

Mystery Patient Drill Exercise Plan (Template)

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Preface

The New York City Mystery Patient Drill (NYC-MPD) series was sponsored by the New York City Health Department and the Region 2 Regional Emerging Special Pathogen Training and Education Center (RESPTC) at NYC Health + Hospitals/Bellevue. This Exercise Plan (EXPLAN) including evaluation materials was produced with input, advice and assistance from a Stakeholder Advisory Group (SAG) and adheres to the Department of Homeland Security Exercise and Evaluation Program format.

This EXPLAN gives exercise controllers, evaluators and observers from participating agencies and organizations the information necessary to participate and observe in a drill designed to measure healthcare facilities' capabilities to identify, isolate and inform appropriate personnel of a patient suspected of having a communicable disease of public health concern, such as Avian Influenza (H5N1), Ebola Virus Disease (EVD), measles, Middle East Respiratory Syndrome (MERS), and Lassa Fever.

The Exercise Evaluation Guide (EEG) Annex is a supplement to this EXPLAN and provides evaluators with detailed information about the drill scenarios and specific evaluation criteria. Evaluators should refer to the EXPLAN for basic information about the exercise.

The NYC-MPD is an unclassified exercise; however, due to operational sensitivity all exercise materials are determined to be For Official Use Only (FOUO).

All exercise participants should use appropriate guidelines to ensure proper control of information within their areas of expertise to protect this material in accordance with current jurisdictional and organizational directives.

Handling Instructions

1. The title of this document is *Mystery Patient Drill Exercise Plan (EXPLAN)*.
2. The information gathered in this EXPLAN is FOUO and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from [agency name] is prohibited.
3. For more information, please consult with the following point of contact (POC):
 - List Point of Contact

Exercise Overview

Exercise Name	Mystery Patient Drill
Exercise Dates	[Month, Day, Year]
Exercise Location	[Location]
Exercise Sponsor	[Agency Name]
Scope	The exercise is an unannounced drill, planned for no more than two hours. Exercise play will begin when the controller/evaluator (“mystery patient”) enters the emergency department (ED) or clinic site and ends at the point of initial evaluation and/or notional report of decision to notify your local health department. Alternatively, the exercise will be terminated when the patient has been unmasked waiting for triage for over 30 minutes, waiting in isolation room for 60 minutes without clinical evaluation, any invasive procedures (bloodwork or swabbing) is about to commence, or the patient is set to be discharged without any isolation or concern for [name of infectious/communicable disease].
Focus Area(s)	The exercise is intended to test the ability of acute care facilities to rapidly and safely identify, isolate and inform infection control and the health department of potential patients with diseases of public health concern.
Capabilities	The following HHS-ASPR capabilities and functions are addressed in this exercise: Capability 1: Health Care and Medical Readiness Objective 4: Train and Prepare the Health Care and Medical Workforce Activity 2: Educate and train on identified preparedness and response gaps Activity 3: Plan and conduct coordinated exercises with health care coalition members and other response organizations Activity 4: Align exercises with federal standards and facility regulatory and accreditation requirements Activity 5: Evaluate exercises and response to emergencies Capability 4: Medical Surge

	Objective 2: Respond to a Medical Surge Activity 9: Enhance infectious disease preparedness and surge response
Objectives	Objective 1: Determine the time it takes to identify a patient with a potential communicable disease of public health concern through initial universal travel/exposure, screening and triage in accordance with facility protocols. Objective 2: Determine the time it takes to implement appropriate infection control measures including source control (patient masking) and isolation of a patient with a potential communicable disease of public health concern (transfer to a private room, preferably airborne infection isolation room). Objective 3: Assess staff adherence to key infection control measures including use of appropriate personal protective equipment (PPE). Objective 4: Assess ability of clinical staff to conduct preliminary assessments including risk factors for a communicable disease of public health concern. Objective 5: Assess staff ability to inform site infection control team or other staff in accordance with facility notification protocols. Objective 6 (optional): Assess the patient experience while at the site.
Threat/Hazard	[Name of Infectious/Communicable Disease]
Scenario	Patient presenting with symptoms consistent with a communicable disease of public health concern that will require identification, isolation and reporting to the local health department. [see Appendix D for detailed scenarios]
Participating Organizations	[Insert a brief summary/list of participating organizations]
Point of Contact	[Insert the name, title, agency, address, phone number, and email address of the primary exercise POC (e.g., exercise director or exercise sponsor)]

Exercise Considerations

Exercise Participants

The following are the categories of participants involved in this exercise series. Note that the term “participant” refers to all categories listed below, not just those playing in the exercise.

