REQUEST FOR APPLICATIONS (RFA)

NEW JERSEY DEPARTMENT OF HEALTH (NJDOH), Division of HIV, STD and TB Services (DHSTS) Notice of Availability of Funds for New Jersey Harm Reduction Expansion

Release Date	July 12, 2024
Mandatory Technical Assistance Webinar **Interested applicants must attend at least one technical assistance webinar by registering at the links provided*	July 18, 2024; 11:30am – 1pm https://events.gcc.teams.microsoft.com/event/53f6df84-b421-4df8-933f-7f35c129fa91@5076c3d1-3802-4b9f-b36a-e0a41bd642a7 July 19, 2024; 10:30am – 12pm https://events.gcc.teams.microsoft.com/event/9fcf5bc5-af0b-44ec-bcaf-1473c39655df@5076c3d1-3802-4b9f-b36a-e0a41bd642a7
SAGE Open Date	August 12, 2024
SAGE Close Date	August 30, 2024
Contract Start Date	October 1, 2024
Budget Period	October 1, 2024-June 30, 2025 (9 months) (to be renewed for 3 years after, based on funding availability and performance)
Amount of funding available	Approximately $6,300,000
Number of grants to be awarded	Multiple
Questions should be directed to **HRC@doh.nj.gov**	

Applications will be submitted through SAGE. If you are a first-time applicant whose organization has never registered in NJSAGE, please visit https://nj.gov/health/grants/resources/.
NOTE: If you have previously applied in NJSAGE please do not reapply to SAGE. Your Organization's information has already been established.
If you have questions or concerns regarding SAGE, please contact the NJDOH SAGE Help Desk at 609-376-8508 or E-mail: njdoh.grants@doh.nj.gov

The New Jersey Department of Health – Division of HIV, STD and TB Services may, in its sole discretion, extend the application deadline or reissue the RFA or portions of the RFA if insufficient qualified applications are received. Applications received after the deadline or that are incomplete will be deemed non-responsive and, therefore, subject to rejection.

EXECUTIVE SUMMARY

Considering the legislative change that occurred in January 2022, the Division of HIV, STD and TB Services (DHSTS), HIV Services Unit is issuing this solicitation to fund grants to support harm reduction services throughout the state with qualified organizations. New Jersey (NJ) currently has approximately twenty entities authorized to provide harm reduction services, comprised of 44 individual Harm Reduction Centers (HRCs). The state looks to increase the availability of harm reduction services throughout New Jersey, with the purpose of mitigating the harms related to drug use. HRCs are proven to decrease the spread of HIV, hepatitis C, and other bloodborne pathogens, prevent overdoses and overdose deaths and provide a bridge to substance use disorder treatment, healthcare services, and social support services for people who use drugs. Harm Reduction is a known, evidence-based, best practice to improve the health of people who use drugs and communities.

The goal of this Request for Applications is to fund harm reduction and drug user health programs in areas of high unmet need. The long-term goal for NJ is to support at least one HRC in every county.

BACKGROUND

What Is Harm Reduction

Harm reduction is a public health approach that emphasizes engaging directly with people who use drugs to: prevent infectious disease transmission and overdose, improve the physical, mental, and social well-being of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services

Harm Reduction Centers (HRCs) are programs that offer a safe, trauma-informed, non-stigmatizing space for people who could benefit from services to reduce the harm associated with their substance use, often people who inject drugs (PWID), to access sterile syringes and other safer use supplies, facilitate the safe disposal of used syringes, and provide counseling on safer use. HRCs integrate behavioral interventions and access to services to prevent and reduce the transmission of HIV, viral hepatitis, and other blood-borne diseases, and the risk of overdose deaths. HRCs can offer services through mobile units, fixed sites, or provide consumers with safer supplies via postal mail or other delivery service. Some HRCs are housed in Drop-In Centers that provide clients with access to food, telephone, laundry services, restrooms, showers, and computer services.

Harm reduction is part of the continuum of care for substance use disorder. It is proven to prevent death, injury, disease, overdose, and substance misuse. Harm reduction is effective in addressing the public health epidemic involving substance use as well as infectious diseases and other harms associated with drug use (National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2019)[i]. It is critical to keeping people who use drugs alive and is a key pillar in the multi-faceted U.S. Department of Health and Human Services Overdose Prevention Strategy.

Research shows that harm reduction increases public health and well-being, without increasing drug use, violence, or crime. Individuals with access to harm reduction services are less likely to die from an opioid-related overdose, more likely to stop substance use that causes them problems, more likely to stop substance use altogether, and less likely to acquire HIV or HCV. HRCs benefit communities and public safety by reducing needlestick injuries and overdose deaths, without increasing illegal injection of drugs or criminal activity.

Harm Reduction is globally understood to be a best practice in public health and is endorsed by:

- the World Health Organization
- the American Medical Association
- the American Public Health Association
- the US Centers for Disease Prevention and Control
- the New Jersey Department of Health

History of Harm Reduction in New Jersey

On December 19, 2006, the "Bloodborne Disease Harm Reduction Act" (P.L. 2006, c. 99) was signed into law, allowing for the establishment of up to six demonstration Syringe Access Programs (SAPs) in New Jersey. The Act mandated that local ordinances be provided by the municipality looking to stand up a site before that site was authorized to provide sterile syringes. DHSTS was charged with implementing the provisions of the law, including identifying those municipalities most in need and capable of implementing a program. Five municipalities were subsequently authorized by DHSTS to operate SAPs:

Municipality	Date
Atlantic City	November 27, 2007
Camden	January 5, 2008
Jersey City	July 6, 2009
Newark	February 19, 2008
Paterson	January 30, 2008

Additional SAP expansions included Asbury Park (August 16, 2017) and Trenton (January 1, 2018).

