EXECUTIVE SUMMARY
Testimony of Shawn S.N. on HB 341
Maryland Commission for Boys' and Men's Health
February 10, 2026
Position: Favorable With Amendments

Overview
HB 341 is a bill that creates the Maryland Commission for Boys' and Men's Health as an 18-member panel in the Maryland Department of Health (MDH) which will focus on addressing the disproportionate burden of chronic diseases, suicide, substance abuse, and early death rates that affect boys and men. The primary factors contributing to these disparities include lack of housing stability, employment, and education. The commission will assess and report on relevant health statistics; provide recommendations to policy makers regarding the development of gender and culturally sensitive health care; and produce an annual report with indicators of biennial progress, starting in 2028.

Why It Matters
Men's health impacts the degree to which men will be involved with their families; whether sons are able to provide support to their aging parents; and whether women have the capacity to continue working at home and outside the home. The direct effects of untreated depression; untreated substance abuse; and chronic disease create a cascade of additional costs to Medicaid, Behavioral Health, Corrections and Disability Systems.

Key Recommendations

1. **Strengthen Commission Representation** – Include members with lived experience as male caregivers, serious mental illness/substance use history, and professional expertise in social determinants of health.
2. **Ensure Rigorous Data Analysis** – Disaggregate (separate) data based on age, race/ethnicity, geography, disability status, income and/or insurance type. Investigate male caregiver engagement; preventive care; suicide/ overdose trends; and cross-system metrics (homelessness, incarceration rates and unemployment) from this data.
3. **Emphasize Transparent Evaluation Methods** –A multi-year trend analysis; a disparity analysis; and an evidence-based design approach (pre-post, matched comparison designs; interrupted time series designs).
4. **Explicitly Include Disability and Caregiving** –Investigate the relationship between the prevalence of disability among males; the role of male caregivers; and unemployment; justice system involvement and institutionalization.

Fiscal Context
Estimated FY 2027 cost: $138,100 (1.5 FTE analysts + operating). ROI: Even modest reductions

in high-cost system utilization (ER visits, crisis interventions, incarceration, premature disability) would exceed operating costs. Biennial progress indicators will track impact.

Federal and Private Funding Opportunities
Maryland currently receives over $140M annually in federal public health resources relevant to boys' and men's health:

- $13.6M CDC Overdose Data to Action (OD2A)
- $17.7M SAMHSA Community Mental Health Services Block Grant (FY 2024–2026)
- $104.5M+ State Opioid Response (SOR) funding
- $8.2M+ CDC chronic disease prevention funding

The bill authorizes acceptance of federal and private funds (as per §13-2406), thus reducing State fiscal exposure.

Proposed Amendments

- Representation: Include lived experience (caregivers, disabled men, behavioral health consumers)
- Data Scope: Disaggregate by age, race/ethnicity, geography, disability, insurance/income
- Disability and Caregiving: Integrate explicitly into analytic mandate
- Evaluation Rigor: Require transparent, evidence-based multi-year trend and quasi-experimental analyses

Consequences of Inaction
Without these amendments, future amendments will be underinformed, leading to delay and delegation. This inaction will perpetuate morbidity and mortality that can be preventable. It will increase reliance on high-cost emergency services, and also increase fiscal burdens on public systems.

Conclusion
HB 341 builds analytic infrastructure to address a documented public health and fiscal challenge. With these targeted amendments, Maryland can identify disparities, evaluate interventions, and link health outcomes to family stability and public expenditures. For families, the stakes are tangible; for the State, measurable and fiscal.