Important: In this drill, the mystery patient can act as the controller/evaluator.

Mystery Patient Actor (simulator): Acts as the patient at the ED or clinic site with the symptoms, history, and behaviors described in the scenario. Their role is to convincingly simulate the scenario so that staff response can be observed under realistic, unannounced conditions.

Controller/Evaluator: The controller/evaluator can be the exercise-designated “mystery patient” or an accompanying companion. The exercise controller/evaluator is responsible for data collection activities and does so in a manner that maintains the unannounced intention of the drill. The controller/evaluator provides feedback based on the exercise objectives and the EEG. The EEG captures both qualitative measures (e.g., presence of appropriate PPE, questions asked of the patient, etc.) and quantitative measures (e.g., time taken to identify the patient and isolate them, etc.)

Trusted Agents: At least one staff person at each facility will be selected to serve as a trusted agent. The trusted agent will be informed of the expected date and time of the drill and will advise the controller/evaluator of any unique considerations that should be made based on the facility itself, applicable plans, and other events that may be taking place. As the trusted agent will be employed by the facility playing in the drill, they will also retain the right to terminate the exercise if at any point they feel it is appropriate.

Players: Players are personnel at each facility (ED or clinic site) who have an active role in providing triage, care and reporting for patients presenting with symptoms consistent with a communicable disease of public health concern. Players for each drill will consist primarily of the front-line staff at each facility that are on duty at the time of the exercise.

Exercise Conduct

The drill will be unannounced and take place during normal business hours, evenings or weekends. It is acknowledged that each facility’s ED/clinic site may be experiencing above or below normal census levels and that this may inadvertently impact the conduct of the exercise. However, it is the intent of these drills to measure the facility’s ability to respond to a communicable disease of public health concern despite these circumstances. The exercise controller/evaluator may terminate the drill at any point that they feel is appropriate based on events or actions being taken by facility staff.

Safety

Participant and patient safety take precedence over exercise objectives at every point in this drill.

- Real-world emergencies always take priority over exercise play. Any participant may pause or end the drill immediately to respond to an actual emergency.
- Although these drills are unannounced, a trusted agent at each facility will coordinate activities with the exercise controller to ensure that all applicable safety and security provisions are followed.
- Each participating facility (ED/clinic site) must designate a safety point of contact (typically the trusted agent) empowered to stop the drill at any time for any safety-related reason, without needing to justify the decision in the moment.

- The trusted agent will retain the right to terminate the exercise if at any point they feel it is appropriate.
- The controller/evaluator will not request, allow, or participate in any invasive procedure, medication administration, or other action that could pose a real health or safety risk to the controller/evaluator or facility staff.
- If the controller/evaluator experiences a real medical concern during the drill (e.g., feels unwell for reasons unrelated to the scenario), the drill ends immediately and real-world care procedures apply.
- The exercise controller/evaluator may terminate the drill at any point that they feel it is appropriate given the actions being taken by facility staff, these may include (but shall not be limited to):
 - Notification to local media outlets of a possible communicable disease
 - Administering medications to the “mystery patient”
 - Performing invasive procedures, such as giving intravenous (IV) fluids or taking blood samples (venipuncture)
 - Evacuation or movement of patients in portions of the emergency department or other actions that may otherwise compromise the care of other patients in the emergency department
 - Any participant is injured, or if a real safety incident occurs during drill play
- If a real safety incident occurs, notify the trusted agent and exercise lead, and document the incident separately from the After-Action Report (AAR).
- Facility staff members are never evaluated on, or penalized for, choosing to prioritize a real patient or safety need over exercise participation.

Questions about safety protocols for a specific drill should be directed to the exercise lead identified in the Handling Instructions section.

Exercise Assumptions

The following assumptions are in play to ensure that the exercise is as realistic as possible. Events taking place during the exercise are intended to progress in a logical and realistic manner and all exercise objectives will be achieved throughout the course of exercise play.

