

## Virginia Department of Health

# FAQs about Monkeypox for Local Health Districts and Healthcare Providers

### Monkeypox Transmission

#### 1. How common is monkeypox transmission due to surface contamination?

From an epidemiologic perspective, it can be very difficult to tease apart fomite transmission (indirect contact) vs. direct contact. So far, we have no clear evidence of transmission associated with this outbreak occurring through indirect transmission. It is thought that indirect transmission might be less effective than direct transmission.

Per the CDC, [during the 2022 global monkeypox outbreak](#), direct skin-to-skin contact (including sexual and/or close intimate contact), has been the predominant type of exposure for those with monkeypox in the United States.

#### 2. How long can monkeypox live on surfaces?

Per the CDC, one study showed that monkeypox live virus was found 15 days after a patient's home was left unoccupied. Other studies have shown that similar viruses can survive in a household for weeks or months. Porous materials like bedding and clothing may harbor live virus for longer than non-porous materials like plastic, metal, and glass. For more information, visit [CDC Disinfecting Home and other Non-Healthcare Settings](#).

#### 3. What cleaning products can kill the monkeypox virus present on contaminated bedding and towels?

For more information on EPA-registered disinfectants for monkeypox, please refer to: [CDC Guidance on Disinfecting Home and Other Non Health Care Settings](#) and the list of [EPA registered disinfectants](#).

#### 4. Is asymptomatic transmission of monkeypox possible?

There is no evidence of asymptomatic transmission to date, however, this is an area of ongoing investigation.

#### 5. Is respiratory transmission a big concern?

Respiratory transmission is not considered a major mode of transmission, but the degree of respiratory transmission is still under investigation. Please refer to [CDC Monkeypox: How it Spreads](#) for more information. Per the CDC, [during the current monkeypox outbreak](#), transmission has not been reported during brief encounters (such as a short conversation) or between people in close proximity and for a long duration (such as an airplane ride), or during health care encounters. For healthcare setting guidance on precautions for patients with monkeypox, please see [CDC Guidance on Monkeypox Infection Control: Healthcare Settings](#).

**6. What are the recommendations for monkeypox prevention in schools and child care facilities?**

Please see the CDC's [Monkeypox Guidance for Schools, Early Care and Education Programs, and Other Settings Serving Children or Adolescents](#) and [Information Sheet for Teens and Young Adults](#), and VDH's [What K-12 Schools Need to Know about Monkeypox](#) and [Template Letter for Monkeypox Notification for K-12 Schools](#).

**7. What is the risk of transmission in public pools?**

Pools are not considered a high risk environment for monkeypox transmission at this time.

**8. Can a person be infected more than once with monkeypox?**

Per the [CDC Monkeypox Updates \(6/29/22\)](#), the possibility of reinfection in the current monkeypox outbreak is unclear and this is still an area of ongoing investigation. It is thought that those infected with *Monkeypox virus* will develop some degree of protective immunity.

**9. How should waste be managed during the monkeypox outbreak?**

Please refer to [CDC Monkeypox Infection Control: Healthcare Settings](#) and [VDH Monkeypox Infection Prevention and Control Recommendations for Healthcare Settings](#).

**10. If a child is diagnosed with monkeypox - should they be quarantined from school and for how long?**

VDH recommends that people with monkeypox remain isolated for the duration of illness. Current data suggest people can spread monkeypox from the time symptoms start until all symptoms have resolved, including full healing of the rash with formation of a fresh layer of skin.

For more information, please see

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/isolation-procedures.html>.

**11. Are there special considerations for athletic teams in a school setting with equipment or close contact sports such as wrestling?**

It's possible that older children who participate in close contact sports, such as wrestling, may be at increased risk of monkeypox compared to children who don't engage in these activities. However, the vast majority of monkeypox cases have been spread through sexual contact. General infection prevention and control principles apply to close contact sports. Athletes should avoid sharing clothing, towels, uniforms, etc. If athletes develop symptoms consistent with monkeypox including general viral symptoms and/or a skin rash, they should be evaluated promptly by a healthcare provider including testing the rash, if needed. If a student athlete develops monkeypox, they should isolate at home until all skin lesions have scabbed over, all scabs have fallen off, and fresh healthy skin has formed.

