Transforming Maternal Health (TMaH) Community Conversations

Final Report

Findings from Focus Groups with Medicaid Beneficiaries Navigating Maternal Care in Washington, D.C.

August 2026

Purpose

This report presents findings from focus groups conducted from February through May 2026 with Medicaid-enrolled individuals navigating prenatal, postpartum, and perinatal care in Washington, D.C., as well as fathers and non-birthing caregivers who shared those experiences. Participants described, in their own words, what it was like to seek care, navigate systems, and stay healthy during pregnancy and the months that followed. These findings are designed to inform planning and implementation of the Transforming Maternal Health (TMaH) model in Washington, DC.

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This report was prepared by Meta Consulting, LLC in collaboration with Community of Hope.

Meta Consulting Team
Lauren Ramsey, PhD, MPH
Kecia L. Ellick, PhD, MS, CFLE
Ivonne Rivera, MPH
Marilyn E. Ramsey

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This project would not have been possible without the authentic engagement of our focus group participants. We appreciate your willingness to share your experiences and thank you for trusting us to uplift your stories.

Authors

Dawn Sherman, PhD, Project Lead, Community of Hope
Lauren Ramsey, PhD, MPH, Lead Author, Meta Consulting
Kecia L. Ellick, PhD, MS, CFLE, Meta Consulting
Jenné Massie Brown, DrPH, MS, Community of Hope

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Table of Contents

List of Tables

List of Figures

I. Executive Summary

BACKGROUND AND PURPOSE

This report presents findings from twelve focus groups conducted with Medicaid-enrolled individuals navigating prenatal, postpartum, and perinatal care in Washington, D.C., and with fathers and non-birthing caregivers who shared those experiences. Participants received care from a wide variety of DC providers and came from across the District of Columbia. The groups were convened by Community of Hope (COH) and Meta Consulting, LLC to inform planning and implementation of the Transforming Maternal Health (TMaH) model. The groups were convened to inform planning and implementation of the Transforming Maternal Health (TMaH) Model, a Centers for Medicare and Medicaid Services initiative that supports states in improving the quality, safety, and experience of maternity care for Medicaid and CHIP enrollees. TMaH is organized around three pillars: expanding access, infrastructure, and workforce capacity; advancing quality improvement and patient safety; and providing whole-person care that addresses the full range of clinical, behavioral health, and social needs across the perinatal period.

The findings reflect what participants said, in their own words, about what it is like to seek perinatal care, navigate systems, and try to stay healthy during pregnancy and in the months that follow. They are organized around nine cross-cutting themes and are intended to inform the design, quality improvement, and whole-person care investments that lie ahead.

WHAT PARTICIPANTS DESCRIBED

Participants valued care that felt personal. They described their best clinical experiences as ones in which providers listened, stayed in contact, followed up, and treated them as people rather than appointments. They described their worst experiences as ones in which they were dismissed, given information that turned out to be wrong, handed paperwork and told to figure it out, or simply not told what they needed to know.

The gap between these two kinds of care was not primarily a question of clinical skill. It was a question of how systems are designed, and what those systems ask of the people who depend on them.

CROSS-CUTTING THEMES

Nine themes emerged consistently across the community conversations:

1. **The quality of care was defined by relational experience.** Whether participants trusted their providers, disclosed concerns, and remained engaged depended more on how they were treated than on what was clinically done.

2. **Getting into care was often possible, but moving through care was inconsistent.** Medicaid coverage disruptions, referrals that did not move, and program-level decisions that left participants without scheduled appointments were among the mechanisms of fragmentation.
3. **Participants often navigated care without clear, accurate, or timely information.** They described resource lists that pointed to defunct programs, benefit windows that closed before they were discovered, and clinical information that never reached fathers or non-birthing caregivers.
4. **Patients and families carried too much responsibility for making the system function.** Self-advocacy was a baseline requirement, not an exception, and its weight was not shared equally.
5. **Mental health support was uneven and incomplete.** Participants described support that missed the broader spectrum of perinatal distress and largely excluded fathers from both information and care.
6. **Complications exposed serious coordination, communication, and safety gaps.** These gaps often remained invisible during routine care and had particularly severe consequences for Spanish-speaking participants whose warning signs were not recognized early.
7. **Administrative systems disrupted care at critical transition points.** Medicaid plan changes, newborn enrollment, SNAP access, and post-delivery paperwork interrupted care at moments when participants could least afford disruption.
8. **Non-clinical supports made care possible.** Transportation, meal delivery, housing assistance, caseworkers, peer community, and group prenatal care were described as foundational rather than supplemental.
9. **Identity, language, insurance status, and cultural context shaped what participants received.** Differential treatment based on race, age, insurance type, and perceived demographic characteristics was named directly and described as affecting clinical safety, not only satisfaction.

IMPLICATIONS FOR TMaH

The findings are directly relevant to each of the three TMaH pillars.

For **Access, Infrastructure, and Workforce**, the findings point to the value of making sure participants know who to contact, maintaining relational continuity, and proactive navigation support for first-time parents; as well as the need to design administrative systems around transition points rather than assuming participants will manage them independently.

For **Quality Improvement and Safety**, participants' experiences highlight the need to address communication during complications, early warning sign recognition, language access as a patient safety variable, respectful treatment as a measurable quality standard, and mental health screening that reflects the full spectrum of perinatal distress rather than only its most extreme endpoints.

For **Whole-Person Care**, the findings reinforce that non-clinical supports are not peripheral. They are the infrastructure that makes clinical care accessible in the first place. This includes maintaining accurate resource information, supporting housing navigation, and extending mental health support to the whole family system rather than only to the birthing parent.

CONCLUSION

TMaH offers a meaningful opportunity to address what participants described. The participants who took part in these groups were clear about what they needed: not simply a longer list of programs, but a more coordinated system that supports people through pregnancy, birth, and postpartum care rather than requiring them to navigate each piece on their own. The findings in this report provide a grounded, participant-centered basis for the planning and design work ahead.

II. Background

This report presents findings from twelve focus groups with Medicaid-enrolled individuals navigating pregnancy, delivery, and postpartum care in Washington, D.C., as well as fathers and non-birthing caregivers who shared those experiences with their partners. Participants received care from a wide variety of DC providers and came from across the District of Columbia. The groups were convened to inform planning and implementation of the Transforming Maternal Health (TMaH) Model, a Centers for Medicare and Medicaid Services initiative that supports states in improving the quality, safety, and experience of maternity care for Medicaid and CHIP enrollees. TMaH is organized around three pillars: expanding access, infrastructure, and workforce capacity; advancing quality improvement and patient safety; and providing whole-person care that addresses the full range of clinical, behavioral health, and social needs across the perinatal period. Community of Hope worked in partnership with the DC Department of Healthcare Finance to develop the focus group questions and support participant identification.

