UniHealth Grant: Year 3 Evaluation Report

Maternal Mental Health Project: A Circle of Support for Expectant and New Parents

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PREPARED FOR: MOMS ORANGE COUNTY (MOMS) & UNIHEALTH FOUNDATION

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Introduction

MOMS Orange County (MOMS) is a non-profit organization based in Orange County, California which provides perinatal educational classes and home visiting support services to individuals expecting a child and new parents after a baby is born.

In April 2022, MOMS was awarded funding from the UniHealth Foundation to expand and enhance their services, prioritizing program activities on mental health support for clients and staff alike. The project was named the *Maternal Mental Health Project: A Circle of Support for Expectant and New Parents*, and is funded from April 2022 through March 2025. Under this project, MOMS works to provide direct service activities to the clients served by MOMS as well as to enhance indirect services, such as building staff capacity through in-service training and additional supports.

There are **three primary goals** that the *Maternal Mental Health Project* hopes to achieve, listed below.

1. Reduce/Mitigate Barriers Clients Face Receiving Mental Health Services
2. Increase the Number of Clients Who Successfully Access Therapy After Mental Health Referral
3. Decrease Symptoms of Clients Affected by Perinatal Mood and Anxiety Disorders

The strategies to accomplish the project goals include efforts to:

1) expand perinatal programming to include individualized sessions with a mental health professional for clients who are struggling with perinatal mood and anxiety disorders (PMADs)
2) enhance components of the educational classes with services focused on mental health and well-being for women and men
3) increase home visitation for clients who may benefit from specialized supplemental services
4) provide in-services support and training to client-facing staff to improve client services and prevent staff from experiencing compassion fatigue and burnout

MOMS executive staff identified current activities within their programs that could support the strategies and goals of the *Maternal Mental Health Project*. Further, they also determined program areas to expand or develop with the help of this funding. The following page shows the program activities that fall within the *Maternal Mental Health Project* and support its three primary goals.

Program activities fall under two umbrellas, either direct or indirect services. Direct services are the immediate interventions or actions taken when offering services to MOMS clients, while indirect services consist of actions that help to support or promote the direct services. These could be items that address staff needs, bolster infrastructure or organizational capacity, or provide marketing and promotion of services offered.

Client-Facing Direct Services

- **Educational Classes:** 4 to 6 weeks in length, expecting and new parents attend once a week and engage in educational activities and discussions to increase knowledge and beliefs about mental health, improve skills for self-care and managing stress, encourage positive feelings of self-worth and self-esteem, increase knowledge and understanding of anxiety and depression, and improve skills in effective communication. These programs are offered in English and Spanish and are provided to expecting mothers and fathers as separate class series.

    - Healthy Woman/Mujer Sana Class (women's group)
    - Strong Fathers Strong Families/Padres Fuertes Familias Fuertes Class (men's group)
- **Mental Health Support Services:** MOMS offers one-on-one therapy sessions to clients referred for mental health support services who have been identified as persons affected by symptoms related to perinatal mood and anxiety disorders (PMADs). In addition, MOMS also provides specialized or extended home visits or one-on-one education to individuals affected by PMADs or those who have experienced or are currently experiencing domestic violence.
    - Client One-on-One Therapy Sessions
    - Specialized and extended home visits/education (Mental Health or Domestic Violence-related content, i.e., Thriving Relationships curriculum)

Indirect Services

- **Subcontracting a Licensed Mental Health Therapist:** MOMS contracted with a licensed mental health specialist to support the direct service activities under the UniHealth Foundation funding. The mental health specialist has training that specializes in providing clients with support for those affected by PMADs.
- **One-on-One Therapy and In-Service Counselor Training for Staff:** The mental health specialist supports staff who work directly with clients by providing them with mental health resources, offering one-on-one therapy sessions and in-service counselor training. Activities provided to client-facing staff intend to promote staff mental health and well-being, prevent compassion fatigue and burnout, and increase their knowledge of PMADs.
- **Marketing and Promotional Efforts:** MOMS team coordinates with their partners to distribute frequent marketing/promotion the Healthy Woman/Mujer Sana and Strong Fathers Strong Families/Padres Fuertes Familias Fuertes classes. Promotion of the new and existing program activities are provided via the MOMS newsletter, partner collaborations, and through the MOMS social media accounts on Facebook, Instagram, and LinkedIn.

Evaluation Overview

A portion of the grant funding supports evaluation services to measure progress towards the project's goals and assess program outcomes. In addition, the evaluation helps determine what challenges and barriers to implementation occurred throughout funding period and provides guidance on future implementation efforts by sharing lessons learned and recommendations based on the evaluation's findings.

As such, MOMS partnered with Fireside Consulting, LLC to conduct the evaluation of the 3-year project. This report shares findings across each year of funding. It highlights the processes to develop the scope of the evaluation in relation to the project's program activities and their overall implementation. Further, it describes key collaboration and coordination efforts conducted throughout the project to ensure the activities were executed effectively and with fidelity to the project's intended goals.

The evaluation team first worked with MOMS to establish learning questions which serve as guides to the scope of the evaluation and its measurement activities. Outlined below are the questions.

Implementation

- Among the proposed program activities, what factors contributed to a successful and/or timely implementation?
- What factors were a challenge to implementation?

Results and Outcomes

- What impact did the program make for MOMS, its clients, and the community?
- How does this impact compare to anticipated outcomes?

Context

- What other factors outside of the program contribute to clients' wellbeing and reduce (or increase) the prevalence of PMAD symptoms?
- What organizational factors (e.g., staff capacity, leadership, resources) might have affected the efforts of the program's implementation and outcomes?

The evaluation is a mixed methods design, using both quantitative and qualitative data sources to assess process and outcome metrics. A majority of process metrics are tracked within the internal database of MOMS, and information for the evaluation is pulled from the system on a frequent basis to report on the number of classes/sessions, attendees, referrals, etc. A few process metrics are tracked outside of the established database using a password protected Excel/Google Sheet file. Furthermore, each program activity has a corresponding post-survey that was developed to measure outcomes/impact of the programming on its participants.

Lastly, the evaluation team also collaborated with MOMS to gather qualitative data at different points in the project timeline (e.g., staff interviews to inform the planned evaluation measurement activities, document/file review of descriptive narratives such as staff training activities, client engagement notes, etc.).

This evaluation report shares data findings spanning from April 2022 to the end of February 2025. More details about each of the outputs and outcomes tracked throughout the evaluation can be found within the "Measuring Progress" section of this report.

Measuring Progress

This section shares a high-level overview of the ways in which each of the project activities are measured within the scope of the evaluation.

- **Data Collection for Educational Classes**
  - **Outputs:** MOMS track the number of classes offered, dates of classes, and attendees within their database to report on educational class activities. Attendance log data entry is completed on an ongoing basis, and indicators to report progress towards target goals include the number of classes and attendees as well as the average number of sessions attended and average number of attendees per session.
  - **Outcomes:** A post-survey was developed for the Healthy Woman/Mujer Sana classes and the Strong Fathers Strong Families/Padres Fuertes Familias Fuertes classes to measure outcome-level data and is administered to clients on the last session of the class series. Surveys include items to assess the following changes: knowledge and beliefs about mental health, skills for self-care and managing stress, feelings of self-worth and self-esteem, knowledge and understanding of anxiety and depression, skills in effective communication, and satisfaction with participation.
- **Data Collection for One-on-One Therapy Sessions**
  - **Outputs:** Similar to the educational classes, MOMS tracks the number of sessions offered and attended, dates of the sessions, and number of individuals referred to mental health services. The referral and scheduling log is kept up to date on a daily basis, and, in addition to reporting on the total counts, rates such as no-shows and linkages are reported.
  - **Outcomes:** A post-survey was developed for the one-on-one therapy sessions to measure outcome-level data and is administered to clients at the last session (among clients who have attended at least four sessions). The survey includes items to assess some of the following changes: skills to cope with symptoms of PMADs, knowledge and awareness of mental health and community resources, and satisfaction with participation.
- **Data Collection for Specialized and Extended Home Visits/Education**
  - **Outputs:** The number of home visits and the dates of facilitation are being tracked by MOMS for each client identified as needing additional supports.
  - **Outcomes:** After at least four home visits and at the final home visit or educational session, a post-survey is administered to clients to collect outcome-level data. Separate post-surveys were developed for the Mental Health and Domestic Violence Specialized Home Visits.
- **Other Data Collection in Support of Project Activities**
  - **Outputs:** Additional items are tracked to monitor progress towards goals related to the number of staff trainings and participants, and the number of marketing and promotion activities through newsletters, partnerships, and social media engagement.
  - **Outcomes:** Both informal (standing check-in meetings) and formal (semi-structured interviews) communication with MOMS team members were conducted throughout Year 1 to ascertain progress towards marketing/promotion goals and perceptions about the overall implementation of the project.

The evaluation plan document provides more detailed information about each output and outcome to be measured along with definitions of the metrics used to measure each output/outcome and the target goals established at the start of the project. Lastly, it indicates how data are anticipated to be collected and the frequency, storage, and handling procedures.

For the purpose of sharing data and insights about project implementation and services, Reporting Years end in February, which is slightly different than the funding year timeline. This is to align with the implementation of project activities and allow for a final reporting window before the March 2025 funding deadline. These reporting years are outlined below.

Reporting Year	Data Start Date	Data End Date
Year 1	April 2022	February 2023
Year 2	March 2023	February 2024
Year 3	March 2024	February 2025

Evaluation Findings

This report is the final annual report for the last year of the 3-year funded grant cycle, thus, findings are shared for data collected between March 2024 and February 2025 and, as applicable, compared to the findings from year one (April 2022 through February 2023) and year two (March 2023 through February 2024).

