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# Compassionate Overdose Response Summit

## Highlights and Key Takeaways

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## SUMMIT OVERVIEW

More than 100,000 people in the United States die every year from drug overdoses. The overdose reversal drug naloxone remains underutilized and restricted in many marginalized communities, while new higher initial dose and long-acting overdose reversal products have been approved and marketed. Health Management Associates, Inc. (HMA) convened the Compassionate Overdose Response Summit on March 19, 2024, to shed light on best practices in overdose prevention and engage participants in a national dialogue about naloxone dosing. Our goals were to explore 1) the impact of different overdose reversal products on people who receive them, 2) the role of rescue breathing in community overdose response, and 3) communication strategies for bystander overdose response steps.

The Compassionate Overdose Response Summit was free and open to the public. A Webinar replay with links to download PDFs of speakers' presentations is linked here. There were 60 in-person attendees and 450 virtual attendees. At a pre-Summit meeting, 40 experts participated in consensus-building activities about compassionate overdose response and the response steps. Their conclusions were shared at the Summit for public feedback.

A chart with currently available opioid overdose reversal products is available at PrescribetoPrevent.org.

# Planning Process

HMA collaborated with members of the Opioid Safety and Naloxone Network (OSNN) to develop the Compassionate Overdose Response Summit. OSNN is an organized collaborative composed of people who work in overdose prevention. It was formed in 2008 to address naloxone access in the United States. OSNN established an information-sharing and networking listserv that today comprises over 1,500 members.

HMA hosted three virtual planning calls. Experts worldwide were invited to share the latest on-the-ground experiences and research to shape the agenda, goals, and outcomes of the event. These experts collaborated with HMA to ensure the voices of people who have survived overdose were present and centered from start to finish. Decisions and action items were summarized in the meeting minutes. All planning materials were publicly available online. Promoting transparency throughout the planning process was key to ensuring community trust in the proceedings and information.

During the first planning call on December 8, 2023, HMA presented a draft of the summit's goals and format for feedback and asked for information to determine summit outputs that would be most useful to the community. On January 10, 2023, HMA presented the conference's overview and goals, discussed the event name, branding, and promotion, and solicited recommendations or requests for presentations. The final planning call took place on February 28, 2024, during which HMA answered questions about the event's purpose, openly discussed concerns about its sponsorship, and brainstormed adjustments to the agenda.

**Contributions**: The Compassionate Overdose Summit was presented with support from HMA, Harm Reduction Therapeutics*, Vital Strategies Inc., The Bloomberg American Health Initiative, and the University of Pittsburgh Graduate School of Public Health. Funds were used to secure event space, speaker hotel accommodations, meals, AV equipment, and event staffing.

# *Highlights and Emerging Themes from the Summit's Panel Discussions*

The Compassionate Overdose Response Summit consisted of four panels with nationally and internationally recognized public health leaders, harm reduction experts, and researchers. The panels highlighted emerging research, strategies and approaches, and compassionate interventions to stop overdose deaths as well as prevent them from happening. Each panel presentation is summarized below.

**SUMMIT HIGHLIGHTS**

## Opening Panel

### Overdose Experience and Why We Need to Talk about Naloxone Dosing

Malcom Visnich from Prevention Point Pittsburgh shared two of his own opioid overdose experiences in which naloxone was used on him, highlighting the risks of high dose naloxone products. In one instance, he was with friends who covered him with a blanket and gave him a small dose of naloxone, bringing him out of an overdose without significant trauma. In the second instance, Mr. Visnich was around several people he did not know when he overdosed. They gave him at least three doses of naloxone nasal spray and called emergency services, who gave him an unknown number of additional doses of naloxone. When he awoke, he began vomiting so much he reported he could barely breathe, and he experienced extreme anxiety. **"I tried to re-dose with heroin every 15 minutes to feel anything other than this horrible feeling."** Mr. Visnich reported: **"For months after that bad overdose, I was super hesitant to use around others. I mostly wanted to use alone to avoid something like that from happening again which put me at great risk."**

### Overdose Response Historical Context

Eliza Wheeler and Maya Doe-Simkins, co-directors of nonprofit Remedy Alliance (RA), covered 20 years of historical context to overdose response in their presentation. They described the first naloxone efficacy study, which focused on affordable naloxone access to the community, and shared historical references of overdose education materials, including rescue breathing instructions, used among people who use drugs. Remedy Alliance described how harm reduction grassroots programs innovated to distribute naloxone to people who use drugs (PWUD), and that continues to be the evidence-based model.