- Exercise players are well versed in their own departmental/organizational response plans and procedures.
- Players will respond in accordance with existing plans, policies and procedures.
- Real-world response actions will take priority over exercise actions.
- The exercise controller/evaluators will present themselves in a manner consistent with symptoms of a communicable disease of public health concern.
- Symptoms described by the controller/evaluator may require some medical evaluation for triage purposes, such as vital signs, but will not require other invasive procedures (e.g., IV fluids, etc.) or medication administration.

- The exercise controller/evaluator will present themselves in a manner that will not require reimbursement to the facility for services through their personal insurance carrier. The facility should plan to delete the “mystery patient” record at the completion of the drill.

Exercise Artificialities

It is recognized that the following artificialities and constraints may detract from realism; however, exercise planners should accept these artificialities as a means of facilitating achievement of the exercise objectives:

- Exercise play and evaluation will be limited to only those items that are under the direct control of the players and the controller/evaluator.
- The exercise controller/evaluator (“mystery patient”) will be describing symptoms but will not necessarily be able to present all symptoms (e.g. fever, conjunctivitis, etc.). As such the controller/evaluator will need to describe symptoms that were experienced prior to arrival at the facility in some cases.
- The exercise will not include admission to the facility.
- The exercise will not include any means of confirmatory testing for an infectious/communicable disease.
- Controller/evaluator will confirm with the facility’s (ED or clinic site) trusted agent that any electronic medical record created for the exercise will be deleted immediately following the exercise.

Post-exercise Activities

Drill termination (ENDEX) criteria:

End the drill and proceed to hotwash once the patient has been masked and isolated, evaluated by a clinician, or the visit concludes for safety or any other reason or if none of these occur first, once the patient has been unmasked awaiting triage for at least 30 minutes, or has waited at least 60 minutes in isolation without initiation of clinical evaluation.¹

Debriefings

At the conclusion of exercise play, a controller or evaluator will lead a **Hotwash** to allow players to discuss strengths and areas for improvement, and evaluators to seek clarification

¹ These thresholds are set from the NYC’s 2026 drills time-to-clinician data (median 31 minutes, IQR 16–53) so that drills are not prematurely ended before reaching their intended endpoint; tighten only if local clinical wait times run shorter.

regarding player actions and decision-making processes. All participants may attend including the trusted agent(s). The information gathered during a hotwash contributes to the AAR and Improvement Plan (IP) and any exercise suggestions can improve future exercises.

Hotwash Questions

- How do you think this exercise went?
- What actions did you take? (Describe the actions you witnessed, see if there was anything you did not see).
- Can you walk me through what you were thinking as this unfolded? What would your next steps have been?
- What made you decide to take those actions?
- What would your next steps have been if drill was not stopped?
- Who, if anyone, did you notify/would you have notified?
 - What department are they a part of?
 - Do you know their name(s)?
- Did you suspect this was a communicable disease of public health concern?
- Is there anything you would have done differently, and why?
- Did you feel you are sufficiently familiar with your facility's communicable disease protocols to know how to respond?
- Did you know, or suspect, that this was a drill? If so, did you know about it ahead of time?
- Did you find this drill valuable?
- How could this drill be improved?
- Anything else you would like to add or comment on?

Annexes

Exercise Evaluation Guide

Exercise Evaluation Overview

This drill is unannounced and run with minimal exercise staff. The controller/evaluator (“mystery patient”) both plays the patient and collects data in real time on the Exercise Evaluation Guide (EEG) below, using notes or a mobile data-capture form.² The trusted agent at each facility is not expected to collect data beyond qualitative impressions offered during the hotwash. Completed EEGs are provided to the exercise lead for incorporation into the After-Action Report (AAR).

Target Time Methodology

Target times are adapted from the Hospital Preparedness Program (HPP) Measure Manual: Implementation Guidance for Ebola Preparedness Measures (July 2015) and validated using pooled results from prior NYC drill cycles³ (2016 and 2019). They are benchmarks for improvement planning, not “pass/fail” thresholds.

Time stamps may be collected by the controller/evaluator on paper or less conspicuously on their phone using notes or text messaging.