Most of the data collection efforts support the evaluation questions pertaining to the **Results and Outcomes**, and, when relevant, the findings from various data collection activities are shared alongside any target goals to demonstrate progress within each year of the grant funding. However, additional data findings help to answer the evaluation learning questions within the areas of **Implementation** and **Context.** Each section has color-coded headers that correspond with the learning questions that the data findings support.

As the *Maternal Mental Health Project* sunsets its final year of funding from the UniHealth grant, the evaluation findings from each funding year can provide key lessons learned and recommendations or next steps for enhancing the program activities and its evaluation in future years or supporting the efforts of similar projects that receive funding.

Implementation

Among the proposed program activities, what factors contributed to a successful and/or timely implementation?

In Year 1, MOMS was able to find a mental health provider to begin implementing one-on-one therapy sessions immediately and brought in an evaluator to gather direct feedback from staff, understand workflows, and design and implement a practical evaluation framework. Details on these interviews are provided in the Year 1 report.

In Year 2, the completion of staff training on intimate partner violence, mental health first aid, and doula support equipped the MOMS team with the knowledge and skills needed to effectively implement new programs such as the Thriving Relationships group and the Postpartum Support Visits.

By Year 3, staff were successfully equipped with the knowledge and skills to provide all direct services outlined in the grant funding proposal and were offering these services at consistent cadences throughout the year. In addition, an increased number of staff were trained to provide the new programs such as the Thriving Relationships group and Postpartum Support Visits, resulting in more than double the number of specialized mental health home visits from Year 1 to Year 3 and a robust number of enrollments in the Thriving Relationships program in Year 3.

The development of a comprehensive evaluation plan and data collection tools in Year 1 provided a roadmap for tracking progress and assessing impact across all program components. Internal data updates and periodic review of this data, as well as the continued use of client feedback surveys allowed MOMS to gather valuable insights and adapt programs to better meet the needs of participants.

What factors were a challenge to implementation?

In Year 1, MOMS experienced challenges with staffing and leadership changes and leaves of absence, as well as the initiation of implementation of the one-on-one therapy program before a final survey was ready, which led to an immediate ability to meet client needs, but a loss of data about these early participants. More information on these challenges is detailed in the Year 1 report.

In Year 2, recruitment for the men's support group was a continued challenge for MOMS; however, staff continued to explore creative ways to engage fathers and have seen some of the most impactful outcomes for the fathers that do participate in this program, further underscoring the potential to make a difference if more fathers enrolled. Recruitment challenges persisted into Year 3, particularly as MOMS expanded the number of classes per series from four to six. While this expansion provided more in-depth support for enrolled clients, it also reduced the total number of class series that could be offered annually, resulting in fewer new enrollments overall.

Although enrollments in the Thriving Relationships program increased in Year 3 compared to Year 2, the proportion of clients who completed the program remained at approximately one-quarter of enrollments, well below the target of 80%. The program is designed to support individuals experiencing elevated stress or family crises, including situations involving domestic violence or abuse. As such, sustained outreach and engagement can be particularly challenging given the complex and often unstable circumstances of the intended participants.

Results and Outcomes

What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

The following tables, figures, and corresponding narrative show progress towards each activity's targeted output and impact goals, along with explanation of these findings. Within the achievement/progress column, color highlighting is used to denote levels of achievement towards target goals, as denoted in the legend below:

Color Legend: Progress on Year 3 Goals
Red=Goal not met (less than 50%)
Yellow=Goal partially met (over 50%)
Green=Goal achieved or exceeded

After each of the presented tables, the evaluation learning questions will be referenced within each program/activity and a narrative response along with figures and charts (as appropriate), will be provided.

Table 1. Annual Measurement for Healthy Woman/Mujer Sana Classes

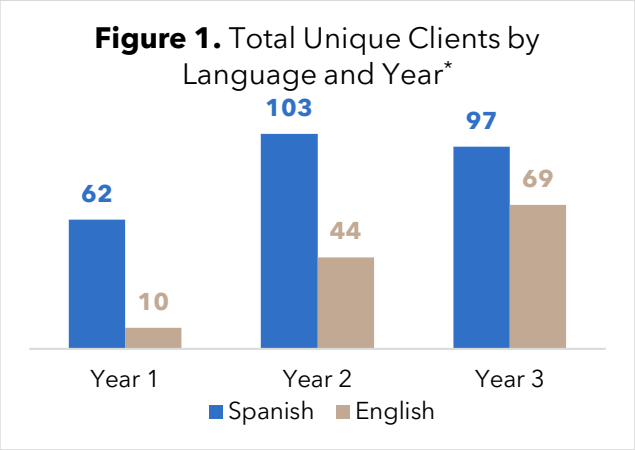
Output/ Outcome	Targets	Years 1-3 Actuals			Achievement/Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*			*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
		Year 1	Year 2	Year 3	
Classes offered and attended	**16 class series** offered per year	**15 class series** (~4-week ea.), totaling **48 classes** and 163 duplicated attendees; average of 3 to 4 attendees per class session	**23 class series** (~4 weeks ea.), totaling **87 classes** and 382 duplicated attendees; average of 4-5 attendees per class session	**23 class series** (~4 weeks ea.), totaling **82 classes** and 463 duplicated attendees; average of 5-6 attendees per class session	**Achieved/Exceeded.** MOMS offered 23 class series in Year 3, maintaining the pace of classes in Year 2 and surpassing the target of 16 class series per year. The average number of attendees per class steadily increased from 3-4 attendees per class session in Year 1 to 5-6 attendees in Year 3.
Classes completed	**80 women** will complete 75% of classes per year	**33 women attended 75% or more of the class series** (46% of 72 total)	**79 women attended 75% or more of the class series** (54% of 145 total)	**94 women attended 75% or more of the class series** (57% of 166 total)	**Achieved/Exceeded.** MOMS achieved this target, building on steady progress over the first two years.
Increased knowledge and beliefs about mental health Improved skills for self-care and improving self-worth and self-esteem Class satisfaction	**Average rating will be at least 4 of 5** on knowledge, belief, skills, and satisfaction items	Not reported due to small samples	Out of 59 clients surveyed, **average rating met or exceeded 4 of 5** on all metrics	Out of 65 clients surveyed, **average rating met or exceeded 4 of 5** on all metrics	**Achieved/Exceeded.** Responses rose substantially in Years 2 and 3 and the average rating met or exceeded 4 out of 5 during the last 2 years of the program. There were small dips in agreement in Year 3 vs. Year 2, while satisfaction increased in Year 3.

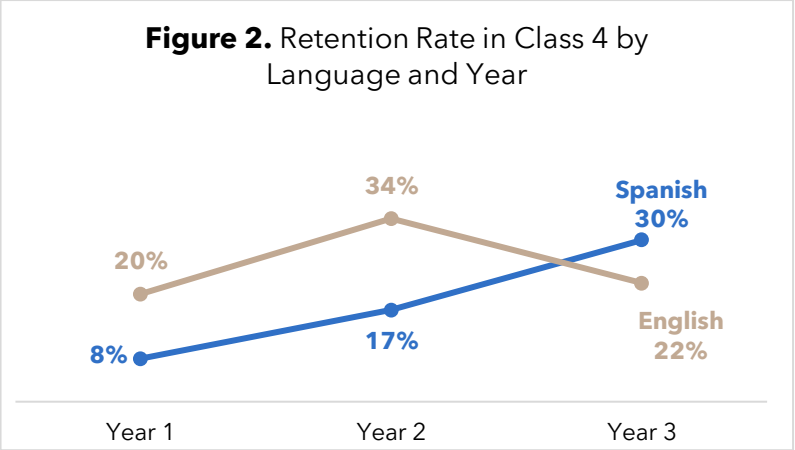
What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

As shown in the table above, the Healthy Woman/Mujer Sana classes successfully scaled each year to meet or exceed the expected targets for both the number of class series offered and the number of participating women who completed at least 75% of sessions. These achievements are particularly remarkable given the organizational and staffing transitions that occurred across funding years. In Year 1, MOMS relied on a contractor to facilitate the classes. In Year 2, facilitation shifted to an internal staff member, but by Year 3, that staff member could no longer continue in the role. As a result, MOMS temporarily returned to the original contractor, who was ultimately hired as an internal staff member during Year 3. Despite these staffing shifts, the program maintained high enrollment, participation, and retention rates, consistently exceeding targets. Additionally, average survey ratings related to improved learning outcomes remained above 4 out of 5 across all metrics each year.

Another noteworthy contextual factor that makes the consistent achievement of the program's targets especially impressive is the expansion of its language accessibility. At the start of Year 1, the classes were offered nearly exclusively to Spanish-speaking clients, with less than 15% of participants identifying as English-speaking. By Year 3, however, 42% of enrolled clients were English-speaking. This shift reflects MOMS OC's ability to successfully reach a new client base at scale, while continuing strong outreach to the Spanish-speaking community. Overall enrollment increased, client satisfaction ratings remained high across each funding year, and strong learning outcomes continued to be achieved.





*Note: Some clients participated in both English and Spanish class series.

Figures 1 and 2. All three years, class participants were primarily **Spanish speakers**; In Year 3, **Spanish-speaking** participants had higher final class retention (30%) than **English-speaking** participants (22%), a significant reversal from previous years. **Spanish-speaking** participants have shown more consistent improvement in retention across all three years, particularly in the final class.

