IN THE WORKS

NEW JERSEY DRUG USER HEALTH SERVICES

ASSESSMENT REPORT

2024

Table of Contents

Table of Contents **1**
Background **2**
Approach **2**
Methodology **3**
Data Review 3
Focus Groups 3
Individual Interviews 4
Results **5**
Focus Groups 5
Overview 5
Survey Results 5
Focus Group Results 11
Promoters of Health Care Services 11
Barriers to Health Care Services 14
Recommendations for Health Care Service Expansion 16
Two Points to Share 18
Interviews 19
Strengths of Existing Services 19
Opportunities for Expanding Drug User Health Services 21
Barriers To Address & Training to Do It Well 23
Guidance for Resources 24
Implications for Action **25**
Service Expansion Led By Harm Reduction Centers 25
Training & Technical Assistance 27
Guidance & Resources 28
Policy and Licensure Considerations 29
Systems Considerations 30
Conclusion **30**
Acknowledgements **30**
Appendices **32**
Appendix A - Harm Reduction Assessment Participants 32
Appendix B - List of Items Included in the Material Review 34
Appendix C - New Jersey Harm Reduction Centers Map (updated as of October 2024) 35
Appendix D - Focus Group Flyer 36
Appendix E - Focus Group Facilitator Guide 37
Appendix F - Focus Group Survey 38
Appendix G - Focus Group Facilitator Guide (Spanish) 45
Appendix H - Focus Group Survey (Spanish) 46

Background

New Jersey has been leading evidence-based harm reduction expansion efforts through new funding, legislation, and policy to improve the health of people who use drugs. In early 2024, the New Jersey Department of Health (NJDOH) and Vital Strategies conceptualized a new initiative to leverage a moment of harm reduction expansion to center access to healthcare access for people who use drugs. In The Works, a national consulting group providing training and technical assistance to groups looking to start or expand harm reduction strategies, was retained to conduct an assessment of access to health care services for people who use drugs in New Jersey. This report was written by Taeko Frost, DrPH, MPH (Principal, In The Works) and edited by Charles Hawthorne, MPH (Consultant, In The Works) and Jessica Peñaranda (Consultant, Reframe Health & Justice).

The information in this assessment report will be used to inform technical assistance, training, and resource development to promote the expansion of healthcare services led by Harm Reduction Centers (HRCs) in New Jersey.

Approach

Between August 2024 and October 2024, In The Works sourced information from people who use drugs, community providers, government officials, technical assistance groups, evaluation groups, and existing reports. In The Works conducted focus groups with participants of HRCs across the state to build relationships with local providers and speak to people most impacted. This practice ensured that subsequent recommendations and technical assistance to expand healthcare efforts would meet the needs of HRCs and the people they serve.

First, In The Works reviewed existing material and met with key NJDOH stakeholders to clarify the goals of the assessment and align with previous evaluation work of other community providers. Then, In The Works set up site visits to HRCs across the state to have in-person discussions about facilitators and barriers to offering healthcare services to people who use drugs. During this same visit, In The Works conducted four in-person focus groups with people who use drugs on current and ideal healthcare service access. An additional two in-person focus groups were conducted with partners (Reframe Health & Justice and New Jersey Harm Reduction Coalition) in Elizabeth and New Brunswick, including a Spanish speaking focus group. In The Works conducted a virtual focus group that was open to participants of the statewide mail-based harm reduction supplies program to capture input from individuals who may not be receiving services at HRCs in-person. To get a provider and systems level perspective, In The Works conducted one-on-one interviews with community stakeholders including government officials, medical providers, Harm Reduction Health (formerly ARCH) nurses, technical assistance providers, evaluation groups, and other individuals who have a role in the system of care for people who use drugs in New Jersey. During these one-on-one interviews, In The Works would share initial themes shared in the focus groups and site visits to contextualize some of the existing barriers to healthcare services. This approach provided an

opportunity to start to problem-solve some of the issues raised by people who use drugs and identify systemic barriers. Lastly, the themes from the focus groups and interviews were synthesized and focus group data analyzed to demonstrate a baseline for existing service access and priorities.

A list of the sites for interviews and focus groups and community stakeholders who participated in the one-on-one interviews can be found in Appendix A.

Methodology

Data Review

The New Jersey Department of Health and Vital Strategies provided a list of resources including training materials, data, reports, and legislation to review to orient to existing services and assessments. A complete list of the sources of data reviewed can be found in Appendix B.

Resources were reviewed for the purposes of:

- Orientation to the policy, funding, and service delivery landscape related to substance use and healthcare access for people who use drugs
- Understanding of existing assessments speaking healthcare access, delivery, and recommendations to prevent duplication
- Identifying training providers and resources currently supporting Harm Reduction Centers to expand healthcare service offerings

In The Works created an open-access Google Map of the Harm Reduction Centers for a visual representation of service saturation across the state including current and planned expansion efforts (See Appendix C). Based on the data review and initial stakeholder conversations with NJDOH and Vital Strategies, In The Works created a list of sites for focus group discussions that would include a broad representation of geography, types of harm reduction centers, populations served, drug use trends, and scope of services offered.

Focus Groups

The purpose of the focus groups was to assess the healthcare needs of people who use drugs, identify barriers for organizations to offer services, and explore potential suggestions for partnerships to best provide services. A focus group format was selected to involve a variety of people across programs to describe the experience of attempting to access, receive, deliver, or expand health services at HRCs and beyond.

In The Works coordinated 30-minute prep calls with each HRC host site to discuss the purpose of the focus groups, recruitment strategy, and logistics for in-person focus groups. A flier was provided to promote in-person during service hours a week in advance of the focus group (See Appendix D). For the virtual focus group, promotion was conducted through a list of clients

accessing mail-based services using an online sign up form. Programs were provided a $250 honoraria to cover the cost of snacks for the group and as a token of appreciation for their collaboration.

Each focus group consisted of 5-8 participants and was facilitated using a semi-structured guide (See Appendix E). Each focus group participant completed an oral consent and a survey to collect demographic information and healthcare services accessed in the past year (See Appendix F). One of the sessions was facilitated in Spanish only and the facilitator guide and survey were translated using professional services (See Appendix G and Appendix H). One of the focus groups was conducted virtually and the survey was completed online. The survey took approximately 20 minutes to complete. Focus group discussions lasted approximately 40-70 minutes. All sessions were audio-recorded and supplemented by debrief recorded audio notes by the facilitators. Participants were provided a $75 gift card in recognition of their participation.

Discussion data were analyzed using thematic analysis and survey data were analyzed using excel. For the purposes of this assessment, the value of the demographic and healthcare access data is to offer a snapshot of the individuals who participated in the focus groups and what healthcare services they currently have access to and/or would prioritize for the future.

Individual Interviews

A total of 19 individuals participated in individual interviews. The purpose of the individual interviews was to add in contextual information for the landscape of healthcare services delivery, policy, training, and technical assistance from providers and government officials who have overseen current and previous efforts. An interview format was selected to answer specific questions and in addition to specific prompts suggested by the team based on the interviewee's expertise. Interviews were conducted virtually for 30-60 minutes depending on the availability of the interviewee. Questions were sent in advance to the interviewees and the interviewer took written notes during the interviews. The questions included:

1. What do you think are some of the strongest existing services and/or resources in New Jersey related to health services for people who use drugs?
2. What do you think are the biggest opportunities for expanding drug user health services in New Jersey & why?
3. To make that happen, what (a) barriers would need to be addressed, (b) training would need to happen, and/or (c) guidance would need to be developed to do this well?
4. We're creating a toolkit for harm reduction centers to use as a resource as they expand their capacity to offer healthcare services onsite and/or via partnerships - what resources would you want to include in that toolkit? (existing or new)

The data from the interviews are synthesized into themes in the results section. Individual quotes or comments are not attributable to specific interviewees.

The quantitative data (focus groups only) and qualitative data (focus groups and interviews) are presented in the following section.

Results

Focus Groups

Overview

Seven focus groups were conducted with a total of 50 participants. Overall, the focus group sessions were lively and well attended with all but two sessions reaching the maximum participation. Focus groups were held at program sites in a separate area from where service delivery occurred to maximize confidentiality. Many participants expressed excitement to participate in the groups, with some stating that they had been “looking forward” to the session and some noted they had “dressed for the occasion”, appreciating “the opportunity to have my voice heard”. Participants readily engaged and contributed with only a few exceptions of individuals who were a bit more reserved in sharing. Participants of the focus groups built off of each other's experience, validating or offering different opinions. There were many opportunities for participants to share positive experiences and offer information about recommended providers to peers at the moment. Following the in-person focus groups, every session had several participants who expressed appreciation for the space to share their experiences and inquired about any future opportunities to continue the conversation.

Two exceptions to this general observation of ready participation included the Spanish-only focus group and virtual focus group. Participants in the Spanish-only group were much more reluctant to participate in the discussion than the English-speaking group participants and several surveys had incomplete sections, particularly related to substance use. The facilitator noted that this may be due to documentation status that resulted in a hesitation to share anything that could be related to cultural reasons to now share due to shame and stigma, or may have been perceived as a threat to immigration. The virtual group relied on participants to use their own technology to join the conversation and had several individuals who had repeated audio issues or chose to participate by chat-only which changed the dynamic of the focus group. Given these challenges, using an interview-style approach may be more appropriate for these two groups to create a sense of safety and solicit more information.

Sociodemographic data from the survey are included in Table 1.

Survey Results

Table 1 - Sociodemographics of Focus Group Participants (N=50)

	n	%
Total	**50**	**100%**
Gender		
Man	30	60%
Woman	19	38%
Transgender	0	-
No Response	1	2%
Race		
White	21	42%
Black	14	28%
Native American	2	4%
Asian/Pacific Islander	1	2%
Other	12	24%
No Response	0	-
Ethnicity - Hispanic/Latinx		
Yes	13	26%
No	37	74%
No Response	0	-
Unstably housed in previous 6 months		
Yes	37	74%
No	13	26%
No Response	0	-
Preferred Language		
English	45	90%
Spanish	4	8%
No Response	1	2%
Site of Focus Group		
Remote/Virtual	5	10%
New Brunswick (NJHRC)	6	12%
*Elizabeth (PROCEED)**	7	14%
Paterson (BLM Paterson)	8	16%
Trenton (Hyacinth)	8	16%
Atlantic City (SJAA)	8	16%
Camden (Camden AHEC)	8	16%

Table 1 - Sociodemographics of Focus Group Participants (N=50)

Substance Use (Past 6 Months)		
Heroin	36	72%
Fentanyl	35	70%
Prescribed Opioids	13	26%
Prescribed Benzos	10	20%
Non-Prescribed Opioids	10	20%
Non-Prescribed Benzos	7	14%
Crack	25	50%
Cocaine	23	46%
Methamphetamine	15	30%
Alcohol	21	42%
Marijuana	17	34%
Tobacco	34	68%
Xylazine	24	48%
Route of Administration (Past 6 Months)		
Injected	34	68%
Smoked	31	62%
Snorted	21	42%
Ingested/Oral	12	24%
Rectal/Vaginal	1	2%
Past Year Emergency Room Visit		
Yes	34	68%
No	16	32%
Past Year Hospital Admission		
Yes	24	48%
No	26	52%
Past Year Insurance		
Yes, I have active insurance	41	82%
Yes, but didn't have it whole year	3	6%
No, I don't have insurance	4	8%
No Response	2	4%
Type of Insurance		
Public Insurance	43	86%
Private Insurance	1	2%
Other	1	2%
No Insurance	4	8%
No Response	1	2%
***Conducted focus group in Spanish**		

Following the socio demographic questions, participants were asked to complete a series of tables by domain of health care service to share:

- If they received the service in the past year (yes/no)
- If they *did* receive the service in the past year, if they received the service at the program where the focus group was being held (*Program)* or another site (*Other)*
- Regardless of whether someone received the service in the past year or not, how would they rank the health service in terms of priority level for their own health (1 = Lowest Priority to 5 = Highest Priority)

In Table 2, this total number of participants who received the service in the past year is reported (N) including the % of focus group participants (%), and whether those individuals received the service at the Program or Other site (Program vs Other).

