinds of jobs do the staff do, some might now know.

A: What's interesting about it is I'm a department of one right here at the medical center, so being a department of one, it really allows me to have this dynamic in which I work very closely with folks from say like -- just for example, because Jeremy is sitting here, our media relations folks; I work very closely with them, but I also work very closely with facilities; with the emergency

department, obviously; with literally every department in the medical center, so by being able to have sort of this free-agent thing, lone wolf kind of dynamic, I'm able to work so intimately with so many different departments, which is fantastic.

Now that being said, when we activate our Hospital Incident Command System, or we have some type of event that we need to structure around and we activate our "disaster mode," or what we call here our Code Triage, which is our emergency operations plan, well then, essentially, I take on the role of the deputy incident commander, which is kind of general oversight of the command of the incident.

Q: Got it. Have you worked on Marathon Monday before?

A: Yes, actually this past Marathon Monday was my 10th or 11th Marathon Monday in this emergency department so that was really -- in various roles, actually, but yes, we worked -- I'm here every marathon Monday. We activate our emergency operations plan that I talked about, our Code Triage; that's every marathon Monday, no matter what. So Marathon Monday, Fourth of July, New Year's Eve, and [00:05:00] because this is Boston, St. Patrick's Day, we activate our Code Triage or emergency operations plan.

So on Marathon Monday, we activate what's called our Incident Command post in the emergency department, so this is right next to the charge nurse's station. We set up a computer in which I log on to all of my city-wide emergency communications systems. I log on to our EM tracker, which is the patient tracking system which we track runners by their bibs so that we can check them into the emergency department. We know who's in the medical tent and who's coming to Tufts Medical Center. So we have all of that sort of set up on marathon Monday in our Incident Command post in the emergency department. Essentially for our hospital emergency management personnel, Marathon Monday is the Super Bowl.

Q: Cool. And so now, sort of reflecting on the last Marathon Monday, 2013, if you could, talk about how the day began, when you knew something had happened, and sort of the things that followed in the few hours after 2:30 p.m.

A: Sure. For Marathon Monday, that's really a point of pride for our emergency department, and it's a point of pride for our organization. We, over the years, have evolved into a day in which Marathon Monday is not a Tufts Medical Center emergency department event, it's a Tufts Medical Center event, so it's a hospital-wise event, and we're talking with people from all corners of the medical center in our

emergency planning. Our planning actually starts months in advance, so not just the planning that we -- that takes place on the city side of the house with the Boston Athletic Association, we certainly have them here, in addition to leadership from Boston EMS. We have those folks here and we do a tremendous job planning with them, and we're grateful for their collaboration and partnership. But internally, we're planning with folks from our lab, from our pharmacy, from patient transport, from hospitality, so we have all these people at the table early on, and our planning begins so early so that on game day and on Marathon Monday, everything is really in place.

So if we look at last year, in 2013, our day on Marathon Monday really starts at about 6:00 a.m. and it doesn't end until about midnight every year. So we started just like it was any other Marathon Monday. We started -- we set up our command post. We actually set up a medical tent outside so that we could put some lower priority patients that just need some fluids and things like that. We up-staff. We bring in additional nursing, additional nursing technicians, stretchers, wheelchairs, all that sort of stuff. So, it was a beautiful day on April 15th of last year. The weather was great; it was a great day for

running, and at the time -- we typically see an influx of marathon runners at about 2:15 on Marathon Monday, so at 2:49 last year, we had two runners in the department and it was a relatively quiet day, and it was also a relatively quiet day just in the department, in general. And so when the notification came through from the city, there's sort of a tone in the emergency department that we have where it's kind of busy, but it's a controlled sort of thing, and then when the tones went out for us to listen for the CMED [Central Medical Emergency Direction system] notification, we heard "Attention Boston hospitals," and then they told about the explosions. And so immediately...

Q: This is over the phone?