**12. As a school nurse, how concerned should I be about monkeypox in schools?**

At this time, the risk of monkeypox to children and adolescents is low according to CDC. The risk of a monkeypox outbreak in the school setting is low. CDC has a [webpage](#) with frequently asked questions regarding schools that provides general monkeypox information. While the risk of monkeypox infection is low in children, they are capable of contracting the illness primarily through close physical and skin to skin contact with someone who has the illness. Monkeypox can also be transmitted through contaminated objects that children may use such as toys, eating utensils, clothing, bedding, sleeping mats, towels, etc.

If a child, teacher, or staff member has a rash that is concerning or consistent with monkeypox, the individual is advised to see a healthcare provider for further evaluation. The rash of monkeypox can be nonspecific in appearance and resemble that of chickenpox, herpes, hand, foot, and mouth disease, allergic skin disease and other common illnesses that are not monkeypox. If needed, the rash can be tested to see if the individual has monkeypox.

Students, teachers, or staff who have monkeypox are advised to isolate for the duration of the illness—until all skin lesions have crusted over, all scabs have fallen off, and a fresh layer of healthy skin has formed. This process can take several weeks.

## Diagnosis and Testing

- 13. The diagnosis and testing for confirmation presents a challenge given multiple mimics of its presentation - herpetic whitlow in acral presentation, folliculitis, shingles. Any practical recommendation on how to handle patients who present with such in our clinics? Patients usually show rashes only after they have been admitted into the offices and clinics already.**

Health care providers might consider adding "rash" to your screening questions on entry/registration. (For COVID-19, many places still ask about travel history).

- 14. When obtaining a swab for testing, does it have to be from open lesions or can intact lesions be swabbed? Does the swab have to be from secretions from a lesion? If a patient only has 1 lesion, would you recommend getting 2 samples of the same lesion or is just 1 sample ok?**

Per [CDC Guidance](#), it is not necessary to de-roof or lance the lesion before swabbing. The recommended specimen type is material collected from the surface of a lesion or crust from a healing lesion. Swab the surface of the lesion vigorously to collect adequate DNA.

Two swabs from each lesion (in general, 2-3 lesions should be sufficient) should be collected for testing. Using two sterile synthetic swabs (including, but not limited to polyester, nylon, or Dacron) with a plastic, wood, or thin aluminum shaft, swab the lesion vigorously to collect adequate DNA. Do not use cotton swabs. For more information, please refer to [CDC Monkeypox Preparation and Collection of Specimens](#) and [CDC Update for Clinicians on Testing and Treatment for Monkeypox](#).

- 15. Can the monkeypox lesions be internal or are they only external on the body?**

The lesions of monkeypox can be present both externally on the skin and internally in other parts of the body. For example, monkeypox lesions can be found in the mouth, the anal canal, the urethra, and other internal parts of the body. Monkeypox can also cause swollen lymph nodes that are located in various parts of the body.

**16. Is testing possible from oral lesions (not saliva or spit) but rather from oral ulcerations?**

According to CDC, skin lesion material, including swabs of lesion surface, exudate, or lesion crusts are the recommended specimen types for laboratory testing of monkeypox virus specimens. CDC doesn't specifically mention testing oral lesions or ulcers. Please see CDC's webpage [Guidelines for Collecting and Handling Specimens for Monkeypox Testing](#).

**17. How detrimental to the fetus is monkeypox?**

Monkeypox infection in a pregnant individual can lead to serious pregnancy outcomes such as spontaneous pregnancy loss, stillbirth, preterm labor, or neonatal infection. The frequency and risk factors for these outcomes is unknown. Data on monkeypox infections during pregnancy are limited.

