Interim Mpox Case Contact Monitoring Guidelines for Local Health Departments
Updated January 2024

Since May 2022, multiple cases of mpox (formerly known as monkeypox) have been reported in countries that don't normally report mpox, including the United States. There are two types of mpox virus: Clade I and Clade II. Clade IIb is the virus type currently circulating in the United States. This guidance is being provided to local health departments to be used for monitoring contacts of probable and confirmed mpox cases, as defined in the CDC Case Definition for 2022 Monkeypox Response.

The Democratic Republic of Congo (DRC) is currently experiencing an mpox outbreak caused by Clade I Monkeypox virus (MPXV). Clade I MPXV has previously been observed to be more transmissible and to cause more severe infections that Clade II. Local health departments should notify NJDOH CDS of any mpox cases with a history of travel to DRC in the 21 days prior to symptom onset. Contact monitoring guidance may vary from guidance below if an mpox case caused by Clade I MPXV is identified in New Jersey.

Exposure Assessment

Once an individual meets probable or confirmed laboratory criteria for case definition (by testing positive for orthopoxvirus or mpox virus), prompt contact tracing should be conducted. Transmission of mpox typically requires prolonged close contact with a symptomatic individual. CDC has guidance for individuals who are sick (https://www.cdc.gov/poxvirus/mpox/if-sick/what-to-do.html), including information on notifying close contacts. CDC also has guidance for healthcare settings online. A summary can also be found below in the Mpox Risk Assessment and Public Health Response Table. While the CDC information and table below serves as a guideline, the exposure risk level of any incident may be recategorized to another risk level at the discretion of public health authorities or clinicians due to the unique circumstances of each exposure incident.

Outside of healthcare settings, close contacts may be anyone who was exposed to a person with mpox through:

- Having sex, including oral, anal, or vaginal sex.
- Touching or coming in close contact with the rash of a person with mpox
- Being hugged, cuddled, kissed, or having other prolonged skin-to-skin contact
- Sharing cups, utensils, towels, clothing, bedding, blankets, or other personal objects and materials used by someone with mpox.

Local health departments should obtain a thorough history from the mpox case on symptom onset, locations that the case visited, healthcare received, and people that may have been exposed while the case was infectious. People who may have been exposed through any of the above activities include:

- Sex partners
- People who share living quarters (family members, roommates or overnight guests)

- Anyone who may have had prolonged skin-to-skin contact at a meeting, gathering or get-together
- People who may have played contact sports with the infected person
- Healthcare personnel, including dentists
- People who have provided services to the patient such as housekeepers, barbers/salon workers, massage therapists, or other personal care providers
- People with whom the person works or volunteers outside the home

Persons with mpox are considered infectious from 1-4 days prior to the onset of symptoms through resolution of the rash (i.e., shedding of crusts and observation of healthy pink tissue at all former lesion sites).

Once close contacts have been identified, LHDs should assess the type of exposure that occurred to determine the degree of exposure, provide public health recommendations, and document findings in CDRSS. NJDOH is available to assist LHDs with risk assessment and public health recommendations. If multiple cases are reported with common exposures (such as exposure at an event where other individuals may have been exposed to mpox), LHDs should notify their regional epidemiologist.

Mpox Exposure Risk Assessment and Public Health Response Table: Exposure in a Healthcare Setting

Exposure Risk Group	Description of exposure	Post-exposure prophylaxis (PEP)
Higher	1. Unprotected contact between an exposed individual's broken skin or mucous membranes and the skin lesions or bodily fluids from a patient with mpox (e.g., inadvertent splashes of patient saliva to the eyes or mouth of a person), or soiled materials (e.g., linens, clothing) -OR- 2. Being inside the patient's room or within 6 feet of a patient with mpox during any medical procedures that may create aerosols from oral secretions (e.g., cardiopulmonary resuscitation, intubation), or activities that may resuspend dried exudates (e.g., shaking of soiled linens), without wearing a NIOSH-approved particulate respirator with N95 filters or higher and eye protection	Recommended
Intermediate	1. Being within 6 feet for a total of 3 hours or more (cumulative) of an unmasked patient with mpox without wearing a facemask or respirator -OR- 2. Unprotected contact between an exposed individual's intact skin and the skin lesions or bodily fluids from a patient with mpox, or soiled materials (e.g., linens, clothing) -OR- 3. Activities resulting in contact between an exposed individual's clothing and the patient with mpox's skin lesions or bodily fluids, or their soiled materials (e.g., during turning, bathing, or assisting with transfer) while not wearing a gown	Clinical determination based on individual risk/benefit
Lower	1. Entry into the contaminated room or patient care area of a patient with mpox without wearing all recommended personal protective equipment (PPE), and in the absence of any exposures above	None
No risk	No known contact with the patient with mpox, their contaminated materials, nor entry into the contaminated patient room or care area	None

Monitoring Healthcare Workers: Decisions on how to monitor exposed healthcare providers for 21 days after mpox exposure are at the discretion of the occupational health program and public health authorities. LHDs should work with occupational health/infection prevention at the facility to determine a plan for symptom monitoring. In general, the type of monitoring employed often reflects the risk for transmission with more active-monitoring approaches used for higher risk exposures. Self-monitoring approaches are usually sufficient for exposures that carry a lesser risk for transmission. Even higher risk exposures may be appropriate for a self-monitoring strategy if occupational health services or public health authorities determine that it is appropriate. Ultimately, the person's exposure risk level, their reliability in reporting symptoms that might develop, the number of persons needing monitoring, time since exposure, receipt of PEP, and available resources, are all factors when determining the type of monitoring to be used.