Table 2 - Health Services Access Past Year by Site of Received Services & Priority Level (N=50)

Total	N	%	Program	Other
Vaccines				
Hepatitis A	12	24%	20%	4%
Hepatitis B	5	10%	-	10%
Influenza "Flu"	14	28%	20%	8%
COVID-19	18	36%	10%	26%
HPV "Gardasil"	2	4%	2%	2%
Point of Care Testing				
Rapid HIV test	17	34%	16%	18%
Rapid hepatitis C test	19	38%	22%	16%
Chlamydia test	11	22%	12%	10%
Gonorrhea test	8	16%	6%	10%
Syphilis test	10	20%	12%	8%
Trichomoniasis test	6	12%	6%	6%
Pregnancy test	7	14%	2%	12%
Other Lab Testing				
HIV viral load	18	36%	14%	22%
Hepatitis C confirmatory	17	34%	14%	20%
Cholesterol	10	20%	12%	8%
Hemoglobin A1c	12	24%	4%	20%

Table 2 - Health Services Access Past Year by Site of Received Services & Priority Level (N=50)

	N	%	Program	Other
Treatment Services				
HIV treatment	4	8%	6%	2%
Hepatitis C treatment	9	18%	4%	14%
Hepatitis A/B treatment	5	10%	6%	4%
Chlamydia treatment	3	6%	2%	4%
Gonorrhea treatment	5	10%	4%	6%
Syphilis treatment	2	4%	-	4%
Trichomoniasis treatment	2	4%	-	4%
Expedited partner tx	3	6%	2%	4%
PrEP	2	4%	-	4%
Contraception	1	2%	2%	-
Emerg contraception	3	6%	6%	-
Medication abortion	0	-	-	-
Buprenorphine	13	26%	8%	18%
Methadone	14	28%	-	28%
Naltrexone	4	8%	2%	6%
Detox services	7	14%	-	14%
Triage & Health Service				
Routine check up	24	48%	8%	40%
Wound triage & care	9	18%	6%	12%
Blood pressure check	23	46%	10%	36%
Glucose test	14	28%	4%	26%
Weight check	20	40%	8%	32%
Nutritional services	15	30%	4%	26%
Dental services	15	30%	6%	24%
Optometry services	11	22%	4%	18%
Prenatal services	2	4%	-	4%
Gender affirming care	1	2%	-	2%
Gynecological check up	5	10%	2%	8%
Urgent/Emergency				
Urgent care	14	28%	-	28%
Emergency visit	16	32%	-	32%
Hospital admission	15	30%	-	30%
Mental/Behavioral Health Services				
One on one therapy	13	26%	8%	18%
Counseling (case manager)	12	24%	4%	20%
Alcoholics Anonymous	10	20%	4%	16%
Narcotics Anonymous	14	28%	4%	24%
Group sessions	9	18%	6%	12%

Table 2 - Health Services Access Past Year by Site of Received Services & Priority Level (N=50)

	N	%	Program	Other
Harm Reduction Services				
Syringes				
Injection supplies	32	64%	60%	4%
Pipes	32	64%	60%	4%
Smoking supplies	24	68%	62%	6%
Snorting supplies	18	36%	32%	4%
Rectal use supplies	17	34%	28%	6%
Safer sex supplies	9	18%	16%	2%
Sex work resources	19	38%	34%	4%
Naloxone	10	20%	18%	2%
Wound care supplies	26	52%	46%	6%
Contingency management	27	54%	48%	6%
Treatment referrals	10	20%	10%	10%
	18	36%	32%	4%

Participants were asked open-ended questions at the end of the survey to share programs that they had received services that they would recommend to others. In Table 3, recommended providers by site are included for consideration of future healthcare partnerships and referral agreements.

Table 3 - Recommended Providers by Focus Group Site (N=8)

Program Site	Recommended Providers
Virtual	● St Joseph's ● Buddies of NJ ● Alcoholics Anonymous ● NJ Harm Reduction Mail Service ● Chosen Generation/Community Corp
New Brunswick (NJHRC)	● NJHRC ● Eric B Chandler ● Detox Poughkeepsie ● Robert Wood Johnson Hospital
PROCEED (Elizabeth)*	● Methadone Clinic (Lenard Clinic) ● Case management/general support for referrals (PROCEED)
Paterson (BLM Paterson)	● Detox at Bergen Regional ● Ruby's Vision ● Cap Co ● New Bridge ● Real Fix ● Pyramid Health ● John Brooks ● Hyacinth
Trenton (Hyacinth)	● Trenton treatment services ● Hunterdon medical center ● Hamilton Treatment ● Pinnacle ● Trenton Soup Kitchen
Atlantic City (SJAA)	● Integrity House ● Veterans Affairs ● Atlantic City Hospital "Healthy Plex" & Atlanticare ● Maryville ● Seabrook House ● Hansen House ● Oasis Site at SJAA ● Lacey treatment center
Camden (Camden AHEC)	● Cooper Hospital & Temple ● Prevention Point ● Market Street Mission & Mission House ● Agape (Saturdays)

Focus Group Results

The purpose of the focus group discussions was to discuss healthcare service access and experiences, and suggestions for expanding access to healthcare services in the future. First, we will review promoters of health care services. Then, we will review barriers to accessing healthcare services. Lastly, we'll review some of the initial recommendations that were offered by participants of the focus groups.

Promoters of Health Care Services

- Participants identified the nature of drop-in services as being the draw to the program and make people feel comfortable to access services.
    - *"The drop-in center, the therapy we receive here - having a little coffee, a big sandwich… it makes a difference and helps with the day to day"**
        - Original: "La sala, la terapia que recibimos aquí, tomar un cafecito, un sándwich grande… se nota la diferencia y ayuda en el día a día"
    - "*Charge your phone, get off the streets… like I'm just out there all day, I feel it, and this is the only place where I can be myself and not be like whoa looking behind my back all the time"*
    - *"The city literally has made it impossible to be anywhere outside… you're just constantly getting swept up, like trash, so if you don't have a place to put your head you're just on the move all the time"*
    - *"You know, we need more people like you, because you helped me so much. Yes, you know, and that's a job in itself. You know, Leah definitely got a place in the golden care."*
    - *"Like someone just knowing your name… they have someone new so they only knew that other guys name not mine, and I felt like damn that made a difference, they called me [name] but that's not my name, but he's new… most people know me here and that feels good"*
- Participants expressed a strong sense of trust and appreciation for harm reduction centers and described the culture and welcoming nature of harm reduction centers as unique compared to other providers that they receive services from. This theme was particularly salient in the Spanish-speaking group and spoke to the frustration and confusion of having to navigate additional service locations.
    - *"This is hands down the best place and only place for me - I don't go anywhere else if I don't have to"*
    - *"I like the people that work here, it just feels good to be here"**
        - *Original: "Como que… es que me gusta la gente que trabaja aquí… es muy bueno estar aquí"*
    - *"Just the space, sometimes I just need the space you know, to just rest and just be… make me feel alive again"*
    - *"People here aren't going to judge me, you know what I mean? That's a big part of it… if you feel the doctor is judging you for being an addict, why would you go"*

- Participants expressed a strong belief that if they needed a healthcare service that the harm reduction center staff would be the first person to ask and get the support needed to receive the service
    - *"I know she [ARCH Nurse] isn't my doctor doctor but I can basically get anything I need here or she will help me get it"*
    - *"They have the van so I got the [hepatitis C] test and they had a telehealth doctor who got me the treatment just like that"*
    - *"I'm out in the streets and like I just got robbed coming here… but they hold onto my medication so yeah this place makes it easier for me to stay on my meds"*
- If given the opportunity to receive health care services at the harm reduction center, they would choose the harm reduction center. For some of the participants that had that option, they expressed positive experiences with care.
    - *"If I could get all my services here, I would - that would be the best option"*
    - *"I'm done going to [hospital name] because they literally let me walk out naked in just the gown because they didn't want to help me - and then I just came here"*
    - *"I can just get everything I need here instead of running around here and there, spending the whole day running around different places… everything in one place here"**
    - "*Like a walk in, even have to be a walk in every day, like maybe Monday, Tuesday, Thursday, or Monday, Wednesday, Friday, or Tuesday, Wednesday, Thursday, whatever you know, just, you know certain days that you have to make a moment, certain days that they had walk ins, you know what I'm saying, that would be great, because sometimes like you have to we forget, or we cut off*"
- Knowledge of and experience accessing buprenorphine was overall very high across all groups and the challenges were specific to the period of time for induction, with several participants remarking on housing access being a key component
    - *After asked multiple prompts about access to buprenorphine "Yes, I hear what you're saying, but it's actually just that easy to get it now - like anyone can get it, it's the easiest thing to get now"*
    - *"You can get it here, the hospital, the mobile unit, [provider names]... it's everywhere"*
    - *"You can get suboxone but its not really about that - its like some places will give you comfort meds but other times they won't so it's just a crapshoot of how painful it will be… and sometimes people just don't want to go thru all that"*
    - *"Where am I supposed to go if I'm like rolling around in like the worst pain… it's just too much to do on your own"*
- Knowledge of and experience with accessing hepatitis C treatment was overall very high across all the groups, specifically referring to NJCRI (North Jersey Community Research Initiative) mobile units when prompted to get more information about testing and treatment access
    - *"That's a good example of how to make it easy - they just have this van and you get all the testing and treatment and information all right there, parked right over there… I tell everyone about that because I got treated just like that [snaps finger]"*

    - *"Just more of those vans, like put them everywhere, and more testing and medication there… it was so easy, I wasn't even planning to do it and BAM it just happened"*
- Participants expressed positive experiences at HRCs and other programs where mobile services were offered to come to them, including encampment or home visits.
    - *"I want to say that I would you know go to a place if you said there was a doctor you liked or whatever… or I'd ask my friends… but how far away are they? Are they like right right here? Because that has a big impact you know… I'm not thinking about that all the time, you gotta come to me and maybe I'll be there maybe not…"*
    - *"Especially when you're diabetic and you know you gotta keep your nails and your feet. They should have people like, yeah, they need more help because they're older and can't get around"*
- Participants expressed appreciation for group-based services
    - *"I like the group services here that focus on recovery even if I'm not always there"**
        - *Original: "Me gusta los grupos aquí… como que se centran en la recuperación, incluso si no siempre estoy presente"*
    - *"We could even play games, like BINGO or something, so we can just forget about the outside world sometimes…"**
        - *Original: "Incluso podemos jugar juegos, como BINGO o algo, así a veces podemos olvidar del mundo afuera"*
    - *"Like yes getting therapy is important but I also think… we're just out here and people don't even know our names, our stories. I think having more spaces for just talking with other people about things that aren't just drugs would be really helpful"*
- Insurance access was not explicitly discussed in either direction except by a few people over the course of the focus groups and, based on the survey data, 90% of participants reported that they had active insurance for the whole year (82%) or part of the year (6%). The issue of insurance coverage or cost was rarely mentioned, except for two remarks in the Spanish-only focus group.
    - *"If you're 60 or older you can get benefits and insurance but if not it's really hard to get… and that doesn't seem right"**
        - *Original: "Si tienes 60 años o más… puedes obtener beneficios y seguro, pero si no, es super difícil conseguirlos… y eso no parece bien"*