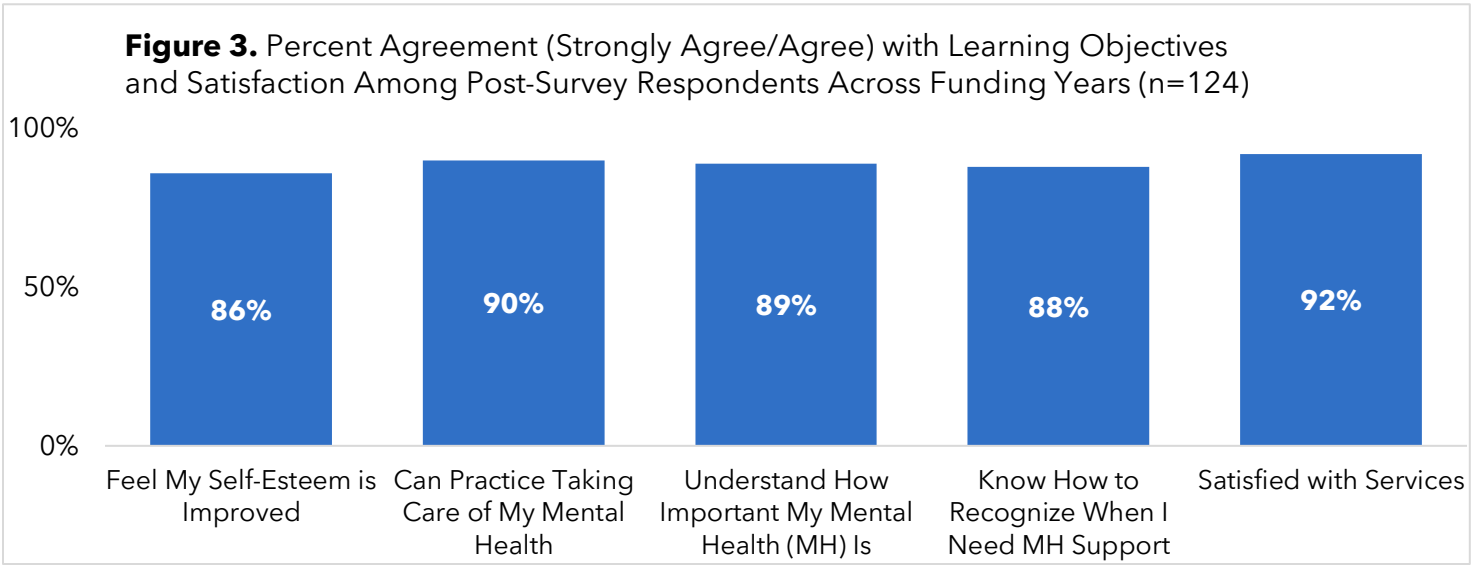


Figure 3. Survey data collected at the end of Year 1 and throughout Years 2 and 3 of the grant funding period show that participants reported high levels of agreement with every metric, including all learning objectives and satisfaction with services.

Actionable Recommendation: The survey results demonstrate the classes are effectively imparting knowledge, skills, and satisfaction when attended regularly. Leveraging success stories and testimonials from "graduates" could inspire newer participants. Adding open-ended questions to the survey could be a useful source of testimonials for this purpose. Furthermore, the addition of open-ended questions can help verify and provide clarity to the responses collected from the close-ended items.

Table 2. Annual Measurement for One-on-One Therapy

Output/ Outcome	Targets	Years 1-3 Actuals			Achievement/ Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*			*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
		Year 1	Year 2	Year 3	
One-on-One sessions offered and attended	**200 sessions** offered per year	**91 sessions** offered, 64 attended (70%)	**440 sessions** offered, 327 attended (74%)	**605 sessions** offered, 426 attended (70%)	**Achieved/Exceeded.** In Year 3, MOMS provided more than triple the targeted number of therapy sessions per year, while maintaining attendance rates comparable to Years 1 and 2.
Clients referred to one-on-one sessions	**75 clients referred** for sessions	**41 clients referred**	**117 clients referred**	**143 clients referred**	**Achieved/Exceeded.** In Year 3, MOMS far exceeded the target number of clients referred and achieved a steady increase in clients referred over the three years.
Referral uptake	**2/3 (50 of the 75) will attend** at least one therapy session per year	**15 of the 41 unique clients** attended at least one session **(36%)**	**74 of the 117 unique clients** attended at least one session **(63%)**	**108 of the 143 unique clients** attended at least one session **(76%)**	**Achieved/Exceeded.** The total number attending at least one session exceeded the target in Years 2 and 3. In Year 3, the percentage attending at least one session (76%) also far exceeded the target of 2/3 (67%).
Time from referral to appointment	Average # of days from referral to appointment for one-on-one therapy will be reduced to **45 days for internal referrals**	Average time from referral to initial intake was **38 days**	Average time from referral to initial intake was **24 days**	Average time from referral to initial intake was **33 days**	**Achieved/Exceeded.** The average time from referral to initial intake was better than the target of 45 days across all three years (i.e., a lower average number of days is better).
Building client skills to cope with symptoms of PMADs Reduced PMAD indicators	Among clients completing 4 to 8 sessions, at least **85% agreement with indicators of increased skills** for coping with PMADs symptoms	Not reported due to small samples	Out of 23 clients surveyed, **87% indicated increased skills in caring for mental health, and 83% indicated ability to find support resources**	Out of 26 clients surveyed, **88% indicated increased skills in caring for mental health, and 88% indicated ability to find support resources**	**Achieved/Exceeded.** Among clients surveyed, average agreement rates exceeded the target in Year 3, representing a small increase above Year 2.

What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

Over the three years of implementation, MOMS significantly expanded access to specialized mental health care for clients who often face systemic barriers to treatment (as shown in the table above). The number of therapy sessions delivered grew from just 91 in Year 1 to 605 in Year 3, far exceeding program goals and reflecting a substantial increase in capacity to serve those in need. This expansion was paired with operational improvements that reduced the average time from referral to intake to just 33 days by Year 3, addressing a persistent challenge in the broader mental health system, particularly for undocumented or underinsured individuals.

> **"Therapy was a way for me to just let go of many things I had in my mind and heart. I felt better knowing that someone was listening to me and provided positive feedback."**
>
> – **Recipient of One-on-One Therapy**

Beyond increased access and efficiency, the program also demonstrated strong clinical outcomes. By Year 3, 88% of clients reported improved skills in managing their mental health and identifying sources of support. These results underscore the program's success in providing trust-based therapeutic interventions that meet clients where they are: offering not only timely access to care, but meaningful progress in mental health and well-being.

Figure 4. Percent Agreement (Strongly Agree/Agree) with Building Skills to Cope with PMADs and and Satisfaction Among Post-Survey Respondents Across Years 2 and 3 (n=49)

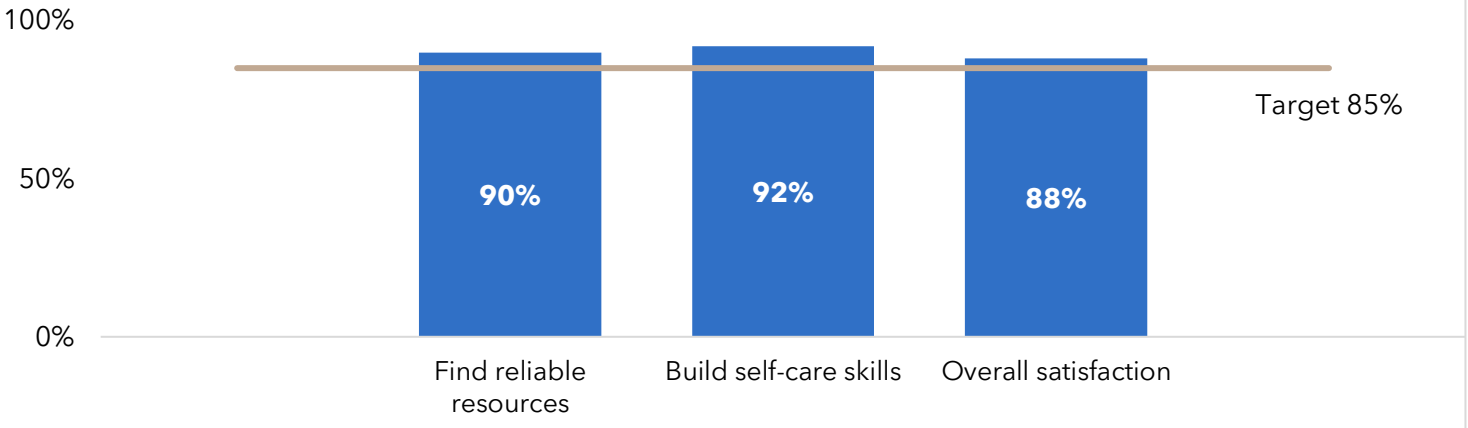


Figure 4. Survey data collected throughout Years 2 and 3 of the grant funding period show that participants reported high levels of agreement with every metric, including all learning objectives and satisfaction with services. Please note, data from Year 1 is included within the Year 2 results when relevant, as survey collection within Year 1 began shortly before Year 2 started, thus, Year 1 had insufficient data to report on class outcomes alone.

Actionable Recommendation: Therapy relies on a strong interpersonal connection between therapist and client, and at times, differences in personality or therapeutic approach may limit the effectiveness of treatment. If funding permits, MOMS may consider hiring an additional therapist to provide clients with more options for care. This would not only support a better therapeutic match for clients but also expand the number and variety of session times available, helping to reduce wait times from referral to intake.