Table 1: Performance Measures and Suggested Target Times

Performance measure	Target time
Time from patient entry to donning a mask (initial source control implementation)	≤ 1 minute
Time from patient entry to placement in isolation room	≤ 10 minutes

Post-Exercise Evaluation and After-Action Reporting

Drill termination (ENDEX): Once the patient has been masked and isolated, evaluated by a clinician, or the visit concludes for any other reason or (if none of these occur first) the patient has been unmasked awaiting triage for at least 30 minutes or has waited at least 60

² See the toolkit for an example RedCap instrument for mobile data capture

³ Foote MM, Styles TS, Quinn CL. Assessment of Hospital Emergency Department Response to Potentially Infectious Diseases Using Unannounced Mystery Patient Drills — New York City, 2016. MMWR Morb Mortal Wkly Rep 2017;66:945–949. DOI: <http://dx.doi.org/10.15585/mmwr.mm6636a2>

minutes in isolation without initiation of clinical evaluation, the exercise controller/evaluator will inform the players that the drill has been completed.⁴

At the conclusion of the drill, the controller/evaluator will conduct a brief hotwash with clinical staff and others involved in triage, treatment, and isolation. Participation is encouraged but not mandatory, since staff members' primary responsibility is patient care. The controller/evaluator will document hotwash findings for inclusion in the AAR.

The controller/evaluator will use all data collected during and after the exercise to draft the AAR for review, finalization, and submission. The AAR will include an IP with draft recommendations for improvement, tied to specific objectives that scored 0 or 1 below.

⁴ These thresholds are set 2026 NYC drills time-to-clinician data (median 31 minutes, IQR 16.0–53) so that drills are not prematurely ended before reaching their intended endpoint; tighten only if local clinical wait times run shorter.

Exercise Evaluation Guide (EEG)

Part 1 — Drill Identification

Facility:		Date:	
Facility type: ☐ ED ☐ Outpatient ☐ UCC		Scenario:	
Controller/Evaluator:		Trusted Agent:	
Start time:		End time:	
Reason drill ended:			

Part 2 — Time-Stamp Log

Milestone	Time	Notes
Patient enters facility		
Symptom / travel screening begins		
Scenario-specific exposure question asked (see Appendix A)		
Patient masked / source control initiated		
Charge nurse / supervisor notified		
Patient placed in isolation		
Clinician evaluation begins		
Facility IPC team notified		
Health department notified / planned		

Rating Scale (used for each objective below)

Performed without challenges (2)	Objective and critical tasks completed in a manner that achieved the objective without negatively affecting other activities or deviating from applicable plans, policies, or procedures.
Performed with challenges (1)	Objective achieved, but performance negatively affected other activities, added health/safety risk, deviated from applicable

	plans/policies, or revealed a clear opportunity for improvement.
Unable to be performed (0)	Objective and critical tasks were not completed in a manner that achieved the objective.

Objective 1: Screening & Identification — Rating: ☐ 2 ☐ 1 ☐ 0

Critical task	Completed?
A. Symptom screening performed (asked about fever, cough, rash/conjunctivitis, as applicable to scenario). If yes, who performed it: ☐ Security ☐ Front desk/registration ☐ Triage/MA ☐ Kiosk ☐ Other	☐ Yes ☐ No
B. Travel history obtained	☐ Yes ☐ No
C. Scenario-specific exposure history obtained (see Appendix A for the active scenario's key questions — distinct from general travel history)	☐ Yes ☐ No ☐ Volunteered unprompted
D. Masking signage was visible at entry/waiting area	☐ Yes ☐ No
E. Masks were visibly available at entry/waiting area	☐ Yes ☐ No
Notes:	

Objective 2: Masking & Isolation — Rating: ☐ 2 ☐ 1 ☐ 0

Critical task	Completed?
A. Patient provided with a mask (source control) If yes, note mask type: ☐ Surgical/procedure mask ☐ Respirator (N95 or similar) ☐ Not provided	☐ Yes ☐ No
B. Patient offered hand hygiene	☐ Yes ☐ No
C. Patient placed in isolation room or private exam room If yes, note room type: ☐ AIIR/negative pressure ☐ Private room (non-AIIR) ☐ Curtained cubicle ☐ Hallway bed	☐ Yes ☐ No
D. Isolation precaution signage posted outside room	☐ Yes ☐ No ☐ N/A
Notes:	

Objective 3: Staff Adherence to Infection Control / PPE — Rating: ☐ 2 ☐ 1 ☐ 0

Record the highest level of respiratory protection worn. “Surgical mask” = procedure/surgical face mask; “N95/respirator” = NIOSH-certified N95 (or higher, e.g., PAPR) filtering-facepiece respirator — jurisdictions should confirm the recommended PPE per current scenario guidance.