Barriers to Health Care Services

- Housing is a major influence on one's ability to stay engaged in healthcare services, including follow up appointments, health insurance, vaccination history, and medication management.
    - *"That's the only thing I'm thinking about - am I going to be sick in an hour, two hours, and then after that is where I'm sleeping tonight or where my stuff is. If it's right in front of me fine yeah maybe but I'm like catch me if you can you know?"*

    - *“Housing housing housing… there’s none here. I went to John Brooks and then got into a halfway house, got a job, I was going every day… I was getting my life back. But then I split a place with a buddy and he didn’t pay his fair share so we lost the apartment… and then I got back in the mix all over again and have to start over… it takes a lot of energy”*
    - *“I have [provider] hold onto my meds otherwise they wouldn’t last with me more than a few hours to be honest”*
- Pain management in general and specific to methadone and detox services was reported as the top barrier to health care services. Several participants described inadequate pain management in hospital settings that prompted participants to leave against medical advice. Others described inconsistent pain medication during detox and exceedingly long runways for increasing methadone dosing to the point where people went back to using illicit drugs. Several times participants would compare providers or practices that they had experienced, emphasizing the inconsistency of pain management.
    - *“There is only one place I go to detox because they basically knock you out for 2 days so you don’t have to go thru all that [pain]... like even an Ativan or something, because I’ve been places where they give you a few Tylenol and that’s it… it's a nightmare”*
    - *“I’ve been trying to increase my methadone for months now… some programs have 200mg as a max, but this one I’ve been stuck at 120mg and they just won’t increase my dose and I don’t understand why… I was taking pills before my injury and I’m like don’t you see I’m trying to keep my good life? I don’t want to go back on pills or heroin but here I am”*
    - *“They aren’t following best practices here… they need to look at Canada because they have these programs and basically use morphine legally for pain management and legal heroin. They use it at Temple right now and I know someone who went through it and said it was amazing… like why aren’t they doing that? I mean we know why but that’s what would be ideal.”*
- Access to primary care services in general were mixed across groups - while some participants expressed confidence in receiving services that were at or supported by the Harm Reduction Center facilitating appointments or several instances of individuals with private insurance with a regular primary care providers, other participants expressed indifference to or disdain for engaging with the medical system
    - *“There's so many people that got little, minor things that you know that have to be done, but they're afraid to go to a doctor… We need something like that, you know, like the old times, you know, they used to have people come and they used to treat them, you know. But now times are getting really harder and harder, and people are backing away from doctors, and people are dying again from these little diseases…they don't want to go to die”*
    - *“Me being a diabetic, I know, like, there's a lot of homeless people who don't have, like, strips reading. We can get somewhere, like, when we get into the other building, like, soon with someone going, check the check their levels, your sugar high, or your sugar real low…it's bad, yeah”*

    - *“I get everything I need here and if I can’t they either bring it to me or bring me to them - that’s it, end of conversation”**
        - *Original: “Tengo todo lo que necesito aquí… y si no, me lo pueden traer o me lo llevan a ellos… eso es… todo, fin de la conversaciòn”*
    - *“I have had my same PCP since I was a kid and he still sees me, I’m on my parents health insurance and they know all about what is going on… it's nice to have that history but also sometimes it feels maybe I’m a lot”*
    - *“If there was a doctor that I could actually talk to about all of me, all the things that are going on - yeah, I would see a doctor and go back. But they have to prove that to me because I ain’t seen it yet”*
- While not a theme across all groups, several groups with one in particular noted that mental health services were limited to not accessible at all. Participants shared emotional testimonials of watching their peers or their own mental health deteriorate over the years and several individuals asked the facilitators to support with getting resources for mental health to the top of the priority list.
    - *“I’ve saved my girlfriend from killing herself two times now… like she needs mental health and medication and she’d get it if she could. I’ve looked into it but haven’t had any luck, and then things will get better but then another episode will come along and I’m like googling everything I can to get her help… and probably for me at this point too”*
    - *“Ever since my wife died I’ve been lost here… I had a whole life, I have kids, she did everything to organize our doctor visits and all of what you’re talking about… now I’m just here, floating in limbo… I got treated for hepatitis C there on that van but other than that? Nothing. And I know I need to do something before it’s too late.”*
    - *“I have a counselor I talk to but the issue is medication… they can’t prescribe it to me so I have to see someone else but I’m not sure how to do that”**
        - *Original: “Tengo un counselor así y hablo con el pero el problema es la medicación… no me pueden recetar así que tengo que ver a otra persona… no se cómo hacerlo”.*

Recommendations for Health Care Service Expansion

Participants were asked a question about how they would prioritize 63 unique individual healthcare services in the survey in addition to discussion in the focus group sessions. To reconcile these two methods of reporting priority level and recommendations for health care service expansion, the health care services that were ranked a 3.6 or above on a 5 point scale are indicated below to represent the top 30% of services and supplemental context from the focus groups is indicated for each.

Table 4 - Priority of Health Care Services for Future Expansion & Focus Groups Notes (N=50)

Service	Priority	Focus Group Comments
Vaccines		
Hepatitis A	2.8	Access to vaccinations was not brought up except for in the context of COVID-19 vaccines being available at some of the sites
Hepatitis B	2.6	
Influenza "Flu"	2.6	
COVID-19	3.1	
HPV "Gardasil"	2.2	
Point of Care Testing		
Rapid HIV test	**3.8**	HIV and hepatitis C testing were brought up as accessible at the sites (HIV) and/or through partnerships (HCV primarily), with some participants (predominantly female) naming that they had ready access to STI screening at the HRC
Rapid hepatitis C	**3.6**	
Chlamydia test	3.0	
Gonorrhea test	3.1	
Syphilis test	3.1	
Trichomoniasis test	2.7	
Pregnancy test	2.7	
Other Lab Testing		
HIV viral load	**3.7**	HIV viral load testing was not brought up in any of the focus groups; hepatitis C confirmatory testing was brought up as one of the easily accessible services via NJRCI and several participants asked about what labs were called for diabetes (A1c) and mentioned having diabetes and/or knowing they were at risk for developing Type 2 diabetes
Hepatitis C confirmatory	**3.9**	
Cholesterol	3.1	
Hemoglobin A1c	**3.6**	

Service	Priority	Focus Group Comments
Treatment Services		
HIV treatment	3.4	Of the treatment services listed, hepatitis C
Hepatitis C treatment	**3.7**	treatment and buprenorphine were the most
Hepatitis A/B treatment	3.2	discussed in the focus groups sessions as
Chlamydia treatment	3.0	described in the focus group results.
Gonorrhea treatment	3.1	
Syphilis treatment	2.8	While there were several focus groups that
Trichomoniasis treatment	2.9	surfaced STI treatment and other reproductive healthcare services, they were raised nearly
Expedited partner tx	3.2	exclusively by women identified participants and in
PrEP	3.2	the context of sharing that they had access to
Contraception	3.2	everything they needed via the HRC or a PCP.
Emerg contraception	2.7	
Medication abortion	2.3	Detox services were not described as easily
Buprenorphine	3.4	accessible across all focus groups and varied by
Methadone	**3.9**	region.
Naltrexone	3.0	
Detox services	**3.9**	
Triage & Health Service		
Routine check up	**4.2**	“Having a doctor” for routine check ups was a high
Wound triage & care	3.5	priority and a focal point of the group discussion,
Blood pressure check	**3.6**	but in the context of how to find a doctor that was
Glucose test	3.4	willing to address pain correctly and who
Weight check	3.2	participants could be open with about substance
Nutritional services	3.3	use.
Dental services	**4.2**	
Optometry services	**3.8**	Dental and optometry services were seen as less
Prenatal services	2.9	available or promoted overall, although two sites
Gender affirming care	2.5	had participants who shared options they had
Gynecological check up	3.3	access to that worked well.
Urgent/Emergency		
Urgent care	**3.6**	While not “services” that someone would
Emergency visit	**3.7**	necessarily choose to access, many of the focus
Hospital admission	3.5	groups started off with stories about health care that involved negative experiences with the local hospital and urgent care settings. While these are ranked on the higher end, it is likely that this is because they are seen as a necessity rather than wanting to prioritize more of this care. However, prioritizing *increased cultural competency* and pain management in these settings was discussed as a priority.

Service	Priority	Focus Group Comments
Mental/Behavioral Health Services		
One on one therapy	3.5	Mental health was not raised as a priority during the groups with the exception of one site. Group-based sessions were discussed as a high priority across at least half of the groups, with a notable emphasis in the Spanish speaking group.
Counseling (case manager)	3.5	
Alcoholics Anonymous	3.4	
Narcotics Anonymous	**3.6**	
Group Sessions	3.2	
Harm Reduction Services		
Syringes	**4.3**	When initially asked about services that participants felt were priority, participants overwhelmingly talked about both the supplies and connection that harm reduction centers offered right away. The highest ranked service across every domain was wound care supplies which speaks to the many accounts of xylazine-specific issues that participants described, including up to amputation of limbs. This theme was apparent across all areas of the state. Treatment referrals was in the top 10 priorities but discussed barriers due to practices for detox, pain management, and lack of housing to "stay out of the mix" after treatment. Several participants remarked that they did not have access to some of the supplies on the list and wanted to follow up to understand why (e.g. smoking supplies, snorting supplies)
Injection supplies	**4.2**	
Pipes	**3.9**	
Smoking supplies	**3.8**	
Snorting supplies	3.5	
Rectal use supplies	3.5	
Safer sex supplies	**4.0**	
Sex work resources	3.3	
Naloxone	**4.2**	
Wound care supplies	**4.6**	
Contingency management	**3.7**	
Treatment referrals	**4.2**	

Two Points to Share

At the end of each focus group, the facilitators asked if they could relay two points to the Governor of New Jersey that would improve the health of people who use drugs, what would they share. Below is a synthesized list of categories that were shared across all 7 focus groups:

- Increase access to affordable, low barrier housing to address health issues to begin with
- Increase the number of harm reduction centers and/or their hours/capacity to operate, including promotion and marketing of the services
- Increase the number of drop-in centers or places for people to connect and "just be"
- Centralize services to have more "one stop shop" options for all forms of healthcare and treatment including basic triage, blood pressure checks, finger sticks, and point of care testing

- Offer humane and evidence-based pain management practices in all settings (hospital, detox)
- Offer training to healthcare providers on how to work with people who use drugs in a non-stigmatizing way
- Improve access to methadone and ability to increase dosage as needed based on patient perspective
- Address the xylazine in the drug supply and general issues with contaminated drug supply
- Increase access to mental health services including prescriptions for mental health medications
- Include more opportunities for people who use drugs to have a say in policies at harm reduction centers and issues that affect them
- Open overdose prevention centers where people can use under supervision of trained personnel
- Offer more pathways to employment and support after drug treatment programs are completed

Interviews

The 19 individuals who participated in the interviews were all asked the same questions with several probes depending on their area of expertise. The tone of the interviews across the board felt high energy, hopeful, and oriented toward action and collaboration. The themes from the interviews are summarized below based on each question posed during the interview.

Strengths of Existing Services

Question: What do you think are some of the strongest existing services and/or resources in New Jersey related to health services for people who use drugs?