The focus groups explored participants' experiences across the spectrum of perinatal care, including prenatal visits, labor and delivery, postpartum recovery, management of medical complications during pregnancy, behavioral health and substance use support, care during a subsequent pregnancy, and the experiences of fathers and non-birthing caregivers as partners in the care process. Participants were asked about their relationships with their care teams, how they accessed services and navigated administrative systems, what information they received and what they wished they had known, how non-clinical needs such as housing, food, and transportation affected their ability to stay healthy, and how they were treated across the settings they encountered. The groups were conducted separately by language, subgroup, and care context to allow participants to speak freely with peers who shared relevant aspects of their experience. Together, the twelve groups provide a fuller picture of the perinatal care experience across language communities, pregnancy stages, and care contexts.

The findings in this report center what participants said, in their own words, about navigating maternity care as Medicaid enrollees in Washington, D.C. They describe what worked, where care and support systems broke down, and what participants identified as necessary for care to be respectful, coordinated, and genuinely responsive to the whole person. The report is intended to support the Community of Hope, DC Department of Healthcare Finance, and their partners in the planning, implementation, and quality improvement work that lies ahead under TMaH. The participants who shared their experiences did so with the hope that their feedback would be useful. This report is intended to carry those experiences forward in a way that supports action, accountability, and better care.

III. Methodology

This report draws on data from twelve focus groups conducted with Medicaid-enrolled individuals navigating pregnancy, delivery, and postpartum care in Washington, D.C. These groups represent a range of participant experiences across prenatal, postpartum, behavioral health, medical complications, and subsequent pregnancy contexts, and include both English-speaking and Spanish-speaking participants, as well as a group of fathers and non-birthing caregivers.

3.1 Participant Recruitment

Recruitment efforts were led by Meta Consulting and supported by Community of Hope, utilizing multiple outreach strategies to engage eligible participants:

- *Community-Based Organizations*: Partnerships with local organizations helped identify and refer potential participants.
- *Social Media Announcements*: Digital outreach efforts included targeted posts and advertisements on platforms such as Facebook, Instagram, and Twitter.
- *Direct Referrals*: Healthcare providers and social service organizations referred individuals who met the eligibility criteria.
- *Flyers and Word-of-Mouth*: Recruitment materials, including electronic and hard-copy flyers, were created in both English and Spanish. The flyers included a QR code that allowed interested individuals to provide their contact information through a SurveyMonkey questionnaire. This enabled the research team to follow up with interested participants to explain the study in greater detail and assess eligibility.

Efforts were made to ensure a diverse participant pool, with a focus on individuals from historically underserved communities, including Black, Latina, and low-income residents, as well as non-English-speaking individuals.

3.2 Eligibility Criteria

People were eligible to participate in the study if they met the following criteria:

- Currently receiving DC Medicaid benefits
- Between the ages of 18-44
- A Washington, DC resident
- Receives maternity care in Washington, DC
- Had a baby within the last 12 months OR currently pregnant
- People who had the following lived experiences were prioritized:
    - Substance use disorder, behavioral health, and/or perinatal mental health conditions while pregnant or postpartum

- Medical complications during pregnancy (e.g., preeclampsia, gestational diabetes, cardiac conditions, obstetric hemorrhage, sepsis, emergency C-section, or other comorbid chronic conditions)
- Non-birthing partners and caregivers (Fathers)

3.3 Data Collection

3.3.1 Quantitative Data: Demographic Survey

Seventy-two focus group participants completed a demographic survey including race/ethnicity, age, education, and ward of residence. They reported their mode of delivery, maternal care providers during prenatal care and delivery, experiences of mistreatment and respectful care, and rated satisfaction with Medicaid at prenatal, labor and delivery, and postpartum stages. Participants could skip any questions they did not feel comfortable answering. A summary of the data can be found in the findings section of this report.

3.3.2 Qualitative Data: Focus Groups

Focus groups were facilitated using a structured discussion guide developed by DC Healthcare Finance in collaboration with Community of Hope. Each session explored participants' experiences with their maternal care teams, access to prenatal and postpartum services, mental health support, non-clinical resources such as housing, food, and transportation, and how they felt they were treated across care settings. Groups were conducted separately by language and subgroup to allow participants to speak freely with peers who shared relevant aspects of their experience. Sessions were recorded and transcribed verbatim. All three additional transcripts used in this final report were full verbatim recordings.

3.3.3 Sample

Between February and April 2026, twelve focus groups were conducted with 72 District of Columbia residents. Four focus groups were conducted in Spanish, and eight were conducted in English. Focus groups with fathers/non-birthing caregivers were conducted by male facilitators. Spanish-speaking focus groups were conducted with a Spanish-speaking facilitator. See Table 1 for the number of participants and focus groups.

Table 1. Count of English- and Spanish-speaking focus group participants by group type

Focus Group Type	*Spoken Language*	*# of Participants*
Prenatal	2 English	13
	1 Spanish	4
Postpartum	2 English	6
	1 Spanish	10
Subsequent pregnancy	1 English	6
Substance use disorder, behavioral health, and perinatal mental health	1 English	3
Medically complex pregnancy or delivery, aka complications	1 English	5
	1 Spanish	10
Fathers and non-birthing caregivers	1 English	8
	1 Spanish	7

3.4 Data Analysis

3.4.1 Quantitative Data Analysis

A demographic survey was administered via the SurveyMonkey platform in both English and Spanish. Data from both English and Spanish were merged into one dataset. Frequencies and percentages were calculated for each item of the demographic survey. Means and standard deviations were calculated where appropriate.

3.4.2 Qualitative Data Analysis

Analysis began with a careful review of each transcript to identify recurring patterns, experiences, and observations across participants. An initial set of themes was developed from the nine-group preliminary analysis and reviewed against the three additional transcripts to assess whether they held, required revision, or needed to be expanded. New findings from the additional groups were integrated where they confirmed existing patterns, added specificity or subgroup nuance, or introduced observations not present in the preliminary data. Where findings from the additional groups contrasted with or complicated earlier patterns, those contrasts were preserved rather than resolved. The final framework of nine cross-cutting themes represents the full analytic synthesis across all twelve groups.

Subgroup differences were considered throughout the analysis and are noted in the findings where they are meaningful and well-supported. Key distinctions include language community, with English-speaking and Spanish-speaking participants frequently describing different patterns of access, communication, and treatment even when navigating the same systems. Additional distinctions include pregnancy stage and

postpartum status, care context (prenatal, postpartum, behavioral health, medical complications, subsequent pregnancy), and the perspective of fathers and non-birthing caregivers, who described care experiences that were parallel to but distinct from those of birthing parents. Subgroup differences are described as patterns and tendencies rather than as universal characteristics of any group. Verbatim excerpts were selected to illustrate findings that were consistent across multiple participants or groups, or to give voice to an experience that was specific, clearly expressed, and meaningfully representative of a broader pattern.