In January 2022, the legislature passed a syringe access expansion bill that Governor Murphy signed into law. The new legislation removed the requirement under the previous law governing syringe access/harm reduction programs, which stated that municipalities must pass an ordinance allowing syringe access/harm reduction programs to operate. The removal of the municipal ordinance requirement eliminated a significant barrier to harm reduction expansion in New Jersey.

New Jersey began accepting new applications for harm reduction centers in July 2023 and in August 2023 DHSTS released a RFA to expand harm reduction services and awarded funding to 12 agencies that operate 27 sites throughout NJ.

These programs provide (at minimum):

Education	• Risk reduction education for HIV and viral hepatitis • Education on safer sex and safer injection practices • Overdose prevention education • Trauma-informed harm reduction education sessions • Counseling and education on PrEP/PEP
Equipment	• Prevention supplies such as ○ syringes, needles, tourniquets, band-aids, alcohol wipes, sharps containers, cotton, cookers, antiseptic ointments, hygiene/dignity kits • Safe disposal of injection equipment • Access to naloxone and fentanyl test strips and other drug checking equipment

The following services are offered by some sites, or are, at minimum, referred out to a vetted agency capable of performing these services:

Care	• Nurse/healthcare services • Low-threshold medication-assisted treatment • Referrals and linkages to drug treatment, medical care, and social/mental health services

Priority Locations and Strategy

The NJDOH aims to establish a Harm Reduction Center in each of the 21 counties, making essential harm reduction services more accessible. This funding opportunity is available to all registered harm reduction centers across New Jersey. It is important to highlight that statewide access to harm reduction services is crucial, however, priority will be given to jurisdictions that have a high unmet need regarding overdose and disease burden as determined by data sets. Pertinent data can be found but is not limited to the following sources:

- Appendix C in this RFA
- https://www-doh.state.nj.us/doh-shad/home/Welcome.html\
- https://www.nj.gov/health/populationhealth/opioid/
- https://www.nj.gov/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2022/Statewide.pdf
- https://www.njoag.gov/programs/nj-cares/nj-cares-data-by-county/
- https://monarchhousing.org/wp-content/uploads/2023/08/New-Jersey-PIT-Report-2023.pdf.

In line with national guidance, DHSTS will consider population health, social determinants of health indicators, and proximity to existing HRCs to inform initial priorities for harm reduction expansion priorities. Currently, the following eight counties do not have harm reduction programs funded by DHSTS: Bergen, Burlington, Gloucester, Hunterdon, Morris, Salem, Somerset, and Warren. These counties will be prioritized in this RFA. Together, these data reflect the current unmet need for harm reduction services and community risk for injection drug-use related harms. Thus, locations where such services are likely to be needed the most will be prioritized; however, all jurisdictions are encouraged to apply.

There are large disparities in nonfatal and fatal overdoses in New Jersey and these disparities are only growing. This funding supports efforts to improve the health of populations that are disproportionately affected by infectious diseases and overdose. Programs should look to leverage existing resources, thereby maximizing the health impact of public health services, reducing disease incidence, and promoting health equity. Health disparities are strongly linked to a complex blend of social determinants of health that influence how communities are impacted by infectious diseases and substance use disorder(s). Additionally, these communities have been shaped by historical conditions and events that continue to influence access and quality of care. These conditions, which can be understood as collective or intergenerational traumas, often result in common mistrust of systems and providers of care. Addressing social determinants of health, as well as communicating an understanding of such collective histories, should be strongly considered when developing harm reduction programming in response to this RFA.

Legislative Changes and Summary of Rules

On January 18, 2022, Governor Murphy approved P.L. 2021, c. 396, the Bloodborne Disease Harm Reduction Act. This enactment expanded the authority of the Department of Health to permit the establishment and operation of harm reduction services in accordance with the Act through its prescribed regulatory requirements. The Act eliminated the requirement that Harm Reduction Centers obtain municipal authorization to operate and required them instead to register with the Department.

Refer to N.J.S.A. 26:5C-25 through 31 and N.J.A.C. 8:63.

- N.J.S.A 26:5C-28 states any eligible entity (for example, an FQHC, a community based organization, a public health agency, a substance abuse treatment program, an AIDS Services Organization, or another entity with the capacity to provide harm reduction services as determined by NJDOH) may provide harm reduction services with NJDOH approval via a registration process, according to the Act.
- N.J.A.C. 8:63 outlines how eligible entities may apply for registration, the operational requirements, and the standard for the management of entities authorized to provide harm reduction services.

On January 8, 2024, Governor Murphy signed into law S3957. This law removed “harm reduction supplies” from paraphernalia laws. It also exempts specific supplies or equipment from paraphernalia law, if provided by an authorized Harm Reduction Center. This expanded what

authorized HRCs are able to distribute to allow safer smoking supplies, safer sniffing supplies, and drug checking equipment such as xylazine test strips and any form of test strips.

REQUIRED ACTIVITIES FUNDED UNDER THIS RFA

Component A: Core Harm Reduction Services – Direct Services: maximum per location awarded $300,000 for a 12-month period.

This section covers the services that must be provided if granted funding through this RFA

The goal of harm reduction services is to prevent the spread of HIV, hepatitis C (HCV), and other bloodborne pathogens, prevent overdoses and overdose deaths, and provide a bridge to substance use disorder treatment, healthcare services, and social support services sought out by persons who use substances.

When responding to this RFA, consider the mode of Service Delivery for the program, the services to include, and the population that your organization is seeking to serve.

Below is the core suite of harm reduction services that your organization must include:

- Needs-based syringe distribution[1]
- Syringe disposal
- Other harm reduction supplies including but not limited to
    - clean cotton
    - tourniquets
    - smoking equipment
    - other harm reduction supplies that meet the needs of clients
- Education on safer use practices
- Referrals to health and social services, including but not limited to HIV and HCV testing, treatment, and prevention
- Access to naloxone, and training on how to administer naloxone
- Harm reduction counseling
- Drug checking equipment (e.g., fentanyl and xylazine test strips)
- Access or referrals to additional health screenings and/or services

Eligibility Requirements: Entities eligible to apply for Component A grant funds under this RFA must be authorized to operate a Harm Reduction Center in New Jersey by the New Jersey Department of Health per N.J.A.C 8:63. Organizations who wish to apply, but have not received authorization, must submit their initial application for registration prior to responding to this RFA.