A: This is over -- it's called a CMED notification, and it's over down in the nurse's station in the emergency department. We have a disaster radio and there's a couple of different radios and phones and all that sort of thing, and that's how the city communicates with all the emergency departments. So we know that when those tones go off, we need to listen because it's very important information. So when they made that announcement, we all just kind of stopped and there was a beat and most of the nursing staff looked at me and said, is this another one of your crazy drills, because you know, we do a lot of exercising and a

lot of drilling. And I said, "No, this isn't a drill, this is for real, we need to huddle up." And so, we have various safety huddles throughout the day on Marathon Monday to ensure that the staff and patients remain safe because we're planning for a major influx of patients. So in our huddle, we basically said we're not sure what this is. We don't know if it's accidental. We don't know if it's intentional, but we need to treat this the same way that we exercised. We don't know what's going to come through the door, however, we need you to just hang in there, do your best and deliver the high quality and expert clinical care that you deliver every day.

[00:10:00] One thing that I give our clinical nursing director in the emergency department, Julie Compton -- she's no longer with the organization, but I give her a lot of credit. She instructed our staff members in the emergency department to contact their families and let them know -- make sure that everybody in their family was safe and let their families know that they were safe, and I thought that was really something that was phenomenal because you're worried about your family members or you know that people worry about you, you can't possibly take care of these people that are coming through our back door

at a time they need us the most. So people took a couple of minutes and dropped out some text messages and that was really, really great. We've actually made that into our plans now, that we want people to do that.

So shortly after that, we ensured that the ED was ready and prepared to take whatever patients would be coming through the back door from the scene, and then we activated our Code Triage formally. We blasted out a Code Triage notification and for our hospital incident command leadership to report to our command center, which is down on the first floor of the Proger building. From there, we developed our incident action plan, which is really our top three priorities for the incident.

We saw a major influx of patients throughout that day, on April 15th. We put eight patients up into the OR, and all in all, together, we saw 19 patients.

We remained in our Incident Command structure for the entire week, which certainly helped us not just a few hours later when we had to evacuate the emergency department, but absolutely helped us on the Friday, in which we had the lockdown situation and there was the shutdown of the MBTA,

to apprehend the perpetrator. So really, us remaining in our restricted access and in our Hospital Incident Command structure definitely aided and assisted in us managing whatever was going to occur that week.

Q: You mentioned an incident action plan, the three priorities. What are those priorities?

A: Those priorities in which we developed our incident action plan -- our IAP differ depending on the situation or the incident at hand, so it could be something like a mass casualty incident certainly, but it could be a facilities related issue in which a pipe bursts or something like that and those are really -- the purpose of our implementing our Incident Command System is to streamline our operations and prioritize what's going to keep our staff and patients safe, what's going to help us stabilize this incident, and what's going to assist in protecting the Tufts Medical Center critical infrastructure and property. So that's really kind of always the three priorities that we take for our incident action plan.

When we talk about last year, safety was always our first concern. What are we going to do to keep folks safe? And so, we implemented what we call our Code Gray, which is our restricted access policy, and what that allows us is for us

to use one single entrance to get people into the building. That allows us to streamline who's coming in, especially in these kinds of incidents, we where it's a public safety-related incident. We wanted to be sure that we had adequate and complete control of the facility. So that was certainly our priority.

Another one of our priorities was how are we going to -- what kind of resources do we need to accommodate the types of patients that are coming in. During Marathon Monday, we're prepared to receive 30 patients -- this year it was 40 patients -- but these are medical patients, patients that are dehydrated or hypothermic, so we want to be sure that we have adequate resources to receive patients that need surgery, traumatic patients. So that was certainly important.

And then, we kind of shifted gears later on in the day into more of a recovery mode from a mass casualty incident, and then, we made sure that on Tuesday morning -- so like I said, we kept our Incident Command structure in place throughout the week, so we had standing meetings to do our Incident Command briefings, and on Tuesday morning, we shifted gears to talk about how we could assist folks like

our media relations team, because we had national and international media here and people coming with their trucks, so we shifted gears to talk about how we're support those logistics and that kind of thing.

Q: Where to put the trucks, where to keep reporters.

