ADVANCING INTEGRATED HEALTHCARE

Best Practices in Addressing Sexually Transmitted Infections (STI) in Primary Care: ECHO® Learning Series

Session 4: Chlamydia & Gonorrhea

Date: December 10, 2024

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting

Care Transformation Collaborative of RI

Agenda

Time	Topic	Presenter
7:30-7:35 AM	Welcome, Announcements Introductions	**Yolanda Bowes,** CTC-RI **Dr. Pat Flanagan**, CTC-RI
7:35-8:00 AM	Chlamydia & Gonorrhea	**Dr. Matthew Perry,** Warren Alpert Medical School Brown University
8:00-8:20 AM	Case Presentation	**Dr. Carol O'Shea,** P.R.I.M.A. Inc
8:20-8:30 AM	Discussion & Questions	**Dr. Pat Flanagan,** CTC-RI

Welcome

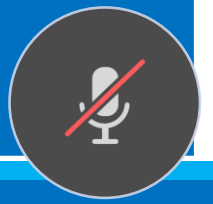
- **The didactic portion of today's session will be recorded for educational purposes and to enhance quality improvement.**
- **Case presentations will not be recorded, in consideration of confidentiality and respect for sensitive information.**
- **Please refrain from sharing any protected health information (PHI) or other sensitive information during the session.**
- **We kindly ask all participants to be respectful of their peers by adhering to the following guidelines:**

Introduce Yourself

- Please enable your video when possible, so we can foster a more engaging & collaborative environment
- Enter your name and organization in the chat box upon joining the session

Microphones

- Please keep your microphone muted when not actively speaking to minimize background noise & interruptions



Announcement:

Webinar: Long-Acting Injectable PrEP for LGBTQIA+ Communities: Implementation in Health Centers

Join Dr. Ard from the National LGBTQIA+ Health Education Center and Jeannie McIntosh from Community Health Center, Inc. for an informative webinar on the benefits and practical implementation of long-acting injectable PrEP in health centers. Focused on improving care for LGBTQIA+ communities, this webinar will explore eligibility and assessment of candidates, administering long-acting injectable PrEP, and common challenges in prescribing and integrating injectable long-acting injectable PrEP.

When: Thursday December 12, 2024
Time: 12:00-1:00pm Eastern / 9:00-10:00am Pacific

Register Here

Case Presentation Schedule

ADVANCING INTEGRATED HEALTHCARE

Date	Topic	Didactic Presenter	Case Presenter
9/25/24	Sexual Health & Confidentiality *Health Disparities, Sexual History, Counseling*	Jack Rusley MD, MHS	
10/23/24	Syphilis	Erica Hardy, MD, MMSc	Dr. Elizabeth Lange
***11/20/24**	HIV and PrEP	Philip A Chan, MD, MS	Dr. Adam Pallant
***12/10/24**	Chlamydia & Gonorrhea	Matthew Perry, MD, ScM	Dr. Carol O Shea
1/22/25	Hepatitis C	Alan Epstein, MD	Kristen Foskett, DNP
2/26/25	Other STIs	Katherine Hsu, MD, MPH, FAAP	

Today's Speaker

Matthew Perry, MD, ScM
Pronouns: they/them

Dr. Matthew Perry received their medical degree from the Warren Alpert Medical School at Brown University, then completed residency in Brown's Family Medicine Department in Pawtucket, RI. They work as a primary care provider at Providence Community Health Center's Crossroads clinic which serves people experiencing homelessness. In this role, they oversee PCHC's street-based medicine program in partnership with local harm reduction agency Project Weber-Renew; they have also served as the medical provider for PCHC's HIV panel for the past two years. They previously worked as a community health worker at a Harlem-based health center for youth with HIV, as well as in community organizing here in Providence. They graduated form the Premedical Postbaccalaureate program at Columbia University and received their Bachelor of Arts in Mathematics from Wesleyan University.

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Disclosures

- None

Agenda

- Epidemiological Trends
- Screening Guidelines
- Clinical Presentation
- Testing & Diagnosis
- Treatment & Prevention
  - What's the Latest?
- Health Equity: Trans Sexual Health