Ms. Wheeler and Ms. Doe-Simkins called out the “mass co-optation” of the harm reduction movement and the *“exclusion and marginalization of harm reduction programs from access to the naloxone that they innovated the distribution of.”* Eliza explained how pharmaceutical industries have **“taken intellectual property, labor, and experiences of PWUD, packaged it, and gave it back to us.”** Media and pharmaceutical industries have misrepresented the experiences, narratives, and data about PWUD to justify the sale of higher-dose, longer-lasting, and/or branded naloxone products in the United States. According to Eliza, harm reduction programs have historically been marginalized and excluded from accessing naloxone – a tool for which they innovated the distribution model. There is a need to **“collectively take back some of the power for drug users and naloxone experts around access and response.”**

*“We want to scale up structural interventions that change the material reality for people who use drugs.”*

*– Maya Doe-Simkins, Remedy Alliance*

## Panel Discussion 1: Field Notes and Emerging Evidence

The first panel highlighted real-world use of naloxone products and their community impact. Speakers shared their experiences from the field and recently published information about the comparison of different naloxone products.

### Community Engagement and Applied Overdose Response Strategies in NYC

Jason Beltre, director of community initiatives and impact with OnPoint | NYC, shared his experience at a sanctioned safe injection site (SSIS) in NYC. He described his role and the programs he has led, including a public safety hotline used to respond to reports of syringe litter and public consumption, a kiosk program launched and managed in partnership with the NYC Department of Health and the NYC Parks Department, and the systematic way in which they tour communities to provide education on SSIS. The core message of his presentation was about **strategic community building to encourage compassionate overdose response**. It is important to support the community in all the ways they are impacted by drug use.

*"It is time to take ownership of what we're doing and step out of the shadows to share with others what is happening."*

*– Jason Beltre, OnPoint NYC*

### Oxygen Monitoring and Administration During Overdose Responses at a Sanctioned Overdose Prevention Site in San Fransisco, California

Cleo Jenkins, manager of outreach with HealthRIGHT360 and former program manager for an overdose prevention center (OPC) in San Franscisco, CA, described OPCs as pop-up tents "where people can safely use what they need to use." He and his team regularly assessed people in the acute and early stages of an opioid overdose. They evaluated people's physical state to determine appropriate next steps, specifically whether to have the person receive rescue breaths or to apply oxygen. If the person remained unresponsive, they would either titrate intramuscular naloxone, or onsite medical staff or emergency medical technicians would administer a nasal formulation.

Over 46 weeks, the OPC responded to 333 overdoses, and all were reversed successfully, either with rescue breathing, naloxone, oxygen only, or a combination of oxygen and naloxone. Mr. Jenkins explained that the purpose of OPCs goes beyond providing a safe place to use drugs; it builds community.

*"We hold space for them and the team around them. We also take care of the people who do the work."*

*– Cleo Jenkins, HealthRIGHT360*

### Field Comparison of Naloxone Products

New York State (NYS) Police contribute the largest number of overdose reports among law enforcement agencies in the state (approximately 360 per year). Sharon Stancliff, MD, NYS Department of Health and Michael W. Dailey, MD, Albany Medical College, presented their research comparing 4 mg with 8 mg intranasal naloxone use in the field. The evaluation, published in the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report on February 8, 2024, makes the first real-world comparisons of survival, average doses administered, prevalence of post-naloxone signs and symptoms, and hospital transport among individuals who received 8 mg versus 4 mg of intranasal naloxone. The presenters described the study's methods, exclusion criteria, statistical methods, results, and conclusions.

Dr. Stancliff and Dr. Dailey said they found no difference in survival and no significant difference in the number of doses administered (despite responders' training to wait 2 minutes between doses). There was a significant difference in reported withdrawal symptoms**. Those who received the initial 8 mg dose had 2.5 times the risk of withdrawal. Findings suggest the increased initial dose from 4 mg to 8 mg may be unnecessary.**

*"Significantly higher risk of post-naloxone withdrawal symptoms among people administered 8 mg of intranasal naloxone."*

*– Dr. Sharon Stancliff, MD, NYS Department of Health*

## Panel Discussion 2: Two Decades of Data– Insights from Syringe Service Participants and EMS

### Analysis of Prevention and Point Pittsburgh Naloxone Use Reports after 17 Years

Alice Bell has led the Overdose Prevention Project of Prevention Point Pittsburgh for over 20 years. Ms. Bell described how fears that fentanyl overdoses might require more naloxone led to a comparison study of overdose reversals in Allegheny County, PA. It compared the number of naloxone doses used before and after fentanyl became predominant in the local drug supply. Key research findings were presented, including the mean number of doses of naloxone administered to restore breathing, preferred naloxone formulations for different contexts (0.4 mg/ml has been the most frequently distributed), and factors reported when more than 2 doses were used. Although deaths in Allegheny County involving fentanyl increased from 3% to 68% to 95%, the reports of naloxone doses used during the same time period did not change.