[1] Needs-based syringe distribution provides PWID access to the number of syringes/needles they need with no restrictions, including no requirement to return used syringes: https://stacks.cdc.gov/view/cdc/127558/cdc_127558_DS1.pdf

Component B: Drug User Health Services – Direct Services: maximum per location awarded $350,000 for a 12-month period.

The Drug User Health Model, soon to be renamed Harm Reduction Health in New Jersey, seeks to improve the health outcomes of people who use drugs (PWUD) by providing comprehensive and integrated healthcare services that do not place stipulations on drug use cessation as a condition for services. Discrimination and negative perceptions attached to drug use can impede access to high-quality healthcare services for individuals who use drugs (Aronowitz and Meisel, 2022)[ii]. People who use drugs may avoid seeking medical care due to instances of mistreatment and dehumanization by healthcare providers. The co-location of primary care and harm reduction services provides access to continuous, non-stigmatized care for PWUD. Examples of co-located healthcare services are satellite clinic hours at an HRC, mobile services paired with harm reduction services, or hosting a practitioner onsite at an HRC to provide care. The above are examples of services to be considered when applying for this component of funding.
The aggregation of HIV, STIs, viral hepatitis, and injection drug use exacerbates disease prevalence and severity, especially among PWUD. Additionally, given the escalating rates of fatal overdose and the growing prevalence of serious complications arising from injection drug use, such as endocarditis and infections of the skin and soft tissues, it is crucial that we prioritize efforts to overcome the obstacles hindering the provision of high-quality healthcare to PWUD. Addressing this syndemic requires a collaborative public health approach (e.g., through the integration of services), centering PWUD in the design of public health services, and addressing shared social determinants (e.g., socioeconomic status, interactions with carceral systems) and barriers to accessibility (e.g., affordability, transportation, and discrimination). Providing primary care services at HRCs will ensure better health outcomes for participants. The Drug User Health Model prioritizes offering testing, treatment, and vaccines, when available, as well as additional services like wound care, care coordination, nutritional counseling, stress management, and mental health services. At this time, the Division will focus Drug User Health expansion efforts on increasing access to wound care, client access to a prescribing provider, and mental health services. Applicants with a prescribing practitioner may also integrate PrEP/PEP and/or MOUD into their Drug User Health services. Various models of care should be explored, including telehealth where available. Offering these low-threshold health services produces positive participant health outcomes that are not reliant on abstinence.

Entities applying for Component B, but not Component A, must meet specific criteria to be eligible for award consideration (see Eligibility, Component B, page 10). Such applicants must partner with an authorized HRC if they wish to be considered for Component B, but either entity is permitted to act as the "lead" applicant. Applicants pursuing this model of service must demonstrate their commitment to harm reduction principles and service. Competitive applicants will have proposed a service model that prioritizes continuity of care for HRC clients, regardless of the location or entity to which the client presents. Prioritizing continuity of care entails offering a baseline of harm reduction resources, including but not limited to: syringe access, syringe disposal, and education relating to safer use practices and overdose prevention. Increased access to drug user health services should not impact a client's access to harm reduction tools. In order to demonstrate such a commitment, applicants must prepare a Collaboration Plan that demonstrates an alignment of core beliefs, centered around harm reduction principles, between the Component B applicant and its authorized HRC partner.

Component C: Overdose Prevention & Response Innovation

Funding within this component is intended to be a one-time award, and applicants will be selected based on their ability to demonstrate innovative programming or projects. Examples of innovative projects include, but are not limited to, harm reduction vending machines, advanced drug checking machines or equipment, start-up costs for safety protocols, novel harm reduction infrastructure, etc. Applicants may propose a planning period of up to 6 months during the grant period, if needed. Applicants must provide a sustainability plan with Component C requests. This can include folding the project into the overall harm reduction/drug user health project in future project years or pursuing future grant funds for sustainability. Examples of innovative projects are described below, though this is not an exhaustive list.

- Harm Reduction Vending Machines/Kiosks: Harm Reduction Vending Machines can help expand access to harm reduction supplies beyond brick-and-mortar/mobile harm reduction services by providing 24/7 access to supplies in strategic locations. Machines can supply a range of supplies such as naloxone, test strips, safer use kits, and wound care kits. Syringe kiosks can also be used to expand syringe disposal options in communities. Funding in this category could be used for the purchase of machines, syringe kiosks, supplies, and staff time to establish community partnerships and policies/procedures.
- Advanced Drug Checking Equipment: The recently enacted P.L. 2023, c.224, removed all criminal penalties associated with harm reduction supplies, including drug testing supplies. Drug checking equipment such as test strips and more advanced technology (e.g., Fourier transform infrared technology or FTIR machines) can be used as a harm reduction strategy to test illicit drug samples for components that are either not expected or that could cause disproportionate harm, to provide information to people who use drugs about the substances that they consume. Funding in this category could be used for the purchase of FTIR machines, contracts with a laboratory for confirmatory testing of samples, sample shipping costs, training, and staff time.
- Safety Protocols: Through technology and protocols, HRCs can ready their spaces to ensure maximum safety for both clients and staff. For instance, many HRCs, businesses, and community-based organizations have instituted practices to prepare for potential overdoses onsite, such as the installation of timers, emergency call buttons, and reverse motion detectors, a policy of frequent checking, and stocking easily accessible naloxone. Some programs have implemented medical monitoring for individuals who arrive to the site overly sedated/intoxicated. Funding in this category could be used for costs such as the purchase of technology/supplies, renovating space, and staff training.