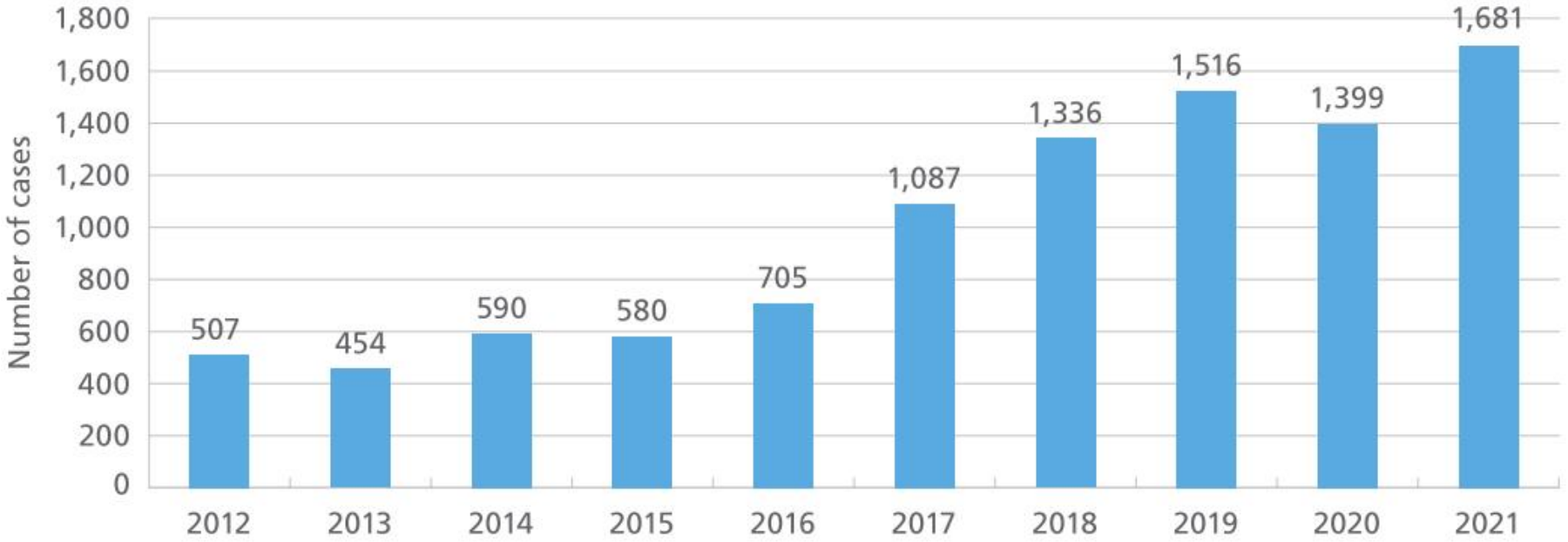
Resources

- CDC's Sexually Transmitted Infections (STI) Treatment Guidelines, 2021
- Rhode Island HIV, Sexually Transmitted Infections, Viral Hepatitis, and Tuberculosis Surveillance Report
- National STD Curriculum from University of Washington
- Injustice at Every Turn: A Report of the National Transgender Discrimination Survey
- 2023 Expedited Partner Therapy Chlamydia/Gonorrhea RI HCP Guidance
- RIDOH: Best Practices Under RI's Confidentiality of Health Care Communications and Information Act