Figure 5. What Was Most Helpful?
Key Themes Reported in Years 2 and 3 (n=47)

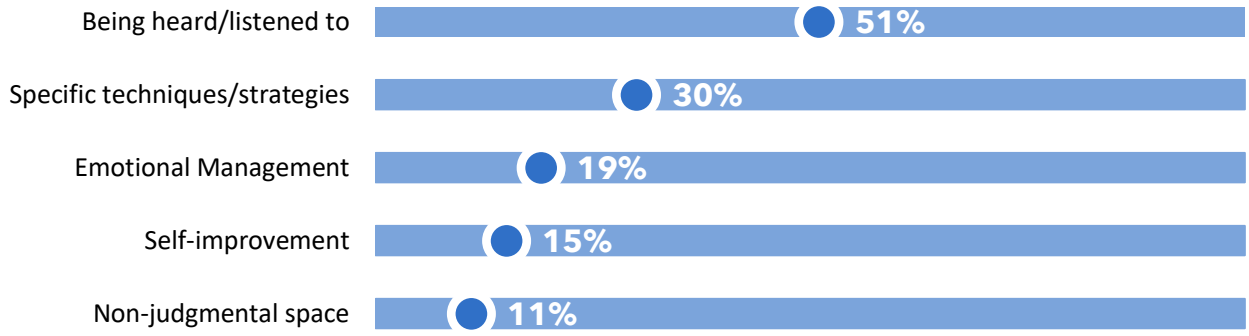
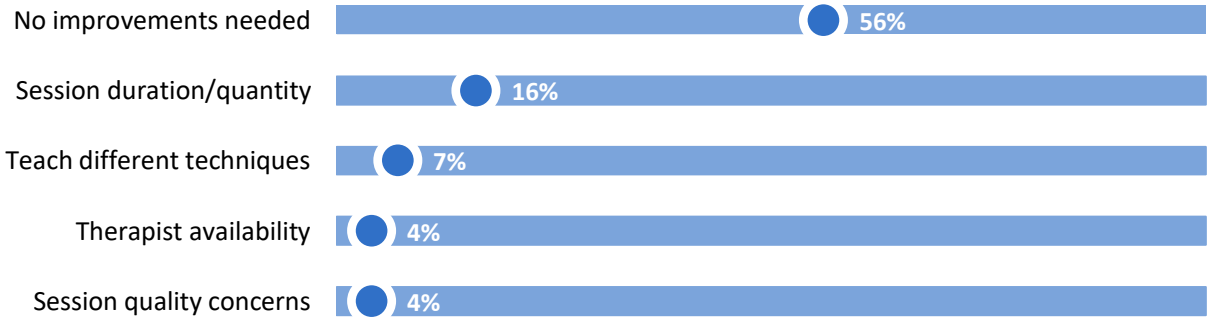


Figure 6. What Could Be Improved?
Key Themes Reported in Years 2 and 3 (n=45)



Figures 5 and 6. There was insufficient data to report on key themes from open-ended feedback in Year 1. In Years 2 and 3, being heard (51%) and receiving specific strategies (30%) were most valued by clients, while over half (56%) indicated no improvements were needed. These findings suggest clients particularly value the therapeutic relationship and practical tools, with most expressing high satisfaction with the current service structure despite some desire for extended sessions.

> **I felt supported and heard as well as learned some things about myself and what I could do to make my relationships better and thankful that I am now feeling more supported by one particular relationship that benefited from these sessions.**
>
> – **Recipient of One-on-One Therapy**

Table 3. Annual Measurement for Specialized Mental Health Home Visits

Output/ Outcome	Targets	Years 1-3 Actuals			Achievement/Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*			*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
		Year 1	Year 2	Year 3	
Specialized supplemental home visits conducted for new mothers with identified need for support with anxiety and depression	**180** specialized mental health home visits	**110** specialized mental health home visits	**151** specialized mental health home visits	**267** specialized mental health home visits	**Achieved/Exceeded.** MOMS conducted 267 postpartum mental health home visits in Year 3, far exceeding the goal of 180 visits, and demonstrating substantial improvement over Years 1 and 2.
	60 mothers engaged in specialized mental health home visits	**44 mothers** engaged in specialized mental health home visits	**49 mothers** engaged in specialized mental health home visits	**66 mothers** engaged in specialized mental health home visits	**Achieved/Exceeded.** In Year 3, 66 mothers engaged in specialized mental health home visits, exceeding the target of 60 mothers. This represents substantial improvement over Years 1 and 2.
Indicators of Success	**85% agreement with indicators of success**	Not reported due to small samples	**76%-82% agreement with indicators of success**	**82%-94% agreement with indicators of success**	**Partially Achieved.** Among clients surveyed in Year 3, 82% to 94% agreed with indicators of success after participating in mental health home visits. Year 3 saw large increases in agreement for most indicators, compared to Year 2 (+6% to +15%)

What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

The postpartum mental health home visiting program showed remarkable growth and impact in its third year of implementation. In Year 3, MOMS served 66 mothers through 267 specialized home visits focused on perinatal mood and anxiety disorders (PMADs), coping strategies, and connections to community support services. This far exceeded the annual targets and represented more than double the number of visits conducted in Year 1. At the end of Year 2, MOMS expanded the program to offer visits in both English and Spanish by training additional staff members, which broadened accessibility. Staff also noted that some clients opted to participate in multiple rounds of home visits, contributing to the higher visit count and highlighting the program's success in fostering continued client engagement.

Survey responses indicate that the postpartum visits are having a meaningful impact. More than 80% of clients agreed that they felt increased confidence, practiced greater self-care, and had better access to community resources after participating. Following an average satisfaction rating of 82% in Year 2, MOMS took steps to refine the curriculum and adapt delivery methods to better meet clients' evolving needs. These improvements were reflected in Year 3, with average satisfaction rising to 91%, a notable increase that underscores the program's responsiveness and effectiveness.

Please note that the original proposal contained a reference to establishing test and control groups to achieve a 25% reduction in postpartum depression and 20% reduction in PMAD symptoms overall. Upon review and discussion with the program evaluator, MOMS recognized that, while this is a valuable research goal, there are substantial limitations to this approach, including ethical considerations, sample size and statistical power, staff resources, and confounding variables. Given these, and other limitations, MOMS and the program evaluator chose to focus on self-reported post-surveys for clients participating in activities that would have a direct effect on reducing PMAD symptoms and building coping skills.

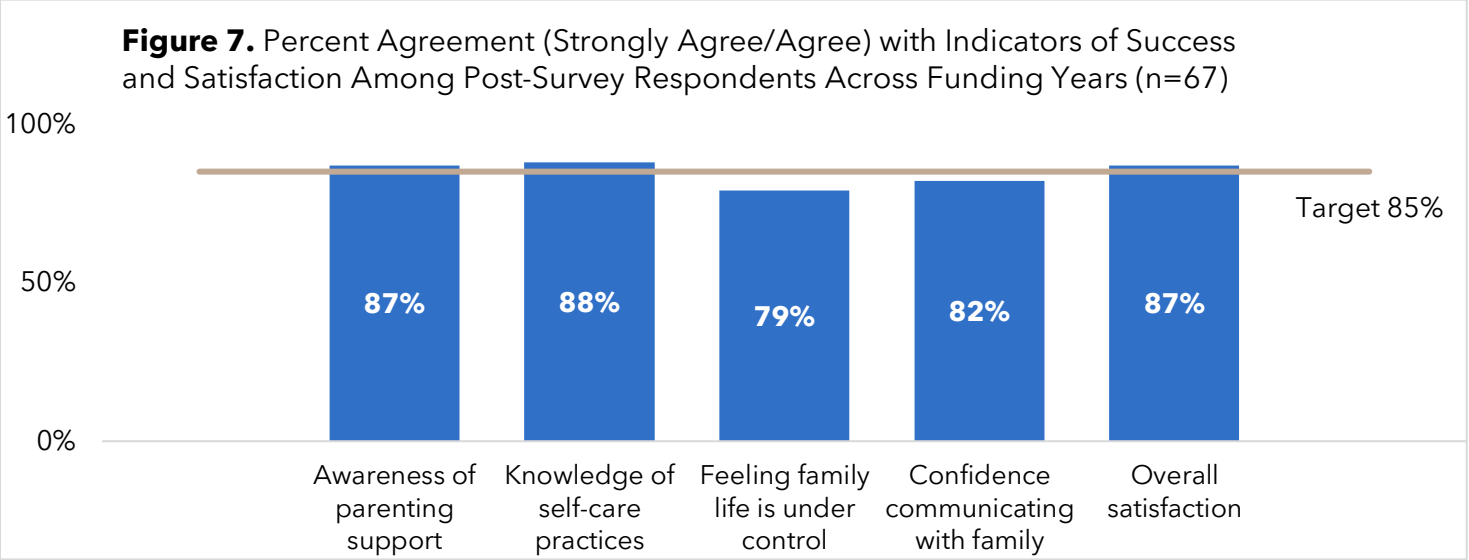


Figure 7. Survey data collected throughout Years 2 and 3 of the grant funding period show that participants reported high levels of agreement with every metric, including all indicators of success and overall satisfaction with services. While a few indicators are slightly below the target, clients served in Year 3 had higher ratings of agreement than those served in the previous year. Please note, data from Year 1 is included within the Year 2 results when relevant, as survey collection within Year 1 began shortly before Year 2 started, thus, Year 1 had insufficient data to report on class outcomes alone.

Actionable Recommendation: The survey results demonstrate the postpartum mental health home visiting program is effectively reducing symptoms of PMADs. Leveraging success stories and testimonials from participants could support marketing to other MOMS clients about the positive impact the home visits can have. Adding open-ended questions to the survey could be a useful source of testimonials for this purpose. Furthermore, the addition of open-ended questions can help verify and provide clarity to the responses collected from the close-ended items.