**18. Can you speak to the pediatric population regarding monkeypox?**

In general, data about monkeypox disease in children is more limited than in adults. Monkeypox is transmitted in children in essentially the same manner as adults and children with monkeypox have symptoms and signs that are similar to adults. Monkeypox can be transmitted to the fetus during pregnancy or to a newborn during close contact after birth. In children less than 8 years of age who have clade I monkeypox, there is evidence that the disease can be more severe. According to CDC, data on the potential complications of infections in children with Clade II monkeypox are lacking.

As in adults, the rash and/or skin lesions of monkeypox in children can be confused with other illnesses such as chickenpox, molluscum contagiosum, herpes, drug reactions, allergic skin reactions, scabies, measles, hand, foot, and mouth disease, and syphilis. If needed, children should be tested for monkeypox and questions should be asked to see if the child meets epidemiologic criteria for monkeypox. Just like with adults, a suspected or confirmed case of monkeypox in a child should be reported immediately to the local health department.

Most cases of pediatric monkeypox will resolve on their own without treatment. Treatment with tecovirimat (brand name = TPOXX) should be considered for children or adolescents with severe disease, those with complications (pneumonia, sepsis, etc.) from monkeypox, and children and adolescents who are at risk of severe disease. Medical conditions that put a child or adolescent at risk of more severe disease include: age less than 8 years, those with immunocompromising conditions, those with a history or presence of atopic dermatitis or exfoliative skin conditions, and those with infections of the eyes, face, or genitals.

Jynneos vaccine can be offered to children or adolescents less than 18 years of age under an expanded access investigational new drug (EA IND) authorization from the FDA. Medical providers interested in obtaining Jynneos for their pediatric patients should contact their local or state health department for assistance.

More information about monkeypox in children can be found on the CDC website [Clinical Considerations for Monkeypox in Children and Adolescents](#).

**19. I have a lot of hand, foot and mouth disease right now in school. How can we differentiate between the two?**

The risk of children getting infected with monkeypox virus is low. Monkeypox typically spreads through close, personal, often skin-to-skin contact and not through casual contact. Risk of infection is more likely for household members and other close contacts of an infected person.

The rash from monkeypox can look similar to other illnesses, including hand, foot, and mouth disease. Clinicians should consider testing for children, if they have a history of close, personal contact with an individual with confirmed or probable monkeypox.

## Vaccination

**20. Where can we find additional guidance for JYNNEOS administration (Dosing schedule, route of administration, etc.)?**

Please refer to the [CDC Interim Clinical Considerations for Use of JYNNEOS](#) and the [Fact Sheet for Healthcare Providers for EUA of JYNNEOS](#).

**21. Where can local health districts (LHDs) and providers administering JYNNEOS vaccine obtain additional needles and syringes required for intradermal administration?**

VDH is currently assessing the resources required for intradermal administration of JYNNEOS and will be providing additional guidance to LHDs and providers on training, supplies, and systems needed for intradermal administration as soon as possible. For more information, including the type of needle needed for intradermal injection, please visit [CDC Vaccine Preparation and Administration Summary](#).

**22. How long can an open vial of JYNNEOS stay out before it can no longer be used?**

Once thawed, vaccine vials that are not currently being used should be placed in the refrigerator between 2°C and 8°C (36°F and 46°F). Do NOT refreeze the thawed vaccine. Use beyond-use date labels for this vaccine to track storage times.

- Beyond-use date/timing:
  - **Refrigerator:** Between 2°C and 8°C (36°F and 46°F).
    - *Unpunctured* vials may be stored in the refrigerator for up to 8 weeks.
    - *Punctured* vials may be stored continuously in the refrigerator for up to 8 hours.
  - **Room temperature:** Between 8°C and 25°C (46°F and 77°F).
    - *Unpunctured* vials may be held at room temperature for up to 6 cumulative hours.
    - There is not sufficient storage data for punctured vials at room temperature; it is recommended that punctured vials go back in the refrigerator, if using as a multi-dose vial.