Epidemiological Trends: Gonorrhea

FIGURE 10

Number of Gonorrhea Cases, Rhode Island, 2012-2021

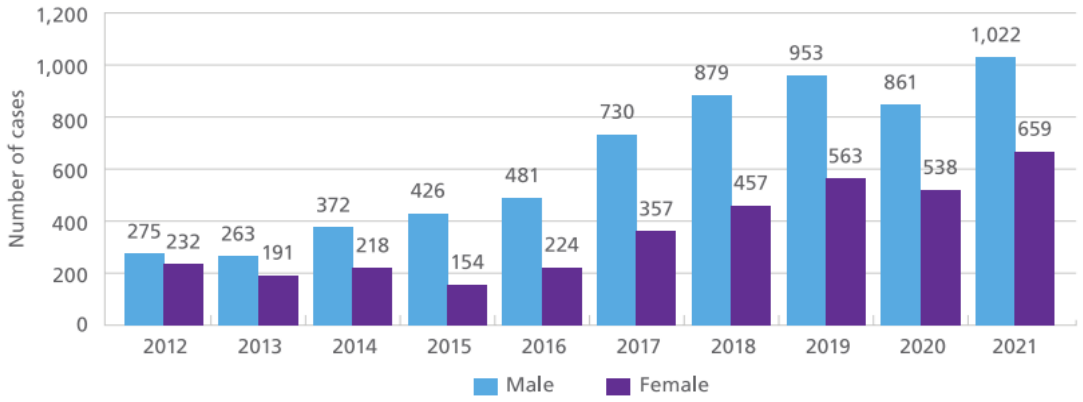


Source: Rhode Island Department of Health

https://health.ri.gov/publications/surveillance/2021/HIVSTI.pdf

FIGURE 11

Number of Gonorrhea Cases, by Sex, Rhode Island, 2012-2021

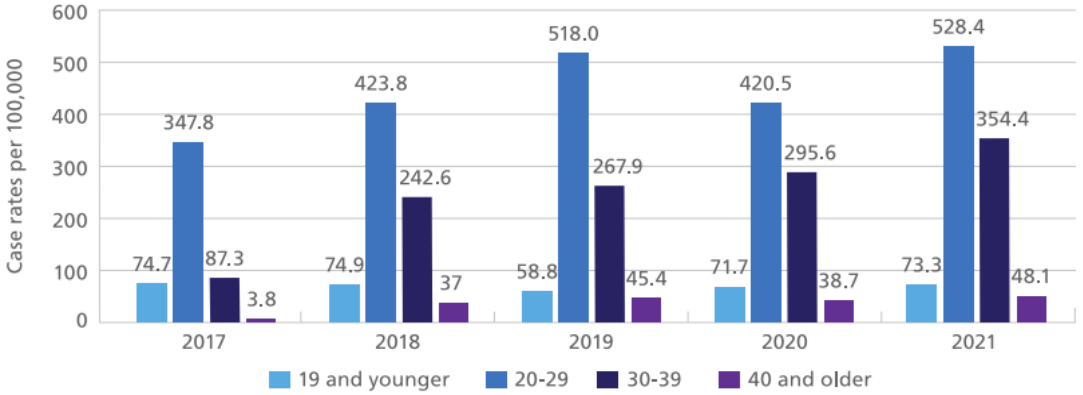


Source: Rhode Island Department of Health

In the last 10 years, more gonorrhea cases have been observed in males than in females.

FIGURE 12

Rates of Gonorrhea Cases, by Age, Rhode Island, 2017-2021

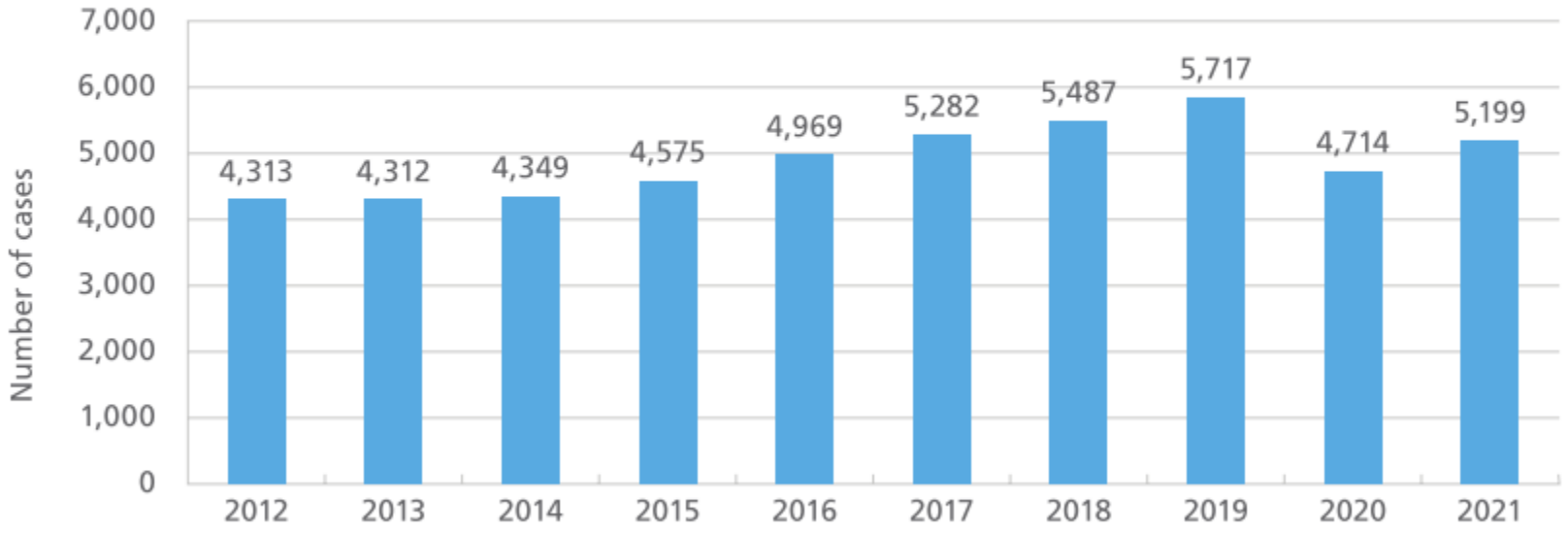


Source: Rhode Island Department of Health

Epidemiological Trends: Chlamydia

FIGURE 13

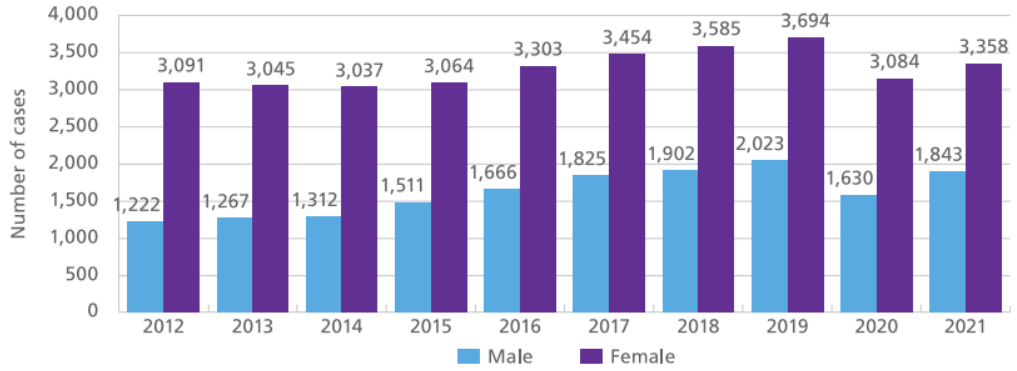
Number of Chlamydia Cases, Rhode Island, 2012-2021