Requested Action: Favorable report with amendments.
Submitted by: Shawn S.N., Baltimore, MD, February 10, 2026
Supporting Materials: Full written testimony, technical addendum, references (14 citations from CDC, MDH, SAMHSA, peer institutions)

TECHNICAL ADDENDUM

Supplemental to Written Testimony of Shawn S.N.
HB 341 – Maryland Commission for Boys' and Men's Health
February 10, 2026

Purpose and Scope

This technical addendum supports the policy recommendations in the foregoing testimony by:

- Clarifying recommended data domains for commission analysis;
- Outlining evaluation framework options consistent with evidence-based public health practice; and
- Quantifying fiscal modeling considerations to inform appropriations and oversight.

All recommendations operate within the commission's advisory authority as defined in Health–General §13‑2405 and §13‑2408.

A. Recommended Core Data Domains

To support biennial progress reporting under §13‑2408, the commission should track indicators across six domains:

Overview: Six Core Data Domains

Domain	Focus Area	Key Purpose
1. Mortality & Morbidity	Death rates, disease burden	Identify leading causes of premature death
2. Behavioral Health	Mental health, SUD treatment	Track treatment cascade and crisis utilization
3. Preventive Care	Screening rates, primary care	Measure upstream intervention engagement
4. Disability & Function	Disability prevalence, LTSS	Understand intersection with other systems
5. Family & Caregiving	Male caregiver roles	Quantify caregiving burden and support needs
6. Cross-System	Justice, housing, employment	Examine non-health drivers of poor outcomes

All domains require stratification by: Age cohort, race/ethnicity, geography, disability status, and insurance type where feasible.

Domain 1: Mortality and Morbidity

Core Indicators: - Age‑adjusted all‑cause mortality rates for boys and men (overall and stratified by race/ethnicity, geography, disability status)
- Cause‑specific mortality:
- Suicide
- Drug overdose (opioids, stimulants, polysubstance)
- Cardiovascular disease
- Cancer (lung, colorectal, prostate)
- Years of potential life lost (YPLL) before age 75

Required Stratifications:

Dimension	Categories
Age Cohort	0–17, 18–25, 26–44, 45–64, 65+
Race/Ethnicity	White, Black/African American, Hispanic/Latino, Asian, Other
Geography	County, Region, Urban/Rural
Disability Status	With/Without Disability

Domain 2: Behavioral Health

Core Indicators: - Prevalence of diagnosed depression and anxiety disorders among boys and men
- Substance use disorder (SUD) diagnosis rates
- Treatment engagement and continuity:
- Medication‑assisted treatment (MAT) initiation and retention
- Outpatient behavioral health visit rates
- Emergency department visits for mental health crises and overdose
- Recurrent overdose events (nonfatal)

Treatment Cascade Framework:

Stage	Indicator	Gap to Monitor
Need Recognition	Screening rates among at-risk populations	% unscreened
Diagnosis	Assessment completion following positive screen	% lost between screen and diagnosis
Treatment Initiation	MAT or therapy start within 30 days	% diagnosed but untreated
Retention	Still engaged at 90 days	% who drop out early
Recovery	Sustained remission at 1 year	% who relapse

Commission should track drop-off rates at each transition point to identify system failure modes.

Domain 3: Preventive Care Utilization

Core Indicators: - Annual primary care visit rates by age cohort (pediatric, adolescent, young adult, midlife, older adult)
- Preventive screening rates:
- Blood pressure screening
- Lipid screening
- Hemoglobin A1c (diabetes screening)
- Colorectal cancer screening (age 45+)
- Prostate cancer screening discussions (shared decision‑making rates)

Current Gaps (Estimated Maryland Rates):

Screening Type	Current Rate (Men)	Healthy People 2030 Target	Gap	Priority Level
Blood Pressure	82%	90%	-8%	Medium
Lipid Panel	68%	85%	-17%	**High**
Colorectal (50+)	71%	74%	-3%	Low
HbA1c (at-risk)	64%	75%	-11%	Medium

Note: Rates estimated from BRFSS and commercial claims data; commission should establish precise baseline.