Table 4. Annual Measurement for Thriving Relationships Curriculum

Output/ Outcome	Targets	Years 1-3 Actuals			Achievement/Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*			*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
		Year 1	Year 2	Year 3	
Specialized home visits conducted for victims/survivors of domestic violence; client completion of Thriving Relationships Curriculum (including recognition of signs of verbal and/or psychological, physical, and sexual abuse)	**20 women** participating in specialized DV home visits	NA	**14 clients** participating in specialized DV home visits; 10 of the 14 clients (71%) completed more than one visit	**50 clients** participating in specialized DV home visits; 44 of the 50 clients (88%) completed more than one visit	**Achieved/Exceeded.** After concentrated efforts to improve enrollment toward the end of Year 2, Year 3 enrollment continued to improve and exceed the target; retention rates also improved in Year 3, with 88% of clients completing more than one visit.
	80% of clients receiving DV home visits will complete Thriving Relationships curriculum	NA	**5 clients (36%)** completed the Thriving Relationships curriculum	**35 clients (70%)** completed the Thriving Relationships curriculum	**Partially achieved.** The overall number and percentage of clients completing the curriculum greatly increased compared to Year 2; However, the percentage of clients completing the curriculum still remains lower than the target of 80%.
Increased self-perception regarding abuse (**70% of clients**), recognition of the signs of unhealthy relationships/behaviors (**90% of clients**), recognition of healthy responses to DV risks (**90% of clients**), and identification of trusted person for ongoing support (**80% of clients**)		NA	**80%** reported self-perception regarding abuse; **87%** recognition of signs of unhealthy relationships and recognition of healthy responses; **100%** reported identification of trusted people for support.*		**Partially achieved.** Clients surveyed reported levels of agreement exceeding targets for 2 of the 4 outcomes associated with Thriving Relationships curriculum and specialized DV home visits. Agreement for the remaining 2 categories was very close to the target (87% vs. 90%).
Satisfaction with Thriving Relationships program	**Average rating will be 4 of 5** on overall satisfaction	NA	**Average rating is 4 of 5** on overall satisfaction.*		**Achieved.** Among the 15 clients surveyed, 9 reported the highest level of satisfaction.

*Note: Due to low survey responses, surveys across Years 2 and 3 were combined for analysis.

What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

The Thriving Relationships program, which provides domestic violence education and support through specialized home visits, launched in Year 2 of the grant cycle. In its first year of operation, the program engaged 14 women, with over 70% completing multiple visits. However, post-survey completion was low (21%), limiting the ability to assess outcomes and client satisfaction. As a relatively new offering for a sub-population that is often defined by acute crisis, yet not always self-identifying as such, the Thriving Relationships program faced common early-stage implementation challenges, including the need to establish internal procedures and build trust with participants.

Enrollments increased in Year 3, yet the proportion of clients who completed the full program remained around one-quarter of enrollments, well below the target of 80%. Given that the program is designed to support individuals experiencing heightened stress or family crises, including domestic violence or abuse, consistent engagement remains a challenge. These circumstances often make it difficult to maintain contact and continuity, despite staff efforts to provide tailored and trauma-informed outreach.

Despite these engagement challenges, outcome data from post-surveys completed by 15 clients suggest strong program effectiveness among those who completed the intervention. Reported outcomes included increased ability to perceive abuse (80%), recognize signs of unhealthy relationships (87%), and understand healthy responses to domestic violence (87%). Notably, 100% of respondents indicated they could

identify at least one trusted person they could turn to for support. These results exceed the program's targets for abuse perception (70%) and trusted person identification (80%) and nearly meet the 90% target for recognizing unhealthy relationships and appropriate responses to violence, demonstrating meaningful progress for participants reached through this specialized intervention.

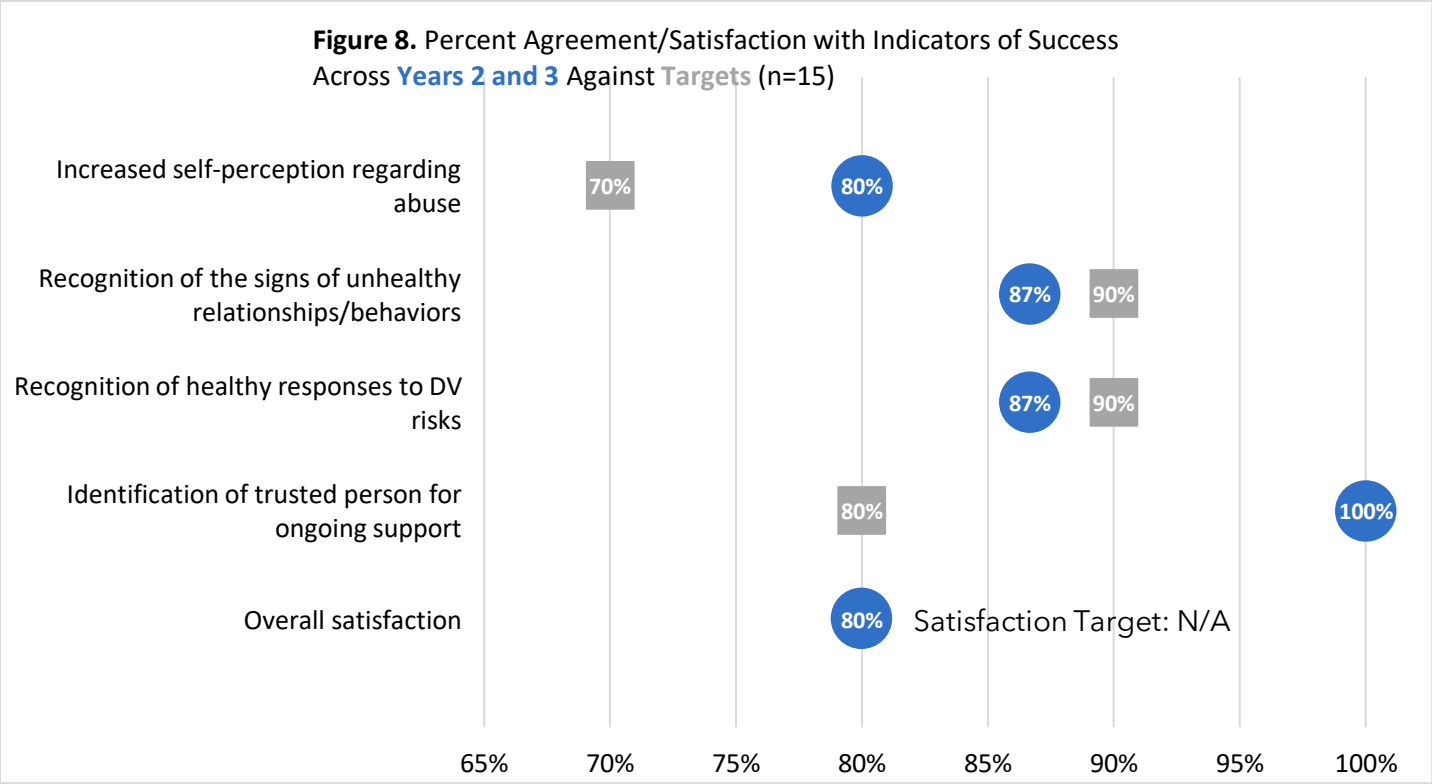


Figure 8. There was insufficient data to report on Year 1; Years 2 and 3 were combined. Clients self-reported the highest levels of agreement with gaining skills to recognize unhealthy relationship, recognize healthy responses to DV risks, and identification of a trusted person for support.

Actionable Recommendation: Survey results indicate that the Thriving Relationships program is positively impacting clients by strengthening their ability to recognize and interpret signs of healthy and unhealthy relationship behaviors, perceive abuse, and identify trusted individuals for ongoing support. Incorporating open-ended questions into the survey tool could enhance the quality of these findings by offering deeper insight and validation for the close-ended responses. In particular, learning more about whom clients consider a trusted support person may help staff identify additional referral opportunities and tailor supports that further build clients' skills to navigate complex relationships and crisis situations.

Table 5. Annual Measurement for Strong Fathers Strong Families/Padres Fuertes Familias Fuertes Classes

Output/Outcome	Targets	Years 1-3 Actuals			Achievement/Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*			*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
		Year 1	Year 2	Year 3	
Classes offered and attended Classes completed	**16 class series** offered per year	NA	**8 class series** were offered, with a total of 38 classes	**9 class series** were offered, with a total of 48 classes	**Partially Achieved.** This represents 56% of the targeted 16 series offered per year.
	60 clients will complete 75% of classes per year	NA	48 clients attended at least one class in a 4- or 6-class series; **19 clients** completed 75% of classes	56 clients attended at least one class in a 6-class series; **16 clients** completed 5 out of 6 classes	**Not Achieved**. 16 clients completed at least 75% of the sessions in the class series, which represents less than half the target goal. In addition, overall attendance (at any completion rate) was under 60 unique clients. However, 26 of 56 clients (46%) completed 4 out 6 classes or two-thirds of the class series. Attendance also increased compared to Year 2, showing improvement over time, and several clients participated in multiple series, but their participation was only counted once. This repeat participation indicates a depth of service not captured by this metric.
Increased knowledge and understanding of anxiety and depression Increased knowledge of healthy coping strategies to manage stress Increased beliefs about the importance of the role of a father Improved skills for communicating effectively, engaging in self-care and improving self-worth and self-esteem Class satisfaction	**Average rating will be 4 of 5** on knowledge, belief, skills, and satisfaction items	NA	Out of 27 clients surveyed, **average rating met or exceeded at least 4 of 5** on all metrics except for feeling that family life is balanced	Out of 19 clients surveyed, **average rating met or exceeded at least 4 of 5** on all metrics	**Achieved/Exceeded.** All clients surveyed (100%) agreed that the classes helped them to become aware of healthy ways to practice self-care and increase awareness about resources for support. 95% of clients felt confident in talking respectfully with their family and felt their family life is balanced; the latter represents a sharp improvement from 70% in Year 2.