Administrative Activities

Cultural Humility

Harm Reduction Centers must employ cultural humility to provide client-centered services that meet the needs of the population they serve. "Cultural humility refers to an orientation towards caring for one's patient that is based on: self-reflexivity and assessment, appreciation of patients' expertise in the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning" (Lekas, Pahl, & Fuller 2020, p. 2)[iii]. The harm reduction approach and strategies arose from PWUD themselves and research indicates that involvement from PWUD is imperative for the success of harm reduction programming (Szalavitz 2021)[iv]. Therefore, professionals need to recognize that they have limitations in knowledge and experience and be open to depending on those with personal experience. This approach can help reduce stigma and create a safe and non-judgmental environment for individuals who use drugs to access harm reduction services. Applicants should address how they plan to involve PWUD in establishing and improving harm reduction services whether through a participant advisory board, peer opportunities, focus groups, etc.

Harm Reduction personnel must also be aware that many consumers face disparities such as poverty, class, discrimination, and racism related to their drug use. However, they may identify with their inequalities differently depending on how they impacted their lives (Jones & Branco, 2021)[v]; the overall stigma correlated with these traits and substance use disorders (SUDs) may negatively impact their willingness to seek resources. Yet, HRCs allow treatment and recovery to be defined by the clients, creating a non-stigmatizing environment whether they move from active use to lower-risk use or abstinence, if desired (Post, Green, & Boss, 2022)[vi], which gives back some control to PWUD and people with SUDs. Learning and accepting others' cultural beliefs and behaviors increases the likelihood of consumers trusting the HRCs and, therefore, having higher chances of having their health needs met.

Technical Training/Capacity-Building

Harm reduction centers must ensure staff are fully trained in the spectrum of approaches and strategies related to harm reduction and drug user health and maintain records of said training for staff and volunteers. As stated in N.J.A.C. 8:63, compliance with, and documented training for the following are required:

- The Bloodborne Pathogens Standard
- The Occupational Safety and Health Act of 1970
- CDC HIV Data Security and Confidentiality Guidelines
- HIV post-exposure prophylaxis in accordance with guidelines of the CDC

Additionally, HRC staff should be trained and remain up to date on current service models related to syringe access, harm reduction supplies, and harm reduction counseling, including the incorporation of trauma-informed practices into service delivery. Please see Appendix C for examples of implementation resources from nationally recognized entities on harm reduction. Existing harm reduction centers in New Jersey may also be referenced as service model examples.

Linkage

Harm reduction centers must ensure that strong linkage relationships or partnerships are established to best meet the needs of clients. A list of available resources, including but not limited to medical and HIV/STD testing services, social services, mental health services, transportation, drug user health, and additional harm reduction services within the harm reduction center's local jurisdiction should be created and regularly updated. Referrals to these resources should include a warm handoff, whenever possible, to initiate a positive experience for each client and decrease stigma.

Community Engagement

Effective implementation and longevity of harm reduction initiatives heavily rely on active involvement and education of the community. When harm reduction programs receive backing from stakeholders such as people who use drugs, local government, medical professionals, social service organizations, and neighbors, they are more likely to find success and acceptance in their communities. Additionally, a variety of stakeholders from across the community can also result in diversified funding and grant opportunities. Harm reduction programs should actively engage and involve PWUD throughout the development and implementation stages. Community involvement, especially of those with lived experience, can improve program effectiveness and community understanding of program services. A more positive community attitude towards harm reduction programming may remove barriers for PWUDs who are deterred from services by community disapproval.

Harm Reduction Centers and their consumers both benefit when they can form positive relationships with local law enforcement. Research has shown that law enforcement interventions have had negative impacts on the ability of HRCs to provide services and engage with clients[vii,viii]. Working with and educating law enforcement about harm reduction is critical to ensure the safety of program staff and participants. Trainings that take public health perspectives, HRC legality, and officer concerns into account have been effective in shifting law enforcement attitudes toward HRCs (Franco et al., 2021)[ix].

Harm Reduction Centers are encouraged to participate in their local Overdose Fatality Review Teams (OFRT), which serve as another opportunity to build community stakeholder buy-in and awareness of harm reduction services. The purpose of OFRTs is to conduct multidisciplinary overdose decedent reviews, identify community-specific themes, and produce recommendations to prevent future overdose fatalities (Janota et al., 2018; Legislative Analysis and Public Policy Association, 2021) [x,xi]. Each team produces annual recommendations which can be used to improve policy, develop best practices, and best distribute local and state resources.

NJ has multiple agencies that operate HRCs and multiple agencies that are considered subject matter experts. As new agencies are offered funding, this community will grow and participation in the larger community of harm reduction and opioid response is required by entities funded from this RFA. It is recommended that efforts to engage with other participating agencies are made. Regular, inter-agency communication can be beneficial to best meet the rapidly changing needs of consumers in NJ.

Policies and Procedures

DHSTS requires that grantees meet all responsibilities outlined in the NJDOH Terms and Conditions for the Administration of Grants as well as all DHSTS service definitions, standards, and measures. Any grantee found to be non-compliant with the standards at any time will be held responsible and required by DHSTS to restore any damages and/or costs associated with grantee noncompliance.

See Appendix C for resources that list evidence-based and best practices in harm reduction and Drug User Health.

ELIGIBILITY

Eligibility Requirements

Component A: Entities eligible to apply for Component A grant funds under this RFA must be authorized to operate a Harm Reduction Center in New Jersey by the New Jersey Department of Health per N.J.A.C 8:63.

Component B: Entities wishing to pursue Component B are not required to apply for Component A or C. However, applicants pursuing Component B only must meet all the following eligibility criteria:

- Have an established partnership with an authorized harm reduction center that does not currently provide DHSTS funded drug user health services.
- Develop and provide a Collaboration Plan that demonstrates an alignment of core beliefs between the two partnering entities, centered around harm reduction principles.
- Able to prioritize continuity of care for clients seeking harm reduction services, including baseline harm reduction offerings, such as safe syringe disposal and immediate, seamless referrals to authorized HRC partners, in addition to drug user health services.