Source: Rhode Island Department of Health

FIGURE 14

Number of Chlamydia Cases, by Sex, Rhode Island, 2012-2021

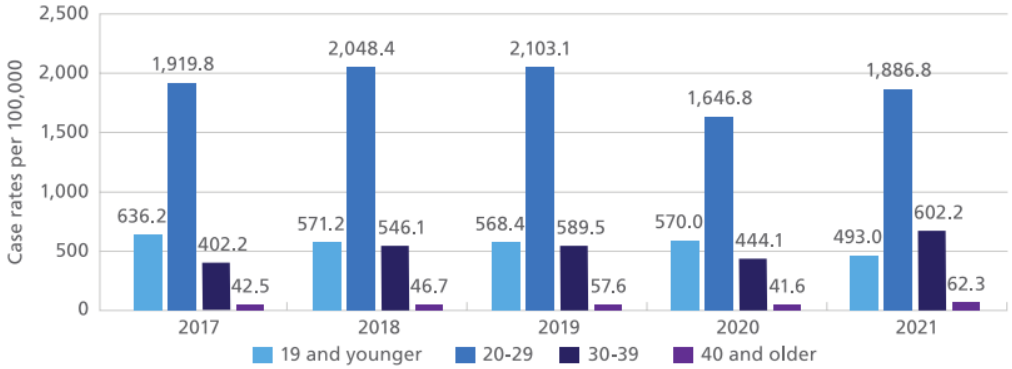


Source: Rhode Island Department of Health

Most chlamydia cases in the last 10 years have been diagnosed in females. In 2021, nearly twice as many cases were diagnosed in females than in males. This difference is likely due to two factors. First, women generally access routine healthcare and subsequent screening more than men. Second, men who have chlamydia often do not have symptons and do not seek health care for screening and treatment.

FIGURE 15

Rates of Chlamydia Cases, by Age, Rhode Island, 2017-2021



Source: Rhode Island Department of Health

What's going on?

"There's a lot of reasons. People obviously continue to have sex. We think people are using condoms less. Use of oral contraceptives is increasing. There's also HIV pre-exposure prophylaxis, which protects against HIV. A lot of people are using that, but it doesn't protect against these other STIs. We're also seeing an increase in substance use. We know that with all substances, alcohol and other drugs, we see more risky sexual behavior."

- Dr. Philip Chan, consultant medical director of the Department of Health, from *The Providence Journal*

https://www.providencejournal.com/story/news/healthcare/2023/02/14/why-are-sti-rates-up-in-rhode-island-dr-philip-chan-answers-our-questions/69881486007/

Screening Guidelines

	Chlamydia	Gonorrhea
Women	• Sexually active women under 25 years of age[1] • Sexually active women 25 years of age and older if at increased risk*[1] • Retest approximately 3 months after treatment[2] • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider[2,3,4]	Sexually active women under 25 years of age[1] Sexually active women 25 years of age and older if at increased risk*[1] Retest 3 months after treatment[2] Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider[2,3,4]
Pregnant Women	• All pregnant women under 25 years of age[1] • Pregnant women 25 years of age and older if at increased risk*[1] • Retest during the 3rd trimester for women under 25 years of age or at risk[2] • Pregnant women with chlamydial infection should have a test of cure 4 weeks after treatment and be retested within 3 months[2]	All pregnant women under 25 years of age, and those 25 and older if at increased risk*[1] Retest during the 3rd trimester for women under 25 years of age or at risk[2] Pregnant women with gonorrhea should be retested within 3 months[2]
Men Who Have Sex with Women	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, STI/sexual health clinic)[1,5]	There is insufficient evidence for screening among heterosexual men who are at low risk for infection[1]

https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm#print

Screening Guidelines, p2

	Chlamydia	Gonorrhea
Men Who Have Sex With Men	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use[2] • Every 3 to 6 months if at increased risk (i.e., MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners)[2]	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use[2] • Every 3 to 6 months if at increased risk[2]
Transgender and Gender Diverse Persons	• Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for chlamydia in cisgender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, persons with a cervix should be screened if at increased risk.)[2] • Consider screening at the rectal site based on reported sexual behaviors and exposure[2]	• Screening recommendations should be adapted based on anatomy (i.e., annual, routine screening for gonorrhea in cisgender women <25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, screen if at increased risk.)[2] • Consider screening at the pharyngeal and rectal site based on reported sexual behaviors and exposure[2]
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter[2,6] • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology[2]	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter[2,6] • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology[2]