The findings in this report describe patterns of experience across participants who shared similar care contexts. They reflect what participants said, in their own words, about what it is like to navigate maternal care in Washington, D.C. as a Medicaid enrollee, and they offer insight into lived experience that survey data alone cannot provide.

IV. Findings

4.1 Demographic Summary

4.1.1 Participant Demographics

A total of 72 DC residents participated in the focus groups; most participants were women (n=59; 81.9%) who were currently pregnant or had a baby within the past 12 months. Fathers/non-birthing caregivers accounted for 18.1% (n=13) of the focus group participants. Most participants identified as African American (n=38; 52.8%), and 47.2% (n=34) identified as Hispanic/Latino. The majority of the sample were single/never married (n=33; 47.8%), spoke English as their primary language (n=43; 56.7%), possessed a high school diploma or GED (n=32; 46.4%), were between the ages of 25 and 34 (n=38; 55.1%), and lived in Wards 7 (n=13; 18.8%) and 8 (n=14; 20.3%). Table 2 summarizes these data.

Table 2. Summary of focus group participant demographics (N=72)

Demographics	*N (%)*
Gender	
Female	59 (81.9)
Male	13 (18.1)
Race and Ethnicity	
Black or African American	38 (52.8)
Hispanic/Latino	34 (47.2)
Marital Status	
Cohabiting with a significant other or in a domestic partnership	10 (14.5)
Divorced	2 (2.8)
Married	14 (20.3)
Single, never married	33 (47.8)
Prefer not to answer	12 (16.7)
Separated	1 (1.4)
Primary Language Spoken in the home	
English	42 (58.3)
Spanish	28 (38.9)
French	2 (2.8)
Education	
Less than high school	23 (33.3)
High school diploma or GED	32 (46.4)
Some college	9 (13.0)
Associate degree	2 (2.9)
Bachelor's degree	2 (2.9)
Master's degree	1 (1.4)

Table 2. Summary of focus group participant demographics (N=72; cont.)

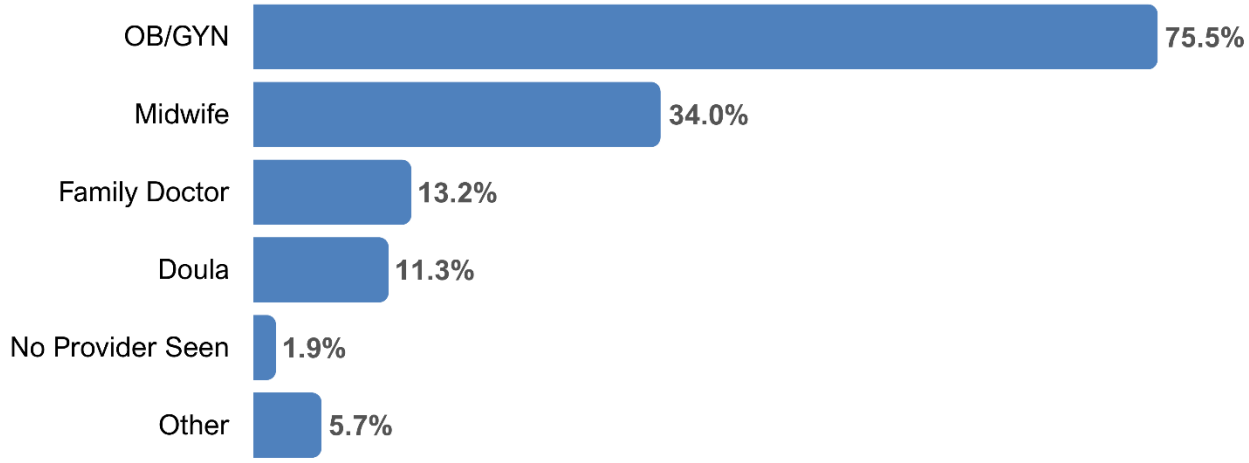
Demographics	*N (%)*
Sexual Orientation	
Asexual	1 (1.4)
Bisexual	3 (4.3)
Heterosexual or Straight	49 (71.0)
Lesbian or Gay	1 (1.4)
Not sure	1 (1.4)
Prefer not to answer	17 (23.6)
Age	
18-24	15 (21.7)
25-34	38 (55.1)
35-44	16 (23.2)
Prefer not to answer	3 (4.3)
Ward of residence	
1	6 (8.7)
2	2 (2.9)
3	3 (4.3)
4	7 (10.1)
5	8 (11.6)
6	2 (2.9)
7	13 (18.8)
8	14 (20.3)
Not sure/Prefer not to answer	25 (34.7)

Note: While there were 72 focus group participants, not all participants completed all demographic questions.

4.1.2 Maternal Care Providers Seen during Prenatal Care

Focus group participants who were prenatal or postpartum were asked to share which providers they interacted with during their prenatal care experience (n=53). The responses were as follows: OB/GYN (n=40; 75.5%), midwife (n=18; 34.0%), family doctor (n=7; 13.2%), doula (n=6; 11.3%), and no provider seen (n=1; 1.9%). Participants could select all that apply. Figure 1 summarizes these data.

Figure 1. Maternal care providers seen during prenatal care (n=53)



4.1.3 Mode of Delivery

Most birthing participants had a vaginal delivery (n=36; 66.7%), while 25.9% (n=14) had a Cesarean section. Table 3 summarizes the data.

Table 3. Mode of delivery reported among birthing focus group participants (n=54)

Delivery Type	*n (%)*
Caesarean/C-section	14 (25.9)
Vaginal	36 (66.7)
Prefer not to say	4 (7.4)

4.1.4 Satisfaction with Healthcare Coverage

Birthing participants (n=54) were asked to share their satisfaction with their Medicaid coverage. Satisfaction was measured on a scale from 1 to 10.

- Prenatal care: The mean satisfaction score was 6.69 (SD=2.56), with the most common score (mode) being 7. Scores ranged from 1 to 10.
- Labor and delivery: The mean satisfaction was 6.59 (SD=2.45), the mode was 8, and scores ranged from 1 to 10.
- Postpartum care: The mean score was 6.37 (SD=2.56), the mode was 8, and scores ranged from 1 to 10.

Overall, satisfaction scores were similar across the three periods, with most participants reporting moderate levels of satisfaction with Medicaid coverage during their maternity care. Table 4 provides a summary of these results.