Component C: Entities who intend to pursue Component C must meet the following criteria:

- Have registered as an authorized harm reduction center.
  OR
- Will pursue Component A and/or Component B.

Eligible applicants must attend at least one mandatory technical assistant webinar by registering via the links below:

Thursday, July 18, 2024, at 11:30 am.

https://events.gcc.teams.microsoft.com/event/53f6df84-b421-4df8-933f-7f35c129fa91@5076c3d1-3802-4b9f-b36a-e0a41bd642a7

Friday, July 19th, 2024, at 10:30am.

https://events.gcc.teams.microsoft.com/event/9fcf5bc5-af0b-44ec-bcaf-1473c39655df@5076c3d1-3802-4b9f-b36a-e0a41bd642a7

Grant awards will be made on a competitive basis and are contingent on applications deemed fundable according to a review by public health officials and in compliance with the following:

I. NJDOH Terms and Conditions for the Administration of Grants
II. Conditions stated in this RFA and all SAGE requirements
III. Eligible applicants must be based in New Jersey
IV. All applicants must have a valid NJ Tax Clearance Certificate issued by the NJ Department of Treasury, Division of Taxation
V. If applicable, eligible entities must have a valid NJ Charities Registration Letter of Compliance issued by the NJ Department of Law and Public Safety, Division of Consumer Affairs, Charities Bureau
VI. All applicants must adhere to all NJDOH communicable disease reporting requirements (N.J.A.C.8:57 and N.J.A.C. 8:65)
VII. Approved applicants must adhere to the program and administrative specifications outlined within Attachment C to be developed jointly by DHSTS and the applicant following the issue of Letters of Intent to Fund.
VIII. All applicants must adhere to N.J.S.A. 26:5C-25 through 31 and NJAC 8:63 and any future revisions. In addition, approved applicants must adhere to the program and administrative specifications outlined within the Attachment C to be developed jointly by DHSTS and the applicant following the issue of Letters of Intent to Fund.
IX. Letter from NJDOH of Harm Reduction Center Registration Approval

NOTE: All information submitted with your application is subject to verification. Submission of unverifiable information in this proposal may result in an agency not receiving any funds.

Application Guidelines

I. Program must follow best practices and evidence-based models in the harm reduction and Drug User Health field(s)
II. Applications must demonstrate that program design supports individuals within a continuum of services for people who use drugs
III. Proposed activities should prioritize highly impacted populations, with specific attention to racial and health equity
IV. Proposed activities should demonstrate the program's ability to respond to emerging needs within its respective geographic area and client population(s)
V. Applications should demonstrate an effort to include PWUDs in program design, service delivery, and/or program evaluation and improvement
VI. Proposed activities should be client-centered, low-barrier, and address social determinants of health
VII. Evaluation plans must include methods for collecting and analyzing feedback from clients engaging in funded services and demonstrate the applicant's commitment to incorporating client feedback into program design.
VIII. Applications should consider collaborations with organizations that currently provide similar and/or complementary services
IX. Continuation of the award will be based on satisfactory performance and availability of funds

REQUIRED APPLICATION COMPONENTS AND SCORING

Applications do not have page limits but MUST BE SUCCINCT. The only prescribed page limit is for the Project Abstract which is limited to 1 page. Applications must be single-spaced, Times New Roman 12-point, 1-inch margins. Each section of the application (Abstract, Narrative, Budget) should be included as a pdf attachment in the Attachments Section of the application in SAGE.

Applicants must include all of the following sections, specific to each component and location they are applying for (Component A – Core Harm Reduction Services, Component B – Drug User Health, Component C – Overdose Prevention and Response Innovation, or any combination thereof).

Project Abstract - Not Scored
The 1-page abstract must contain a summary of the proposed activities suitable for dissemination to the public.

Project Narrative – 100 maximum points
The project narrative should consist of five (5) sections:
1. Needs Assessment
2. Objectives
3. Methods

4. Evaluation
5. Organizational Capacity to Implement the Approach

The project narrative should address activities to be conducted over the grant period and must include the following items in the order listed below:

1. **NEEDS ASSESSMENT (Javed et al., 2020)[xii] (20 points)**
   Need:
   - Prevalence/incidence of injection-related diseases
     - Hepatitis C[xiii]
     - HIV[xiv]
     - Optional: bacterial infections[xv]
   - Estimates of the burden of drug use in the community
     - Non-fatal overdoses[xvi, xvii]
     - Fatal overdoses[xviii]
     - Optional: drug-related arrests
   - Community conditions that may influence drug use
     - Poverty/income[xix]
     - Prevalence of common comorbidities (e.g., mental illness, chronic conditions)[xx]
     - Optional: other measures of social determinants of health such as crime or social vulnerability
   - Client characteristics (estimates/qualitative data acceptable if quantitative are not yet available)
     - Age
     - Race/ethnicity
     - Sex or gender identity
     - Drug use characteristics
     - Comorbid health conditions
     - Optional: other social/structural vulnerabilities such as pregnancy, sex work, sexual minority status, and any cultural or linguistic barriers
   - Demonstrated unmet need, e.g., absence of harm reduction center in the proposed service area

   Resources: workforce and space
   Partnerships: health departments; local, state, or national agencies; community-based organizations; substance use disorder treatment programs; elected officials; public safety; community/political/agency support

2. **OBJECTIVES (20 points)**

Describe the activities that will be performed, the number of times, and the number of unduplicated participants.
Examples:

- *"HRC will distribute X number of syringes to X number of unduplicated participants."*
- *"Program will conduct X number of naloxone training sessions to X number of community members that are not direct HRC participants."*

Present S.M.A.R.T. (specific, measurable, achievable, realistic, time-phased) objectives, working toward the overarching goals of the project.

3. **METHODS (25 points)**

Describe how the proposed objective will be carried out and methods for harm reduction services.