This information has been provided by the vaccine manufacturer based on available supportive stability data. Please be aware that this differs from the [JYNNEOS package insert](#). For more information, see the [JYNNEOS EUA](#) and [CDC Vaccine Preparation and Administration Summary](#).

**23. Should LHDs and providers use the JYNNEOS vaccines that were initially received as a single dose?**

VDH recommends following [CDC Clinical Considerations](#) for vaccine dosing. If someone is eligible for a second dose, they should receive it. The authorized alternative regimen involves an intradermal (ID) route of administration with an injection volume of 0.1mL. This approach could increase the number of available JYNNEOS vaccine doses by up to five-fold. For more information on ID JYNNEOS use, visit [CDC JYNNEOS Vaccine](#).

**24. What protection do those previously vaccinated against smallpox have? Should they still be vaccinated if otherwise eligible? Can titers be obtained to determine if those previously vaccinated with smallpox vaccine require vaccination?**

Because *Monkeypox virus* is closely related to the virus that causes smallpox, the smallpox vaccine can protect people from getting monkeypox. Past data from Africa suggests that the smallpox vaccine is [at least 85% effective](#) in preventing monkeypox. The effectiveness of JYNNEOS against monkeypox was concluded from a clinical study on the immunogenicity of JYNNEOS and efficacy data from animal studies.

Although there may be some protection afforded by the prior smallpox vaccination, it is not clear how long it lasts. There have been reports of people in past or current outbreaks getting monkeypox even if they were previously vaccinated against smallpox.

There are no current recommendations around using titer testing for those previously vaccinated against smallpox to determine if monkeypox vaccination is needed or not. The CDC recommends that eligible people consider getting vaccinated, [if they have not received the smallpox vaccination in the last 3 years](#). For more information on who is recommended to receive the vaccine, visit the CDC [Interim Clinical Considerations](#).

**25. Does an individual under age 18 need parental permission for the JYNNEOS vaccine even if it is part of an STI visit?**

**For vaccination of minors, parental consent is required.** The single-patient IND requiring FDA authorization prior to administration in children <18 years of age is **no longer necessary** with FDA's issuance of the [Emergency Use Authorization \(EUA\) for JYNNEOS](#) that was [August 9, 2022](#). Please refer to the [Fact Sheet for Healthcare Providers](#) regarding JYNNEOS administered subcutaneously as two doses (0.5 mL each) 4 weeks apart in children <18 years of age. The FDA-required informed consent form that was previously used for single-patient IND is **no longer required**; however, parental consent is still required prior to vaccination. Provide the [Fact Sheet for Recipients and Caregivers](#) to parents/guardians/recipients.

Vaccination providers should report adverse events and vaccine administration errors to [VAERS](#) as described in the [Fact Sheet for Healthcare Providers](#) (i.e., vaccine administration errors

whether or not associated with an adverse event, serious adverse events irrespective of attribution to vaccination, cases of cardiac events including myocarditis and pericarditis, and cases of thromboembolic events and neurovascular events).

**26. With Jynneos approval for <18yo, what is the age range?**

The US Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for the emergency use of JYNNEOS by subcutaneous injection for prevention of monkeypox disease in individuals less than 18 years of age determined to be at high risk for monkeypox infection. No minimum age has been listed. The EUA also allows immunization by intradermal injection for prevention of monkeypox disease in individuals 18 years of age and older determined to be at high risk for monkeypox infection.

**27. Any guidance on error if intradermal (ID) administration given to <18 years old?**

CDC provides guidance on monkeypox vaccine administration errors and deviations at <https://www.cdc.gov/poxvirus/monkeypox/interim-considerations/errors-deviations.html>.