- **Scaling Harm Reduction:** Overall, there was a lot of energy and recognition that New Jersey has a supportive administration, legislation to support harm reduction expansion, and new resources to fund new harm reduction initiatives. Interviewees in other systems of care noted that harm reduction was becoming “mainstream” and more widely accepted in theory, but that the programs rolling out were not always well coordinated or funded long term. Many interviewees noted that HRCs were “somewhat siloed” either intentionally or because they tended to be smaller programs and that harm reduction providers would benefit from sharing the value of their program to other systems of care. One interviewee described successes in a hospital system related to ensure that naloxone was being distributed to any patient who had come in for a non-fatal overdose, going from under 20% compliance to over 90% compliance in two years. Most interviewees working in the health sector said “this is the moment to do the big push” because there is an openness, more acceptance, and political will to expand harm reduction initiatives.

- **Naloxone:** Every single interviewee described the success of naloxone distribution and saturation in the state, across HRCs and NJDOH and OTPs - that the public's awareness of naloxone seemed to be high and supply has not been an issue. Several interviewees mentioned that the successes around naloxone has been a "common denominator" for different systems of care to embrace harm reduction.
- **Policies:** Recent harm reduction legislation to expand services was cited by nearly all interviewees as a major win for harm reduction to support the existing services. Several interviewees mentioned that the OTP regulations were in the process of being updated by NJDOH and would offer more opportunities for harm reduction initiatives onsite.
- **HRHN Program (formerly ARCH Nurse Program):** The rebrand to *Harm Reduction Health Nurse* was cited as an important reframe of how to center harm reduction approaches in health care and recognized that the program was working well overall. The HRHN interviewees reported feeling connected to other HRHN's and that they had access to training they needed. The HRC staff that were interviewed quickly cited having a nurse onsite was "a godsend" and felt that participants were receiving care or follow up they needed related to health issues.
- **Partnerships:** Several interviewees mentioned that the Cooper Center for Healing partnership was a strong example of how HRCs can effectively partner with healthcare providers, that having the connection between the HRHN Nurse and a provider who could see patients for prescriptions and follow up was essential because "if they are there and ready to be seen, you may only have that one window". Interviewees discussed that an under-documented or less known component of what makes a partnership successful is having "charismatic and motivated leaders in each organization, person to person contact that is focused on the partnership being successful" to really make it work. Several hospital system adjacent interviewees were clear that any larger scale impact had to come from the top and if initiatives don't come with a financial incentive to bigger systems of care, they aren't likely to follow through.
- **Hepatitis Screening & Treatment:** The NJCRI hepatitis screening and treatment model was brought up as one of the strongest services across the state by most interviewees. The strengths of this program were that it was statewide and had both telehealth and mobile components to meet people where they are at. This program was also connected to other systems of care (e.g. drug treatment programs, prisons) and got people from testing to treatment in a short period of time compared with other sites. Several individuals credited the funding mechanism via the 430b program as being a key component to the nimble nature of the services being provided. Some interviewees expressed concern that additional state funds may come with red tape and compromise the ease with which they operate. It was also noted that word-of-mouth is incredibly important and that participants receiving services are the most effective promoters of its services by sharing their positive experience.
- **Opioid Treatment Programs:** Several interviewees noted that opioid treatment program initiatives including low barrier buprenorphine, more progressive wardens in jails seeing harm reduction expansion as a benefit, are working well. Access to low barrier MOUD has been modeled after other states that have had successful expansion and there are many entry points. Several interviewees mentioned that low threshold buprenorphine at

programs that aren't necessarily licensed via mobile services have expanded and there are 3 new units contracted through opioid settlement dollars to expand in under-resourced communities. Low threshold buprenorphine is also available in some homeless shelters.

Opportunities for Expanding Drug User Health Services

Question: What do you think are the biggest opportunities for expanding drug user health services in New Jersey & why?

- **Scaling Harm Reduction:** Harm reduction is still relatively new in both medical and social services worlds outside of harm reduction centers and people are motivated to implement harm reduction if there is leadership in support and resources to run with, but needs to come from a "top down" approach. One interviewee described that "culture change is the easiest lift" compared to building up new services that require equipment/credentials/capacity, so investing in some of the organizations that are newer to harm reduction but have the administrative infrastructure to do the services is a good match; that "when you pair non-billable service and billable services, you get sustainability - if you're small and grassroots, you have to figure out what is billable, and if you're bigger, you have to build the culture change to support harm reduction".
- **Harm Reduction Centers:** For the HRCs, several interviewees described that the real opportunity is to share their value to healthcare systems and hospitals because they see overlapping patients. If HRCs are able to bill Medicaid or create partnerships, they can address some of the issues related to sustainability that continue to come up. While some interviewees noted that it's important to be geographically specific and focus on local partners to address local issues, other interviewees shared they felt that the HRCs did not have a lot of power to change what is fundamentally a "money driven system" and that the opportunity rests with NJDOH to work with other systems to support wider scale harm reduction expansion and "no wrong door" policies to see meaningful change.
- **Partnerships:** While most interviewees who spoke about partnerships with hospitals and healthcare organizations said that they could rely on some smaller scale person-to-person initiatives to improve access to care, larger systems change starts at the top. One interviewee recommended that NJDOH work with New Jersey Hospital Administration and call each CEO to get a group agreement that harm reduction services need to be expanded in the hospitals, and come up with a handshake agreement to make it happen. Another interviewee suggested working with the OTPs to better partner to provide harm reduction services co-located at OTPs since their regulations may limit them from expanding services. Another interviewee suggested looking into NJ Quality Improvement Plan (NJ QIP) opportunities to better integrate harm reduction into the behavioral health and hospital admission prevention programs.
- **HRHN Program:** Several interviewees discussed that the HRHN program rebrand and focus on harm reduction is important and that there may be a perception that there isn't enough outreach done by the HRHN program and/or other staff about what services are available. While the training for HRHN's is the same and people felt they were mostly on

the same page, there was a divide of “old school” versus “new school” HRHN’s and that some values and approach to practice should be reconciled to ensure everyone is on the same page. Another interviewee suggested that onboarding HRHN’s to shadow other harm reduction focused HRHN’s in person for the first month would be an effective strategy to promote learning, mentorship, and networking.

- **Hepatitis Screening & Treatment:** The near unanimous message from interviewees was to “just triple or quadruple what NJCRI is already doing” and viewed the best opportunity to expand would be more mobile units with staff to fully scale and meet the need across the state. Several interviewers recommended more peer navigators specific to Hepatitis C to challenge stigma and logistically connect people to care.
- **Opioid Treatment Programs:** Several interviewees identified that the main barrier is the cultural transition of traditional recovery-oriented staff to adopting a harm reduction framework and practice, making it less welcoming and “more of the same” for people who use drugs who have been treated poorly in these programs. Two interviewees mentioned that DMHAS should increase funding to get people into drug treatment and recovery centers.
- **STI Testing & Treatment:** Need to increase rapid testing due to lack of follow up with the priority being chlamydia/gonorrhea/trichomoniasis and some syphilis. One HRHN specifically shared that follow up and supplies for syphilis testing and treatment was particularly challenging.
- **Wound Care:** About half of the interviewees talked about wound care as a top priority but were split on whether higher threshold medical services were needed versus scaling lower threshold training with paraprofessionals would be efficient. Interviewees were mixed in responses of whether xylazine was an issue across the state versus in just the Camden area.
- **Vaccines:** Need to expand access to vaccines - there aren’t clear funding mechanisms to launch vaccine services for people who are uninsured
- **Housing:** More than half of the interviewees recognized and named access to affordable housing as being a major barrier to uptake of health care services and drug treatment. Several interviewees discussed the challenges of seeing patients who had received medications but then lost them in an encampment sweep, or that people had been through the hoops to get housing and finally got a section 8 voucher, but weren’t accepted anywhere. Housing was identified as a predictor of one’s ability to successfully navigate health care and drug treatment and a barrier that feels well beyond the scope of anyone consulted as part of this project.
- **Mental Health:** While some HRCs are receiving funding to offer mental health services, a major barrier to offering mental health has been (a) dual credentials required for substance use and mental health, and (b) difficulty to get a prescriber to offer medications creating a feeling that “our mental health work only goes so far when people really just need medication” and “you can’t get people to stop using drugs when they’re in the throws of being bipolar”. One interviewee identified that undiagnosed or untreated ADHD in early teens had been a pattern in patients that she had been seeing and wondered about that being at the root of initiation into substance use. However, a few

interviewees noted that the HRHN capacity to do mental health services may be very limited and recommended a different strategy to get those needs met.

Barriers To Address & Training to Do It Well

Question: To make that happen, what (a) barriers would need to be addressed, (b) training would need to happen, and/or (c) guidance would need to be developed to do this well?

- **Scaling Harm Reduction:** Harm reduction as a practice continues to experience pushback from providers and/or people are just starting out so they're learning and imperfect, and some silos are created by harm reduction centers intentionally or unintentionally isolating themselves. There is a desire to meet in the middle and give enough space for people who are learning to make mistakes or use imperfect language versus being told that they aren't "real harm reductionists" and feeling discouraged. One interviewee described that "recovery feels like a bad word to some people" and that the recovery focused initiatives get dismissed in harm reduction centered conversations. To scale harm reduction training, create initiatives in partnership with member organizations (e.g. New Jersey Hospital Association) that have influence on providers to get on the same page about the evidence, approach, and challenging stigma. Training should be virtual and accessible to providers across the state with differing schedules/shifts. Another interviewee described the need to work toward adding harm reduction services to be Medicaid billable as the only true way to sustain and scale harm reduction services. The same interviewee described that some initiatives and conversations had taken place but "went nowhere", while another interviewee shared that regulations and conversations about Medicaid funding harm reduction services were well under way. Several interviewees expressed that so long as there is a major structural issue with substance use and mental health credentialing being separate licenses and billing processes, people can't work in the same place to bill for services and can't grow or be sustainable long term.
- **Geographic Specific:** Several interviewees discussed the hyper-localization of determining what services are needed because there is so much variation across the state, particularly noting that Southern New Jersey has the most limited resources and newer emerging populations of people using drugs. One interviewee suggested that doing a "high level meeting with outpatient and acute care" organizations to get on the same page about harm reduction services, referrals to HRCs and/or partnerships" would have the most impact across the state because many providers in more remote areas of the state aren't "getting the memo and falling behind".
- **Harm Reduction Centers:** For the HRCs, there was some expressed concern that programs with limited infrastructure may begin to offer health care services without having the proper training, bandwidth, or sustainability to do it well. Therefore the opportunity for more partnerships with FQHCs and CCBHCs that are leaning toward harm reduction but aren't offering the same scope of services may be preferable, or sharing a statewide provider network (similar to NJCRI) to round out health care services across the state.