Role	Surgical mask	N95 / respirator	Gloves	Gown	Eye protection	N/A
Front desk / reception	☐	☐	☐	☐	☐	☐
Triage nurse / medical assistant	☐	☐	☐	☐	☐	☐
Clinician (or note N/A if interviewed remotely by audio/video)	☐	☐	☐	☐	☐	☐
Notes:						

Objective 4: Clinician Risk Assessment — Rating: ☐ 2 ☐ 1 ☐ 0

Critical task	Completed?
A. Clinician identifies patient as at risk for the scenario disease, or notes need for confirmatory testing (based on patient discussion or hotwash debrief)	☐ Yes ☐ No
B. Clinician asks scenario-specific exposure questions directly (see Appendix A-1)	☐ Yes ☐ No
Notes:	

Objective 5: Notification — Rating: ☐ 2 ☐ 1 ☐ 0

Critical task	Completed?
A. Internal IPC / infection control notified or scheduled to be notified	☐ Yes ☐ No
B. Health department notification made or planned (per hotwash)	☐ Yes ☐ No

Critical task	Completed?
C. Notification followed facility's internal protocol	☐ Yes ☐ No
Notes:	

Objective 6: Patient Experience (optional — see Appendix B for full instrument)

Collecting the full patient-experience instrument (Appendix B, ~30 items covering communication, relationship-building, and patient activation) in real time while also playing the patient and tracking Objectives 1–5 is a substantial burden for a single-person controller/evaluator model. Jurisdictions with a two-person team, or those specifically prioritizing patient-experience data, can complete Appendix B. Otherwise, this objective may be skipped without weakening the core infection-control findings.

Appendix A: Scenario-Specific Exposure Screening Prompts

Use this table to identify the exposure question most specific to the active scenario, for use with Objective 1C and Objective 4B above. “Travel history obtained” (Objective 1B) captures general travel; this table captures the exposure detail that drives risk classification for a given pathogen. Evaluators should confirm whether staff asked this question or note if the patient volunteered the information unprompted.

Scenario	Key exposure question to confirm was asked
Avian Influenza A (H5)	Contact with sick or dead birds, poultry, livestock, or other mammals; contact with contaminated water, unpasteurized milk, or animal parts.
Ebola Virus Disease (EVD)	Travel to or residence in a country with an active outbreak within 21 days; direct contact with a person confirmed or suspected to have EVD, their body fluids, or their remains.
Measles	Travel to a region with an active measles outbreak; known exposure to a confirmed or suspected measles case; vaccination status.
Middle Eastern Respiratory Syndrome (MERS)	Travel to or residence on the Arabian Peninsula within 14 days; contact with camels or camel products; contact with a health care setting in an affected region.
Lassa Fever	Travel to West Africa within 21 days; contact with rodents or rodent excreta; contact with a person confirmed or suspected to have Lassa fever.
Other/novel pathogen	Consult current CDC/jurisdictional health department guidance for the pathogen-specific exposure question before the drill and insert it here.

Appendix A-1: Clinician History Gathering (Objective 4 supplemental metrics)

History Gathering	Yes	Partly Done	Not Done	Comment:
Asked about where you work				
Asked about travel (or staff did)				
Asked about close contact with someone who is sick (or with sick animal)				
Asked name and date of birth				
Asked about past medical problems				
Asked about who you live with				
Management and Treatment	Done	Partly Done	Not Done	Comment:
Reviewed care plan with you				
Asked what further questions you have				
Patient discharge plan includes appropriate infection control instructions and follows up care				
Gave information about:	Yes	Partly Done	Not Done	
How to get home (e.g. no public transit)				Comment:
follow-up care and further contact with provider				
Stay home, away from others as much as possible (including people you live with)				
Don't share personal items (towels, dishes, cups)				
When to seek further/emergency care				
Other				

Appendix B: Patient Experience Assessment (Objective 6)