The vaccination provider must report all serious adverse events and vaccine administration errors to the Vaccine Adverse Event Reporting System (VAERS) by submitting online at [vaers.hhs.gov/reportevent.html](https://vaers.hhs.gov/reportevent.html).

**28. Are laboratory testing personnel and healthcare professionals eligible for PrEP?**

Pre-Exposure Prophylaxis (PrEP) is recommended for those whose jobs may put them at risk for orthopoxviruses, including monkeypox, based on [CDC recommendations](#). At this time, **most clinicians in the United States and laboratorians not performing the orthopoxvirus generic test to diagnose orthopoxviruses, including monkeypox, are not advised to receive orthopoxvirus Pre-Exposure Prophylaxis (PrEP)**. Laboratorians should consult with laboratory biosafety officers and supervisors to identify risks and precautions, depending on the type of work they are doing. Any vaccination given for PrEP **must be approved by the CDC prior to administration**. For more information, visit, CDC [Monkeypox Vaccine Guidance](#) for PrEP guidance. Additionally, clinicians and laboratorians should use recommended infection control practices.

**29. Can individuals with monkeypox get vaccinated?**

No. Individuals who are positive for monkeypox are not eligible for vaccination. However, individuals who have been exposed to monkeypox virus may be eligible for vaccination. For more details, please see [CDC Interim Clinical Considerations](#).

**30. Can immunocompromised individuals receive JYNNEOS vaccines?**

Yes, if they otherwise meet criteria for vaccination as per the [CDC Interim Clinical Considerations for Use of JYNNEOS and ACAM2000 Vaccines during the 2022 U.S. Monkeypox Outbreak](#).

**31. Will vaccination strategies or distribution change as colleges and universities start back up for fall semester?**

We expect the groups eligible for "extended PEP" will change and expand as the outbreak evolves and more doses of vaccine become available. Right now we are still focused on high risk populations and people with high risk exposures.

**32. Would VDH consider recommending the vaccine for pre-exposure prophylaxis for patients with HIV in light of the recently reported high incidence of monkeypox in patients with HIV? Perhaps distributed through Ryan White clinics?**

Yes, on September 26, VDH expanded the monkeypox vaccine eligible population to include people of any sexual orientation or gender who are living with HIV/AIDS OR have been diagnosed with any sexually transmitted infection in the past three months. People in this category would receive the Jynneos vaccine series as part of the expanded PEP (also known as PEP ++ ) criteria rather than for pre-exposure prophylaxis (PrEP).

**33. What is the cost of vaccines?**

For people who meet current VDH eligibility criteria for Jynneos vaccine given for postexposure prophylaxis (PEP) or for expanded postexposure prophylaxis (also known as PEP ++), the vaccine doses and administration are free of charge. Due to the limited availability of Jynneos doses, VDH requires proof of Virginia residency to receive the monkeypox vaccine; however, exceptions may be made on a case-by-case basis.

**34. Will we get guidance on how to administer JYNNEOS as ID? (Amount to pull, location, how do you know if successfully given, expected results, etc.)**

Yes. Training was previously provided about intradermal immunization using Jynneos by the Virginia Department of Health (VDH). VDH has a [webpage about Jynneos intradermal administration](#). VDH also has a [Jynneos intradermal administration training checklist](#) and a [Jynneos intradermal administration job aid](#).

**35. What is the anticipated threshold when Healthcare Providers will need to consider vaccination (NOT in the situation of/for post-exposure)?**

Currently, CDC recommends immunization with the Jynneos vaccine series for three specific groups of healthcare workers to protect them if they are exposed to an orthopoxvirus. The groups include:

- Clinical laboratory personnel who perform testing to diagnose orthopoxviruses, including those who use polymerase chain reaction (PCR) assays for diagnosis of orthopoxviruses, including *Monkeypox virus*, and
- Research laboratory workers who directly handle cultures or animals contaminated or infected with orthopoxviruses that infect humans, including *Monkeypox virus*, *replication-competent Vaccinia virus*, or *recombinant Vaccinia viruses derived from replication-competent Vaccinia virus strains*, and
- Certain healthcare and public health response team members designated by public health authorities to be vaccinated for preparedness purposes