- **Hepatitis Screening & Treatment:** For NJCRI, the capacity and system is in place and need to know what other stakeholders need to deliver the services in partnership. However, there needs to be continued work on increasing access to testing and treatment in the jail system.
- **Opioid Treatment Programs:** To decrease stigma and improve harm reduction practices in OTPs, several interviewees recommended (a) partnerships with HRCs to offer harm reduction supplies and services if the OTP is not comfortable or ready to do so, and (b) scale training to staff to understand the basics of harm reduction and how it fits into their current work and practice.
- **STI Testing & Treatment:** Increase the funding for rapid testing to expand to HRCs who have capacity to take it on and use data to inform when additional testing may be needed. More training is needed on syphilis specifically because it requires more skill in terms of how to track rapid plasma reagin (RPRs) tests and levels.
- **Wound Care:** For a higher threshold service, having a partnership with a medical provider to look at wounds and provide necessary debridement was one suggestion. For lower threshold service, training all staff to talk to participants about wound deterioration (vs infection) for xylazine wounds only requires a visual handout and some basic supplies.
- **Vaccines:** Identify a funding source to improve the existing vaccine program to make it eligible for people without insurance; consider partnerships with providers who can host vaccine events and/or hold appointment times or walk in times for vaccines
- **Mental Health:** There was agreement that addressing the dual credential issue is a high priority to effectively scale and expand mental healthcare access. Two interviewees suggested doing lower barrier mental health services with a social worker or therapist and sharing a provider who could do telehealth appointments and write prescriptions for mental health medications as a work around to meet an unmet need across the state.

Guidance for Resources

Question: We're creating a toolkit for harm reduction centers to use as a resource as they expand their capacity to offer healthcare services onsite and/or via partnerships - what resources would you want to include in that toolkit? (existing or new)

- **Scaling Harm Reduction:** Basic harm reduction training accessible to providers in other systems of care that is required or has some kind of mechanism for ensuring that providers are receiving training. For programs that are newer to harm reduction or staff who are newer to harm reduction, offer a “credential” or process to get everyone on the same page. One interviewee spoke about the integration of peer recovery specialists into a hospital system and the lack of basic training around harm reduction, seeing most encounters be focused on recovery oriented steps without the option of referrals to HRCs. One interviewee shared that The College of New Jersey got a contract to do training for peers and this should be continued and scaled for a broader audience.
- **Partnerships:** To promote partnerships, HRCs need a tool to understand how they fit into the existing system of health care. One interviewee described a resource as a “check list” for HRCs to reflect on how they partner with programs (e.g. CCBHCs,

hospitals, OTPs) and prioritize exploring partnerships first before trying to expand their own services.

- **STIs:** Refer to the soon-to-be updated HRHN website for resources and guidance materials.
- **Hepatitis C Testing & Treatment:** Information for HRCs to know how to plug into existing hepatitis C testing and treatment initiatives
- **Wound Care:** Clarification on who can do "basic" wound care for participants and a strategy to scale education for providers across the state is needed. Several interviewees offered guidance and resources for trainings or materials they have used that they believed would be effective if used by staff at HRCs
- **Testing & Treatment Services:** Clear guidance for HRCs who want to expand healthcare services - what is the minimum credential of personnel by services offered, equipment or spaces needed, policies needed, guidance needed. One interviewee recommended the CDC webinar series and tutorials on STIs that were easy to access and may be an appropriate level of information for HRC staff.
- **Pregnancy & Parenting:** More training or guidance and resources to navigate how to support people who are pregnant and using drugs and local partners who will use a harm reduction approach to support them in receiving care. While the focus group participants who identified as women expressed confidence that their reproductive health needs were met, continued review of service access remains important for future expansion.
- **Overdose Prevention:** Some programs are beginning to use oxygen to manage opioid overdoses, but there isn't guidance on who can use it or when. When it comes to overdose response there should be clearer guidance on practices.
- **Harm Reduction Supplies:** Some programs are not giving out safer smoking supplies and it's unclear why; since the transition from injection to smoking is considered a harm reduction strategy, several interviewees identified that more education and training is needed to get programs on the same page. The New Jersey legislature only recently changed the law to allow HRCs to distribute smoking supplies earlier this year which may be one explanation for the delay in distribution.

Implications for Action

The findings from the focus group survey, focus group discussion, and interviews with community partners have many potential implications for action. The following section reconciles the recommendations from people who use drugs and interviewees. The implications for action are described in the following categories as they relate to the locus of control for who has the role to take action: Service Expansion Led by Harm Reduction Centers, Training, & Technical Assistance, Guidance & Resources, and Policy & Systems Considerations.

Service Expansion Led by Harm Reduction Centers

1. **Drop-In Centers** were repeatedly named in focus group discussions as a top priority because of the lack of available space to be during the day. Drop-in centers (e.g. The

Engagement Center in Boston) offer a place to connect to services, socializing, and other resources that participants shared were less available or not available in other settings. Particularly for people who are unhoused, considering how to integrate well care services like showers, washers, dryers, computers, phone charging, and other basic living need services may be worth exploring.

2. **Harm reduction supplies** were identified as the top priority of services for people who use drugs - continuing to expand capacity to offer additional hours, sites, and ways of connecting with people in person and remotely is a top priority for people who use drugs. Several participants and interviewees noted that safer smoking supply distribution was not consistent across programs or perceived as available and may benefit from some additional education and training for programs.
3. **Wound care supplies and services** were identified by both people who use drugs and interviewees as a top priority. Xylazine related wounds are impacting people who use drugs across the state and continuing to offer both wound care supplies and basic instruction of how to navigate both xylazine and other wounds is a top priority for people who use drugs. While there was some discussion of whether wound care services should or shouldn't be offered by paraprofessionals, the majority agreed that the potential risk to the organization didn't outweigh the consequences of limiting wound care services for the person who needed assessment and supplies. Pathways to offer more wound care support may mean (a) offering additional wound care supplies and education, (b) training staff to offer more hands on assessment and support for people with wounds including how to identify when to go to the doctor or emergency room, (c) for HRCs without an HRH nurse look into partnerships or provider agreements to offer wound care and assessment, and/or (d) develop partnerships with local providers who will receive an active referral for wound care services.
4. **Routine medical care** was a top priority for people who use drugs. HRCs with a HRHN had participants who shared that many of their health needs were met compared to sites without an HRHN. HRCs can increase access to routine medical care by (a) continuing to offer services through the HRHN, (b) the HRHN program to continue to expand to serve other HRCs, (c) for HRCs with and without HRHN's explore partnerships with local CCBHCs and FQHCs to identify opportunities to partner or co-locate, (d) explore partnerships with local hospital and acute care settings to identify a champion to co-locate or have a warm-line to receive patients for services.
5. **Referrals to MOUD and Detox** were a top priority for people who use drugs and multiple interviewees described opportunities to partner with OTPs to better integrate services. Several interviewees identified that drug treatment program regulations were being modified to allow for integration of harm reduction services as one way to expand harm reduction services, but noted that for a variety of reasons some programs may not want to expand services but may be open to partnerships. HRCs should explore pain management protocols to understand and share practices with participants so they are aware of the protocol before initiating treatment, and prompt conversations to connect with COEs for academic detailing if protocols are not in line with recommended practices.

6. **Mental health** services and specifically prescription medications were a high priority for both people who use drugs (in discussions of the focus groups specifically) and identified by providers at HRCs. The recognition of untreated mental health issues that were underlying substance use was identified as a priority, but logistically more complicated because of licensing requirements and provider availability. Several HRHNs noted that it was a priority but felt difficult to take on and that a shared prescriber and telehealth would be an ideal expansion strategy.
7. **Dental services** were a top priority for people who use drugs but did not come up in any of the interviews. HRCs would benefit from inquiring with their participants where they receive dental services (if at all) to try to source peer-recommended services and reach out to partner to create a warmline.
8. **Optometry services** were a top priority for people who use drugs but did not come up in any of the interviews. HRCs would benefit from inquiring with their participants where they receive optometry services (if at all) to try to source peer-recommended services and reach out to partner to create a warmline.
9. **Rapid HIV and Hepatitis C** testing and treatment were a top priority to be continued for people who use drugs and mobile-based services were echoed by both participants and interviewees as the most effective strategy to engage people in care. Participants and interviewees recommended expanding or replicating NJCRI's model and not reinventing the wheel.
10. **Group-based services** were a top priority for people who use drugs but weren't mentioned by many interviewees. For those that did speak to it, the emphasis was on drop-in center education on different topics. For participants, the emphasis was on community connection and having a place to be. Narcotics Anonymous and Alcoholics Anonymous are seen as valuable resources and can be used as a resource for those who are looking for that option.
11. **STI Testing and Treatment** was amongst the higher priority services to be continued. Multiple HRHNs spoke to the need for syphilis specific training and materials to expand services. While reproductive health care services were not ranked as higher priority or discussed in focus groups or interviews, continuing to seek out partnerships that offer reproductive healthcare services should still be prioritized.

Training & Technical Assistance

1. **Harm reduction supplies**
    a. Refresh on safer smoking patterns and value as a harm reduction strategy to share the value of safer smoking supplies
    b. While not mentioned during the focus groups or interviews, expanding awareness and technical support for implementation of vending machines to maximize supply access across the state
2. **Wound care supplies and services**
    a. Share resources on virtual and in-person wound care training for HRC staff
    b. Review current wound care kits and materials used by HRC staff to align with best practices

    c. Review current capacity to offer wound care services and map out additional options for lower and higher threshold services including partnerships
3. **Routine medical care**
    a. Create learning cohorts to map out strategies for expanding onsite services, exploring partnerships, and/or co-location models of partnerships to expand healthcare services to HRC participants
    b. Offer individual technical assistance to organizations pursuing different partnership strategies that are geographically specific including creating value propositions for partnerships and prospective budgets for onsite integration
4. **Referrals to MOUD and Detox**
    a. Create an assessment survey for HRCs to do quick identification of service utilization, priorities, and potential partnerships *including barriers to care*
5. **Mental health**
    a. Offer individual technical assistance to organizations to identify potential pathways to integrate mental health services through onsite services, shared providers, and/or partnership strategies
6. **Dental services**
    a. Offer individual technical assistance to organizations to identify potential pathways to integrate dental services through onsite services, shared providers, and/or partnership strategies
7. **Optometry services**
    a. Offer individual technical assistance to organizations to identify potential pathways to integrate optometry services through onsite services, shared providers, and/or partnership strategies
8. **Rapid HIV and Hepatitis C**
    a. Offer individual technical assistance to organizations to identify current partnerships with existing mobile-based providers, barriers to partnership, and interest in expanding services onsite
9. **Group-based services**
    a. Offer individual technical assistance to organizations to consider low-lift strategies to promote group-based services and staff capacity and interest to explore services
10. **STI Testing and Treatment**
    a. Continue to use Rutgers/FXB training resources for HRHNs and HRC staff
    b. Supplement resources with recommendations from community stakeholders

Guidance & Resources

Based on the recommendations from people who use drugs and interviewees and in consideration of the **original request for proposals list****, guidance and resources developed to support this work may include the following.

Section 1 - Approaches to Expand Access to Health Care Services for People Who Use Drugs

- Background on Access to Health Care Services for People Who Use Drugs

- Menu of Health Care Services and Considerations for People Who Use Drugs
- Pathways for Expanding Access to Healthcare Services overview
- NJ Specific Opportunities (e.g. NJ QIP, NJ DOH recent RFPs)
- Needs assessment**
- Stakeholder engagement**
- List of potential services**
- Evaluation**

Section 2 - Harm Reduction Training Resources

- Background/Introduction
- Training Checklist for Providers Newer to Harm Reduction
- Health Care Training Resources
    - Reconcile with HRHN Nurse resources (old website and new)

Section 3 - Guidance for Onsite Healthcare Services

- Background/Introduction
- "Compare Plans" approach to services available depending on provider, space, and billing
- Policies and guidance for non-clinician provision of wound care services
- Best practices**
- Legal and licensure requirements**
- Sample staffing structures**
- Sample budget**

Section 4 - Guidance on Creating Healthcare Partnerships

- Background/Introduction
- Case studies on integrated care (e.g. complex care in Camden)
- NJ QIP and more opportunities
- Billable services estimator and budget template
    - (e.g. Financing Healthcare Services via USC Street Medicine)
- Sustainability**

Policy and Licensure Considerations

1. **Wound care services** are a high priority but continue to have a lot of misinformation about what can or can't be provided by different providers or sites. Developing clear guidance for HRCs at minimum and considering a more systematic approach to integrating wound care education into other care settings would provide additional points of entry and connection for people with wounds.
2. **Dual credentials** required for substance use and mental health is a huge barrier to providing and integrating services. Participants spoke to unmet mental health needs across the state and interviewees described the logistical barriers to integration because of the dual licensing requirements.
3. **OTP Regulations** review and amendment to offer clarification of what harm reduction services OTPs may be able to provide.