*Note: Survey respondents across Years 2 and 3 include duplicated clients; if clients participated in multiple class series, each survey response is included.

What impact did the program make for MOMS, its clients, and the community?

How does this impact compare to anticipated outcomes?

In response to client feedback, MOMS expanded the class series from four to six sessions midway through Year 2. While this change improved the depth of client engagement, it also introduced challenges in meeting established program targets. First, the longer series format reduced the total number of class series that could be offered annually, as staff capacity limited the ability to run multiple series concurrently. In addition, adequate lead time was needed to market the classes and recruit participants, creating gaps between cohorts and ultimately resulting in fewer series offered each year. Second, the completion

target of 60 clients attending at least 75% of sessions became more difficult to achieve. Under the original four-class model, this required attending three sessions; under the revised six-class model, clients needed to attend five, effectively raising the bar for what counted as successful completion.

While the proportion of attendance required may seem comparable, the increased expectation places a higher burden on clients and may not reflect a realistic standard. These challenges suggest a need to revisit the program's performance metrics to better align with the updated delivery model: potentially adjusting the attendance threshold to two-thirds (approximately 67%) and lowering the expected number of series per year.

One of the ongoing challenges MOMS faces with the Strong Fathers, Strong Families program is engaging fathers in the community. Despite efforts to increase the number of class offerings and adjust the format and scheduling to better accommodate participants, attendance remains inconsistent. Staff have noted that those who do attend often view the opportunity as a privilege, underscoring both the value of the program and the barriers to access for many fathers. While participation in this program was lower than the target goals, the value of the programming to its recipients was apparent in the post-survey responses.

Figure 9. Percent Agreement (Strongly Agree/Agree) with Indicators of Success and Satisfaction Among Post-Survey Respondents Across Funding Years (n=46)

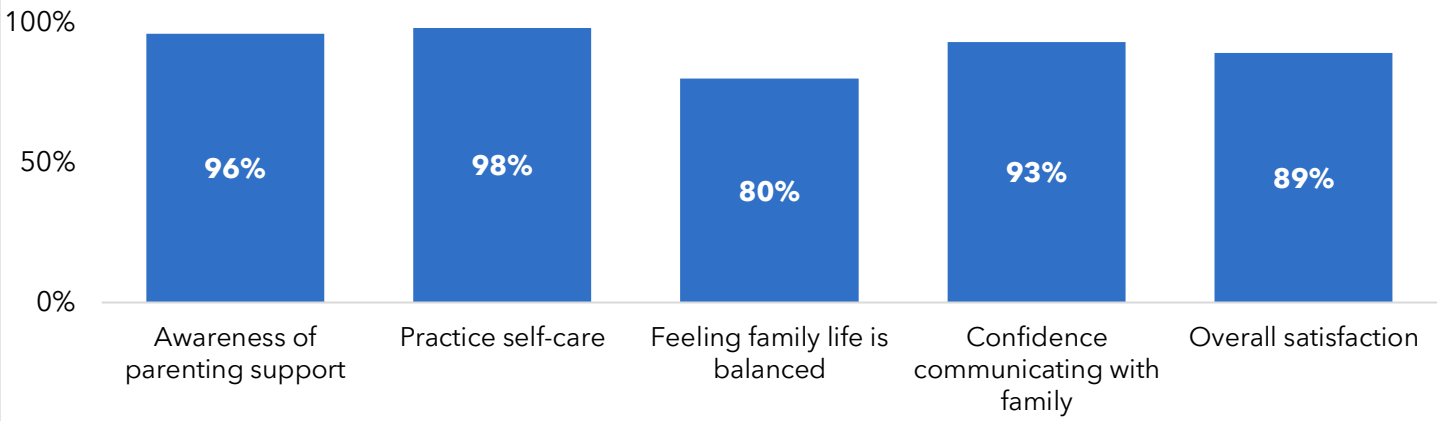


Figure 9. Survey data collected throughout Years 2 and 3 of the grant funding period show that participants reported high levels of agreement with every metric, including all indicators of success and overall satisfaction with services. There was insufficient data to report on class outcomes in Year 1.

> **Everything was excellent, very grateful for all your support, thank you … for all the information.**
>
> – **Recipient of Men's Support Group Classes**

Figure 10. How can we improve this program to serve other fathers?
Key Themes Reported in Years 2 and 3 (n=38)

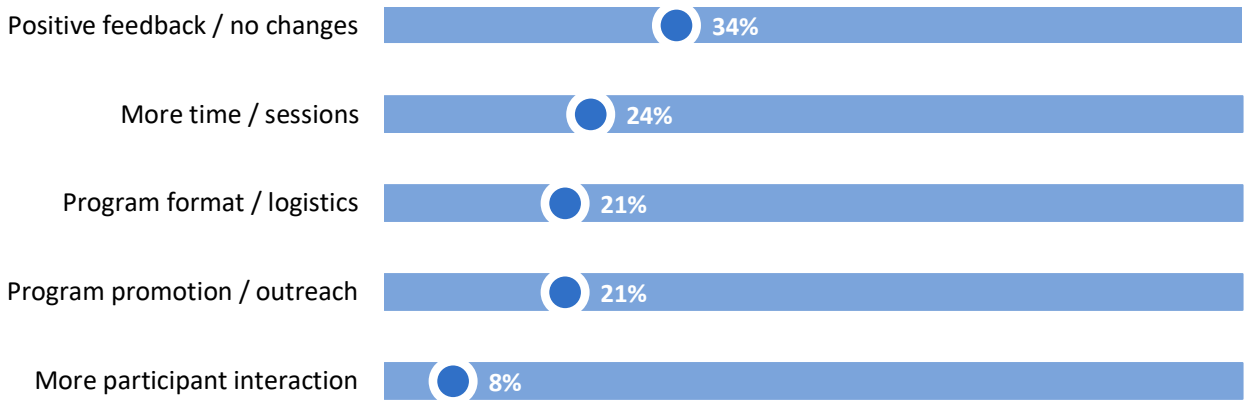
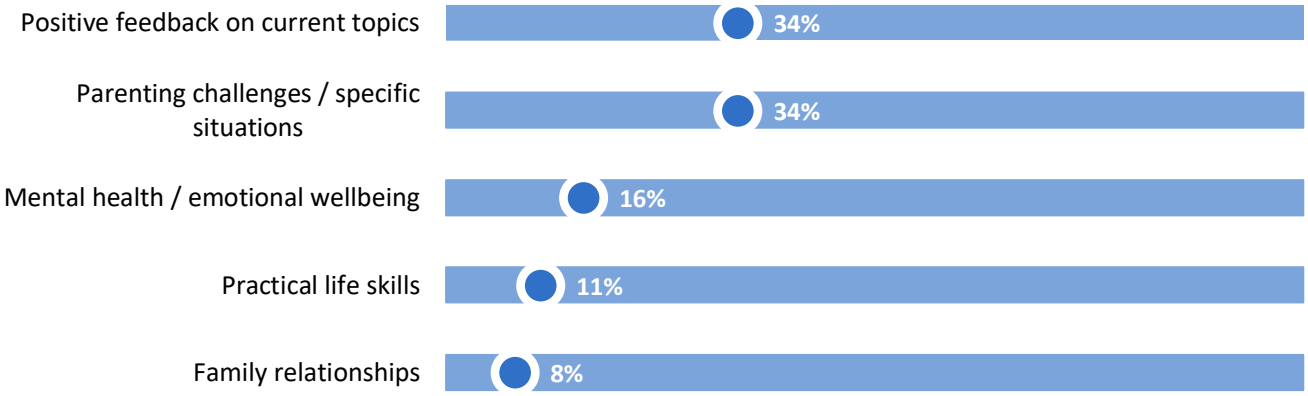


Figure 11. What other topics would you like us to cover?
Key Themes Reported in Years 2 and 3 (n=38)



Figures 10 and 11. There was insufficient data to report on key themes from open-ended feedback in Year 1. In Years 2 and 3, program feedback reveals strong satisfaction with the current format, while clients suggesting improvements focused primarily on extending session duration (24%) and increasing program outreach (21%) to benefit more fathers. Regarding requested topics, participants were equally interested in addressing specific parenting challenges (34%) and maintaining current content (34%), with notable interest in mental health and emotional wellbeing topics (15%).

Actionable Recommendation: To strengthen engagement, MOMS may consider deepening partnerships with trusted community leaders, cultural institutions, and faith-based organizations to increase awareness and credibility of the program among target populations. Incorporating testimonials and success stories from past participants into recruitment materials could further highlight the program's impact and inspire new fathers to enroll. Additionally, creating opportunities for program alumni to stay involved, such as through special events, volunteer roles, or peer mentorship, may help foster a stronger sense of community and sustained connection to the program.