Domain 4: Disability and Functional Status

Core Indicators: - Prevalence of disability among boys and men by type (mobility, cognitive, sensory, self-care)
- Intersection of disability with:
- Unemployment and labor force non-participation
- Medicaid long-term services and supports (LTSS) utilization
- Nursing facility admission rates for men under age 65

Key Intersections to Track:

Disability Type	Primary Intersections	Policy Relevance
Physical	Employment, housing access, transportation	ADA compliance, accessibility
Cognitive	Educational attainment, justice involvement	Special education, diversion programs
Sensory	Health care access, social isolation	Telehealth, assistive technology
Self-Care	LTSS utilization, caregiver burden	HCBS expansion, respite services

Cross-Cutting Concerns: - Disability + unemployment → Economic instability
- Disability + housing instability → Institutionalization risk
- Disability + justice involvement → Incarceration without appropriate supports
- Disability + untreated behavioral health → Compounded functional limitations

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Domain 5: Family and Caregiving Indicators

Core Indicators: - Male participation in pediatric well-child visits (proxy for paternal engagement)
- Prevalence of male caregivers in Maryland households
- Male caregiver access to formal support services (e.g., respite care, caregiver training)
- Multigenerational household composition trends

Male Caregiver Profile (Estimated Maryland Data):

Characteristic	Estimate	Data Source
Total male caregivers statewide	~285,000	ACS 5-year estimates
Caring for parent/in-law	38%	AARP/NAC
Caring for child with disability	22%	NHIS
Caring for spouse/partner	28%	National Alliance for Caregiving
Caring for multiple family members	12%	State surveys
Receiving formal support services	**<15%**	State surveys

Gap Analysis: Over 85% of male caregivers receive no formal support (respite, training, care coordination), despite significant caregiving burden.

Domain 6: Cross-System Indicators

Core Indicators: - Justice involvement:
- Arrest rates by age and offense type
- Incarceration rates
- Reentry and recidivism rates
- Intersection of justice involvement with untreated behavioral health conditions
- Homelessness and housing instability among men
- Labor force participation and employment stability by age cohort
- Educational attainment and school disengagement (males aged 16–24)

Cross-System Risk Pathway:

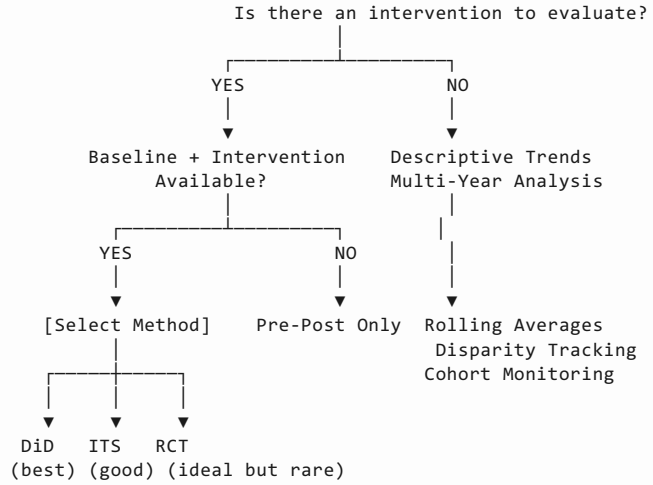
Starting Point	Intermediate Outcomes	Terminal Outcomes	Estimated Annual Cost
Untreated mental illness or SUD	School dropout, job loss, justice contact	Chronic homelessness, incarceration, disability	$638M (justice alone)
School disengagement (age 16-24)	Unemployment, low earnings	Justice involvement, poor health	$85M (lost productivity)
Housing instability	Emergency health utilization, crisis care	Institutionalization, premature mortality	$42M (ED + EMS)

Commission should map these pathways quantitatively to identify highest-leverage intervention points.

B. Evaluation Framework Options

The commission's biennial progress reports should employ rigorous, transparent methods to assess trends and intervention impacts.