- Describe how your agency will achieve the objectives identified
- Demonstrate how process outcomes will lead to final outcomes
- Describe the program activities your application intends to implement
- Describe how health disparities and health equity will be addressed
- If applicable, refer to any examples of the use of best practices, novel or innovative approaches this proposal plans to implement
- Describe a history of successful engagement in the area and with the target community
- Describe your existing formalized relationships or how you plan to formalize relationships with nontraditional partners
- Describe the plan for participating in local and state-planning bodies and/or advisory groups.
- Describe your program's plan for the involvement of people who use drugs in service delivery/planning
- Describe services that the program will prepare to refer to and any existing or future linkage agreements
- If syndemic testing is not offered, describe the intended plan to connect individuals to testing and related services.
- Describe how referrals will be made and followed upon.

4. **EVALUATION (15 points)**

Describe an evaluation plan that will illustrate if objectives were met and if programming was effective.

- Describe an evaluation method that will measure the effectiveness of the proposed activities in relation to your intended goals
- Describe an evaluation plan that will produce findings to inform the need for your program to adapt, change, or respond to delays, barriers or unintended outcomes, or lack thereof
- Describe an evaluation approach that will produce findings to inform the impact your partnerships are having on your activities and intended outcomes

5. **ORGANIZATIONAL CAPACITY TO IMPLEMENT THE APPROACH (10 points)**

Provides an opportunity for applicants to demonstrate their experience and ability to operate a harm reduction center and provide harm reduction services. Applicants should include information about the overarching organization's mission and current suite of services. Applicants should place emphasis on what services they currently provide to PWUD, their current relationship with PWUD, and demonstrate adequate experience in program planning, program implementation, program monitoring, and program evaluation. Applicants should include information regarding staffing and partnerships demonstrating adequate capacity and expertise to provide harm reduction services and meet deliverables. Letters of support are not required but may be used to demonstrate the ability to build and maintain partnerships.

Budget - 10 points

A line-item budget must be included in your application submission. Budgets should reflect a prorated 9-month budget period (October 1, 2024 – June 30, 2025). SAGE will have a budget section for personnel information (Schedule A) as well as for programmatic and miscellaneous spending (Schedule B). The budget should be balanced, focusing on direct services, with minimal administrative costs. Ensure administrative costs are directly associated with the operation of harm reduction services. Applicants should also include a pdf line-item budget in the Attachments section of their application.

Reviewer Criteria for Scoring

NEEDS ASSESSMENT (20 points)

Does the needs assessment (1) identify all relevant stakeholders, (2) review existing data, policy, resources, and services (or lack thereof); (3) include original data collection and analysis; and (4) demonstrate the need for harm reduction services?

OBJECTIVES (20 points)

Has the applicant described the activities that will be performed, including the number of times the service will be provided, as well as the number of unduplicated clients? Did the applicant provide specific, measurable, achievable, realistic, time-phased (S.M.A.R.T.) objectives? Did the applicant describe how each objective works towards achieving the overall project goal?

METHODS (25 points)

Addressing Objectives

Does the applicant describe activities, identify objectives addressed by those activities, and what outcomes are expected to be produced by the completion of those activities? Does the applicant provide evidence or best practices to support expected outcomes?

Community Engagement and Partnerships

Does the applicant identify community engagements and partnerships? Did they describe activities to maintain existing relationships or to develop new relationships? What long and short-term outcomes are expected to be produced? Did the applicant include evidence or best

practices to support their expected outcomes? Did the applicant include a plan to involve people who use drugs in service delivery/planning?

Linkage

Did the applicant describe existing or future linkage services? Did the applicant describe syndemic testing capabilities? If syndemic testing is not offered, did they describe efforts to connect clients with testing and related health services?

Health Equity

Did the applicant describe objectives and activities that address health disparities and health equity? Did they highlight expected outcomes? Did the applicant include best practices or evidence to support the highlighted activities and expected outcomes?

EVALUATION (15 points)

Did the applicant describe an evaluation method that will measure the effectiveness of the proposed activities in relation to your intended goals? Did the applicant describe an evaluation plan that will produce findings to inform the need for your program to adapt, change, or respond to delays, barriers or unintended outcomes, or lack thereof? Did the applicant describe an evaluation approach that will produce findings to inform the impact your partnerships are having on your activities and intended outcomes?

ORGANIZATIONAL CAPACITY TO IMPLEMENT THE APPROACH (10points)

Did the applicant show experience working with PWUD? Does the applicant's mission and current services demonstrate experience providing services to PWUD? Are adequate partnerships in place to ensure referrals are available?

BUDGET (10 points)

Did the applicant list adequate front-line staff to provide direct services? Did the applicant provide supportive documentation and itemized lists of Schedule B expenses?

✓ **Required Documents**

A list of required documents will be expected to be submitted with the application including, but not limited to, the following. Refer to https://www.nj.gov/health/grants/resources/ for the New Jersey DOH Terms and Conditions, Federal Regulations and other resources for grant requirements and administration.

- *Proof of non-profit status (if applicable)*
- *Tax Clearance Certificate*
- *Letter of Compliance – Charitable Registration (if applicable)*
- *Proof of Interest-Bearing Bank Account (if applicable – Advanced Payment only)*
- *Audit Engagement Letter*
- *Audit Report*
- *Resumes of key personnel*
- *Organizational Chart*
- *Lease/Mortgage Documentation (if applicable)*

REVIEW PROCEDURES

An RFA review committee will review the applications. Applications will be rated on the criteria listed in this document. DHSTS reserves the right to render final decisions on the awarding of funds under this RFA.

Applications will be screened for completeness and eligibility as specified in this RFA. Only those applications deemed to be eligible, complete, and in compliance will be sent to the RFA review committee.

SELECTION

Applications will be ranked in order by score as determined by the review panel.

SUBMISSION OF APPLICATIONS

Please refer to the cover of this document for important grant application dates. All applications must be completed and submitted on time.