Table 6. Annual Measurement for Client-Facing Staff Support Activities (In-Service Training)

Output/ Outcome	Targets	Year 1-3 Actuals		
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*		
		Year 1: **Achieved/Exceeded.**	Year 2: **Achieved/Exceeded.**	Year 3: **Achieved/Exceeded.**
Two to four client-facing staff trainings offered and **100% of client-facing staff will attend** at least one in-service counselor training		**A total of two trainings** for staff were provided between April 2022 and February 2023. • Intimate Partner Violence Staff Development Training: provided by Human Options, consists of staff completing 40 hours of intensive content covering a variety of topics on intimate partner violence. The initial training was completed by two maternal-child health coordinators. • Fireside Consulting: facilitated in January 2023 to educate staff about the various data collection initiatives that support the UniHealth grant. All MOMS home visitors and class facilitators involved in data collection participated. In addition to the two trainings held during the evaluation reporting timeframe, **two other trainings were provided prior to the award of UniHealth grant funding.** • PMAD training: provided February 2022 by experts from the OC PMAD Collaborative. The training educated staff about perinatal mood and anxiety disorders and trauma-informed approaches to address PMAD symptoms. All MOMS home visitors have completed this training. • Staff mental health training: provided in March 2022 by Hoag Hospital. The training provided staff with the tools to manage stress, build strategies for self-care, and focus on mental health among staff. 100% (33) staff were in attendance.	**A total of four trainings** for staff were provided between March 2023 and February 2024. • Mental Health First Aid: provided by St. Joseph's Hospital on October 26, 2023. This 8-hour training equipped staff to become Mental Health First Aiders for clients, community members, or family members experiencing substance use or mental health crises. 24 MOMS team members participated. • Doula Training: provided by La Matriz Birth Services on January 20-21, 2024, over a 2-day period. 23 MOMS staff members participated in this training to gain further knowledge of the birth and postpartum period and supported the expansion of MOMS Postpartum Support Visits to provide mental health, lactation, and other supports to birth givers in the first few months postpartum. • Domestic Violence In-Service: provided by Ashley Peniche Montenegro, Esq. on February 1, 2024. This attorney specializing in Family Law provided training to 16 Maternal Child Health Program team members on navigating the legal system with clients experiencing domestic violence, including restraining orders, clients' rights, and tips for serving clients in this difficult situation. • OC Family Justice Center: Tracy Theodore, Executive Director, provided an in-service on February 20, 2024, to the Maternal Child Health Program team regarding services offered for domestic violence victims and survivors.	**A total of three trainings** for staff were provided between March 2024 and February 2025. • A total of 12 MOMS program staff participated in a Maternal Mental Health Training provided by Postpartum Support International and sponsored by CalOptima Health in the fall of 2024. The online webinar series featured top experts and trainers in the field of perinatal mental health and included eight live sessions, small group discussions, and supplemental reading materials. • In partnership with Start Well, MOMS provided Infant/Early Childhood Mental Health Consultation to a MOMS Mommy and Me health educator. By January 2025, MOMS piloted the model with 5 MOMS home visitors as well as home visitors from other agencies. The purpose of this training is to increase capacity to promote infant/early childhood mental health to reduce disparities and improve the outcomes of children and families. • Cynthia Rodriguez from BrightLife Kids provided an in-service to MOMS home visitation team on January 21, 2025. The training focuses on helping understand how to support children's behavioral health milestones and challenge areas.

Prior to Year 2, trainings focused on offering tools to improve technical skill and build knowledge on relevant topics (intimate partner violence and data collection). In Year 2, MOMS continued to equip staff with skill-building trainings to support clients in the areas of mental health, the post-partum experience, and legal issues and services to support clients experiencing domestic violence. Throughout Year 3, MOMS continued efforts to offer trainings that would support staff in building skills in the areas of maternal and family mental health.

Actionable Recommendation: In the future, MOMS might consider polling staff to understand more about whether it makes sense to lean into skill-building trainings or bring more opportunities to focus on self-care and avoid burnout.

Table 7. Annual Measurement for Marketing and Promotion of Direct Services

Output/ Outcome	Targets	Year 1-3 Actuals	Achievement/Progress
Specific outcomes or changes	*Target goal established for outputs*	*Frequencies and other descriptives for Years 1-3*	*Indication of achievement or progress towards target goals along with contextual factors and interpretation of findings*
Newsletter distributed marketing classes	Market educational classes at least 2 times per year in newsletter	**A total of 4 newsletters** highlighted UniHealth grant activities between March 2024 and February 2025, compared to 5 in Year 2 and 3 newsletters in Year 1. The newsletters were sent to **9,884 email addresses with an average open rate of 47%**, an increase from 9,043 addresses and 44% open rate* in Year 2 and 8,640 addresses with a 39% open rate in Year 1.	**Achieved/Exceeded.** The MOMS electronic newsletter "Little Bits of News" was sent to nearly 10,000 subscribers 4 times during Year 3, exceeding both the target of 2 newsletters per year marketing the UniHealth classes and consistent with marketing efforts from previous years.
Community partners who promoted classes and method of promotion	Partner with at least 2 community partners per year to promote classes to their clients	MOMS maintained existing partnerships from previous funding years to promote classes, including the County's PMAD Collaborative, Home Visiting Collaborative, First 5 OC, multiple safety net health centers, FRCs and private physician offices. Newly added collaboratives include: UC Irvine Black PEARL (Promoting Equity, Anti-Racism, and Love) Community Advisory Board (CAB) for the year 2025, and Orange County Family, Infant and Early Childhood Mental Health Initiative.	**Achieved/Exceeded.** MOMS continued to partner with at least 2 community organizations to promote its classes in Year 3 and increased its number of partnerships from Year 2.
Social media posts/content from MOMS OC promoting classes	Promote classes through social media accounts at least 4 times per year	MOMS posted content about UniHealth classes frequently on **Facebook (18 posts), Instagram (18 posts), and LinkedIn (3 posts)** during the Year 3 period, keeping pace with the previous funding years' number of social media posts promoting UniHealth-funded programming.	**Achieved/Exceeded.** MOMS consistently promoted UniHealth classes through multiple social media platforms in Year 3, far exceeding the target of 4 posts per year.

*Please note: the Year 2 open rate is inclusive of one newsletter sent in February 2023 (Year 1).

MOMS notably exceeded target goals related to newsletter distribution, community partnerships, and social media posting to promote UniHealth programming. While data on social media reach and engagement were not available this year (as had been reported in previous years), the volume of posts remained consistent, and the number of newsletter subscribers increased compared to prior years, indicating continued growth in audience reach.

Actionable Recommendation: To strengthen outreach and visibility, MOMS may consider enhancing its social media strategy and community partnerships by gathering data from UniHealth program participants about how they learned about available services and which partner agencies referred or promoted the programming. This information could inform a more targeted and effective marketing approach, particularly for programs that face challenges with enrollment or retention.

Context

What other factors outside of the program contribute to clients' wellbeing and reduce (or increase) the prevalence of PMAD symptoms?

MOMS embraces a holistic, multi-sectoral approach to promoting maternal mental health, working in partnership with healthcare providers, social service agencies, and community organizations to address the complex, intersecting factors that shape the environments in which clients live and parent. A deeper understanding of these external influences can help MOMS tailor its programs and advocacy efforts to better meet the unique needs of the diverse families it serves. In Year 3 of the UniHealth grant, the evaluation team conducted an informal review[1] of existing literature and public data to explore key contextual factors that may influence client wellbeing and the prevalence of PMAD symptoms. The intent was to identify factors that MOMS could potentially address in the near term, requiring minimal additional effort or resources, yet offering meaningful opportunities to support improved outcomes.

Recent data from *The 30th Annual Report on the Conditions of Children in Orange County* (Orange County Social Services Agency, 2024) and the *25th Annual Report of Orange County Community Indicators* (Walrod et al., 2024) offer critical insight into the structural and environmental factors that influence maternal and child well-being in the region. These reports track trends related to health care access and use, early prenatal care, perinatal behavioral health services, childcare, and broader socioeconomic conditions, all of which provide valuable context for interpreting MOMS' programming outcomes.

Health care access remains a key determinant of maternal and infant health. As of 2022, approximately 7% of Orange County residents were uninsured, with rates varying by race, income, education, and age (Walrod et al., 2024). White residents had the lowest uninsured rate (3%), while those identifying as 'some other race' had the highest (14%) (Walrod et al., 2024). Disparities in insurance coverage suggest ongoing inequities in access to prenatal, postnatal, and pediatric care. Additionally, the report notes a decline in Medi-Cal enrollment in 2024, which may further limit access to care for low-income families. While a recent merger between two major children's hospitals (Children's Hospital of Orange County and Rady Children's Hospital) was announced as a promising step toward improving regional child health outcomes, the long-term impacts of this integration remain to be seen.

Economic factors further complicate families' ability to access critical services. Nearly one in five Orange County households reported financial instability in 2022 (Walrod et al., 2024), limiting their ability to afford nutritious food, quality healthcare, childcare, and stable housing. A 2021 First 5 Orange County study found that 40% of caregivers reported being unable to work due to the cost or lack of childcare, an issue that disproportionately affected women and women of color in family households (Orange County Social Services Agency, 2024).

When examining prenatal care and perinatal behavioral health services specifically, local indicators show mixed progress. Orange County's early prenatal care rates remain relatively high (89% in 2022), exceeding state (86%) and national (77%) averages. However, significant disparities persist across racial and ethnic groups: individuals identifying as Black or Native Hawaiian/Other Pacific Islander received early prenatal care at notably lower rates (81% and 72%, respectively). The Conditions of Children report also introduced a new indicator on perinatal behavioral health, showing a decrease in reported symptoms of depression

[1] Fireside Consulting used OpenAI tools like ChatGPT and NotebookLM to support the literature review. Tools were provided with articles and public reports collected by Fireside staff and then asked to help organize and summarize the information, search for cross-cutting trends and connections between sources. Fireside makes this note to be transparent in their use of AI tools. We acknowledge our use of these tools in enhancing our work but not replacing the efforts of a human and the human-centered perspective necessary to interpret findings and/or research.

during or after pregnancy—from 15% in 2019 to 11% in 2021. Yet, disparities remain here as well, with Asian/Pacific Islander residents reporting the highest rates of depressive symptoms during the perinatal period compared to other groups.