Evaluation Framework Decision Tree



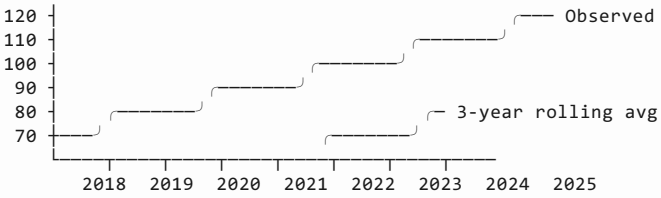
Method 1: Multi-Year Trend Analysis

Use Case: Baseline descriptive reporting; identifying long-term patterns

Approach:
- Use 3–5 year rolling averages to smooth year-to-year volatility in suicide, overdose, and other low-frequency events
- Identify inflection points or sustained directional changes associated with major policy shifts (e.g., Medicaid expansion, SOR funding, school-based mental health initiatives)

Visual Output Example:

Overdose Deaths Among Men (Ages 25-44)



[Commission should track whether slope changes after interventions]

Method 2: Disparity Gap Tracking

Use Case: Monitoring health equity progress

Approach:
- Calculate absolute and relative disparity measures (e.g., rate differences and rate ratios) across race/ethnicity, geography, and disability status
- Track whether gaps are widening, narrowing, or stable over time
- Prioritize interventions in populations and regions with the largest gaps

Disparity Metric Table:

Group Comparison	Absolute Gap	Relative Gap (Rate Ratio)	Trend	Action Priority
Black vs. White men (suicide)	+8 per 100k	1.4	Stable	Medium
Rural vs. Urban men (overdose)	+22 per 100k	1.8	Widening	**High**
Disabled vs. Non-disabled (unemployment)	+18%	2.3	Narrowing	Monitor

Method 3: Cohort Monitoring

Use Case: Understanding life-course transitions and cumulative risk

Approach:
- Follow specific male age cohorts longitudinally across multiple reporting periods:
- Males aged 10–17 (adolescent behavioral health, school engagement)
- Males aged 18–25 (transition to adulthood, justice involvement, SUD onset)
- Males aged 26–44 (employment stability, chronic disease onset, caregiving roles)
- Males aged 45–64 (cardiovascular disease, disability, early retirement/disability benefit uptake)
- Examine transitions between key states (e.g., school to work, community to incarceration, independent living to institutionalization)

Example: Age 18-25 Cohort Tracking

Status Category	Year 1 (Baseline)	Year 3	Year 5	Interpretation
Employed full-time	65%	58%	52%	Declining employment stability
In school/training	25%	18%	20%	Some credential completion
Neither employed nor in school	10%	16%	18%	Growing disconnection
Justice-involved	3%	8%	6%	Peak contact in early 20s
On disability benefits	1%	4%	7%	Rising disability claims
SUD diagnosis	5%	12%	9%	Peak use, some recovery

Commission tracks percentage in each state over time and identifies intervention points.

Method 4: Pilot Evaluation Models

Where targeted interventions are implemented (e.g., malelspecific mental health outreach, workplace wellness programs, reentry supports), the commission should encourage use of:

A. Pre–Post Comparisons

Strength: Simple and lowlcost; appropriate for small pilots
Limitation: Cannot rule out secular trends or external factors

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Metric: Primary Care Visit Rate (Men 18-25)

Before Intervention:  ███████▒▒▒▒▒▒▒▒▒▒▒▒  40%
After Intervention:   ███████████▒▒▒▒▒▒▒▒▒  55%

Change: +15 percentage points (p < 0.05)
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B. Matched Comparison Groups