A: Exactly, exactly. But most importantly, our priority, like we talked about on our incident action plan, our priority beginning on that Tuesday morning was mental health support. Mental health support, certainly for these victims that came from the [00:15:00] scene, part of this horrendous incident, but also for staff. A lot of our staff, we do a lot of exercises and our folks are some of the most highly skilled and highly experienced clinicians in the business, frankly. But a lot of these folks saw injuries that they had never seen before, so we wanted to be sure that they had the mental health and the assistance they needed to cope with this type of incident.

I also mentioned earlier, I'm a product of this city, so for folks like me and for other folks who may be residents of the city or just from here, this was something that we hadn't experienced before in our own neighborhood, so that was very startling, so we wanted to be sure that folks had the right resources at the right time and had any support

that they have needed mentally.

Q: So, the Code Gray that you mentioned, I was interviewing Dr. Barnwell, who said that there was a lockdown because there was a patient who came in who law enforcement thought might have a suspicious backpack or something, and ended up being totally fine, but you mentioned that was a lockdown. Was that when the Code Gray was in place?

A: Yeah, so we actually had had -- we implemented the Code Gray, but that was already in place before we had evacuated the emergency department, and in fact, with us being in that Code Gray, in that restricted access, that allowed our atrium doors to be closed, so when we evacuated the emergency department, we evacuated into the atrium; it was very, very helpful and very conducive to the fact that the atrium doors were closed because we were able to set up sort of this makeshift emergency department in the atrium.

That patient that you referred to that had the "suspicious package" had already been in the facility and the well-meaning registrar brought the bags back, which is something that we normally do every day, but we were very fortunate that we had law enforcement personnel really descend on the emergency department immediately.

Our plans call for, based on international intelligence, that hospitals can be secondary targets in the event of one of these types of attacks. So we were very concerned about that, and our initial discussions immediately went to should we go to restricted access or can we go to restricted access. So to have law enforcement personnel on site was really a great asset and we're very appreciative of it. So it was actually the law enforcement personnel that were here that made the call for us to evacuate the emergency department.

Now to be completely forthcoming, I've never exercised the emergency department to do a complete evacuation, and the staff, there, were phenomenal in that evacuation. They evacuated in a very, very short time, about seven minutes, which is kind of unheard of. Luckily, all of our high acuity patients had already gone upstairs, either to the or the ICU, so we had the patient that were in the emergency department evacuated to the atrium, and while our staff had never done a full-scale evacuation exercise of the emergency department, a lot of them reported that because of previous exercise experience, they just knew that take a deep breath, think about what we're going to have to do to keep these folks safe, then evacuate calmly and

collectively, and that's what they did. It was really, really something special.

Q: And in terms of that evacuation, it's all patients with their monitors and IVs, everything hooked in. They just wheeled them through. If they needed beds, the beds are wheeled out and then (overlapping dialogue; inaudible).

A: So that's exactly right. They wheel the patients right in the stretchers, just from the emergency department into the atrium. We had ED techs. We had folks that work in finance, folks that work in research that just said, you know what, we'll help, we'll do whatever we can. Folks were grabbing linen carts and just wheeling them out into the atrium or grabbing medical equipment or things like bed pans and stuff like this and just wheeling them out into the atrium saying, hey, we may need this. So it was really -- when I talk about how at Tufts, we really function as an ensemble, and it's not just an emergency department event, it's a Tufts Medical Center event.

Last year on April 15th, that was certainly something that was very, very evident in which we had people from all aspects of the medical center saying, hey, what can we do?

Q: Great. You've touched on this a little bit, but if there were -- the evacuation of the atrium being one, but if --

are there other important ways in which you deviated form the plan that you would normally do or [00:20:00] improvise in a way that you've never tried before that turned out to be really successful or challenging? It seems like it was quiet to protocol, but if there were any important, special circumstances.

A: You know, one thing that we train on and one thing that we exercised is our plans are really guidelines. So no emergency plan is a complete cookout. They're not designed to be that way. They're designed to be scalable. Our Incident Command structure is designed to be scalable, and we really saw that last year, and frankly, we've seen that in any incident. We take a plan, it functions as a guideline. We really take an all-hazards approach here at Tufts Medical Center, so that a lot of our plans have very different applications even though it's a plan designed for one specific event.