In addition to localized data, a broader body of research reinforces the significance of structural, psychosocial, and environmental factors influencing maternal mental health and the prevalence of PMADs. Structural inequities such as food insecurity, as detailed by Liebe et al. (2024), place considerable mental health burdens on mothers, particularly in households where women prioritize children's food intake over their own. These burdens manifest in elevated rates of anxiety and depression and are compounded by societal expectations of "intensive mothering" that exacerbate guilt and burnout when resources are scarce. Similarly, Zhang (2021) highlights how features of the built environment, such as poor walkability, lack of green spaces, and limited mixed-use zoning, are associated with reduced prenatal care engagement and heightened risk of postpartum depression, particularly in under-resourced urban neighborhoods.

Intersectional research on Black maternal health further illustrates how overlapping systems of racism, gender inequity, and healthcare bias exacerbate disparities in outcomes. Gilliam et al. (2024) found that the mental health of Black birthing individuals is shaped not only by the stressors of pregnancy itself, but by layered experiences of racialized and gendered discrimination that undermine well-being and access to care. These experiences call for antiracist, culturally grounded interventions. At the same time, the protective role of social support is well-documented. Feinberg et al. (2022) show that mothers with consistent emotional and functional support had half the prevalence of PMAD symptoms compared to those without such support, while Jiang & Zhu (2022) extended this insight to digital spaces, demonstrating that perceived support from online peer communities can significantly reduce depressive symptoms and improve postpartum outcomes.

Further compounding maternal mental health risk are chronic physical health conditions. Abu-Zaid et al. (2023) found that women with heart disease, epilepsy, lupus, or migraines had significantly higher odds of postpartum depression and psychosis, underscoring the need for integrated physical and mental health care during the perinatal period. Similarly, Valdes et al. (2023) point to inconsistencies in screening for peripartum depression across health settings, noting that while most care teams report having protocols in place, only 70% routinely screen all patients, and gaps in referral pathways persist, especially in acute care environments.

A history of trauma also plays a critical role. Armer et al. (2024) emphasize that childhood maltreatment is a significant predictor of postpartum depression and PTSD, with mental health trajectories over time strongly influenced by whether mothers experience positive or negative post-traumatic changes. Their study suggests that fostering post-traumatic growth could be a promising target for intervention, even beyond traditional clinical risk factors. Similarly, Almeida et al. (2024) show that migrant and refugee mothers face compounded stress due to displacement, discrimination, and limited access to mental health care, placing them at disproportionate risk for maternal mental distress. Despite widespread documentation of these challenges, maternal mental health services remain underfunded and under-integrated in primary care systems globally.

Finally, Cai et al. (2022) offer a promising avenue for prevention: their meta-analysis reveals that physical activity during pregnancy significantly reduces prenatal depression, anxiety, and stress, while improving quality of life. Despite this, most pregnant women fall short of recommended activity levels, often due to time, safety, or environmental barriers. These findings point to physical activity promotion as a low-cost, scalable strategy that may enhance mental health and well-being when integrated into prenatal care settings.

What organizational factors (e.g., staff capacity, leadership, resources) might have affected the efforts of the program's implementation and outcomes?

Across the three years of UniHealth grant implementation, several organizational factors, including staffing capacity, internal infrastructure, and adaptive leadership, played a critical role in shaping program activities and outcomes.

In Year 1, implementation efforts were significantly impacted by foundational challenges such as staff changes, limited organizational infrastructure, and delays in project start-up. These early obstacles affected the pace and scope of programming and were documented in detail in the Year 1 evaluation report.

In Year 2, MOMS faced additional organizational barriers, particularly during the launch of the Thriving Relationships program. A pilot involving the first two clients surfaced unexpected crises, prompting a comprehensive review of internal policies and procedures to ensure staff were adequately trained and supported to respond to high-stakes situations involving domestic violence. Following this reflection and revision of the program infrastructure, the Thriving Relationships program was officially launched in January 2024, with steady enrollment. However, engagement challenges remained, especially for clients who were ambivalent about change or did not identify as survivors of domestic violence, even if they had disclosed experiences of abuse.

That same year, the Strong Fathers, Strong Families/Padres Fuertes, Familias Fuertes program underwent a restructuring, transitioning from a four- to six-week class series. This required a temporary pause in programming to revise curriculum and recruitment strategies, further emphasizing the need for flexible planning and staff coordination.

By Year 3, many of the early organizational challenges had been resolved. MOMS successfully scaled up its staffing, expanding the number of trained home visitors and hiring a fulltime in-house health educator for the Healthy Woman/Mujer Sana classes. Therapy services also expanded significantly, with more than 600 one-on-one sessions delivered compared to under 100 in Year 1. Importantly, MOMS sustained long-standing partnerships while also cultivating new relationships with local organizations which enhanced both referral networks and service delivery.

These organizational improvements, staffing stability, stronger internal infrastructure, and strategic partnership development, contributed to the overall success of MOMS' UniHealth programming in Year 3. As a result, the organization achieved or exceeded 79% of its targeted program outputs and outcomes, underscoring the impact of thoughtful, adaptive implementation practices over time.

Conclusion

As the UniHealth Foundation grant sunsets after three years of funding, MOMS Orange County concludes this phase of the *Maternal Mental Health Project* with deepened insights, expanded reach, and strong evidence of impact. The program, originally designed to address the gaps in maternal mental health services for expectant and new parents, has matured into a multifaceted model that integrates clinical services, education, outreach, and staff development, delivering culturally and linguistically responsive care to hundreds of families across Orange County.

Three years of implementation reflect a clear trajectory of growth, adaptation, and effectiveness. From Year 1's foundational development—including therapist onboarding, evaluation planning, and piloting new initiatives—to the expansion and refinement of services in Years 2 and 3, MOMS has demonstrated resilience and commitment to evidence-based improvement. In the final year alone, MOMS exceeded or achieved 79% of all program output and outcome targets (i.e., 19 of 24 targets), a substantial accomplishment considering the challenges typical of behavioral health service delivery, particularly within underserved communities.

Programmatic success was evident across multiple intervention areas. The Healthy Woman/Mujer Sana classes not only met targets for class completion but maintained consistently high satisfaction and learning outcomes, even as they broadened accessibility for English-speaking clients. Similarly, the Strong Fathers, Strong Families program, though still facing challenges in engagement and retention, showed improvements in participant satisfaction and was viewed by many attendees as a critical and valued opportunity for connection and growth.

The one-on-one therapy component expanded significantly, with MOMS delivering over 600 sessions in Year 3, which is more than a sixfold increase since Year 1. Clients reported improvements in their ability to manage symptoms of PMADs, seek support, and care for their mental health, highlighting the program's role in facilitating meaningful therapeutic relationships. In parallel, specialized mental health home visits more than doubled, and outcome data revealed gains in client self-confidence, connection to community resources, and reduced PMAD symptoms.

Organizationally, MOMS evolved its internal capacity to sustain and scale services. The agency expanded staffing, secured a fulltime health educator, and cultivated new partnerships while retaining trusted community collaborators. Early implementation challenges such as staffing transitions and program start-up delays gave way to more structured infrastructure and a culture of continuous quality improvement. This was reflected in refined curricula, improved referral workflows, and more nuanced use of data to inform decisions.

At the same time, the evaluation revealed areas for ongoing attention. Some programs, such as Thriving Relationships, faced continued barriers to engagement and curriculum completion, likely due to the acute crisis nature of the target population and broader structural constraints. Likewise, while participation in the Strong Fathers, Strong Families program grew, retention goals remain unmet, suggesting a need to revisit expectations, redefine success metrics, and deepen community-rooted engagement strategies. Additionally, limited collection of open-ended feedback across all programs indicate a need for continued investment in data systems and qualitative evaluation tools to better capture participant voice and inform practice.

Contextual and environmental factors outside of MOMS' control such as food insecurity, housing instability, systemic racism, and chronic health conditions continue to shape clients' lived experiences and

mental health trajectories. As the evaluation team explored both local data and peer-reviewed literature, it became evident that sustainable maternal mental health interventions require more than individualized care. They demand attention to systemic inequities, cross-sector collaboration, and structural investments in the social determinants of health. MOMS has already taken important steps in this direction by embedding mental health strategies across its educational programs and home visits, expanding language accessibility, and advocating for clients through partnership-based outreach and referral systems.

As this final year closes, MOMS stands at a promising threshold. The capacity built through UniHealth support—organizationally, clinically, and relationally—positions the agency to deepen and sustain its maternal mental health programming in the years ahead. Continued success will rely on flexible funding, ongoing staff training, integrated evaluation processes, and a focus on equity. The lessons learned from this three-year effort underscore that trust-building, culturally responsive care, and intentional outreach are central to addressing PMADs and creating pathways for thriving families.

The Circle of Support for Expectant and New Parents envisioned at the start of the Maternal Mental Health Project has grown stronger, broader, and more resilient, and is anchored in community and guided by evidence. As MOMS transitions beyond this grant, the organization carries forward not only a track record of achievement but a roadmap for continued impact.

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