Systems Considerations

1. **Housing** is a widely recognized and understood barrier to accessing all of the health care services and continuation in care described in this project. While it may be beyond the scope of work for most people involved in this project, it has to be stated first on this list.
2. **Medicaid reimbursement** for harm reduction services at a rate that will encourage systems of care to offer the services.
3. **Provider training on harm reduction** continues to be champion-led and not proliferated throughout systems of care. Strategies to promote wider systems education is essential to challenge stigma and develop continued support for harm reduction strategies.
4. **Exploring the role of hospitals, CCBHCs and FQHCs to proactively partner with HRCs** in the absence of Medicaid billable services via value propositions, statewide initiatives, and other relationship-based strategies to “tip harm reduction over the edge” for larger systems of care.

Conclusion

There is a strong appetite to leverage the moment to expand harm reduction into larger systems of care, recognizing that HRCs have been part of a siloed safety net for people who use drugs. HRCs have the opportunity to explore integration of health care services through expanding onsite capacity and/or leveraging partnerships. Conducting this assessment has reaffirmed that a multi-prong strategy will be essential to scale health care services for people who use drugs, including pushing levers at the top to address policy and system barriers like credentialing, regulations, and Medicaid billing. In the short term, HRCs have an opportunity to review and assess their own local opportunities to respond to some of the priorities surfaced by people who use drugs through this assessment. The participants who were engaged in this project expressed appreciation and excitement to have their voice heard and HRCs should continue to implement self-assessments to stay aligned with their constituents' priorities. To create real change, technical assistance and training to promote HRC sustainability in staffing, training, and funding to promote healthcare services must be matched with changes at the systems level.

Acknowledgements

In The Works extends our deepest gratitude to everyone who participated in our focus groups, site visits, and interviews. Your invaluable expertise, willingness to share insights, and commitment to this project have significantly enriched our findings. We recognize the time you dedicated, the trust you placed in us, and the enthusiasm with which you contributed. Your perspectives were essential in shaping our understanding and will have a lasting impact on the outcomes of this work. Thank you for your support and for helping us drive meaningful progress forward to improve the lives of people who use drugs in New Jersey.

Appendices

Appendix A - Harm Reduction Assessment Participants

Focus Group Locations & Host Programs

1. Remote/Virtual - *Recruitment conducted by NJHRC statewide mail program*
2. New Brunswick (NJHRC)
3. PROCEED (Elizabeth) - *Spanish only*
4. Paterson (BLM Paterson)
5. Trenton (Hyacinth)
6. Atlantic City (SJAA)
7. Camden (Camden AHEC)

Interviews

1. Kelly LaBar, CPRS, Statewide Harm Reduction Technical Program Manager, Vital Strategies
2. Michele Calvo, MPH, Executive Director, Opioid Response & Policy, NJDOH
3. Charla Cousar, Harm Reduction Coordinator, NJDOH HIV/STI
4. Sarah DuBow, MPH, Harm Reduction Lead, Cicatelli Associates
5. Beth Hurley, MPH, Deputy Director, Cicatelli Associates
6. Laura Taylor, PhD, MCHES, HCV Program, Communicable Disease, NJDOH
7. Babette Richter, RN, HRHN Nurse & Team Leader, SJAA
8. Kevin Leyden, BSN, RN, CARN, HCV Elimination Program Manager / Research Nurse Coordinator, North Jersey Community Research Initiative (NJCRI)
9. Clement Chen, PharmD, Clinical Pharmacist/Academic Detailer/Clinical Assistant Professor, Northern NJ Medication-Assisted Treatment Center of Excellence (COE)
10. LaTricia Gordon, RN, Academic Detailer, Northern NJ Medication-Assisted Treatment Center of Excellence (COE)
11. Joanne Phillips, François-Xavier Bagnoud Center School of Nursing, Rutgers University
12. Elizabeth Lazo, MPH, PMP, Program Manager, François-Xavier Bagnoud Center School of Nursing, Rutgers University
13. Jessica Tkacs Way, RN, HRHN Nurse, Camden AHEC
14. Alexis LaPietra, DO, FACEP, System Director of Addiction Medicine, Emergency Medicine Service Line, RWJ Barnabas Health
15. Iris Jones, MA, Executive Director - Office of Women's Health, NJDOH
16. Rachel Haroz, MD, FAACT, Center Head, Cooper Center for Healing
17. Diana Harvey Davis, RN, Public Health Outreach Liaison - Hepatitis C, Infectious and Zoonotic Disease Program, NJDOH
18. Adam Bucon, MSW, NJ State Opioid Treatment Authority, New Jersey Department of Human Services, Division of Mental Health and Addiction Services
19. Bob Eilers, MD, Medical Director at New Jersey DHS, Division of Mental Health and Addiction Services

Site Visits

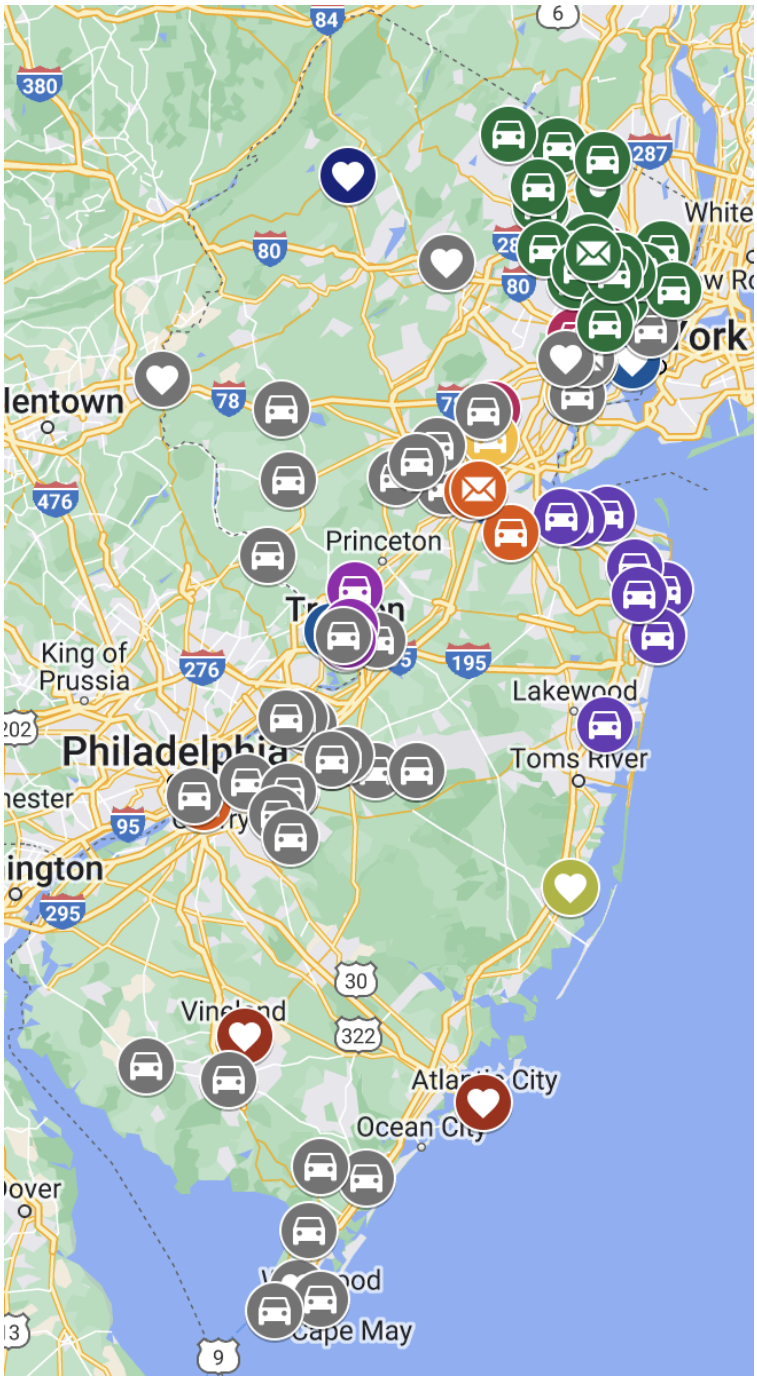
1. Chosen Generation - Samantha Boseski, Dr. Moody
2. BLM Paterson - Bre Azanedo
3. New Jersey Harm Reduction Coalition (New Brunswick) - Laura Buckley, Jenna Mellor, Caitlin O'Neill, Lea Rumbolo, Keith Pittman, Sheilah Powell
4. PROCEED (Elizabeth) - Mildred Diaz
5. Hyacinth (Trenton) - Alicia Parker, John, Natasha
6. VNA Prevention Resource Network (Asbury Park) - Cole Zaccaro, Connie Petine, Chad Harlan, John Denson, Dan Perry, Sam Schubel, Deshaun Rua, Lou Gorra, Jenny DeStefano, Lee McCully
7. South Jersey AIDS Alliance (Atlantic City) - Rachel
8. Camden AHEC (Camden) - Amir Gatlin-Colon, Martha Chavis, Gary

Appendix B - List of Items Included in the Material Review

- Harm Reduction Center Registration Application (NJDOH)
- Harm Reduction Services website (NJDOH)
- List of authorized HRCs (NJDOH)
- Harm Reduction Center Rules & Regs (NJDOH)
    - Adopted Special Repeals and New Rules and Concurrent Proposed Readoption of Specially Adopted Repeals and New Rules: N.J.A.C. 8:63
- New Jersey AETC trainings and resources
- Jefferson Health AETC offerings
- Biennial Report 2020-2021
- ARCH Nurse Program
- Recommendations for Expanding Harm Reduction Healthcare Services in New Jersey (2024)
- ARCH Program Needs Assessment Summary (Rutgers School of Nursing, December 2023)
- Opioid Settlement Tracker for New Jersey
- NJ Quality Improvement Program
- NJ Association for the Treatment of Opioid Dependence resources
- Standards for Licensure of Outpatient Substance Use Disorder Treatment Facilities NJAC 10:161B
- New Jersey Federally Qualified Health Centers list
- Viral Hepatitis website (NJDOH)
- A Framework for Viral Hepatitis Elimination in New Jersey - 2022 (NJDOH)
- New Jersey Department of Health Hepatitis Services Locator
- Viral Hepatitis Dashboard (NJDOH)

Appendix C - New Jersey Harm Reduction Centers Map (updated as of October 2024)

Created by In The Works



Appendix D - Focus Group Flyer

Example Focus Group Flyer to promote focus group sessions to participants

Appendix E - Focus Group Facilitator Guide

Domain 1: Accessibility of current services

1. What do you like about this program?
    a. What is one service or tool you get from this program that you really appreciate?
    b. What is one relationship or connection you've gotten from this program that has been really helpful?