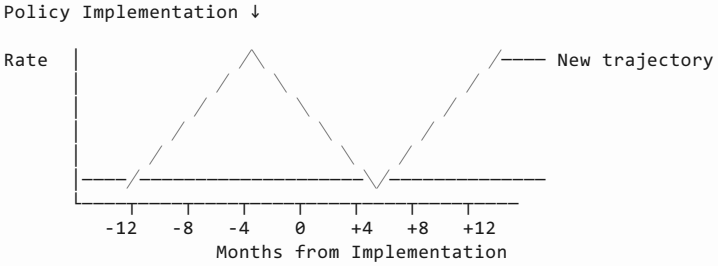
Strength: Strengthens causal inference relative to pre–post alone
Method: Compare outcomes in jurisdictions or populations participating in an intervention to similar nonparticipating ones matched on baseline characteristics (propensity score matching)

Example Table:

Group	Baseline Rate	Follow-up Rate	Change	Statistical Significance
Intervention counties	42%	58%	**+16%**	$p < 0.01$
Matched comparison	41%	47%	+6%	$p = 0.08$
Net treatment effect	—	—	**+10%**	$p < 0.05$

C. Interrupted Time Series Analysis

Strength: Controls for secular trends and seasonality
Requirement: Sufficient preand postintervention time points (typically 8+ per period)



[Assess whether level or slope changes significantly]

D. Differencein-Differences (DiD)

Strength: Accounts for timeinvariant confounders and common trends; standard approach in peerreviewed policy evaluation

Formula:

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Effect = (Treatment_post - Treatment_pre) - (Control_post - Control_pre)
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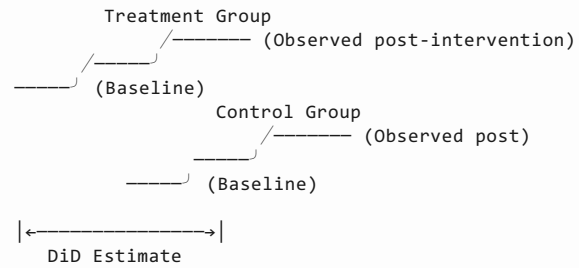
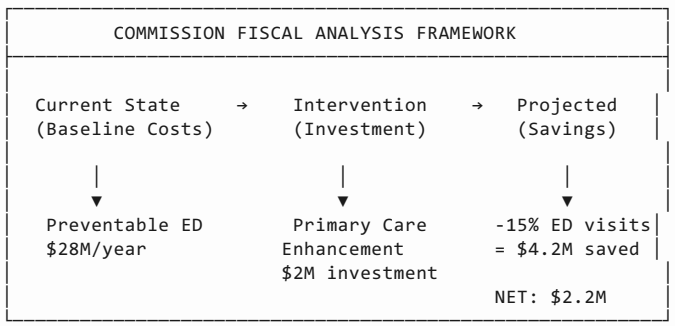
Visual Representation:



C. Fiscal Modeling Considerations

The commission's advisory role includes identifying opportunities for cost avoidance and improved resource allocation. The following fiscal modeling exercises would support that mandate:

Fiscal Modeling Framework



Model 1: Preventable Emergency Utilization

Objective: Estimate annual cost burden of emergency department visits among men for conditions manageable in primary care settings

Data Sources:
- Maryland All‑Payer Claims Database (APCD)
- Hospital discharge data (HSCRC)

Method:
- Identify ED visits classified as "potentially preventable" using validated algorithms (e.g., NYU ED Algorithm, AHRQ Prevention Quality Indicators)
- Stratify by sex, age, payer, and geography
- Calculate total annual charges and allowed amounts for male patients
- Model cost reduction scenarios assuming 10%, 20%, and 30% reductions through improved primary care access

Scenario Table:

Scenario	Baseline Annual Cost	Reduction %	Savings	Investment Needed	Net Benefit
Status Quo	$28,000,000	0%	$0	$0	$0
Modest Improvement	$28,000,000	10%	$2,800,000	$1,000,000	$1,800,000
Moderate Improvement	$28,000,000	20%	$5,600,000	$2,000,000	$3,600,000
Substantial Improvement	$28,000,000	30%	$8,400,000	$3,500,000	$4,900,000