People who reported using more than two doses to reverse an opioid overdose most frequently reported 1) they did not wait to allow the initial doses to work before administering additional doses, 2) the overdose involved non-opioid drugs which kept the person sedated but not responsive, or 3) they administered all the naloxone they had after the person was not breathing for a long time and was already deceased. Ms. Bell cautioned about the risks of high dose naloxone products in cases where people administered additional doses without waiting three minutes**.** High dose products would lead to excessive amounts of naloxone being administered in those cases with the potential for severe withdrawal symptoms as Mr. Visnich described. High dose products are unnecessary. In a case where more naloxone was felt to be needed, additional standard dose products (.4 mg intramuscular and ≤4 mg intranasal) can always be administered.

*"After [nearly] 18 years of getting reports from people who used naloxone to reverse an overdose, not a single one said a person died because they did not have enough naloxone."*

*– Alice Bell, Prevention Point Pittsburgh*

Nabarun Dasgupta, PhD, University North Carolina at Chapel Hill, presented recent analyses of those reports that Prevention Point Pittsburgh collected over 17 years. Average naloxone doses per reversal have remained steadily below two in 2010−2023, with a slight increase in 2022 as xylazine entered the local opioid supply in Pittsburgh. **Almost identical to the New York data presented, people who received 4 mg of nasal spray were twice as likely to experience emesis as those who received 0.4 mg/ml injection.**

### Naloxone Dosing Patterns for Opioid Overdose by EMS in Kentucky During Increased Fentanyl Use in 2018-2021

Svetla Slavova, PhD presented on behalf of Peter Rock et al., who published findings that compared EMS naloxone dosing patterns for opioid overdose to fentanyl-involved overdose over time. Dr. Slavova said the study's objective was to leverage statewide population data to examine changes in naloxone doses administered for suspected opioid overdose by EMS personnel in Kentucky. **After analyzing data from more than 30,000 suspected overdose encounters, they were unable to identify a relationship between fentanyl availability and the dose of naloxone administered by EMS and bystanders together.** The study found no relationship/significant association between the naloxone dose used to reverse overdose with the number of police drug seizures containing fentanyl and its analogs. Dr. Slavova concluded with a statement that their findings do not support a need for high dose naloxone formulation in opioid and/or fentanyl overdose encounters with EMS involvement.

### Missouri Overdose Field Report: Naloxone Dosing Remains Stable Despite Concerns

Rachel Winograd, PhD, University of Missouri, and Marcus Ryan Doll, Bureau Chief of Emergency Medical Services, St. Charles Fire Department, presented Missouri's Overdose Field Report and emphasized the importance of allyship with EMS. The field report used across Missouri is a quick, anonymous, web-based survey tool that collects data on naloxone administration and dosing. Dr. Winograd walked through key data findings and takeaways. She noted that **nearly 90 percent of overdoses were reversed with one or two doses of naloxone.** Mr. Doll followed up by sharing his perspective about allyship, stating that system change is possible through relationship building. Dr. Winograd concluded by saying, **"The findings do not support a need for extra strength naloxone."**

"Overdose is a medical emergency with differences in its presentation and appropriate response."