CDC also notes that people who can get PrEP if they want to receive it include healthcare personnel who administer ACAM2000 or anticipate caring for many patients with monkeypox

Other than for the groups above, CDC doesn't recommend routine Jynneos vaccination for healthcare personnel at this time. Please see CDC's website about [Monkeypox and Smallpox Vaccine Guidance](#) and VDH's website about monkeypox [Vaccine Guidance](#) for more information.

**36. Are you advertising in any way to sex workers to come in and get the monkeypox vaccine?**

Currently, VDH central office is not advertising specifically to sex workers to get the monkeypox vaccine. It's possible that local health districts may be reaching out to sex workers in their respective communities in an attempt to encourage them to get vaccinated with Jynneos. VDH central office has placed general monkeypox posts on dating apps. When these posts are clicked, it takes the reader to a VDH monkeypox webpage.

**37. Do you anticipate an increase in preventative immunizations for the general population as the vaccine supply increases?**

At this time, the risk of monkeypox infection in the general public is felt to be low. Therefore, there is no recommendation at this time for the general public to be vaccinated against monkeypox. Currently, we are not aware of a plan for immunization of the general public as the supply of vaccine increases. Outbreaks are fluid events, however, and if the characteristics of this situation changes, this may lead to discussion about whether to expand the recommendations for immunization.

## **Treatment**

**38. Are there any age restrictions for the use of TPOXX for the treatment of monkeypox?**

TPOXX is authorized for use in patients of any age. Dosing will vary based on the patient's weight. Refer to the [Expanded Access Investigational New Drug protocol](#) for additional eligibility and dosing information.

**39. Can TPOXX be used during pregnancy and breastfeeding?**

The CDC recommends prioritizing treatment of pregnant and breastfeeding women with monkeypox with TPOXX since they are at higher risk of complications from the disease. More information about monkeypox in pregnancy and breastfeeding can be found at [CDC Clinical Considerations for Monkeypox in People Who are Pregnant or Breastfeeding](#).

**40. How soon after the starting of treatment does documentation for CDC need to be completed?**

Providers have up to 7 days after treatment initiation to return required paperwork to the CDC. Detailed guidance on obtaining and using TPOXX can be found online: <https://www.cdc.gov/poxvirus/monkeypox/clinicians/obtaining-tecovirimat.html>

#### 41. What is prescribed for monkeypox for pain? Tylenol or something stronger?

There are a number of options for the pain from monkeypox lesions. First, the illness can be treated with the antiviral drug tecovirimat (brand name is TPOXX) so that the lesions will heal faster. Second, over-the-counter pain medicines, such as acetaminophen (Tylenol) and ibuprofen (Motrin and others) can be used. In cases where more severe pain is present, consideration can be given to using prescription pain medicine such as opioids. If opioids are used, typically this would be a lower potency medication that is only used for a short period of time. Patients need to be counseled about the use of the medication along with potential side effects including the possible development of dependence.

For more information, see [CDC's Clinical Considerations for Pain Management of Monkeypox](#).

### Long Term Care Facilities (LTCFs)

#### 42. How can monkeypox be transmitted in long-term care facilities (LTCFs)?

Close skin-to-skin or mucosal contact with a person who is symptomatic with monkeypox, or close contact with oral secretions of a person who is **symptomatic** with monkeypox, can lead to transmission.

A resident of a LTCF may potentially be exposed to monkeypox while in the LTCF or in the community via:

- Sexual contact with a person who has [symptoms](#) of monkeypox  
OR
- Direct contact with a person infected with monkeypox including healthcare personnel (HCP), a caregiver, visitor, or roommate  
OR
- Indirect contact with objects (such as linens) or surfaces that have been contaminated with bodily fluids of a person infected with monkeypox

#### 43. How can I prevent or promptly identify monkeypox infection among healthcare personnel and/or residents in LTCFs?