https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm#print

Screening Guidelines, Adolescents

- CDC:
  - Annual screening for sexually active females* & MSM age <25 (g,c)
  - Selected annual screening for males* (excl. MSM) age <25 if:
    - "High prevalence" settings - adolescent clinics, correctional facilities, STD clinics
    - Chlamydia only
- *Upcoming CTC-RI STI QI Project: Regular screening for all adolescents 16-24, regardless of sexual activity*
- Confidentiality Concerns
  - Can remain on parents' insurance until age 26
  - RI Law: Insurers required to offer *confidential communications request form*:
    - EOB & other medical information can be sent to alternate address, email, or phone number so it goes directly to the patient; no age requirement listed

**sex not clearly defined by CDC, presumably assigned sex at birth*

Clinical Presentation

- Persons with vagina/cervix/uterus
  - Cervicitis
    - discharge, bleeding, pain
    - often asymptomatic (G>C)
  - Urethritis (C>G)
  - Pelvic Inflammatory Disease, endometritis, salpingitis
  - Perihepatitis (*Fitz-Hugh-Curtis Syndrome*) – usually only seen if PID also present (GC)
  - Bartholin Gland Infections (G)
- Persons with penis/testes
  - Urethritis
    - Often asymptomatic (C>G)
    - Can cause discharge/pain, and lead to epididymitis

https://www.std.uw.edu/go/comprehensive-study/chlamydial-infections/core-concept/all

Clinical Presentation

- Extragenital Infections
  - Regardless of biology
  - Anorectal Infections
    - Often asymptomatic // mild proctitis (G)
    - Lymphogranuloma Venereum (C) - rectal infection, proctitis, inguinal lymphadenopathy
  - Conjunctivitis (GC)
  - Oropharyngeal infection (G>C)
  - Reactive Arthritis (FKA Reiter's syndrome) (C)
    - Post-inflammatory // autoimmune
    - Syndrome: Conjunctivitis, urethritis, oligo-arthritis, skin lesions (keratoderma blennorrhagica), and circinate balanitis
  - Disseminated Gonococcal Infection (G)
    - skin lesions arthralgia, tenosynovitis, arthritis, hepatitis, myocarditis, endocarditis, and meningitis – very rare, can be fatal

Testing

- NAAT testing
  - POC testing available for both chlamydia and gonorrhea
  - Culture & gram stain available for gonorrhea
- **Site-Specific Testing is Essential**
  - Vaginal/cervical infections: vaginal, cervical swabs or first-void urine
  - Penile infections: urethral swab or first-void urine
  - Rectal swabs
  - Oropharyngeal swabs
    - Gonorrhea swabs may pick up other Neisseria infections
  - **Self-swabs are great!**
    - Perform similarly to provider-collected swabs at all sites
- POC Testing: Specificity & Sensitivity Study[1]
  - Gonorrhea
    - Sensitivity: ~100.0% in women*, 97.3% in men*
    - Specificity: 99.9% in women*, 100.0% in men*
  - Chlamydia
    - Sensitivity: 96.1% in women*, 92.5% in men*
    - Specificity: 99.1% in women*, 99.3% in men*

**Study did not define how sex/gender information was collected*

Van Der Pol B, Taylor SN, Mena L, Lebed J, McNeil CJ, Crane L, Ermel A, Sukhija-Cohen A, Gaydos CA. Evaluation of the Performance of a Point-of-Care Test for Chlamydia and Gonorrhea. JAMA Netw Open. 2020 May 1;3(5):e204819. doi: 10.1001/jamanetworkopen.2020.4819. PMID: 32407506; PMCID: PMC7225902.

Treatment - Chlamydia

- First line: Doxycycline 100mg twice daily for 7 days
- Second line // First line in pregnancy: Azithromycin 1g once
- Alternative regimens:
  - Levofloxacin 500mg daily for 7 days
  - Amoxicillin 500mg three times daily for 7 days (2nd line in pregnancy)
- Doxycycline is *significantly* more effective than azithromycin
  - *A randomized trial for the treatment of rectal chlamydia infection among MSM reported microbiologic cure was 100% with doxycycline and 74% with azithromycin*[1]
  - *It is common for urogenital infections to reach rectum in patients with vaginal anatomy*

1 Dombrowski JC, Wierzbicki MR, Newman LM, Powell JA, Miller A, Dithmer D, Soge OO, Mayer KH. Doxycycline Versus Azithromycin for the Treatment of Rectal Chlamydia in Men Who Have Sex With Men: A Randomized Controlled Trial. Clin Infect Dis. 2021 Sep 7;73(5):824-831. doi: 10.1093/cid/ciab153. PMID: 33606009; PMCID: PMC8571563.