– Kailin See, OnPoint NYC

## Panel Discussion 3: Engagement of People Who Use Drugs in Overdose Response Policies and Protocols

### Giving Naloxone Rescue Kits to People Who Use Drugs Saves Lives

Jennifer Plumb, MD, University of Utah department of pediatrics, presented data collected from five community-based organizations on reported naloxone use by program participants. The data focused on successful reversal and survival rates (97.5% of survey respondents indicated successful overdose reversal and survival), average number of doses used (75% used one to two doses), and percentage of cases when EMS responded to the scene (35% of reported instances). **Dr. Plumb recommended increasing EMS education in overdose response that meets a compassionate standard level of care.**

### Consulting PWUD on Naloxone Preferences: Results from Michigan and Replicable Survey Methods

Ashley Shukait, harm reductionist and public health consultant, and Pamela Lynch, Executive Director of Harm Reduction Michigan, presented data that the Michigan Drug Users Health Alliance (MIDUHA) collected. A survey distributed in 2023 and published on the MIDUHA website in early 2024 asked people who use drugs about their overdose experiences and reversal product preferences. More than 90 percent of the respondents said they had experienced an overdose, and 87 percent reported experiencing withdrawal after an overdose reversal. **Most of the respondents (90%) said longer-acting antagonists (i.e., eight to 12 hours) and stronger dose alternatives than the standard 0.4 mg intramuscular and ≤4 mg intranasal were unnecessary.** This, and the numerous amounts of survey feedback, imply that naloxone works, and an adequate supply is necessary to save lives, Mrs. Shukait said, **"we must listen to the people being actively tortured"** by experiences of withdrawal post-overdose. Shukait and Lynch stressed that programs and government should listen to people who use drugs and center the lived experience community's voice in any response to the overdose crisis.

### Overdose Response Protocols for Programs: Recommendations from a Sanctioned Safe Injection Site in NYC

Kailin See, Senior Director of Programs with OnPoint NYC, described the overdose response protocols built from experiences of a sanctioned safe injection site in New York City. Ms. See described it as a patient-directed care for PWUD. **Key takeaways are to return to the fundamentals of assessing breathing and oxygenation, monitoring the person's symptoms, and using agitation to confirm responsiveness.** She noted that in the safe injection site setting, naloxone is rarely necessary because the staff can monitor and support the person with oxygen. **In its first year of operation, trained staff responded to over 600 potential overdoses and 83% of those were resolved without the need for naloxone through oxygenation, agitation, and close monitoring (100% survived).** This approach demonstrates the value of programs that provide spaces in which drug use can be supervised. An intervention can occur when a person displays early signs of an overdose before it becomes severe, the person stops breathing, and it is fatal.

*"What you [the U.S.] describe as low dose, the 4 mg ones would in most European countries be considered a high dose, and when you start talking about 8 mg naloxone, [Europeans] are shaking our heads and can't really understand it."*

*– Dr. Arne Skulberg, MD, PhD, Oslo University Hospital*

## Panel Discussion 4: International Perspective

The final panel shed light on international research centered on the experience of the person who received naloxone and standards for ethical clinical trials of overdose reversal products. The research scope and anticipated next steps also were discussed.

### Understanding Negative Reactions following Naloxone Administration

Joanne Neale, MSc, DPhil, CQSW, professor at Kings College London, explained why some people experience negative reactions following naloxone administration. She described years of study of people's experiences of overdose reversal and the factors that may affect withdrawal. Negative reactions following naloxone administration may be avoided, and anger can potentially be managed via low-dose naloxone titration and "a positive communication style," she said. Dr. Neale described ideal communication as a calm, compassionate, and considerate exchange between the person who overdosed, the person administering naloxone, and bystanders, including EMS.

Dr. Neale shared that withdrawal symptoms and anger didn't always occur together. When they did, it did not necessarily follow the same order, so they could be unrelated. **Withdrawal symptoms seem to be associated with the administration of more than one dose of naloxone, whereas anger can be a reaction to aftercare factors, including communication. It may be possible to manage withdrawal via titration and anger via communication skills, she said.**

### Scope of International Research and Emerging Questions

Arne Skulberg, MD, PhD, post-doctoral fellow and anesthesiologist at Oslo University Hospital, Norway, described international research findings and implications, and the data points for the next research questions. The United Kingdom distributes primary 1.6 mg intranasal naloxone. He emphasized the **need to consider risk environments and contexts that can affect the overdose response, like the substances used and the person's tolerance.** Dr. Skulberg referenced Alice Bell's research to further explain how his research showed no linear relationship between opioid potency and naloxone dose.

Dr. Skulberg stressed the need to raise the bar on research and data to support the development and release of new overdose reversal products. He explained the need to collect postmortem data to measure naloxone in the blood at the time of death.