2. If you were in charge, what would you change about this program?

3. We just reviewed a long list of health services that could be offered through this program. What should we know about the health services that are offered at this program as it is today?
    a. What other places do people in your community get health services?
    b. What other places do people in your community get buprenorphine?
    c. What other places do people in your community get hepatitis C treatment?

4. What else should we know about the experience of accessing healthcare services here?

Domain 2: Priorities for expanded health services

5. Are there any health services that you indicated as a priority that you want to share more about here?
    a. Prompt related to hepatitis C treatment, substance use treatment, & mental health service access

6. If you had an opportunity to have a regular care doctor based at this program, would you consider getting care here? Why or why not?

7. What would your dream regular medical provider be like?
    a. What would they ask you about?
    b. How would it feel to talk to them?
    c. How would your provider keep in touch with you about appointments, medications, and results

8. If you could design a program where you could get your healthcare needs met, what would it look like?
    a. Where would it be?
    b. What would it mean to be "accessible" to you? What would the physical space look like?
    c. Would there be elements of the care that were remote/online?
9. If we can relay only 2 major points to harm reduction centers in New Jersey about what to focus on to expand healthcare services, what would you say?

Appendix F - Focus Group Survey

Harm Reduction & Health Care Services - Survey

Please complete a consent form prior to filling out this survey.

The purpose of this focus group is to understand more about…

- **Your access** to health-related services, and
- **Your priorities** for health care services that could be available to you in the future

The focus groups will be no more than 90 minutes. The first 30 minutes will be a guided survey activity where we will review what we mean by “health services” and reflect on your individual access and priorities. Then we will spend the last 60 minutes in a group discussion about **how** you would like to receive these health care services to meet your needs.

The focus groups are voluntary and you may choose to participate at your level of comfort. You will be compensated with $75 for your time and expertise following the completion of the focus group session.

Part 1: Let’s learn more about you. Please fill out the below the survey so we have your sociodemographics & drug use history:

1. **How old are you? (in years) _____**

2. **Gender (Check all that apply)**

   ❑ Man ❑ Woman ❑ Transgender ❑ Two Spirit
   ❑ Queer/Gender non-conforming ❑ No Response ❑ Other:

3. **Race (Check all that apply)**

   ❑ Black or African American
   ❑ White
   ❑ Asian
   ❑ American Indian or Alaskan Native
   ❑ Native Hawaiian or Pacific Islander
   ❑ Other:
   ❑ No Response

4. **Are you Hispanic/Latinx? (Check all that apply)**

   ❑ Yes ❑ No ❑ No Response

5. **In the past 6 months, have you considered yourself homeless or unstably housed?** *We define unstably housed as living in a single room occupancy hotel or shelter in place hotel, a house or apartment of a family member, a house or apartment of a friend, a garage or other place not meant for human habitation, a mobile home (RV), a van, a car, a shelter, navigation center, transitional housing or in a homeless encampment.*

   ❑ Yes ❑ No ❑ No Response

6. **What is your preferred language for services**

❑ English	❑ Mandarin	❑ Persian (Farsi)
❑ Spanish	❑ Tagalog	❑ Other:
❑ French	❑ Vietnamese	❑ No Response
❑ Creole	❑ Arabic	

7. **In the past year, what drugs have you used?** Check all that apply

❑ Heroin	❑ Crack	❑ Xylazine
❑ Fentanyl	❑ Cocaine	❑ Other:
❑ Prescribed opiates	❑ Methamphetamine	❑ No Response
❑ Prescribed benzos	❑ Alcohol	
❑ Non-prescribed opiates	❑ Marijuana	
❑ Non-prescribed benzos	❑ Tobacco	

8. **In the past year, *how* have you used any of the drugs you listed?** Check all that apply

   ❑ Injected drugs ❑ Smoked drugs ❑ Snorted drugs
   ❑ Ingested drugs ❑ Used drugs rectally (via the anus) or vaginally
   ❑ No Response ❑ Other:

9. **In the past year, have you been to the emergency room for yourself for any reason?**

   ❑ Yes ❑ No ❑ No Response

10. **In the past year, have you been admitted to the hospital (beyond the emergency department) for any reason?**

    ❑ Yes ❑ No ❑ No Response

11. In the past year, have you had any form of active health insurance?

❑ Yes, I have active health insurance
❑ No, I have not had insurance
❑ Other:
❑ Yes, but I didn't have it for the whole year
❑ No Response

12. If you are insured, what describes your insurance status right now?

❑ Public insurance (e.g. Medicaid, NJ FamilyCare) ❑ Private insurance
❑ Other:

Part 2: Let's start with health services activity. We'll review each of the services and request that you fill out the following to reflect your own service access and priorities.

	Received in the last year?	**Location**		**Priority Level (1-5)**
Type of Health Service	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
Vaccines				
Hepatitis A		Program	Other	1 2 3 4 5
Hepatitis B		Program	Other	1 2 3 4 5
Influenza "Flu"		Program	Other	1 2 3 4 5
COVID-19		Program	Other	1 2 3 4 5
HPV "Gardasil" human papillomavirus		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5
Point of Care Testing Services				
Rapid HIV test		Program	Other	1 2 3 4 5
Rapid Hepatitis C test		Program	Other	1 2 3 4 5
Chlamydia test		Program	Other	1 2 3 4 5
	Last Year?	**Location**		**Priority Level**

Type of Health Service	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
Syphilis test		Program	Other	1 2 3 4 5
Trichomoniasis test		Program	Other	1 2 3 4 5
Pregnancy test		Program	Other	1 2 3 4 5
Other testing:		Program	Other	1 2 3 4 5
Other lab testing services (usually a full blood draw)				
HIV viral load test		Program	Other	1 2 3 4 5
Hepatitis C confirmatory test		Program	Other	1 2 3 4 5
Cholesterol test		Program	Other	1 2 3 4 5
Hemoglobin A1c for diabetes "glucose/sugar levels' test		Program	Other	1 2 3 4 5
Liver panel test		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5
Treatment Services				
HIV treatment		Program	Other	1 2 3 4 5
Hepatitis C treatment		Program	Other	1 2 3 4 5
Hepatitis A or B treatment		Program	Other	1 2 3 4 5
Chlamydia treatment "DoxyPep"		Program	Other	1 2 3 4 5
Gonorrhea treatment "DoxyPep"		Program	Other	1 2 3 4 5
Syphilis treatment "DoxyPep"		Program	Other	1 2 3 4 5
Trichomoniasis treatment		Program	Other	1 2 3 4 5
Expedited Partner Therapy "EPT" (medication for any partner who may be infected by an STI)		Program	Other	1 2 3 4 5
	Last Year?	**Location**		**Priority Level**

Type of Health Service	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
"PrEP" medication to prevent HIV infection		Program	Other	1 2 3 4 5
Contraception/Birth Control		Program	Other	1 2 3 4 5
Emergency Contraception "Plan B"		Program	Other	1 2 3 4 5
Medical termination of pregnancy "abortion with pills"		Program	Other	1 2 3 4 5
Buprenorphine or "suboxone"		Program	Other	1 2 3 4 5
Methadone		Program	Other	1 2 3 4 5
Naltrexone		Program	Other	1 2 3 4 5
Detox services		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5
Triage & Routine Services	**Last Year?**	**Location**		**Priority Level**
	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
General well visit with a doctor/physical exam to discuss your health overall "Check up"		Program	Other	1 2 3 4 5
Wound triage and care		Program	Other	1 2 3 4 5
Blood pressure check		Program	Other	1 2 3 4 5
Finger stick for glucose levels ("sugar" levels for diabetes testing)		Program	Other	1 2 3 4 5
Weight check		Program	Other	1 2 3 4 5
Nutrition services and discussion		Program	Other	1 2 3 4 5
Dental services		Program	Other	1 2 3 4 5
Optometry services (for eye sight)		Program	Other	1 2 3 4 5
	Last Year?	**Location**		**Priority Level**

Type of Health Service	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
Prenatal health services (pregnancy)		Program	Other	1 2 3 4 5
Gender affirming care services		Program	Other	1 2 3 4 5
Gynecological Services (pap smears, pelvic exams)		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5
Urgent/Emergency Services	**Last Year?**	**Location**		**Priority Level**
	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
Urgent care visit to address an urgent health concern		Program	Other	1 2 3 4 5
Emergency visit to address an urgent health concern with a medical team		Program	Other	1 2 3 4 5
Hospital admission following an emergency visit (overnight)		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5
Mental & Behavioral Health	**Last Year?**	**Location**		**Priority Level**
	"X" if yes	At This Program	Another Location	1 = Lowest 5 = Highest
One-on-one therapy with a licensed mental health provider		Program	Other	1 2 3 4 5
One-on-one mental health or counseling support with a case manager or care coordinator		Program	Other	1 2 3 4 5
Alcoholics Anonymous (AA)		Program	Other	1 2 3 4 5
Narcotics Anonymous (NA)		Program	Other	1 2 3 4 5
Other group-based sessions		Program	Other	1 2 3 4 5
	Last Year?	**Location**		**Priority Level**
Type of Health Service	"X" if yes	At This	Another	1 = Lowest

		Program	Location	5 = Highest
Harm Reduction Services				
Sterile syringes		Program	Other	1 2 3 4 5
Other safer injection supplies (water, cooker, ties)		Program	Other	1 2 3 4 5
Glass pipes for smoking		Program	Other	1 2 3 4 5
Other safer smoking supplies (filters, stem tips)		Program	Other	1 2 3 4 5
Safer snorting materials (straws)		Program	Other	1 2 3 4 5
Safer rectal use materials (syringe without a needle, lube, water)		Program	Other	1 2 3 4 5
Safer sex supplies (lube, condoms)		Program	Other	1 2 3 4 5
Sex work specific resources or groups		Program	Other	1 2 3 4 5
Naloxone and overdose prevention supplies		Program	Other	1 2 3 4 5
Wound care supplies		Program	Other	1 2 3 4 5
Contingency management		Program	Other	1 2 3 4 5
Treatment counseling options		Program	Other	1 2 3 4 5
Other:		Program	Other	1 2 3 4 5

What are some of the programs or providers that you've received services at?

Would you recommend any of these programs/providers?

Appendix G - Focus Group Facilitator Guide (Spanish)

Consentimiento (oral)

Hola y gracias por participar en el grupo focal de hoy. Antes de comenzar, me gustaría revisar cierta información importante.

La participación en este grupo de discusión es completamente voluntaria y eres libre de retirarte en cualquier momento sin consecuencias ni sanciones. Durante esta sesión, hablaremos sobre tu acceso a los servicios de salud en el pasado y en el futuro ideal. Comenzaremos con una encuesta guiada para que la llenes, en la que incluirás información demográfica, pero no tu nombre. Luego, pasaremos a una conversación sobre tu acceso a los servicios de salud ideales. Tu aporte es muy valioso para nosotros y agradecemos tu disposición a compartir tus ideas y opiniones.

Todo lo que compartas en este grupo será confidencial. No identificaremos a nadie por su nombre en ningún informe o publicación que resulte de esta conversación; solo el equipo de investigación tendrá acceso a la información recopilada. Sin embargo, debido a que se trata de un entorno grupal, no podemos garantizar la confidencialidad total, por lo que solicitamos que todos respeten la privacidad de los demás y no compartan con terceros nada de lo que se discuta en esta sesión.

La sesión se grabará en audio para garantizar que registremos con precisión todas las ideas y puntos de vista compartidos. Las grabaciones se guardarán de forma segura y solo se utilizarán para nuestro fin de registrar los temas de este grupo focal. Si en algún momento no deseas que te grabemos, infórmanos y podremos adaptarnos a tus preferencias.