Table 4. Mean satisfaction with Medicaid coverage across the maternal health continuum (birthing participants; n=54)

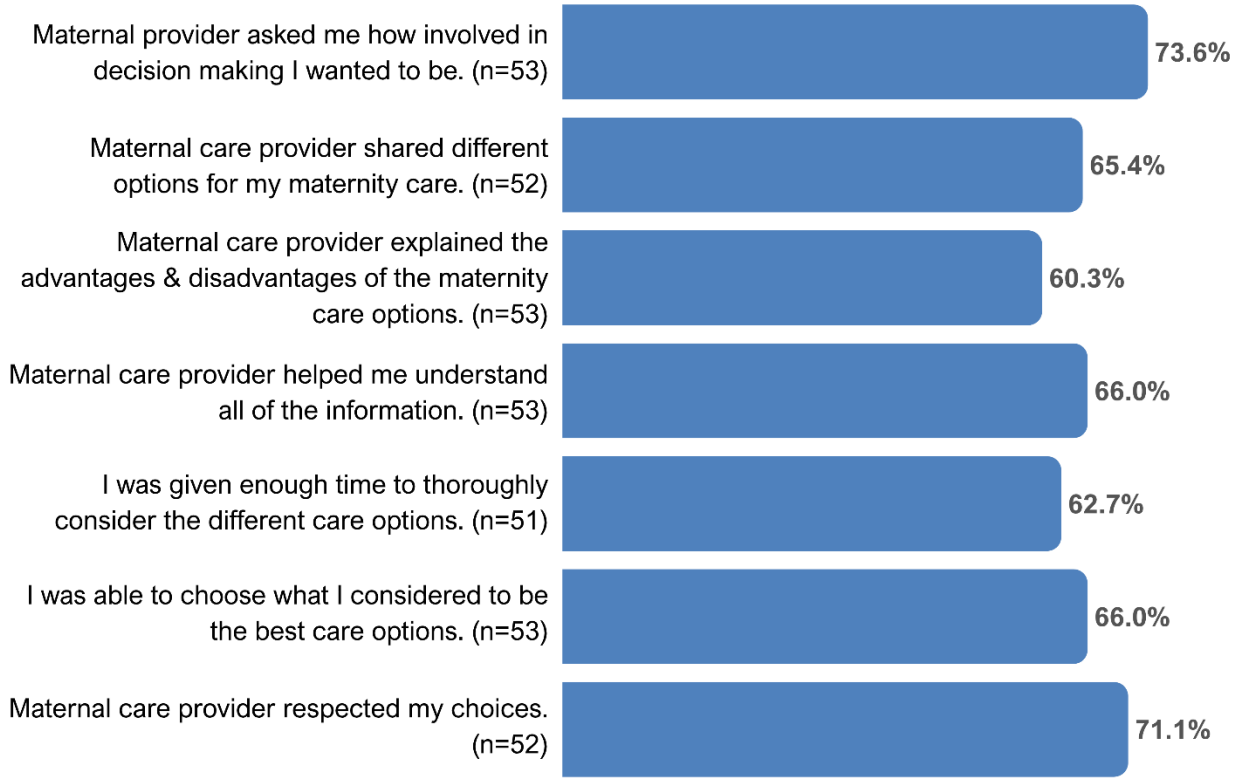
Satisfaction with Medicaid Coverage	*Mean (SD)*	*Mode*	*Range*
During prenatal care	6.69 (2.56)	7	1-10
During labor and delivery	6.59 (2.45)	8	1-10
During postpartum care	6.37 (2.56)	8	1-10

4.2 Maternal Healthcare Experiences

4.2.1 Decision Making

Participants provided insights into their interactions with maternal care providers, specifically regarding involvement in medical decision-making. While the majority indicated that they felt included in treatment decisions, fewer participants reported a complete understanding of all information provided by their care providers. This suggests that additional support may have been necessary to facilitate patient comprehension. Figure 2 illustrates the percentage of participants who completely or strongly agreed with statements concerning decision-making.

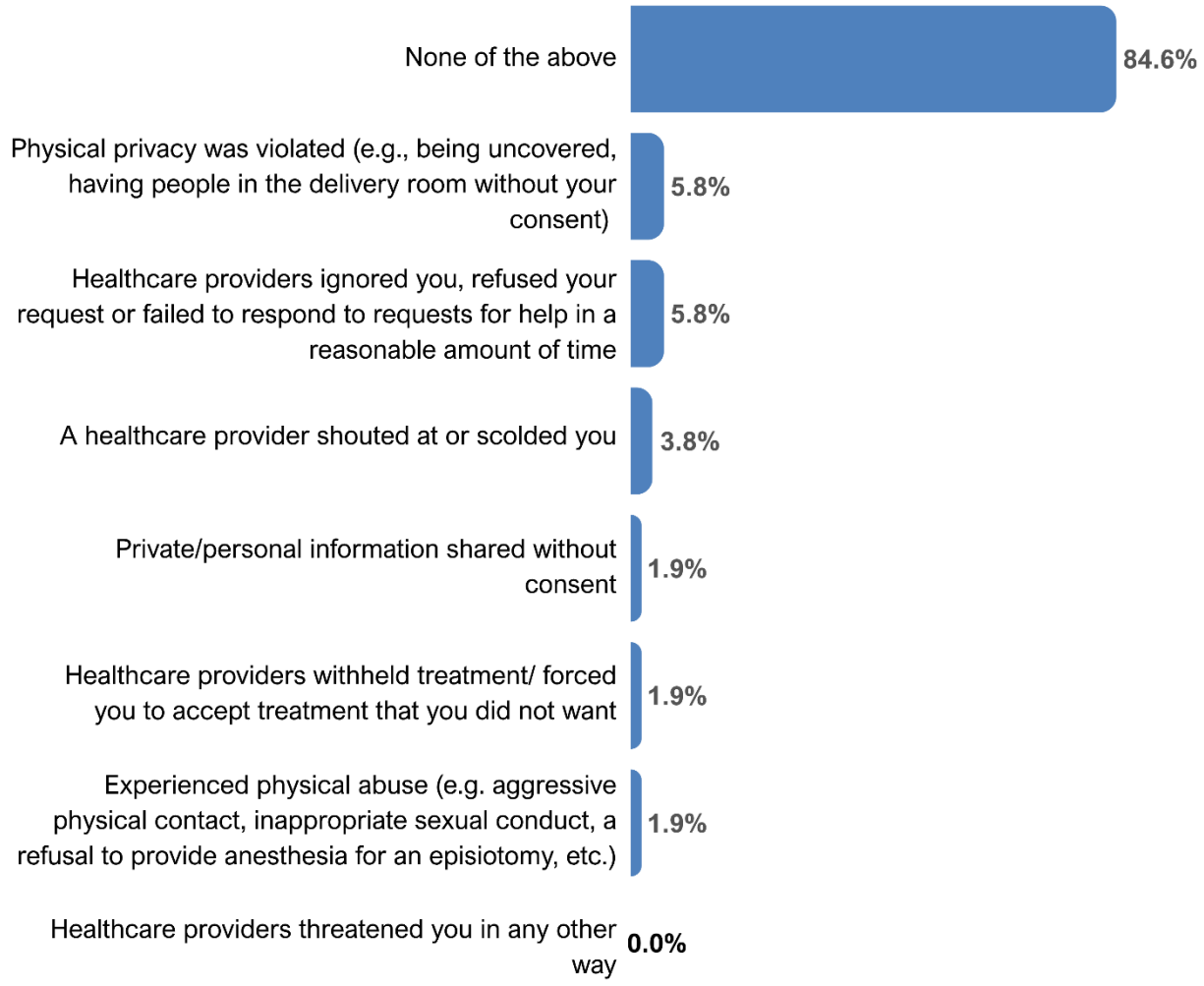
Figure 2. Decision-making and involvement with treatment decisions among birthing focus group participants