Contact Monitoring

Exposed healthcare providers:

LHDs should work with infection control and/or occupational health to coordinate symptom monitoring in healthcare facilities. Additional recommendations from CDC can be found here: Infection Control: Healthcare Settings | Mpox | Poxvirus | CDC. Correct and consistent use of PPE when caring for a patient with mpox infection is highly protective and prevents transmission to healthcare providers. However, unrecognized errors during the use of PPE may create opportunities for transmission to healthcare providers. In the absence of an exposure described in the table above, healthcare providers who enter a contaminated patient room or care area while wearing recommended PPE should be aware of the signs and symptoms of mpox, and if any signs or symptoms develop, they should notify occupational health services for further evaluation and should not report to work.

The healthcare facility should notify public health immediately should any symptoms develop in exposed healthcare providers and provide routine monitoring updates as requested.

Community Contacts:

LHDs should create an mpox case in CDRSS for all contacts that require symptom monitoring. If a NJ resident was exposed to a NJ mpox case, the contacts should be linked to the index NJ mpox case in CDRSS. Contacts should be monitored for 21 days after their last exposure. Signs and symptom information can be found here.

On the initial call to contacts, LHDs should:

1. Verify contact information and ask if the contact prefers to be subsequently contacted by telephone, text, or email. Symptom monitoring can be conducted by phone, video conferencing, other electronic means (e.g., text message, email, app, web form), or in person.
2. Provide contact with a 24/7 LHD contact number to call if mpox symptoms develop.
3. Advise contact that if mpox symptoms develop, they should isolate immediately, notify the LHD, and if they need medical care to call the healthcare provider in advance to tell them about their exposure history. If medically appropriate, the healthcare provider may see the individual "virtually." Should emergent care be needed, the contact should call 911 and tell them about their exposure history.
    a. If a rash develops, the individual should follow isolation and prevention practices until (1) the rash can be evaluated by a healthcare provider, (2) testing is performed, if recommended by their healthcare provider, and (3) results of testing are available and negative.
    b. If the individual develops a new rash or other mpox symptoms, they should see a healthcare provider. They should stay away from other people and avoid sharing items with others until they see a healthcare provider. The individual should be instructed to cover all parts of the rash with clothing, gloves, or bandages when seeking care, wear a mask, and let the healthcare provider know they may have mpox.
4. Educate contact to self-monitor for fever (greater than or equal to 100.4°F or 38°C) and other mpox symptoms twice daily for 21 days following their last exposure. If the contact does not have a thermometer, the LHD should provide an FDA-approved thermometer.
5. LHDs should check in with contacts on day 10-11 and then at day 21 to ensure that the contact doesn't have symptoms of mpox. LHDs should document this check-in and document symptom monitoring data/temperatures in CDRSS in the Mpox Monitoring Section. LHDs can opt to implement more frequent monitoring.
6. Advise contact that if they plan on leaving NJ to continue their self-monitoring outside of NJ, to notify the LHD and provide the date(s) and out-of-state address and phone number if different. LHDs should also ask if the person has planned airline travel and obtain flight information. LHDs should include relocation information, including air travel plans in CDRSS Comments and notify the CDS Regional Epidemiologist, providing the CDRSS case ID#.

PEP

Vaccination with JYNNEOS after a mpox exposure may help prevent the disease or make it less severe. CDC recommends that the vaccine be given within 4 days from the date of exposure in order to prevent the onset of the disease. If given between 4–14 days after the date of exposure, vaccination may reduce the symptoms of disease, but may not prevent the disease. Information on the vaccines that can be used for mpox post-exposure prophylaxis (PEP) can be found here. LHDs should coordinate PEP for close contacts when it is indicated. LHDs who do not already have JYNNEOS vaccine should contact their LINCS agency to get JYNNEOS vaccine for PEP administration to close contacts. LHDs may also contact vax.operations@doh.nj.gov about ordering JYNNEOS vaccine.

Movement Restriction

Contacts who remain asymptomatic can be permitted to continue routine daily activities (e.g., go to work, school). Contacts should not donate blood, cells, tissue, breast milk, semen, or organs while they are under symptom monitoring. LHDs should contact NJDOH if contacts plan to travel out of state for the remainder of their monitoring period so that they can be transferred to the appropriate jurisdiction.

Contacts who develop mpox compatible symptoms

If a contact under monitoring notifies the LHD that they are ill, or if the LHD is notified by a healthcare provider that the contact under monitoring sought medical care, the LHD should collect information on symptoms, onset, severity, and progression and document them in CDRSS. LHDs should also document if laboratory testing is pending for the individual in the case comments. LHDs may contact CDS for assistance.

CDS Contact Information

Contact Information:

Healthcare providers *should contact their LHDs.*
Business hours and after hours contact information for LHDs is posted online: www.localhealth.nj.gov

LHD*s should consult with their CDS epidemiologist during business hours and*
call the CDS After-hours emergency number at 609-392-2020 in evenings and on weekends.

Resources

mpox (nj.gov)
2022 Outbreak Cases and Data | Mpox | Poxvirus | CDC
Infection Control: Healthcare Settings | Mpox | Poxvirus | CDC
Isolation and Infection Control At Home | Mpox | Poxvirus | CDC
What to Do If You Are Sick | Mpox| Poxvirus | CDC
If You're a Close Contact | Mpox | Poxvirus | CDC