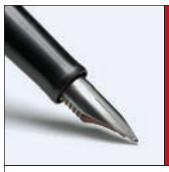

LETTER FROM THE EDITOR-IN-CHIEF

H1N1: The Sequel

Unless you have spent the entire summer on *Gilligan's Island*, I assume everyone remains attuned to the daily reports on H1N1 streaming from *every which way but loose*.

While the prevailing opinion is that the flu season will be *Superbad*, it remains difficult to predict how things will play out. We will be dedicating the October issue of *JUCM* to pandemic flu planning, though given the likelihood of an early spike of flu, there are some critical areas of planning that shouldn't wait until next month.

Preparedness is always based on an unknown, and is inevitably imperfect. What if I over-prepare; how many resources will I invest that may never get used? What if I under-prepare; what is the cost of being caught off-guard?

Rather than making the common mistake of allowing uncertainty to paralyze us from taking any action at all, let's discuss a few key points to remember as we enter the season:

- First: Before all else, establish a task force, led by one "general" to keep your plan organized and focused.
- Second: Research. Before you can establish a plan, you need the latest information
- Third: Be flexible. The "latest" information is guaranteed to be fluid. Any plan should be flexible enough to change in light of news from the battlefront and the "intelligence" from central command
- Fourth: Don't be trigger happy. Despite the urge to change your plan based on evolving information, it is prudent to not overreact to every bit of news. Let your general evaluate whether new information is actionable or whether it is wiser to "wait and see."

  During the initial H1N1 outbreak, the experts at central command (CDC), changed their recommendations several times a day in the first few weeks. This created significant headaches for the general public and healthcare community alike: test/don't test; treat/don't treat; close/don't close; mask/don't mask. In hindsight, perhaps we needed to be more patient before declaring the battle plan.
- Fifth: Understand the difference between "public health" and "patient care." The CDC must plan according to the overall public good. Their job is to ensure against panic, to track movement, and to conserve resources. The information that flows from central command is meant to maintain control. It is not meant to represent the gospel for treating the patient that sits before you. Just like all clinical guidelines, it must be evaluated in the context of how it meets the needs of your patient, and your community.
- Sixth: Call or meet with your local health department *now*. Do not wait until they are knee deep in a crisis. They will not be able to help as much then as they can now. Let them know you are an important front-line resource. Offer your services as part of the solution, whether it be for a mass vaccination plan, or for the evaluation, management, and triage of the sick and worried well.

  Urgent care is the perfect setting to handle a flu pandemic. We can de-burden an overstressed emergency department, and mitigate exposure of the healthy and chronically ill in the primary care office.
- Seventh: Meet with local hospitals to confirm understanding of admission criteria. If you have a patient that needs admission, and the hospital has a bed, you should arrange for a pathway for direct admission. These patients should not go to an ED unless they are in need of stabilization.
- Eighth: Meet regularly with all the key players in your plan and to assess its effectiveness.

Finally, even if you over-prepare, the exercise in preparedness is important. A crisis looms somewhere; now is as good a time as any to plan your response.

Once I knew what was coming, Freddy Krueger wasn't half as scary in *Nightmare on Elm Street Part 2*. ■

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