Clinician Communication Skills				
Information Gathering	Done	Partly Done	Not Done	Comment:
Elicited your responses using appropriate questions				
Managed the narrative flow of your story				
Clarified information throughout by repeating to make sure they understood you				
Allowed you to talk without interrupting				
Relationship Development	Done	Partly Done	Not Done	Comment:
Communicated concern or intention to help				
Non-verbal behavior enriched communication (e.g., eye contact, posture)				
Acknowledged emotions/feelings appropriately				
Was accepting/non-judgmental				
Used words you understood and/or explained jargon				
Education and Counseling	Done	Partly Done	Not Done	
Asked questions to see what you understood (checked your understanding)				Comment:
Provided clear explanations/information				
Collaborated with you in identifying possible next steps/plan				
Organization and Time Management	Done	Partly Done	Not Done	Comment:
Managed time effectively				

Patient Focused Outcomes				
Patient Centeredness	Done	Partly Done	Not Done	Comment:
Answered questions or addressed all your concerns				
Took personal interest in you; treated you as a person				
Gave you enough information				
Made you feel you had enough time (not rushed				
Patient Activation	Done	Partly Done	Not Done	Comment:
This encounter helped you understand the nature and causes of this illness				
This encounter helped you understand how to manage the illness in the future (including how medications work and how to use them)				
Because of this encounter, you feel confident you can keep this illness from interfering too much with your life				
Because of this encounter, you feel confident you can figure out solutions if something comes up				

Clinic Environment						
	Done	Partly Done		Not Done		Comment:
Hospital staff functioned well as a team						
The atmosphere in the clinic. <i>Rated on 1 (calm) to 5 (hectic)</i>	1	2	3	4	5	

Clerical Associate				
	Done	Partly Done	Not Done	Comment:
Clerical Associate was friendly				
Clerical Associate was respectful				
Clerical Associate gave you clear instructions				

Patient Care Associate / Medical Assistant / Nurse				
	Yes	No		Comment:
Greeted you within a reasonable time frame				
Introduced self				
Acknowledged/apologized for any delays				
Asked you your name				
Asked you your date of birth				
Wore a visible name tag				
Washed/sanitized hands before touching you (observed)				
Was friendly				
Was professional				
Was respectful				
	Done	Partly Done	Not Done	
Took care to explain things to you				
Overall, were you satisfied with the way the medical assistant or nurse treated you?				

Appendix C – Debrief Drill Sign-in Sheet

Facility:	Drill Location:
Date:	Time:
Name	Title

Appendix D: Detailed Exercise Scenarios

1. **Avian Influenza H5N1:** A patient (age 21–28) presents at the facility (ED/clinic site) complaining of general malaise as well as conjunctivitis, fever, muscle aches, and a cough. The patient indicates their pink eye began the morning prior and the rest of the symptoms began overnight/the morning, in which the drill takes place. The patient had a fever of 101°F (at home) and indicates that they took a Motrin and Tylenol 1 hour before they arrived to the facility.
 - a. *The patient lives with 3 roommates, none of whom are sick. The patient has not traveled recently. If asked about sick contacts at any point during the drill by the front desk/triage/clinician, the patient will say, “does a sick bird count?”. If prompted for their story, they attempted to save a sick duck in [name of the park] Park and bring it to the Wild Bird Fund rehabilitation center. Before the patient was able to leave the park, the bird died on them. They disposed of the bird in the nearest dumpster. They were not wearing gloves and came into direct contact with this sick, ailing bird. If the patient is not asked about sick contacts at all during the drill, they will share the sick bird story with the clinician, even if unprompted.*
 - b. *For Instructions on simulating conjunctivitis, see the MPD Training slides in the toolkit.*
2. **Adult EVD:** A patient presents at the facility (ED/clinic site) and indicates that they awoke this morning experiencing fatigue and a headache and their temperature as of around 7:30AM was 102°F. After seeing their temperature, they promptly took Tylenol and the fever subsided roughly 30 minutes later.
 - a. *The patient has recently returned from Uganda, near the border with DRC’s North Kivu Province*, after providing humanitarian aid unrelated to the recent Ebola epidemic. The patient indicates they are from Connecticut, returned from Uganda 7 days ago and have traveled to the city to debrief after working with International Medical Corp (an international medical aid organization). While in Uganda, the patient was assisting with medical care in a refugee camp, but not in an Ebola Treatment Unit.*

**Use location with current cases or outbreak*
3. **Pediatric EVD:** A 17-year-old **patient** presents at the emergency department and indicates that they are not feeling well. Their symptoms include headache and fatigue and that they thought they may have had a fever but had already taken Tylenol for the headache.