4.2.2 Mistreatment by Maternal Care Providers

Participants were asked to share if they had any negative experiences with their maternity care providers, such as breach of privacy, physical abuse, threats, and other concerning behaviors during appointments and delivery. Participants could select multiple responses. Most participants selected “none of the above,” indicating that most did not experience some of these issues. Figure 3 summarizes this data. Participants could select all experiences that applied.

Figure 3. Mistreatment by maternal care providers reported by birthing focus group participants (n=52)



4.3 Cross-Cutting Themes Across Groups

This section presents nine cross-cutting themes that emerged across the full set of twelve focus groups. These themes synthesize the broader patterns most relevant to TMaH planning, implementation, quality improvement, and whole-person care design.

Across the subgroup analyses, several broader patterns emerged consistently. The nine cross-cutting themes below synthesize findings across all twelve focus groups while preserving meaningful differences by language, care context, pregnancy stage, and participant role. Together, these themes describe how participants experienced maternity care as a set of interconnected systems: relationships with providers, access to information, administrative processes, clinical safety, mental health support, practical resources, and trust.

These themes are not presented as isolated issues. In participants' experiences, the same systems that created barriers in one area often shaped experiences in others. A lack of clear information could affect access to benefits, mental health support, postpartum care, and fathers' ability to support their partners. Administrative burdens could disrupt clinical care, food access, newborn enrollment, and recovery after birth. Respectful relational care could make it easier for participants to disclose concerns, ask questions, and remain engaged when systems became difficult to navigate.

The themes that follow are intended to support TMaH planning by showing where participants experienced care as supportive, where systems broke down, and what kinds of changes could make maternity care feel more coordinated, responsive, and whole-person centered.

4.3.1 Care Is Defined by How It Feels, Not Just What Is Done

Across all twelve focus groups, participants evaluated the quality of their care less by what was clinically done and more by how they were treated while it was happening. Respect, attentiveness, and genuine responsiveness were not framed as extras. They were the benchmarks by which care was measured, and their presence or absence shaped whether participants trusted their providers, felt comfortable disclosing concerns, and remained engaged in care even when other parts of the system were difficult to navigate. This was true across prenatal, postpartum, behavioral health, medical complications, and fathers' groups, and it held across both English-speaking and Spanish-speaking participants, even when the specific ways participants named it differed.

The care experiences participants described as most meaningful were defined by specific, observable behaviors: a provider calling to check in when a participant arrived late to an appointment, a midwife sharing her personal contact number so a patient could reach out directly between visits, a care team verifying that a referral was covered by the patient's insurance before offering it rather than after. One participant, recovering from an emergency cesarean section, described a care team that continued checking on her months after delivery, asking whether she had healed correctly, adding follow-up appointments, and referring her to physical therapy and other services she had not known to ask about.

> *"I say even personally off the clock, and I really, really genuinely appreciate that."*

Another described her midwife as someone who tracked missed appointments, followed up proactively, and functioned as what she called an accountability partner throughout her pregnancy.

> *"[She] checked on me more frequently than sometimes my family even did."*

These are not descriptions of vague warmth. They are accounts of specific practices that can be named, taught, and expected.

Midwives were the provider type most consistently associated with this kind of relational engagement, named positively across multiple groups and both language communities. For Spanish-speaking participants, the relational dimension of care carried particular weight. Trust was not assumed. It was built through respectful interpersonal treatment, and it was also broken by dismissiveness, inattention, or care that felt routine rather than personal. When that trust was present, it often filled gaps that information or system clarity left behind. Participants described continuing with care, attending appointments, and following through on referrals because they believed in their provider, even when they did not fully understand the system around them. For many Spanish-speaking participants, the quality of that relationship was what made the rest possible.

The contrast with transactional care was drawn clearly and consistently. Participants described appointments that felt scripted or rushed, providers who asked questions without genuine interest in the answers, and interactions that communicated that the visit was a procedure to complete rather than an encounter between people. These experiences did not simply leave participants dissatisfied. They led to reduced disclosure, lower trust, and in some cases withdrawal from care. Fathers and non-birthing caregivers experienced the relational dimension of care from a different vantage point. When providers acknowledged them directly, explained procedures, and included them in clinical conversations, they felt respected and prepared. When they were treated as peripheral, they described being "just there," present in body while the care happened around them. The relational quality of care, then, was not a preference or a courtesy. For participants across all groups, it was the condition under which everything else about the clinical encounter was possible.

4.3.2 Getting Into Care Is Possible, but Moving Through It Is Not Consistent

Most participants in this study were able to access prenatal or postpartum care. Getting into the system was rarely the final barrier. What proved far more difficult was moving through it in a coordinated, predictable way once care had begun. Delays in referrals, gaps between providers, insurance disruptions, and the loss of established relationships created patterns of fragmentation that participants described as both exhausting and, in some cases, harmful. The difference between a smooth experience and a fractured one often came down to a single factor: whether a participant already knew how the system worked.

Prior pregnancy experience was the most consistent predictor of smooth access across all groups. Participants who had navigated the system before, who had an established relationship with a clinic, or who had a specific provider they could call directly described scheduling their first prenatal appointment without significant difficulty.

"Again, because it's my fifth child, I knew what to do. I knew where I wanted to go at to get my care. So, it was pretty easy and smooth."

First-time parents, by contrast, described a different experience entirely, one of uncertainty about where to go, who accepted their insurance, and how long they would have to wait. One participant described calling five to ten providers before finding one that could see her as a Medicaid enrollee and being told by some that she would need to pay out of pocket. Having to call that many places, she said, was something that should not fall on a person who is newly pregnant and trying to do the right thing. This gap between those who know and those who are learning is not a reflection of individual capability. It is a structural inequity built into a system that communicates its own rules primarily through the experience of using it.