Treatment - Gonorrhea

- Antimicrobial resistance has been observed over the past 20 years
  - Initially to fluoroquinolones
  - MIC levels began to increase for cephalosporins and azithromycin
    - *"Amount of antibiotic needed to be effective"*
  - Recommendation initially changed to dual therapy (azithro + ceftriaxone), however ctx has continued to be effective; **this may change again**
- Current 1st line: Ceftriaxone IM single dose
  - Weight >150kg → 1gm ; weight < 150kg → 500mg
- 2nd line
  - other cephalosporins (cefixime 800mg oral x1)
  - Azithromycin + gentamicin (available at TMH ID clinic, **severe allergies only**)
  - Ciprofloxacin *only* if culture-demonstrated sensitivity is available

Management Considerations

- Abstain from sexual activity until:
  - 7 days after treatment **or** completion of 7 day oral antibiotic course (chlamydia)
  - **AND** Resolution of symptoms
  - **AND** Partners have been evaluated & treated
- Test of cure: Not necessary **except** oropharyngeal gonorrhea
- Successful treatment does **not** protect against reinfection
  - Reinfection (new infection after treatment) vs. persistent infection (from resistance or incomplete course of medication)

Sexual Partner Management (both g & c):

- All sexual partners within the last 60 days should be referred for evaluation, testing, and presumptive treatment
- If no partners within the past 60 days, most recent partner should be referred
- If significant barriers to care exist, Expedited Partner Therapy is a reasonable option (legal in 47/50 states including RI)[1][2]

1. https://www.cdc.gov/sti/php/ept-legal-status/index.html
2. https://health.ri.gov/publications/guidelines/provider/expedited-partner-therapy.pdf

Prevention: DoxyPEP

- *Doxycycline as post-exposure prophylaxis against sexually transmitted infections*
- Protocol: 200mg doxycycline within 72 hours of sexual encounter; ideally within first 24h
- Rationale
  - STI prevalence rising
  - Doxy is well-tolerated, used for longer-term courses in other situations, e.g. malaria prevention
  - Low cost
- Doxycycline Appropriateness
  - 1st line for Chlamydia
  - 2nd line for Syphilis
  - Some efficacy against Gonorrhea

Borrowed heavily, with permission, from "Clinical Update in HIV/STI Prevention" by Dr. Phillip Chan

Prevention: DoxyPEP

Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections

- **Study**: Open label, randomized study 2:1; 200mg doxycycline within 72 hours of sex vs. no prophylaxis
- **Inclusion Criteria**: MSM or TGW; 1+ STI in past 12 mo; condomless sex; +HIV or on PrEP
- N = 501 (327 PrEP, 174 HIV)
- **Results:** Trial stopped early due to effectiveness; 65% reduction in STI incidence

Second Study (Stewart, et al) among Kenyan cis-women taking HIV prep showed no significant efficacy, *likely explained by 44% nonadherence rate to doxycycline during study*

1. *Luetkemeyer AF, Donnell D, Dombrowski JC, Cohen S, Grabow C, Brown CE, Malinski C, Perkins R, Nasser M, Lopez C, Vittinghoff E, Buchbinder SP, Scott H, Charlebois ED, Havlir DV, Soge OO, Celum C; DoxyPEP Study Team. Postexposure Doxycycline to Prevent Bacterial Sexually Transmitted Infections. N Engl J Med. 2023 Apr 6;388(14):1296-1306. doi: 10.1056/NEJMoa2211934. PMID: 37018493; PMCID: PMC10140182.*
2. *Stewart J, Oware K, Donnell D, Violette LR, Odoyo J, Soge OO, Scoville CW, Omollo V, Mogaka FO, Sesay FA, McClelland RS, Spinelli M, Gandhi M, Bukusi EA, Baeten JM; dPEP Kenya Study Team. Doxycycline Prophylaxis to Prevent Sexually Transmitted Infections in Women. N Engl J Med. 2023 Dec 21;389(25):2331-2340. doi: 10.1056/NEJMoa2304007. PMID: 38118022; PMCID: PMC10805625.*

DoxyPEP: Unanswered Questions

- Will people take it?
- How do we effectively reach BIPOC communities?
- What about efficacy in cis-gender women?
- Is antimicrobial resistance a risk?
- Will this impact patients' microbiome?
- How do we define the **target population**?
  - HIV+ or on PrEP
  - Social History: Sex work, anonymous sex, condomless sex (12 months)
  - STI history (12 months)
  - Study populations: MSM/TGW vs. AFAB
- Effect on Condom Use?
  - **Condoms remain the most important prevention strategy for bacterial STI's**

Oral Abstract Session-04

Monday, March 4, 2024

Doxy-PEP Associated With Declines in Chlamydia and Syphilis in MSM and Trans Women in San Francisco