- a. *The patient indicates that they recently returned home to Connecticut from [area of current outbreak] roughly 10 days ago where they were doing missionary work. The patient indicates that their parents work in Connecticut and they have been unable to reach them by cellular phone. *Consider using medical students as actors and an adult controller as an escort.*
- 4. **Adult and pediatric measles:** A patient presents to the facility and states that approximately 4 days ago they started experiencing fevers (if asked, max 104°F) and subsequently also developed a runny nose and dry cough. Two days ago a rash appeared, starting on their face and spreading down the neck and chest. The patient recently returned from Poland 2 weeks ago where they had also visited family.
 - a. *Notes: if they take patient's temperature, the patient should say they took Tylenol a few hours ago and if they ask if they received their childhood measles shot; the patient should say they do not know.*
 - b. *For Instructions on measles rash moulage, see the MPD Training slides in the toolkit.*
- 5. **Adult MERS:** A patient presents at the facility complaining of malaise, fever and flu-like symptoms. The patient indicates they started feeling ill about 4–5 days ago but started to feel worse in the past 12–24 hours and have now developed a cough and some shortness of breath.
 - a. *The patient indicates that they recently spent roughly 2 weeks in Riyadh, Saudi Arabia doing Life Safety consulting work through the Ministry of Health for some newly designed hospitals. During that trip they spent time visiting hospitals. The patient returned 4 days ago and other than some gastrointestinal issues (likely due to food) the patient indicates they had no illness while in Riyadh. The patient has since stayed at home in their apartment; however, they came to the hospital after they started experiencing worsening cough, experiencing shortness of breath and over-the-counter medications stopped alleviating symptoms.*
- 6. **Pediatric MERS:** A patient presents at the emergency department complaining of malaise, fever, and flu-like symptoms. The patient indicates they started feeling ill about 4–5 days ago but started to feel worse in the past 12–24 hours and have now developed a cough and some shortness of breath.
 - a. *The pediatric patient presents to an emergency department with an adult parent or caregiver. The patient or caregiver informs emergency department staff they recently spent 2 weeks in Riyadh, Saudi Arabia with their parent where they were working as a consultant for a surgical equipment manufacturer. The patient returned to the United States traveling through JFK airport and started to feel unwell. The patient has been staying home, but the symptoms began to worsen.*

The patient is experiencing a worsening cough, experiencing shortness of breath, and over-the-counter medications stopped alleviating symptoms.

**If an individual is unable to act as a parent, the patient can state that their parent had to stay in Riyadh for work and the patient returned home to return to school.*

7. **Adult Lassa Fever:** A patient presents to the emergency department. The patient indicates that they have had a headache and fever of 103°F (managed by Tylenol currently), general weakness and malaise over the past few days and today they have begun to experience a headache, dry cough, sore throat, nausea and chest pain.
 - a. *The patient indicates that they have just returned from Nigeria 5 days ago after conducting missionary work in various parts of Nigeria over the past month, including rural areas staying in basic accommodations. If prompted, they did notice rodents in and around one of the rural accommodations they stayed in.*

Appendix E: Acronyms

Acronym	Definition
AAR	After-Action Report
AIIR	Airborne infection isolation room (negative pressure room)
ED	Emergency department
EEG	Exercise Evaluation Guide
ENDEX	End of exercise (drill termination point)
EVD	Ebola virus disease
EXPLAN	Exercise Plan
FOUO	For Official Use Only
H5N1	Avian influenza A (H5N1)
HHS-ASPR	U.S. Department of Health and Human Services, Administration for Strategic Preparedness and Response
HPP	Hospital Preparedness Program
IP	Improvement Plan
IPC	Infection prevention and control
IV	Intravenous
MERS	Middle East Respiratory Syndrome
N95	NIOSH-certified N95 (or higher) filtering-facepiece respirator
NYC-MPD	New York City Mystery Patient Drill
POC	Point of contact
PPE	Personal protective equipment
RESPTC	Regional Emerging Special Pathogen Treatment Center
SAG	Stakeholder Advisory Group
UCC	Urgent care center

Jurisdictions adapting this toolkit should add or remove entries to match locally used terminology.