*"I think there should be a harm reduction call for more real studies—randomized control studies in overdose situations. It is the only way we can really show that the higher doses are not needed, and how harmful withdrawal can be in those situations."*

*– Dr. Arne Skulberg, MD, PhD, Oslo University Hospital*

## Compassionate Overdose Response Summary Presentation

Joy Rucker, a national harm reduction consultant, founder of the Texas Harm Reduction Alliance, and co-founder of the Black Harm Reduction Network shared her experience of being revived from three separate overdoses through rescue breathing alone. Ms. Rucker explained she overdosed before naloxone existed and lived. **The pressure from pharmaceutical companies selling higher initial dose naloxone products is profiteering and involves corrupt marketing strategies.**

*"When you have withdrawal symptoms, you want to die. You feel like you're going to die. If it's not necessary to bring someone there, don't. We must get someone breathing to save their life."*

*– Joy Rucker, Texas Harm Reduction Alliance, Black Harm Reduction Network*

Ms. Rucker concluded with a call for rescue breathing to mitigate the possibility that people are driven to use opioids again to "get well" and emphasized the need for care to be compassionately offered to the person afterwards. **"Harm reduction started from a place where people wanted to provide resources to people who could not access resources and started by people who knew what they needed the most. To me, this has not changed. We need to listen to the people we are serving. We're here [at this Summit] because they can't use their voice to say what they know is true."**

Stephen Murray, MPH, NRP, and Kimber King from the Massachusetts Overdose Helpline at Boston Medical Center also shared aspects of their overdose experiences and those through the helpline. The Massachusetts Overdose Prevention Helpline (1-800-972-0590) is a helpline to call while using substances to prevent PWUD from using alone and/or experiencing overdose. It is staffed by Harm Reduction workers and people with lived experience. Ms. King said **less than 1 percent of people who called the hotline experienced an overdose.** Mr. Murray emphasized that the most compassionate overdose response is one that doesn't have to happen, meaning overdose prevention strategies are as important as skillful overdose response.

These speakers reinforced a call for multiple overdose response protocols that can be applied in different contexts including setting, the responder's relationship with the person who sought help and training, and the equipment and tools available. **Mr. Murray encouraged an approach that uses the lowest available dose as one tool, alongside rescue breathing or assisted oxygen and the creation of a safe environment for the person experiencing the overdose.** He encouraged safety planning for people who are not transported to an emergency department.

# *Summary*

Speakers called for a standard opioid overdose response procedure centered on rescue breathing, titrated naloxone as needed, and supportive and compassionate aftercare.

Experience across four states (Missouri, Kentucky, Pennsylvania, and New York) made clear that an increase in naloxone dose is not a necessary response to the presence of fentanyl in the drug supply (Winograd, Doll, Slavova, Bell, Dasgupta, Stancliff, Dailey). There is a preference among people who use drugs for standard dose naloxone, defined as 0.4 mg intramuscular injection and ≤4 mg intranasal spray (Shulkait, Lynch, Bell, Visnich). When provided naloxone, people who use drugs administer it effectively, skillfully, and with compassion (Plumb, Neale). Initial doses of naloxone higher than 4 mg contribute to greater experiences of withdrawal in a field comparison study (Stancliff) and these conclusions are backed by decades of research in the US and abroad (Neale). The way a person is treated during an overdose, i.e., the communication style of the responder and the care they are offered after, affects their risk behavior such as using more opioids to feel better (Visnich, Murray, Rucker).

HMA is committed to advancing national discussion, policy decisions, and program implementation strategies to make overdose response more compassionate for all people.

*"A compassionate overdose response is looking at the entire person. It's not that moment of reviving them. It's [also] what happens afterward."*

*– Joy Rucker, Texas Harm Reduction Alliance, Black Harm Reduction Network*


Pictured left to right: Maya-Doe Simkins; Alice Bell; Joy Rucker; Nabarun Dasgupta, Ph.D.; Stephen Murray, MPH, NRP; and, Dr. Rachel Winograd, Ph. D.