LTCFs should raise awareness and encourage open communication regarding certain exposure risks including:

- Contact with a person or people with a rash consistent with monkeypox or who received a diagnosis of confirmed or probable monkeypox OR
- Close or intimate physical contact with individuals in a social network experiencing monkeypox activity; this includes men who have sex with men who meet partners through an online website, digital application (“app”), or social event (e.g., a bar or party)  
OR
- Traveling outside the US to a country with confirmed cases of monkeypox or where monkeypox virus is endemic OR

- Contact with a dead or live wild animal or exotic pet that is an African endemic species or use of a product derived from such animals (e.g., game meat, creams, lotions, powders)

LTCFs should encourage their staff to report any [rashes or symptoms consistent with monkeypox](#) infection, even mild, and to stay home when symptoms occur. Leave policies should be flexible and non-punitive.

#### **44. What should the LTCF do if there is a potential monkeypox exposure?**

The LTCF should notify the [local health department](#) (LHD) and follow their guidance. Maintain a linelist of individuals who are exposed to monkeypox as directed by the LHD and share the linelist with the health department at the time the exposure is identified and at the end of the monitoring period. A [VDH tool](#) is available to assist with exposure assessment, monitoring, and postexposure prophylaxis recommendations for HCP. Isolate any residents with suspected or confirmed monkeypox in a single room with a private bathroom. Testing can be done through commercial labs. Follow the [CDC infection prevention and control recommendations](#). For more information on preparedness and response, consult VDH's "[What LTCFs Need to Know About Monkeypox](#)".

#### **45. How should LTCFs monitor exposed healthcare personnel?**

Decisions on how to monitor exposed HCP are at the discretion of the facility's occupational health program and their LHD. In general, LTCFs are responsible for monitoring their own healthcare personnel and residents while admitted to the facility. If any visitors are exposed in the LTCF setting, the facility should notify the visitor(s) about the exposure and the local health department will be responsible for the monitoring. For all those exposed, the LTCF should share an initial line list with the LHD including the individual's exposure risk group and other key variables (line list template provided by VDH), notify the LHD if someone develops symptoms or if an exposed resident is discharged, and provide a final disposition line list. VDH has developed a [tool](#) to assist with exposure assessment, monitoring, and postexposure prophylaxis (PEP) recommendations for healthcare personnel. When assessing HCP exposures to a resident with monkeypox, evaluate all staff who may have had contact with the resident or resident's environment, including (but not limited to) ancillary departments such as dietary, environmental services, patient/resident transport, or registration.

The type of monitoring (i.e., active monitoring or self-monitoring) often reflects the risk for transmission with more active monitoring approaches used for higher risk exposures. 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.

#### **46. When do HCP exposed to monkeypox need to be restricted from work in LTCFs?**

Asymptomatic HCP with exposure to monkeypox do not need to be excluded from work, but should be monitored (at least daily assessment conducted by the exposed HCP for [signs and symptoms of monkeypox infection](#)) for 21 days after the exposure.

- HCP classified as high or intermediate risk should refrain from caring for residents who are immunosuppressed and children or adolescents, where possible.
- During the the 21-day monitoring period:
  - If a rash occurs, HCP should be excluded from work until (1) the rash can be evaluated, (2) testing is performed, if indicated, and (3) the results of testing are available and negative.
  - If other symptoms are present, but there is no rash, HCP should:
    - Be excluded from work for 5 days after the development of any new symptom, even if this 5-day period extends beyond the original 21-day monitoring period.
      - If 5 days have passed without development of any new symptom and a thorough skin examination reveals no skin changes, HCP could return to work with permission from their occupational health program.
    - If a new symptom develops again at any point during the 21-day monitoring period, then HCP should be excluded from work and a new 5-day isolation period should begin.