In fairness to all applicants, no exceptions will be made. Incomplete or late applications will not be considered. The SAGE site is accessible by all users at www.sage.nj.gov. When applying, please use the following naming convention:

"[Agency], [HRC, Drug User Health, or Innovation], [City/County], [Service Modality].

After the final TA webinar, no questions can be answered about the RFA or submission. The SAGE Helpdesk will be available for technical issues surrounding submission. This is a competitive RFA and thus all submissions must be made by the deadline date and time, NO EXCEPTIONS.

Question should be directed to HRC@doh.nj.gov.

All programmatic questions will be answered until July 19th (the second TA webinar). After the webinar DHSTS will enact a blackout period, no longer responding to programmatic questions. SAGE questions are allowable and should be directed the SAGE Help Desk at 609-376-8508 or njdoh.grants@doh.nj.gov.

Appendix A

Municipalities with currently funded Harm Reduction Services

Newark, Essex	Keyport, Monmouth County
Plainfield, Union County	Long Branch, Monmouth County
Trenton, Mercer County	Lower Township, Cape May County
Asbury Park, Monmouth County	Middle Township, Cape May County
Atlantic City, Atlantic County	Millville, Cumberland County
Barnegat Township, Ocean County	New Brunswick, Middlesex County
Brick, Ocean County	Newton, Sussex County
Bridgeton, Cumberland County	Paterson, Passaic County
Camden, Camden County	Red Bank, Monmouth County
Cliffwood, Monmouth County	Toms River, Ocean County
East Orange, Essex County,	Union City, Hudson County
Eatontown, Monmouth County	Upper Township, Cape May County
Elizabeth, Union County	Vineland, Cumberland County
Jersey City, Hudson County	Wildwood, Cape May County
Keansburg, Monmouth County	Woodbine, Cape May County
Middlesex County	Statewide Mail Based

Appendix B

Top 25 NJ Jurisdictions for Drug-Related Arrests by Resident Municipality (2021, sorted by count)

City Name	Number of arrests	Rate per 100,000 population
Newark	1617	526.3
Camden	1348	1878.1
Trenton	891	985.0
Paterson	869	550.7
Jersey City	669	235.62
Toms River	293	301.12
Elizabeth	285	210.48
Perth Amboy	269	486.5
Plainfield	252	461.5
Pemberton	245	913.9
East Orange	227	329.4
Vineland	219	358.1
Brick Twp	219	292.38
Irvington	211	349.3
Millville	195	705.6
Hamilton Twp (Mercer Co.)	184	200.86
Winslow Twp	168	421.2
Atlantic City	167	434.1
Passaic	165	236.96
Long Branch	155	478.6
Asbury Park	154	1013.6
Woodbridge	150	145.33
Neptune Twp	127	449.3
New Brunswick	125	224.38
Bridgeton	119	447.2

Note: Shaded areas represent cities with a harm reduction center in 2022. Philadelphia, the Bronx, and Brooklyn residents also represented a large number of arrests; however, they are not included because of the purpose of this report.

Source: New Jersey Drug Monitoring Initiative, 2022.

Appendix C

Resources for evidence-based and best practices for harm reduction and drug user health

Harm Reduction

Centers for Disease Control and Prevention. (2019). Syringe Services Programs (ssps). Centers for Disease Control and Prevention. https://www.cdc.gov/ssp/index.html

Centers for Disease Control and Prevention. (n.d.). NHRTAC. Centers for Disease Control and Prevention. https://harmreductionhelp.cdc.gov/s/topic/0TOt0000000CwJGGA0/basics-getting-started-for-harm-reduction-programs

Guide to developing and managing Syringe Access Programs. National Harm Reduction Coalition. (2020). https://harmreduction.org/issues/syringe-access/guide-to-managing-programs/

Harm reduction 101. NJ Harm Reduction Coalition. (2022). https://njharmreductioncoalition.org/harm-reduction-101/

Javed, Z., Burk, K., Facente, S., Pegram, L., Ali, A. & Asher, A. (2020). Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation. Atlanta, GA: US Department of Health and Human Services, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease, Control and Prevention; 2020.

K. Barber, B. Pauly, H. Hobbs, D. Lynn, H. Strosher, T. Thompson, B. Wallace, (2020) "An Evidence Brief: Harm Reduction Implementation Framework (HRIF)." Canadian Institute for Substance Use Research. https://static1.squarespace.com/static/5eb1a664ccf4c7037e8c1d72/t/5f68f6c153f2314986bc25af/1600714448833/Harm+Reduction+Implementation+Framework.pdf

Lopez, Thomann, Dhatt, Ferrera, Al-Nassir, Ambrose, and Sullivan (2022). Understanding Racial Inequities in the Implementation of Harm Reduction Initiatives. American Journal of Public Health 112(S2), S173-S181. https://doi.org/10.2105/AJPH.2022.306767

National Governors Association (2022). *Supporting and sustaining access to harm reduction services for People Who Use Drugs*. https://www.nga.org/publications/supporting-and-sustaining-access-to-harm-reduction-services-for-people-who-use-drugs/

The Network for Public Health Law. (2020). *Harm Reduction and Overdose Prevention 50-state survey. Harm Reduction Laws in the United States*. https://www.networkforphl.org/wp-content/uploads/2020/12/50-State-Survey-Harm-Reduction-Laws-in-the-United-States-final.pdf

Drug User Health

Altice, F.L., Madden, L. (2022). Strengthening Systems of Care for People with or At Risk for HIV and Opioid Use Disorder (HRSA-038). Yale School of Medicine. https://ssc.jsi.com/sites/default/files/2022-06/Yale_Project_MOHRE_JSI_Workshop_Presentation_6.16.22%20LMM.pdf

Centers for Disease Control and Prevention (CDC) (2012). Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services. *MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports*, *61*(RR-5), 1–40.

Cunningham, C. O., Sohler, N. L., Cooperman, N. A., Berg, K. M., Litwin, A. H., & Arnsten, J. H. (2011). Strategies to improve access to and utilization of health care services and adherence to antiretroviral therapy among HIV-infected drug users. Substance use & misuse, 46(2-3), 218–232. https://doi.org/10.3109/10826084.2011.522840.