Once in care, movement through the system depended heavily on how well different parts of it communicated with each other. Referrals to specialists, mental health providers, and community services did not always move. When Medicaid coverage changed mid-pregnancy, either through plan name changes, managed care transitions, or recertification processes, care relationships that had taken months to build could be disrupted overnight. Participants described discovering these changes not through proactive notification but at the pharmacy counter, at the front desk, or when a previously scheduled appointment suddenly could not be honored. For participants with complex medical needs, for whom frequent visits and stable provider relationships were especially important, these disruptions were not minor inconveniences. They interrupted care at the moments when it mattered most. Spanish-speaking participants who were already connected to a clinic tended to describe entry into care as relatively smooth; fragmentation appeared not at the beginning of their care journey but at the referral points, when conditions required handoffs to hospital or specialist settings the primary clinic did not control. English-speaking participants described disruptions spread more broadly across the care timeline. Continuity was also broken in ways that originated closer to the clinic. In one case, a group prenatal care session at a participant's location was canceled due to low attendance. No individual follow-up appointment was scheduled in its place. That participant was five months pregnant and had attended only one prenatal visit. That gap originated in a program management decision, not a patient choice, and it fell entirely on a first-time mother to notice and resolve.

One structural feature that clearly reduced access friction was direct, named contact with a trusted provider. Participants who described smooth scheduling almost always pointed to a specific person they could reach, typically a midwife with whom they had a prior relationship and whose personal or direct number they held.

"What would make it even smoother, or what made my last pregnancy smoother as far as scheduling appointments, is having direct contact information for whatever midwife I was most comfortable with at [facility] so that I can be like, 'Hey.' So just having that extra connection, I would say."

This kind of access, reaching a person who knows you rather than a general intake line, is not available in all settings, and it should not require a prior pregnancy to obtain. For participants in the subsequent pregnancy group, the irony ran deeper: they had navigated the system successfully before and still described delays in this pregnancy that were worse than in prior ones, as clinic capacity strained and wait times grew. The lesson from this theme is not that access is impossible. It is that what determines whether care is truly accessible has less to do with formal eligibility and much more to do with whether the system is designed to carry people through it, or whether it expects them to find their own way.

4.3.3 People Are Often Navigating Care Without Clear Information

Information gaps were a consistent feature of participants' experiences across all groups, appearing in prenatal, postpartum, behavioral health, complications, and fathers' discussions alike. But the gaps were not all of the same kind. Treating them as a single problem would obscure what actually needs to change. Three distinct patterns emerged across the dataset. In the first, information simply was not provided: participants were not told about available programs, did not understand what their coverage included, received no preparation for what labor and delivery would involve, and learned about postpartum resources largely by chance rather than through any deliberate communication from their care teams. In the second, information was provided but turned out to be wrong: participants were given resource lists and referrals that directed them toward organizations that had lost funding, ended partnerships, or no longer existed. In the third, information that did reach providers stopped at the birthing parent and went no further, leaving fathers and non-birthing caregivers to educate themselves through whatever means they could find. Each of these failures produces distinct harm, and each requires a different response.

The first failure mode, information simply not provided, was present across all groups but showed up differently by subgroup. Spanish-speaking participants described uncertainty about insurance coverage, unexpected changes in their plans, and a general reliance on trust in their providers rather than actual clarity about the system around them. Many continued attending appointments and following instructions without fully understanding what was happening or why, filling the gaps with confidence in a provider who had treated them well. English-speaking participants described a different but related problem: the existence of programs they could have benefited from but did not know about until too late, benefits with time-limited eligibility windows that had already closed by the time they learned of them, and resources available through their insurance that required knowing to ask. First-time parents were the most vulnerable to this pattern in every subgroup. The system communicates itself primarily through use, and those experiencing it for the first time had no prior experience to draw on.

The second failure mode, inaccurate information, was named with particular clarity and frustration by participants in two separate focus group sessions. Being handed a resource list by a care team carries an implied assurance that the resources on it exist

and are accessible. When that turns out not to be true, the harm goes beyond a wasted phone call. Participants described working through lists of fifty or more resources, spending twenty minutes or more making calls, and finding nothing that came through.

> *"I just feel as though we are given a list of resources and things like that. But when you call these, it's always, we know this place or we know that place... and some of the resources are not in partnership with them or just stop or doesn't... have the funding because a lot of funding has closed with a lot of different organizations and stuff like that. So, it just be like, that's disappointing. I just sat and spent 10, 20 minutes going down the list of 50 plus resources that was given to me and nothing's coming through."*

The same experience appeared in a separate group, where a participant described being referred to a housing program at a named location, going there directly, and being told the program's funding had stopped. In both cases, the care team had offered something that no longer existed. The damage was not only practical. It was the steady accumulation of effort that produced nothing, which for some participants eventually produced a decision to stop trying altogether. This is a different problem from not knowing about a resource. It is a problem of institutional maintenance, of care teams providing information that has not been updated to reflect a shifting funding landscape.

The third failure mode was most visible in the fathers' group, where participants described being systematically excluded from the informational exchange of prenatal care. Providers communicated with the birthing parent. The birthing parent then communicated with her partner, when and if the information made its way there. In some cases, partners described their role during prenatal appointments as asking specific questions that their partners had already coached them to ask, because the partner already knew the answers and was trying to get the father to learn them too. No structural mechanism existed to direct information to the non-birthing caregiver. The sharpest example of this gap was postpartum depression. When asked directly whether anyone had spoken with them about postpartum depression and how to support their partner through it, participants in the English-speaking fathers group responded immediately and unanimously: no.

> *"No, no, no, no. And I went through that, man." "We deal with it the way that we had to deal with it."*

4.3.4 Patients Carry the Burden of Making the System Work

Across all twelve focus groups, participants described a care system that required their active, sustained effort in order to function. This was not framed as exceptional. It was the baseline. Following up repeatedly when referrals did not move, calling back after being disconnected, keeping their own records of symptoms and communications so that concerns would be taken seriously, advocating for themselves when they were dismissed or undertreated: these were not strategies participants chose because they wanted to. They were the things participants learned they had to do if they wanted care

that was timely, complete, and responsive to their actual needs. The system, as many participants experienced it, did not run on its own. It ran on their effort and labor.

The burden took different forms depending on where participants were in the care journey. During pregnancy, it often looked like clinical advocacy: speaking up at appointments, asking the same question until it was answered, pushing back against a provider's assumptions, or seeking a second opinion when something felt wrong. For participants navigating medical complications, this type of advocacy was not optional. Several described it as what kept them safe. After delivery, the burden shifted toward administrative management. Participants described being responsible for tasks they reasonably expected the system to handle: enrolling newborns in Medicaid, resolving billing errors, correcting birth certificate mistakes, and following up on paperwork submitted weeks or months earlier.