So for example, when we had the lockdown last April and the city went into sort of a complete lockdown mode, we actually used one of our severe weather and blizzard plans. So with the MBTA being shut down, as you can imagine, it's a huge impact. With us, more than 70% of our staff take the MBTA, so for the MBTA being shut down, we're

essentially here, having to use what use what staff we have in house or getting people in by any means necessary. And one of the plans that we used was our blizzard response plan because that calls for OK, how are we going to feed people, how are we going to put people up that have to stay here, utilizing on-call rooms, empty patient rooms, cots, air mattresses, things like this, so that was really -- that was really one of the great things that came from the lessons learned on that Friday, was adapting some of our plans for multiple uses across the enterprise.

Q: Got it. And did the -- and you touched upon this a little bit, too, already, but the presence of news media, social media, affect your work in any way or did you -- I assume you were working with PR staff, but...

A: Yeah, so that's one of the great luxuries -- and I call it a luxury that we have here at Tufts Medical Center -- is working so intimately together. I think a lot of -- or some of my counterparts have challenges which folks operating in silos and things like this, but we're always at the same table together, so our media relations folks are involved in the planning early on with the Boston marathon response. So for us to talk about where can we share information or communication or all that, once we activate our Incident Command System, our media relations

folks and our communications folks are sitting right at the table. They actually sit at the table right behind me in our Hospital Command Center, so if they're picking something up or if I'm picking something up through one of my channels, our information-sharing is instant, and that's really part of what I think is embedded in the culture here, is our clear communication and our very high level of communication and working with one another.

Q: And several Tufts interviewees have mentioned this Hospital Command Center, and it seems like it's a room of a couple of TVs and tables and chairs, and the press people are there, you're there, it's -- if you can, describe the place and who's there.

A: It would probably be easier if I just take you down there after. I have a meeting -- after this, I have a meeting in there, and you're more than welcome to join me in that meeting. We're actually talking about disaster communication, so you're more than welcome to come down there if you like.

So our Hospital Command Center is our central hub of communication during an emergency. Essentially, it's a conference room with multiple televisions. We have a wall of televisions on one side that are also linked into

computers so you can monitor multiple news stations, but I can also pull up some of those city-wide software systems that we discussed earlier. We have another television at the front that displays our bed boards. We can see how many patients we have in house, what types of patients we have in house. We're linked into security cameras in there so that we're able to pull up live feeds from our security cameras in real time to kind of monitor what's going on in the emergency department or outside on the perimeter or something like that.

We have maps in there. We have plans in there. We have a whole bunch of computers, both desktops and laptops. We have emergency equipment in there. You name it, we have it, including a Keurig (chuckle) so that's also very, very important. But that's really kind of where I base during an emergency. That's where we're developing that incident action plan that we talked about. That's where [00:25:00] we have our standing meetings. That where folks within our Incident Command structure know where to report to during an incident. It's really our kind of central hub and our headquarters.

Q: Great. Did you use some of your new technologies that day?

A: So that day, we utilized a couple of different page groups

and communication groups, but since that day, we've actually done a lot of work on refining -- we've developed a couple of new groups, but we've also implemented a mass communication system that allows us to send employees text messages during an emergency.

Here at Tufts Medical center, we pride ourselves on our ability to engage in quality improvement and process improvement and we're constantly trying to be better.

So one of the things that we did shortly after the events of last April was I sent out a communication in an email to all of our employees and said, "We are very, very grateful for your willingness and your dedication to patient care that we saw over the course of that week, but I want to know what I can do better, what Tufts Medical Center emergency management can do better, how we can do better."

You know, with every emergency or every disaster, communication is always the major, major problem, in any emergency. So, we found that there's a lot of ways in which we can improve our communication and not just in how we do it, technologically, but also the frequency in which we do it. Sometimes, there are going to be things where we

don’t have any new information or we need to dispel a rumor or something like that, and we need to do that more often. That’s something that we’ve done a lot of work with over this year, and we’ve gotten really, really great at it, especially with implementing the mass text-messaging system so that we can send a message to employees at the point with just a few clicks, at the point of notification.