Model 2: Behavioral Health and Justice System Intersection

Objective: Quantify association between untreated mental illness/SUD and incarceration costs among men

Data Sources:
- Maryland Department of Public Safety and Correctional Services (DPSCS) data
- Medicaid and behavioral health claims
- Pretrial Services data

Cost Components:

System Touchpoint	Annual Cost per Individual	Volume (Est.)	Total Annual Cost
Arrest processing	$500	45,000 men	$22,500,000
Pretrial detention (30 days avg)	$3,500	12,000 men	$42,000,000
Incarceration (avg 18 months)	$67,500	8,500 men	$573,750,000
TOTAL	—	—	**$638,250,000**

Diversion Potential:

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If 10% of justice-involved men with untreated behavioral health
conditions were diverted to community treatment:

Diverted: 850 men × $67,500 = $57.4M avoided incarceration cost
Treatment cost: 850 men × $12,000 = $10.2M
NET SAVINGS: $47.2M annually
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Model 3: Preventive Screening Cost‑Effectiveness

Objective: Model cost avoidance from increased uptake of cardiovascular and cancer screening among men

Data Sources:
- Medicaid and commercial claims data
- BRFSS (Behavioral Risk Factor Surveillance System)
- Clinical trial and cost‑effectiveness literature

Cost per QALY Analysis:

Screening	Current Rate (Men)	Target Rate	Cost per QALY	Meets Threshold?
Blood Pressure	82%	90%	$8,500	✓ Cost-effective
Lipids	68%	85%	$12,000	✓ Cost-effective
Colorectal	71%	80%	$15,000	✓ Cost-effective
HbA1c (at-risk)	64%	75%	$9,200	✓ Cost-effective

Threshold: $50,000 per QALY (standard benchmark)

Projected Impact (10-Year Horizon):

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Scenario: Increase all screening rates to targets

Upfront Investment:        $18M (outreach, mobile clinics, EMR alerts)
Avoided CVD events:        2,400 events × $45,000 = $108M
Avoided late-stage cancer: 180 cases × $150,000 = $27M
TOTAL AVOIDANCE:          $135M
NET BENEFIT:              $117M over 10 years
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Model 4: Caregiving and Medicaid LTSS

Objective: Estimate fiscal impact of supporting male caregivers to delay or prevent institutionalization of care recipients

Data Sources:
- Maryland Medicaid LTSS utilization data
- ACS caregiving module
- National longitudinal studies (e.g., NHATS)

Cost Differential:

Care Setting	Annual Medicaid Cost	Difference from Nursing Facility
Nursing Facility	$94,000	Baseline
Assisted Living	$68,000	-$26,000
Home & Community (HCBS)	$57,000	-$37,000
Informal Care (family)	$12,000 (respite/support only)	-$82,000

Scenario: Male Caregiver Support Program

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Investment:
  • Respite care subsidies: $3,000 per caregiver
  • Training and care coordination: $1,500 per caregiver
  • Total per caregiver: $4,500
  • Serve 1,000 male caregivers: $4.5M

Outcome:
  • Delay institutionalization by 12 months for 200 care recipients
  • Savings: 200 × $37,000 = $7.4M

NET BENEFIT: $2.9M in Year 1
             (Cumulative benefit grows in subsequent years)
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D. Data Infrastructure and Partnerships

To execute the analytic agenda outlined above, the commission will require:

Data Sources and Partnership Structure

Category	Specific Sources	Access Mechanism	Primary Use
State Health Data	Vital statistics, Medicaid claims, APCD	Data use agreements with MDH, MHCC	Mortality, morbidity, utilization trends
Corrections & Justice	DPSCS data, pretrial services	MOUs with public safety agencies	Justice involvement, reentry outcomes
Education	MSDE enrollment, attendance, outcomes	FERPA-compliant data sharing	School engagement, educational attainment
Federal Data	CDC WONDER, SAMHSA surveys, Census/ACS	Public use files + restricted data applications	National benchmarks, social determinants
Academic Partners	UMD SPH, JHU BSPH, RAND, Urban Institute	Evaluation contracts, IRB protocols	Methodological support, peer review

Privacy & Security: All data sharing complies with HIPAA, FERPA, and Maryland confidentiality statutes. Secure data warehouse with role-based access controls.