JSI Research and Training Institute. (2022). A Guide to Support Individuals with HIV/ Hepatitis C in Substance Use Service Settings. https://ssc.jsi.com/sites/default/files/2022-09/SSC_%20A%20Guide%20to%20Support%20Individuals%20with%20HIV_Hep%20C%20In%20Substance%20Use%20Settings.pdf

JSI Research and Training Institute. (2023). Using Data Partnerships to Integrate HIV and Opioid Use Disorder Services. https://ssc.jsi.com/sites/default/files/2023-03/SSC-StateStrategies-Data-Partnerships_FINAL508.pdf

Schafer, P., Calvo, M. (2015). The integration of harm reduction and healthcare implications and lessons for healthcare reform. The *New York Academy of Medicine*. *https://media.nyam.org/filer_public/54/58/54582424-33a5-4e45-94ab-c5938f4c2024/harmreductionhealthcareimplicationsforhealthcarereform.pdf*.

---

[i] Centers for Disease Control and Prevention. (2019). Syringe Services Programs (ssps). Centers for Disease Control and Prevention. https://www.cdc.gov/ssp/index.html

[ii] Aronowitz, S., & Meisel, Z. F. (2022). Addressing Stigma to Provide Quality Care to People Who Use Drugs. JAMA network open, 5(2), e2146980. https://doi.org/10.1001/jamanetworkopen.2021.46980

[iii] Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking Cultural Competence: Shifting to Cultural Humility. *Health Services Insights*, *13*. https://journals.sagepub.com/doi/10.1177/1178632920970580

[iv] Szalavitz, Maia. (2021). Undoing Drugs: *How Harm Reduction is Changing the Future of Drugs and Addiction*. Hachette GO. https://www.hachettebookgroup.com/titles/maia-szalavitz/undoing-drugs/9780738285757/?lens=hachette-go

[v] Jones, C. T., & Branco, S. F. (2021). Cultural Considerations in Addiction Treatment The Application of Cultural Humility. NAADAC. https://www.naadac.org/assets/2416/aa&r_winter2021_cultural_considerations_in_addiction_treatment.pdf

[vi] Post, R., Green, L., Boss, R. (2022). *Boosting the power of harm reduction with culturally responsive housing, recovery supports, and treatment*. TAC. https://www.tacinc.org/blog/boosting-the-power-of-harm-reduction-with-culturally-responsive-housing-recovery-supports-and-treatment/

[vii] Beletsky, L., Heller, D., Jenness, S. M., Neaigus, A., Gelpi-Acosta, C., & Hagan, H. (2014). *Syringe access, syringe sharing, and police encounters among people who inject drugs in New York City: a community-level perspective*. International Journal of Drug Policy, 25(1), 105-111.

[viii] Bluthenthal, R. N., Malik, M. R., Grau, L. E., Singer, M., Marshall, P., Heimer, R., & *Diffusion of Benefit through Syringe Exchange Study Team. (2004). Sterile syringe access conditions and variations in HIV risk among drug injectors in three cities*. Addiction, 99(9), 1136-1146.

[ix] Franco, C. Y., Lee-Winn, A. E., Brandspigel, S., Alishahi, M. L., & Brooks-Russell, A. (2021). "We're actually more of a likely ally than an unlikely ally": relationships between syringe services programs and law enforcement. Harm reduction journal, 18(1), 81. https://doi.org/10.1186/s12954-021-00515-2

[x] Andrea Janota, et al., Indiana Drug Overdose Fatality Review, IUPUI RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH (Oct. 2018), https://fsph.iupui.edu/doc/research-centers/overdose-fatality-review-20181010.pdf.

[xi] Legislative Analysis and Public Policy Association. (2021). Model Overdose Fatality Review Teams Act. http://legislativeanalysis.org/wp-content/uploads/2021/03/LAPPA-Model-Overdose-Fatality-Review-Teams-Act.pdf

[xii] Javed, Z., Burk, K., Facente, S., Pegram, L., Ali, A. & Asher, A. (2020). Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation. Atlanta, GA: US Department of Health and Human Services, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease, Control and Prevention; 2020.

[xiii] New Jersey Department of Health, Communicable Disease Services. Overdose Data Dashboard – Viral Hepatitis. Department of Health | Population Health | Viral Hepatitis (nj.gov)

[xiv] New Jersey Department of Health. New Jersey State Health Assessment Data (NJSHAD). Infectious and Communicable Diseases. https://www-doh.state.nj.us/doh-shad/topic/InfectiousDisease.html.

[xv] Michael Enich, Claire Marie Kemp, Peter Treitler, Amesika Nyaku, Jenna Mellor, & Caitlin O'Neill. Preventable Harms: Injection Drug Use-Related Infections in New Jersey. New Jersey Harm Reduction Coalition. 2022. https://njharmreduction.org/preventable-harms-injection-drug-use-related-infections-in-nj/.

[xvi] New Jersey Department of Health, Office of Emergency Medical Services, Overdose Data Dashboard – Naloxone Dashboard. https://www.nj.gov/health/populationhealth/opioid/opioid_naloxone.shtml.

[xvii] New Jersey Department of Health, Healthcare Quality and Informatics, Overdose Data Dashboard – Drug-related Hospital Visits. https://www.nj.gov/health/populationhealth/opioid/opioid_hospital.shtml.

[xviii] New Jersey Department of Health, Office of the Chief State Medical Examiner, Drug-related Deaths Dashboard. https://www.nj.gov/health/populationhealth/opioid/.

[xix] U.S. Census Bureau. (2022). *Poverty.* https://www.census.gov/quickfacts

[xx] New Jersey Department of Health. New Jersey State Health Assessment Data (NJSHAD). https://www-doh.state.nj.us/doh-shad/home/Welcome.html.