> *"It's a lot of stuff that I had to end up doing myself that I know for a fact that they could have done or they were supposed to do, but they just like, 'Oh, here's the number for this. You got to call them and say this and say that.' And I'm like, 'That don't really seem like it's my job, but it is what it is.'"*

Another, whose son's birth certificate contained an error that went uncorrected for nine months despite repeated calls, put the underlying need plainly: if you have submitted our paperwork, let us know. Tell us when it was submitted, whether it was processed, and whether something went wrong.

> *"We need receipts. We need receipts."*

These were not unreasonable requests. They were descriptions of a system that transferred its own accountability to the people it was supposed to serve. The implications of these failures extended beyond inconvenience. Participants described administrative breakdowns that carried practical, financial, and emotional consequences for families already managing pregnancy, recovery, caregiving, and limited resources. A delay in adding a newborn to Medicaid could affect access to pediatric care, prescriptions, billing, and a family’s sense of security in the first weeks after birth. An incorrect birth certificate was not simply a paperwork error. It affected a core legal document that families reasonably expected the system to complete correctly and correct promptly. An unresolved medical bill or coverage lapse could create the risk of out-of-pocket costs for families who were already navigating material constraints. The burden was not only that these tasks were frustrating. It was that the system assumed participants had time, flexibility, information, and emotional bandwidth that many did not have.

The form of the burden varied by language and context, though its presence did not. English-speaking participants more often described self-advocacy in the language of frustration and exhaustion, as something they had to do in spite of the system and often against resistance. Spanish-speaking participants described it more quietly, as a necessity they navigated with less confrontation but no less effort. Asking for an

interpreter rather than waiting for one to be offered, leaving a provider who was disrespectful, documenting concerns carefully before appointments so they would not be forgotten or minimized: these were the quieter forms of labor that ensured care continued. Fathers and non-birthing caregivers carried a parallel version of the burden that looked less like advocacy and more like independent study. In the absence of information from clinical providers, they turned to YouTube, TikTok, Google, books, and older family members to learn what to expect, what to watch for, and how to support their partners. Some described their partners actively directing them to ask specific questions at clinical appointments, because the partner already had the information and was trying to pass it along. In this way, the information burden was distributed back onto the person who was already managing the most.

The burden of self-advocacy did not fall evenly across participants. Medicaid-enrolled participants described being treated differently when their insurance status was known. Black participants described encounters in which providers appeared to hear them but did not act on what they were saying. Spanish-speaking participants described having to ask for interpretation rather than having it consistently offered. Young and first-time mothers described not knowing what to ask for until after a benefit, program, or opportunity had already passed. These experiences reflected different versions of the same structural problem: the system placed the burden of getting appropriate care on patients and families, while those most affected by insurance status, race, language, age, and first-time parenthood often had to work harder to be heard, informed, and taken seriously.

Doula support also appeared in the data as one way to reduce the burden of self-advocacy. Participants who had doulas described the value of having someone who could ask questions, communicate with providers, advocate during labor, and remain attentive when the participant herself was in pain, overwhelmed, or unable to speak. This support mattered because it shifted some of the responsibility away from the patient at precisely the moment when self-advocacy was hardest. At the same time, access to doula support was inconsistent. Some participants received doula support through specific community programs, while others had never been offered it, learned about it only by asking, or found that private options were too expensive.

What the dataset also showed was that the capacity to sustain this kind of effort is not unlimited. For participants who encountered repeated dead ends, who called numbers that led nowhere, who followed every instruction they were given and still found nothing available to them, the accumulated weight of that effort eventually reached a point where continuing did not seem possible.

> *"You just don't know. It's one minute you hear one thing and then they always referring you somewhere, and when you get to the place they refer you to, 'Oh, we don't no longer fund this or accept this.' So, it's just like, no."*

This is not a personal failure. It is the predictable consequence of a system that repeatedly asks for more than it delivers. Participants in the subsequent pregnancy group noted that advocacy became more confident the second time around, not because the system had improved but because they had learned it through the first pregnancy. That experience brought skill. It also brought clarity about how much the system had asked of them the first time, and how little it had changed.

4.3.5 Mental Health Support Is Uneven and Often Misses the Postpartum Family System

Emotional strain was part of the perinatal experience for participants across every group in this study. Anxiety, overwhelm, fear, grief, and in some cases more serious distress appeared in prenatal, postpartum, behavioral health, complications, and fathers' discussions. What varied was not whether emotional challenges were present but whether the care system recognized them, responded to them, and provided meaningful support. That variability was significant, and it often had real consequences for participants and their families.

When mental health support worked well, it worked because it was immediate, personal, and did not require the person who was already struggling to do additional work to access it. At its best, a provider who heard a disclosed concern brought a mental health staff member directly into the room rather than handing over a phone number and leaving the participant to schedule her own intake. Therapists in some settings sent check-in messages through patient portals when sessions were missed, recognizing that postpartum scheduling constraints would reduce attendance on their own without any intervention. These practices are reproducible. They describe a system that treats mental health support as part of care rather than as an optional referral. When support did not work well, it relied on standardized screening that covered only the most extreme endpoints of perinatal mental health experience, whether a participant was having thoughts of harming herself or her baby, while asking nothing about the broader range of anxiety, overwhelm, numbness, disconnection, or difficulty bonding that many participants described.

> *"Especially with my first pregnancy as a lot of women can't identify with, I didn't know what I was feeling because it's the first time of me feeling it. I didn't know what to compare it to and I wasn't really offered the resources or tools to really identify that within myself. It would either be the extreme points of postpartum like, 'Are you having thoughts of hurting yourself or hurting baby?' Things like that, but not really inclusive about the spectrum."*

Participants who were experiencing real distress but nothing that registered at the extreme end of the screening instrument were often left without a pathway to support or, perhaps more troublingly, without a framework for understanding what they were going through at all.

Fear of child removal was named directly by participants as a reason some people did not disclose how they were actually feeling. This was not an abstract or hypothetical concern. Participants described knowing people personally who had lied to their providers about their mental state because they were afraid that an honest answer would set in motion a process that would separate them from their children. The consequence, as participants described it, was that untreated distress continued and worsened. The provider had asked, and the patient had answered, but the information exchanged was not the information that was needed. Screening frequency was a related variable. Several participants in both prenatal groups described being asked about mental health and substance use only at their initial appointment. At clinics where consistent, empathetic check-ins continued throughout pregnancy, participants described feeling genuinely supported and were more likely to disclose concerns when they arose. At settings where screening was a form completed once and filed, it functioned as documentation of the question having been asked, not as care. Provider continuity mattered here as well. Participants who saw different providers at successive appointments described concluding, with time, that there was no point in saying how they were really doing, because the person sitting across from them would not be there the next time.