E. Implementation Timeline

Commission Development Roadmap (FY 2027 – FY 2031+)

Fiscal Year	Phase	Key Activities	Major Deliverables
FY 2027	Startup	• Commission appointments • Initial organizational meetings • Data access agreements negotiated • Stakeholder listening sessions	• Commission bylaws adopted • Data sharing MOUs executed • Baseline data collection begins
FY 2028	First Report	• Baseline data analysis across 6 domains • Disparity gap identification • Priority area selection • Pilot intervention design	• **First biennial report to General Assembly** • Progress indicators established • Pilot programs launched
FY 2029	Pilot Evaluation	• Continue data tracking • Mid-course pilot assessment • Refine fiscal models • Expand academic partnerships	• Interim evaluation reports • Revised intervention protocols
FY 2030	Scaling Decisions	• Cohort analysis (2-year follow-up) • Cost-effectiveness analysis • Identify successful pilots for scaling	• **Second biennial report** • Scaling recommendations • Budget requests for expansion
FY 2031+	Mature Capacity	• Longitudinal datasets enable causal inference • Rigorous impact evaluations • Evidence-based policy recommendations	• Ongoing biennial reports • Policy impact documentation • Continuous quality improvement

Key Milestones by Quarter

Milestone	Target Quarter	Responsible Party	Success Indicator
Commission fully appointed	FY27 Q2	Governor, legislative leaders	18 members sworn in
Data access agreements signed	FY27 Q3	MDH, commission staff	MOUs executed with 5+ agencies
Baseline data collection complete	FY27 Q4	Commission analysts	6 domains populated with 3+ years data
First biennial report submitted	FY28 Q2	Commission chair	Report delivered to General Assembly
Pilot interventions launched	FY28 Q3	Partner agencies	3+ pilots operational in priority areas
Mid-course pilot evaluation	FY29 Q4	Academic partners	Interim findings documented
Second biennial report submitted	FY30 Q2	Commission chair	Trend analysis + pilot results included
Mature evaluation capacity achieved	FY31 Q1	Commission, partners	DiD or ITS analysis published

F. Expected Outputs

Commission Biennial Report Structure

Section	Content	Purpose
I. Executive Summary	Key findings, top recommendations, fiscal implications	Accessible overview for legislators and public
II. Trend Analysis (6 Domains)	Data tables with confidence intervals, disparity gap tracking, geographic maps	Document progress and identify persistent gaps
III. Priority Findings	Where disparities are greatest, populations at highest risk, system failure points	Focus attention and resources
IV. Intervention Evaluations	Pilot program results, cost-effectiveness analysis, scaling recommendations	Evidence base for budget requests
V. Policy Recommendations	Statutory changes, appropriations, administrative actions	Actionable guidance for General Assembly
VI. Appendices	Technical methods, data sources/limitations, stakeholder input summary	Transparency and replicability

Report Format: Printed document + interactive web dashboard with downloadable datasets.

Dissemination: Submitted to General Assembly, posted publicly, presented at stakeholder forums.

Conclusion

This technical addendum demonstrates that the commission envisioned in HB 341 can move beyond descriptive reporting to provide actionable intelligence for policymakers and appropriators.

Key Takeaways:

✓ **Six core data domains** provide comprehensive view of boys' and men's health
✓ **Four evaluation methods** enable rigorous assessment of interventions
✓ **Four fiscal models** quantify return on investment
✓ **Clear implementation timeline** from startup through mature capacity
✓ **Structured outputs** support legislative oversight and appropriations

By systematically tracking disaggregated health indicators, applying transparent evaluation methods, and quantifying fiscal implications, the commission can help Maryland identify where investments in boys' and men's health will yield the greatest returns in both human and budgetary terms.