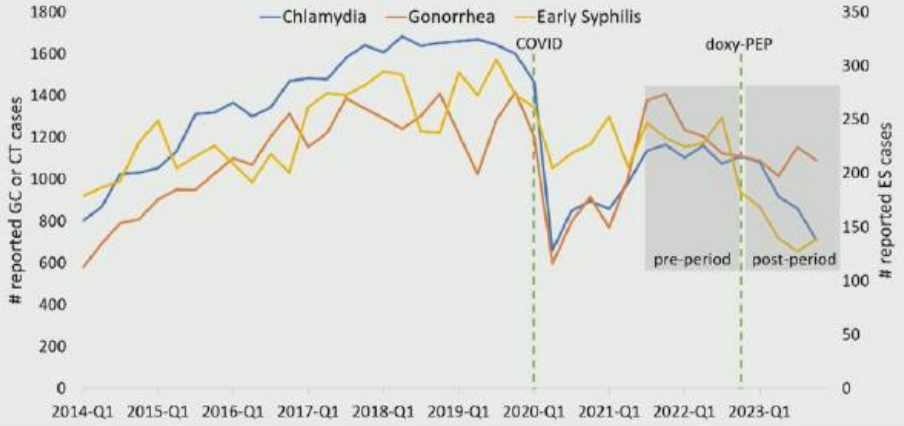
Madeline Sankaran
San Francisco Department of Public Health, San Francisco, CA, USA

Disclosure: Ms Sankaran reported no relevant financial relationships with ineligible companies.

CROI 2024

Background: STI Trends in San Francisco

MSM and TGW, 2014-2023



Background: Doxy-PEP Uptake at 3 SF Clinics

- 3 SF clinics provide sentinel surveillance data on uptake
- Rapid adoption of doxy-PEP
  - ~600 starts in first 2 months
- Starts through 2023:
  - >3,700
  - 20% of MSM and TGW

GETTING TO ZERO SAN FRANCISCO

CROI 2024

Methods

- Interrupted time series analysis – **ecologic test of association**
  - Monthly case counts among MSM and TGW from citywide surveillance data
  - Chlamydia, gonorrhea, and early syphilis
  - Pre-period: Jul 1, 2021 - Oct 31, 2022
  - Post-period: Nov 1, 2022 – Nov 30, 2023
  - Supplemental analysis of chlamydia among cis women
- Autoregressive integrated moving average (ARIMA) models to predict post-period incidence in the absence of doxy-PEP
- Compared model predictions to observed trends in the post-period

Schaffer et al, BMC Medical Research Methodology 2021; 21:58

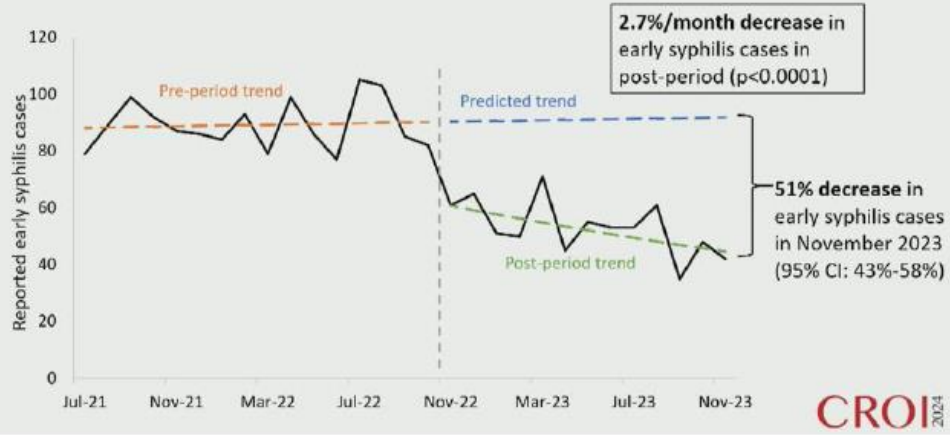
CROI 2024

October 2022: SFDPH released guidelines for doxy-PEP use

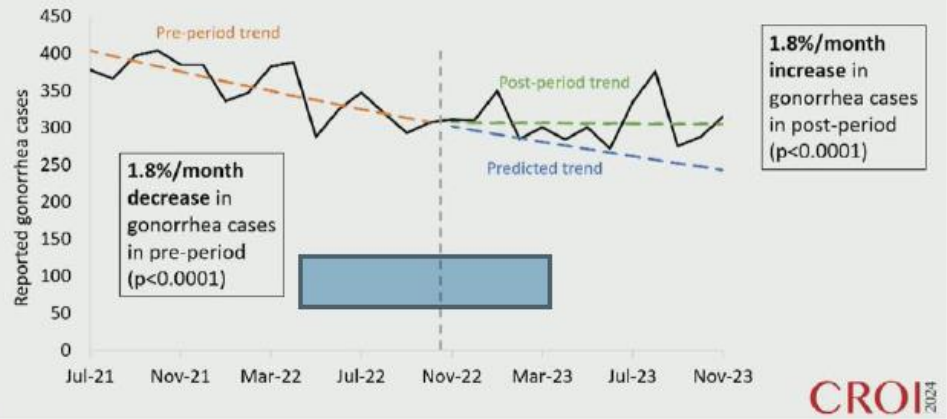
- Recommend doxy-PEP to cis men and trans women who in the past year:
  1. had a bacterial STI, and
  2. reported condomless anal or oral sex with at least 1 cis man or trans woman
- Offer to broader population of cis men and trans women with multiple partners but no bacterial STI in the past year