## APPENDIX

### Table 1. Agenda for the Compassionate Overdose Response Summit

| Agenda Item | | Time |
|---|---|---|
| **Welcome / Orientation to the Day**<br>Erin Russell, Health Management Associates | | 10:00 – 10:10 |
| **Why are we talking about this?** | | 10:10 – 10:40 |
| Overdose experience and why we need to talk about naloxone dosing<br><br>Overdose response historical context | Malcom Visnich, Prevention Point Pittsburgh<br><br>Maya Doe-Simkins and Eliza Wheeler Co-Directors, Remedy Alliance | |
| **Summary of Naloxone Dosing Meeting and Feedback Process**<br>Erin Russell, MPH, Health Management Associates | | 10:40 – 10:55 |
| **Break** | | 10:55 – 11:00 |
| **Panel 1: Field Notes & Emerging Evidence** | | 11:00 – 11:30 |
| Community engagement and applied overdose response strategies at a sanctioned safe injection site in NYC<br><br>The role of oxygen monitoring and administration during overdose responses at a sanctioned overdose prevention site in San Francisco, California<br><br>Field comparison of naloxone products | Jason Beltre, Director of Community Initiatives & Impact at OnPoint NYC<br><br>Cleo Jenkins, Manager of Outreach, HealthRIGHT360<br><br>Dr. Sharon Stancliff, MD, NYS Department of Health & Dr. Michael W. Dailey, MD, Albany Medical College | |
| **Break** | | 11:30 – 11:35 |

| Agenda Item | | Time |
|---|---|---|
| **Panel 2: Two decades of data: Insights from syringe service participants and Emergency Medical Services** | | 11:35 – 12:05 |
| Analysis of Prevention Point Pittsburgh Naloxone Use Reports after 17 years | Nabarun Dasgupta, PH.D., University North Carolina + Alice Bell, Overdose Prevention Project, Prevention Point Pittsburgh | |
| Examination of naloxone dosing patterns for opioid overdose by emergency medical services in Kentucky during increased fentanyl use from 2018 to 2021 | Dr. Svetla Slavova, Ph.D., University of Kentucky College of Public Health | |
| Missouri's Overdose Field Report: Naloxone dosing remains stable despite concerns otherwise | Dr. Rachel Winograd, PH.D., Associate Professor, University of Missouri-St. Louis and Marcus Ryan Doll, EMT-P, RN, Bureau Chief – Emergency Medical Services, St. Charles Fire Dept | |
| **Lunch Break** | | 12:05 – 12:25 |
| **Panel 3: Engagement of People who Use Drugs in Overdose Response Policies and Protocols** | | 12:25 – 12:55 |
| When you give naloxone rescue kits to people who use drugs, guess what happens: they save lives | Dr. Jennifer Plumb, MD, University of Utah Department of Pediatrics | |
| Consulting people who use drugs on naloxone preferences: results from Michigan and replicable survey methods | Ashley Shukait, MPH, CHES, Public Health Consultant, Michigan and Pamela Lynch, LMSW, CAADC, Harm Reduction Michigan | |
| Overdose response protocols for programs built from experiences of a sanctioned safe injection site in NYC | Kailin See, Senior Director of Programs, OnPoint NYC | |

| Agenda Item | | Time |
|---|---|---|
| **Panel 4: International Perspective** | | 1:00 – 1:20 |
| Understanding negative reactions following naloxone administration<br><br>Scope of international research and what are the next research questions | Dr. Joanne Neale, MSc, DPhil, CQSW, Professor, Kings College London<br><br>Dr. Arne Skulberg, MD. PH. D, Post Doctoral Fellow, Attending Anesthesiologist, Air Ambulance Department at Oslo University Hospital | |
| **Compassionate Overdose Response Summary** | | 1:20 – 1:50 |
| Stephen Murray, MPH, NRP, Director, Mass Overdose Helpline at Boston Medical Center<br>Kimber King, Program Assistant, Massachusetts Overdose Helpline at Boston Medical Center<br>Joy Rucker, National Harm Reduction Consultant, Founder of the Texas Harm Reduction Alliance | | |
| **Wrap Up: Actionable Next Steps**<br>Erin Russell, MPH, Health Management Associates | | 1:50 – 2:00 |
| **Summit Q&A**<br>Frequently asked questions will be posed to the day's panelists | | 2:00 – 3:00 |

*Harm Reduction Therapeutics, Inc. (HRT) is a 501(c)(3) nonprofit organization founded to save lives by making over-the-counter RiVive (naloxone HCl nasal spray 3 mg) available free of charge or at the lowest possible cost. HRT is a client of Health Management Associates (HMA). Under their agreement, HRT engaged HMA in strategic planning, communication strategies, and providing general advice regarding the naloxone distribution landscape. HRT paid for a portion of person-time during the planning of the Compassionate Overdose Response Summit and those related to the writing and publication of this report. HRT is impartial to the Summit's proceedings and the contents of this report. HRT did not provide input into the direction of the Summit, its structure, or its content. They have not seen, reviewed, or contributed to the contents of this report prior to its publication.