Q: Does the system have a name, just for researchers who want to learn more about it.

A: Yes, so the system that we implemented is called VOLO.

Q: FOLO, F-O-L-O?

A: V-O-L-O.

Q: V-O-L-O.

A: It’s Latin. It means to move quickly with speed.

Q: And now, as we’re moving into the sort of the reflection part of the interview, let’s see, have there been any other changes to disaster plans, protocols that you’ve put in place that you wanted to note? Have you changed your drills, way you try and do practices in the future?

A: Sure. What we’ve done is we actually did a drill a week before last, last weekend, and we are at the point, now where we’re drilling much deeper than we had before. You know, we really learned a lot about our internal protocols. We learned a lot about our internal plans, and we learned a

lot about how we respond here at the medical center, and it's all good. We developed a couple of plans as to how we can better leverage and utilize those staff members that said hey, I'm here to help, what can I do? Part of that is really refining our, what we call the labor pool plan, and how we can better deploy staff to where they're needed and where they're necessary during these types of incidents. I'm fortunate to work very, very closely with both our emergency department and our trauma division, so we worked in conjunction with our perioperative services to further enhance our mass casualty plans and our trauma plans, in addition to bringing in some additional equipment and storing some stockpiled equipment so that in the event of a mass casualty incident, manmade or accidental, we have the ability to care for the greatest number of individuals that we can.

Like we talked about, a lot of work -- a lot of work has gone into how we can improve our communications to staff, but also how we can gather information quickly, working very closely with our media relations folks on social media and things like this.

Another benefit that I had already talked about is how we

work very, very closely within the city of Boston. I work with my counterparts across the other hospitals very closely, with Mary Divine, who is our liaison to the Conference of Boston Teaching Hospitals. She is really a tremendous asset. She actually has a seat on our emergency planning committee here at Tufts Medical Center. Working very closely with police, with fire, with EMS, like I said, we very, very, very much value those [00:30:00] partnerships. And maintaining our transparency among our emergency plans and constantly trying to improve them, that's really some of the work that we've done over the past year, and I'm really proud of the work that we've done, what we've done in the past, certainly leading up to last year. I think we've come a long way in our disaster preparedness and our emergency response here at the medical center, but we also recognize that we have a long way to go. We should be constantly trying to improve and trying to further refine so that we can ensure that should the unthinkable happen, we can keep our patients safe and deliver the highest quality care that we can.

Q: Right. I had meant to ask something earlier, so since you've been surveying crisis management at Tufts for over a decade, were there any events of a level of mass casualty or crisis that were similar to the marathon in your time?

Is there anything that even came close to last year, or is this unique in your career?

A: That's a great question. You know, in my role, -- I've been in this role for four years, but I've been involved with disaster planning and response here at the medical center, like you said, for 10 or so, and so you know, working in EMS and -- undergraduate, I worked EMS in Manchester, New Hampshire, and then, I went to graduate school for emergency management disaster response and put my focus on healthcare emergency response and worked in a variety of capacities there, not just in the city, but certainly out in the suburbs as well, emergency planning, and the truth is I've been involved in countless exercises and countless trainings, and I've been invited to sit on national panels and speak and all kinds of international forums, but you know, every emergency is different, and they all warrant a very different response, and they each have unique demands. But I will say that because of the very high level of training that our staff has here at the medical center and because they always put our patients at the center of everything we do, they've developed skills, and I would hope that I can include myself in this category, we've developed skills that allow us to be adaptable to each emergency. So while I think that last

year's events on April 15th certainly had -- they warranted a very specific type of response and a very specific type of objective, I think a lot of the skills and a lot of the things that we brought to the table that day were things that came from years of previous training and exercising. And you know, the truth is, I develop plans and policies and protocols for a living, but nothing would make me happier than the plans that I developed for days like April 15th of last year to go on a shelf and never be picked up again.

Q: Well, thank you so much. Do you want to put in anything, a last word?

A: I wouldn't know what to say. I'd like to have a really good sort of joke to put in right now, but, so thank you very much. I really appreciate it.

Q: Thank you.

END OF AUDIO FILE