Chlamydia Results: Monthly SF cases among MSM and TGW

Early Syphilis Results: Monthly SF cases among MSM and TGW



Gonorrhea Results: Monthly SF cases among MSM and TGW



Conclusions and Next Steps

- **Implementation of doxy-PEP guidelines was associated with significant decreases in chlamydia and early syphilis among MSM and TGW in San Francisco, but not gonorrhea**
  - Findings supported by increase in chlamydia among cis women
- Immediate decrease in early syphilis not likely due to doxy-PEP
- Lack of decline in GC warrants further investigation
- Monitor for disparities in uptake and impact in different racial/ethnic groups
- Monitor tetracycline resistance pattern in GC and impact on doxy-PEP efficacy

*Limitations: No data on adherence, ecologic associations and can't control for confounders or identify causality (changes in testing volume? Changes in sexual practices, i.e., due to mpox outbreak summer of 2022?)

Health Equity Impact: Trans Sexual Health

- Challenge: “Prevalence studies of transgender persons among the overall population have been limited and often are based on small convenience samples.”
- “A systematic review and meta-analysis of HIV infection among transgender women estimated that HIV prevalence in the United States is 14% among transgender women, with the **highest prevalence among Black (44%) and Hispanic (26%) transgender women**[1]”
- “A recent study using data from the STD Surveillance Network revealed that the proportions of transgender women with extragenital chlamydial or gonococcal infections were similar to those of cisgender MSM[2]”

1. 344. Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the prevalence of HIV and sexual behaviors among the US transgender population: a systematic review and meta-analysis, 2006–2017. Am J Public Health 2019;109:e1–8. PMID:30496000 https://doi.org/10.2105/AJPH.2018.304727

2. 349. Pitasi MA, Kerani RP, Kohn R, et al. Chlamydia, gonorrhea, and human immunodeficiency virus infection among transgender women and transgender men attending clinics that provide sexually transmitted disease services in six US cities: results from the Sexually Transmitted Disease Surveillance Network. Sex Transm Dis 2019;46:112–7. PMID:30278030 https://doi.org/10.1097/OLQ.0000000000000917

Health Equity Impact: Trans Sexual Health

- Barriers to Care:
  - Lack of provider knowledge
  - Active discrimination // denial of care
  - Implicit bias // unsafe clinical environments
  - General SDOH Impacts
- **National Transgender Discrimination Survey[1]**
  - 19% refused medical care due to gender, higher among BIPOC patients
  - 28% have been harassed in medical office
  - 50% had to teach their providers about gender care
  - Intersectionality with other barriers:
    - 19% history homelessness
    - 46% uncomfortable contacting police
    - 1 in 8 report experiencing sexual assault in schools

1. https://www.thetaskforce.org/resources/injustice-every-turn-report-national-transgender-discrimination-survey/

Health Equity Impact: Trans Sexual Health

- Competency: Know Your Anatomy, Get Comfortable Asking
- The majority of trans women have *not* undergone genital-affirmation surgery;
  - May have receptive oral/anal or insertive sex
  - STI patterns most closely resemble MSM
- "Neovaginal STIs have infrequently been reported in the literature and include HSV and HPV/genital warts in penile-inversion vaginoplasty, ***C. trachomatis*** **in procedures that involved penile skin and grafts with urethra mucosa or abdominal peritoneal lining (*353*), and *N. gonorrhoeae* in both penile-inversion and colovaginoplasty**"
- Q: How do we talk about sex with our patients?

Summary & Clarifying Questions

CME/CEU Credits - *pending*
(applied for MDs, PAs, Rx, RNs, NPs, PhD)

- CME/CEU Credits – Please request session credits when filling out the evaluation at the end of the meeting.
- Evaluation/Credit Request Form: https://www.surveymonkey.com/r/STI_ECHOSERIES
- Evaluations must be completed to receive credit
- Certificates will be mailed ~ 1 month after event

The AAFP is reviewing "ECHO Series Focused on Best Practices and QI," and is pending approval if deemed acceptable for AAFP credit. Term of approval is from 9/2/24 to 9/2/25. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Thank you!

Next Meeting:

Date: Wednesday January 22, 2024, 7:30-8:30 AM

Session: **Hepatitis C – Dr. Alan Epstein**

Evaluation/Credit Request Form: https://www.surveymonkey.com/r/STI_ECHOSERIES