**Appendix**

**Departmental Communication**

Each day a department e-mail was issued from the Chairman’s office disseminating information such as updated COVID-19 case numbers and institutional statistics. It posted the current clinic and on-call schedules, updated COVID testing site information, relevant hospital policies, instructions for access to Personal Protective Equipment (PPE), and information regarding mental wellness services. The e-mail was accompanied at times with relevant attachments, including evolving recommendations for hygiene intended to protect family, ventilator reviews, and important educational materials.

Weekly resident meetings were led by the residency program director via Skype® or Zoom®. Residents were invited to actively participate in the scheduling and reallocation of resident manpower. These sessions were used to provide updates regarding the in-hospital experiences on medical services and as a forum to facilitate resident-led programs. A written residency memo was also issued via e-mail periodically, providing similar updates, information, and inspiration. An online spreadsheet was created to track resident temperatures and to remove those febrile from active patient care roles.

**Inpatient and Emergent Orthopaedic Care**

As the department escalated to more spartan staffing, options were weighed. For a brief period, the department considered an attending-only inpatient staffing plan. To transition into this arrangement, a few faculty members shadowed residents to orient them to various aspects of inpatient and emergency room care. It became clear that this staffing approach was sub-optimal and a poor use of everyone’s time and modified as noted.

Multiple contingency plans were also created to account for future staffing shortage possibilities. For example, if the PGY-4 residents were re-allocated to medical services, plans were to have the PGY-5 residents cover the night float shift and to have attending faculty assume daytime in-house coverage. Finally, in-person coverage of one of the smaller emergency departments within the institution was discontinued, and was instead covered by a senior resident by telephone from home, freeing up additional personnel.

**Outpatient Orthopaedic Care**

Each provider was tasked with managing his or her schedule for the imminent future. Planning entailed having each provider reach out to their patients with scheduled upcoming visits. Providers communicated with their patients to arrive at a decision for how to proceed with care, and to devise reasonable plans for both temporary postponement as well as eventual follow up and resumption of care. Patients previously scheduled for surgery were contacted and counseled.

PPEs were eventually provided to all staff and visitors in the lobby upon entry as well. PPEs (face masks +/- eye protection) were donned by all providers, face masks were worn by all patients and proper hand washing etiquette was employed. Orthopaedic residents were excused from clinic coverage duties to make them available for inpatient orthopaedic coverage and to allow them to staff non-orthopaedic medical wards. Efforts were made to avoid congregating of any kind, including crowding patients in waiting rooms.

**Telemedicine**

Close coordination with the call center was essential when triaging patients to an in-office visit, a telemedicine visit, or a postponed visit in the future. To help navigate the clinical dilemmas that often arose within the call center, a provider was assigned to sit within the call center as the pandemic escalated. This provided in-person real-time clinical input, which helped guide both call center personnel as well as patients alike. It ensured that emergent cases would be properly referred or advised and helped reassure everyone involved that a delayed appointment would sometimes be appropriate.

**Human Resource Considerations**

Providers who were “elderly “(over the age of 65), pregnant, and/or immunocompromised met the institutional definition of high-risk and were made unavailable for roles in which exposure was likely and were preferentially assigned to telemedicine duties. Additionally, departmental leadership was initially assigned to the “orthopaedic surgery service,” to facilitate future logistical and operational management. Finally, extenuating circumstances that were either real or perceived, such as having a newborn baby, elderly family members, or families within very close living quarters were all taken into account and managed on a case by case basis with as much sensitivity as possible.

As many of the office-based physician assistants did not have extensive inpatient experience, efforts were made to pair or link outpatient physician assistants on teams with inpatient physician providers. This provided a training mechanism which permitted providers a gradual period of transition and an increasing assumption of responsibilities.

**Pandemic-Specific Considerations in Orthopaedic Care**

On rare occasions, either when institutional resources were entirely exhausted or when other mitigating factors demanded as much, patients were transferred to an appropriate accepting institution for surgical care. Interestingly, despite all being within close proximity and within the same city, institutional experience has varied substantially and some remained capable of managing certain surgical needs more so than others at varying time points. Understanding which neighboring institutions can assist by accepting and caring for an injured patient on a case-by-case basis is important. Knowing the transfer procedure, transfer contact, and other relevant logistics proved critical to effectively moving patients to where they could be best served.