¿Estás de acuerdo en participar en este grupo focal y en que se registren tus aportes? Si es así, ¿podrías confirmar verbalmente tu consentimiento diciendo "Sí"?

Área 1: Accesibilidad de los servicios actuales

1. ¿Qué te gusta de este programa?
    a. ¿Qué servicio o herramienta recibes de este programa que valoras mucho?
    b. ¿Qué relación o conexión has conseguido con este programa que te ha resultado muy útil?

2. Si fueras el encargado, ¿qué cambiarías de este programa?

3. Acabamos de revisar una larga lista de servicios de salud que se podrían estar ofreciendo a través de este programa. ¿Qué debemos saber sobre los servicios de salud que se ofrecen actualmente en este programa?
    a. ¿En qué otros lugares las personas de tu comunidad reciben servicios de salud?
    b. ¿En qué otros lugares las personas de tu comunidad consiguen buprenorfina?
    c. ¿En qué otros lugares las personas de tu comunidad reciben tratamiento contra la hepatitis C?

4. ¿Qué más debemos saber sobre la experiencia de acceder a los servicios de salud en este lugar?

Área 2: Prioridades para la ampliación de los servicios de salud

5. ¿Hay algún servicio de salud que hayas indicado como prioritario sobre el que te gustaría compartir más aquí?
    a. Tal vez relacionado con el tratamiento de la hepatitis C, el tratamiento del consumo de sustancias y el acceso a servicios de salud mental

6. Si tuvieras la oportunidad de tener un médico de cabecera habitual en este programa, ¿considerarías recibir atención aquí? ¿Por qué sí o por qué no?

7. ¿Cómo sería el médico habitual de tus sueños?
    a. ¿Qué te preguntaría?
    b. ¿Cómo te sentirías al hablar con él o ella?
    c. ¿Cómo se mantendría en contacto contigo en cuanto a citas, medicamentos y resultados?
8. Si pudieras diseñar un programa que te permitiera atender tus necesidades de atención médica, ¿cómo sería?
    a. ¿Dónde estaría?
    b. ¿Qué significaría para ti ser “accesible”? ¿Cómo sería el espacio físico?
    c. ¿Habría elementos de la atención que fueran remotos/en línea?
9. Si solo pudiéramos informar sobre dos puntos principales a los centros de reducción de daños en Nueva Jersey, en los cuales hay que centrarse para ampliar los servicios de salud, ¿cuáles dirías?

Appendix H - Focus Group Survey (Spanish)

Encuesta sobre reducción de daño y atención de salud

Por favor llena un formulario de consentimiento antes de contestar esta encuesta.

El objetivo de este grupo focal es comprender más sobre:

- **Tu acceso** a los servicios relacionados con la salud y
- **Tus prioridades** en cuanto a servicios de salud que podrían estar disponibles para ti en el futuro

El grupo focal no durará más de 90 minutos. Los primeros 30 minutos serán una actividad de encuesta guiada donde revisaremos lo que entendemos por “servicios de salud” y reflexionaremos sobre tu acceso y prioridades individuales. Después, pasaremos los últimos 60 minutos en una discusión grupal sobre **cómo** te gustaría recibir estos servicios de atención médica para satisfacer tus necesidades.

Los grupos focales son de participación voluntaria y puedes elegir participar en el nivel que te resulte cómodo. Recibirás una compensación de $75 por tu tiempo y experiencia, después de terminar la sesión del grupo focal.

Parte 1: Infórmanos más sobre ti. Por favor llena la encuesta a continuación para que tengamos tus datos sociodemográficos y tu historial de uso de drogas:

1. **¿Cuál es tu edad? (en años) _____**

2. **Género (Marca todos los que apliquen)**

   ❑ Hombre ❑ Mujer ❑ Transgénero ❑ Fluido
   ❑ Queer/no conforme ❑ Sin respuesta ❑ Otro:

3. **Raza (Marca todos los que apliquen)**

   ❑ Negra o afroamericano
   ❑ Blanca
   ❑ Asiática
   ❑ Indio americano o nativo de Alaska
   ❑ Nativo de Hawái o isleño del Pacífico
   ❑ Otra:
   ❑ Sin respuesta

4. **¿Eres hispano/latino? (Marca todos los que apliquen)**

   ❑ Sí ❑ No ❑ Sin respuesta

5. **En los últimos 6 meses, ¿te has considerado en condición de calle o de vivienda inestable?** *Definimos "vivienda inestable" como vivir en un hotel con habitación individual o en un albergue, en una casa o apartamento de un familiar, en una casa o*

apartamento de un amigo, en un garaje u otro lugar no destinado a la vivienda humana, en una casa rodante (RV), una furgoneta, un carro, un refugio, un centro de alojamiento temporal, una vivienda de transición o en un campamento para personas sin hogar.

❑ Sí ❑ No ❑ Sin respuesta

6. ¿Cuál idioma prefieres al recibir los servicios?

❑ Inglés
❑ Español
❑ Francés
❑ Criollo
❑ Mandarín
❑ Tagalo
❑ Vietnamita
❑ Árabe
❑ Persa (Farsi)
❑ Otro:
❑ Sin respuesta

7. **En el último año, ¿cuáles drogas has consumido?** Marca todas las que apliquen

❑ Heroína
❑ Fentanilo
❑ Opiáceos recetados
❑ Benzodiacepinas recetadas
❑ Opiáceos no recetados
❑ Benzo no recetadas
❑ Crack
❑ Cocaína
❑ Metanfetamina
❑ Alcohol
❑ Marihuana
❑ Tabaco
❑ Xilacina
❑ Otra:
❑ Sin respuesta

8. **En el último año, ¿*cómo* has consumido cualquiera de las drogas que anotaste?** Marca todas las que apliquen.

❑ Inyectadas ❑ Fumadas ❑ Inhaladas
❑ Ingeridas ❑ Vía rectal (ano) o vaginal
❑ Sin respuesta ❑ Otra:

9. En el último año, ¿has estado en la sala de urgencias por alguna razón?

❑ Sí ❑ No ❑ Sin respuesta

10. En el último año, ¿te han ingresado al hospital (más allá de la sala de urgencias) por alguna razón?

❑ Sí ❑ No ❑ Sin respuesta

11. En el último año, ¿has tenido activa alguna forma de seguro de médico?

❑ Sí, tengo un seguro médico activo
❑ No, no he tenido seguro
❑ Sí, pero no lo tuve durante todo el año
❑ Sin respuesta

❑ Otra:

12. Si estás asegurado, ¿qué describe mejor el estado de tu seguro en este momento?

❑ Seguro público (p. e. Medicaid, NJ FamilyCare) ❑ Seguro privado
❑ Otro:

Parte 2: Comencemos con la actividad de servicios de salud. Revisaremos cada servicio y te pediremos que completes lo siguiente para reflejar tu acceso al servicio y tus prioridades.

	¿Lo recibiste durante el último año?	**Lugar**		**Nivel de prioridad (1-5)**
Tipo de servicio de salud	Marca una “X” para sí	En este programa	Otro lugar	1 = Más baja 5 = Más alta
Vacunas				
Hepatitis A				
Hepatitis B				
Influenza “gripe”				
COVID-19				
Virus del papiloma humano VPH “Gardasil”				
Otro:				
Pruebas en punto de atención				
Prueba rápida de VIH				
Prueba rápida de Hepatitis C				
Prueba de clamidia				
	¿Último año?	**Lugar**		**Nivel de prioridad**
Tipo de servicio de salud	Marca una “X” para sí	En este programa	En otro lugar	1 = Más baja 5 = Más alta

Prueba de sífilis				
Prueba de tricomoniasis				
Prueba de embarazo				
Otras pruebas:				
Otros servicios de pruebas de laboratorio (Generalmente una extracción de sangre completa)				
Prueba de carga viral del VIH				
Prueba confirmatoria de hepatitis C				
Prueba de colesterol				
Prueba de hemoglobina A1c para diabetes “nivel de glucosa/azúcar”				
Prueba panel de función hepática				
Otra:				
Servicios de tratamiento				
Tratamiento para el VIH				
Tratamiento para hepatitis C				
Tratamiento para hepatitis A o B				
Tratamiento para clamidia “DoxyPep”				
Tratamiento para gonorrea “DoxyPep”				
Tratamiento para la sífilis “DoxyPep”				
Tratamiento para la tricomoniasis				
Terapia acelerada para la pareja (EPT) (medicación para cualquier pareja que pueda estar infectada por una ITS)				

	¿Último año?	Lugar		Nivel de prioridad
Tipo de servicio de salud	Marque una "X" para sí	En este programa	En otro lugar	1 = Más baja 2= Más baja
"PrEP", medicamento para prevenir la infección por el VIH				
Anticoncepción/Control de la natalidad				
Anticonceptivo de emergencia "Plan B"				
Interrupción médica del embarazo "aborto con pastillas"				
Buprenorfina o "Suboxone"				
Metadona				
Naltrexona				
Servicios de desintoxicación				
Otro:				
Triaje y servicios médicos de rutina				
Visita de bienestar general con un médico/examen físico para analizar tu salud en general. "Chequeo"				
Triaje y cuidado de heridas				
Control de presión arterial				
Punción en el dedo para medir los niveles de glucosa (niveles de "azúcar" para la prueba de diabetes)				
Control del peso				
Servicios de nutrición y discusión				
Servicios dentales				
Servicios de optometría (para la				

vista)				
	¿Último año?	**Lugar**		**Nivel de prioridad**
Tipo de servicio de salud	Marque una “X” para sí	En este programa	En otro lugar	1 = Más baja 2= Más alta
Servicios de salud prenatal (embarazo)				
Servicios de atención para afirmación de género				
Servicios ginecológicos (pruebas de Papanicolaou, exámenes pélvicos)				
Otro:				
Servicios médicos de urgencia/emergencia				
Consulta de atención de urgencia para atender un problema de salud urgente				
Consulta de emergencia con un equipo médico para atender un problema de salud urgente.				
Ingreso hospitalario tras una visita de urgencia con al menos una noche de hospitalización				
Otro:				
Servicios de salud mental y conductual				
Terapia individual con un proveedor de salud mental autorizado				
Apoyo individualizado de salud mental o asesoramiento con un gestor de casos o un coordinador de atención				
Alcohólicos Anónimos (AA)				

Narcóticos Anónimos (NA)				
Otras sesiones terapéuticas grupales				
Otro:				
	¿Último año?	**Lugar**		**Nivel de prioridad**
Tipo de servicio de salud	Marque una “X” para sí	En este programa	En otro lugar	1 = Más baja 2= Más alta
Servicios de reducción de daños				
Jeringas estériles				
Otros suministros más seguros para inyección (agua, recipientes metálicos, liga torniquete)				
Pipas de vidrio para fumar				
Otros suministros más seguros para fumar (filtros, tubos)				
Materiales para inhalar de forma más segura (popotes)				
Materiales de uso rectal más seguros (jeringa sin aguja, lubricante, agua)				
Suministros para sexo seguro (lubricantes, condones)				
Recursos o grupos específicos para trabajo sexual				
Naloxona y suministros para la prevención de sobredosis				
Suministros para el cuidado de heridas				
Manejo de contingencias				
Opciones de tratamiento por asesoramiento				
Otro:				

¿Cuáles son algunos de los programas o proveedores en los que ha recibido servicios?

¿Recomendaría alguno de estos programas/proveedores?