The analytic infrastructure and partnerships outlined here are feasible within the commission's statutory authority and the modest staffing allocation identified in the fiscal note ($138,100 FY27). Federal and private funding, as authorized in §13I2406, can further augment capacity.

The commission's value will be measured not by the volume of reports produced, but by the quality of evidence generated and the measurability of outcomes improved.

END OF TECHNICAL ADDENDUM

Key References

Centers for Disease Control and Prevention. (2023). *Budget and funding: Maryland – Injury and overdose prevention*. U.S. Department of Health and Human Services. https://www.cdc.gov/injury/budget-funding/maryland.html

Centers for Disease Control and Prevention. (2023). *CDC grants profile report, Maryland, FY 2023*. National Center for Chronic Disease Prevention and Health Promotion. https://fundingprofiles.cdc.gov/Report_Docs/PDFDocs/Rpt2023/Maryland-2023-CDC-Grants-Profile-Report.pdf

Centers for Disease Control and Prevention. (2024). *NCCDPHP budget and funding*. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/nccdphp/budget-funding/index.html

Centers for Disease Control and Prevention. (2024). *Overdose Data to Action (OD2A): Cooperative agreement NU17CE010200 – Maryland Department of Health* [Grant award information]. U.S. Department of Health and Human Services. https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=NU17CE010200&arg_ProgOfficeCode=111

Centers for Disease Control and Prevention. (2024). *Overdose Data to Action (OD2A)*. National Center for Injury Prevention and Control. https://www.cdc.gov/overdose-prevention/php/od2a/index.html

HigherGov. (n.d.). *CDC Overdose Data to Action (OD2A), cooperative agreement NU17CE010200 – Maryland Department of Health*. Retrieved [Month Day, Year], from https://www.highergov.com/grant/NU17CE010200/

Maryland Department of Health. (2022–2024). *Maryland inter-agency opioid coordination plan 2022–2024* (EXORD01.01.2015.13). https://dlslibrary.state.md.us/publications/Exec/MDH/EXORD01.01.2015.13_C(4)_2022-2024.pdf

Maryland Department of Health. (2024). *Maryland overdose data dashboard*. Vital Statistics Administration. https://stopoverdose.maryland.gov/dashboard/

Maryland Department of Health. (2024). *Maryland's Overdose to Action initiative: Annual report* (EXORD01.01.2023.21). https://dlslibrary.state.md.us/publications/Exec/MDH/EXORD01.01.2023.21_2024.pdf

Maryland Department of Health. (2024, July). *FY25 Maryland Opioid Operational Command Center/Maryland Office of Overdose Response block grant program award summary*. https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2024/07/FY25-MOOR-Block-Grant-Program-Award-Summary.pdf

Maryland Department of Health. (2025). *Maryland Department of Health awards $48 million in mental health and substance use grant funds* [Press release]. https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-awards-%2448-million-in-mental-health-and-substance-use-grant-funds-.aspx

National Association of State Alcohol and Drug Abuse Directors. (2024). *Maryland State Opioid Response (SOR) initiatives brief*. https://nasadad.org/wp-content/uploads/2024/09/Maryland-SOR-Brief-Draft-2024_Final.pdf

Substance Abuse and Mental Health Services Administration. (2024). *Community Mental Health Services Block Grant (MHBG): Program overview*. U.S. Department of Health and Human Services. https://www.samhsa.gov/grants/block-grants/mhbg

Substance Abuse and Mental Health Services Administration. (2024). *Maryland: Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) expenditures* (Report No. RPT56455). U.S. Department of Health and Human Services. https://www.samhsa.gov/data/sites/default/files/reports/rpt56455/Maryland.pdf