The postpartum period was where the mental health gap was most acute. Support that had been available during pregnancy ended, in many cases, around six weeks after delivery, at a time when participants described being only just beginning to feel the full weight of recovery, new parenthood, and sustained sleep deprivation. One currently pregnant participant put into words what that period actually required:

> *"I think it's first to be able somebody to come in and talk about the mental, the depression. And if that was a program that be able to have the mom just step out of the house for an hour to be able to go back to the clinic or go back to the hospital to be able to just do the checkup or talk to somebody just outside, not just inside... that will really help the mom mental health, just being able to step out for a second and just worry about herself and then not herself and the baby at the same time."*

That is a specific and reasonable request: time to exist as an individual, not only as a caregiver. It is also a description of something the current system does not routinely provide. Worth noting too is that participants who were still pregnant described anticipating postpartum depression before experiencing it, based on what they had observed in their communities and their awareness of their own emotional sensitivity. That anticipation, and the fear behind it, represents an opening. Participants were already thinking about postpartum mental health before delivery. Prenatal visits are an underused opportunity to meet them there, to offer psychoeducation about what to expect, to introduce the support structures that will be available, and to create a plan before the postpartum period begins.

Fathers and non-birthing caregivers were absent from the mental health support system in two distinct ways. Their own emotional experiences during pregnancy, delivery, and the postpartum period were not acknowledged or addressed. And they were not informed about postpartum depression in their partners or prepared in any way to recognize or respond to it. These were fathers who had been present throughout pregnancy and delivery, who were in the home during the postpartum weeks, and who were often the first and most consistent witnesses of their partners' well-being during recovery. No one had prepared them for what they might see. Some described navigating their partners' postpartum depression with no framework other than what their partners chose to explain to them. In the Spanish-speaking fathers' group, the pattern was the same. One exception was noted: a participant who had attended a first-time fathers' support group described it as genuinely helpful. That a single support group stood out as exceptional, rather than as expected, reflects the overall absence. One English-speaking father described eventually seeking therapy on his own initiative, arriving, through his own effort, at a framework he articulated simply:

> *"Mental health is real, man. We got to continue to find time for ourselves. We give so much time, we give so much energy, we give so much effort that we forget ourselves. Just finding something that you love to do. If we got 365 days out the year, at least five of those days got to be just for us."*

4.3.6 Complications Reveal Where the System Breaks Down

Routine care conceals a great deal. For participants whose pregnancies and deliveries proceeded without serious medical events, the gaps in coordination, communication, and follow-through that exist throughout the system remained largely in the background. For those who experienced complications, those gaps moved to the foreground. When a warning sign needed to be recognized, a diagnosis communicated, a referral coordinated across settings, or a transition managed between clinic, hospital, and specialist, the places where the system was not well connected became both visible and consequential. The complications data in this study contains some of the most serious findings in the full dataset.

The most significant distinction in the complications data runs along language lines. Spanish-speaking participants more often described delayed or absent recognition of serious conditions, including accounts of symptoms being present or reported and not acted upon, diagnoses not communicated until after delivery, and care that did not escalate appropriately until a situation had become urgent or dangerous. In at least one account, language-concordant care was described not simply as a matter of comfort or trust, but as a clinical turning point. A Spanish-speaking participant described a same-language provider stepping in during a complication, reading the chart, recognizing what had not been addressed, and providing the care that, in her view, prevented a worse outcome.

"Yes, I say it did have a lot to do with it because this doctor, Hispanic, was the one who helped me. Because otherwise, something worse would have happened."

English-speaking participants, by contrast, more often described increased monitoring and follow-up after a complication had been identified, a response that was appropriate once the problem was known but that could not address what had occurred before it was identified. Taken together, these accounts suggest a system that may respond adequately to complications that have already been named but that is less reliably alert to warning signs before they become emergencies, particularly for patients for whom language and communication already require more effort from all parties.

When complications did occur, the transitions between care settings were frequently poorly managed. Participants described moving from routine clinic visits to hospital stays to specialist care with inadequate communication between the providers involved in each setting. Information that had been established at one point of care did not reliably arrive at the next. Participants were asked to repeat their history and their concerns at each transition, sometimes at moments of acute distress when doing so was both difficult and felt beside the point. Some described rapid escalations from what had been routine appointments to emergency situations without adequate preparation or explanation of what was happening or why. The experience of complication in these accounts was not only a medical event. It was also a communication failure and, in many cases, a logistical breakdown in which the pieces of the care system were not coordinating around the person at the center of it.

In some accounts, the breakdown was not only that participants were unheard, but that their own bodily experience was actively contradicted. One participant described feeling herself being cut during a cesarean procedure and being told that was not what was happening. That kind of denial is more than poor communication. It is a failure to treat the patient’s report of her own body as clinically meaningful.

These breakdowns are especially consequential because the conditions that increase risk during pregnancy are not distributed evenly across populations. Black, Brown, and immigrant birthing people, Medicaid-enrolled patients, and people with fewer financial and social supports often experience structural conditions that can increase risk during pregnancy and make complications harder to prevent, identify, and manage. In that context, a missed warning sign, delayed escalation, or poorly managed handoff does not occur in isolation. It occurs within a broader maternal health landscape in which the people most likely to need coordinated, responsive care may also be least able to absorb the consequences when that care breaks down.

Doula support was one of the clearest examples of how advocacy outside the clinical team could change what happened during a complication. When doulas were present and able to function as part of the care environment, participants described them as advocates who spoke up when concerns were not being heard, helped protect the birth

plan, and supported communication during moments when the participant was in pain or unable to speak for herself. In one account, a participant described reporting that she could not breathe during surgery and not being taken seriously until her doula intervened. The participant recalled that once the doula escalated the concern,

> *"Their whole attitude changed and they were being a lot more responding and attentive."*

These accounts do not suggest that doulas should substitute for clinical responsiveness. They show that participants sometimes needed an additional advocate because the clinical system was not responding reliably on its own.

The emotional and mental health consequences of complications were significant and largely unaddressed by the care system. Participants described lasting fear, grief, and in some cases, depression connected to their medical experiences, including accounts of conditions that were not recognized until after delivery, deliveries that were frightening or traumatic, and postpartum periods that were shaped by what had happened during pregnancy and birth. Several described the mental health support they received in the aftermath of complications as inadequate or absent: care teams acknowledged the medical event but did not consistently ask about or respond to its emotional aftermath. For Spanish-speaking participants, discrimination and disrespectful treatment during complications added a layer to the experience that extended beyond the medical situation itself. One participant described explicitly naming her right to care and her refusal to accept treatment that humiliated her.

> *"From the moment they started to humiliate me, I said no. I told them, 'I have a right to my health.' Because if I don't speak up, they won't listen."*

That act of self-advocacy, during a complication, at a moment of maximum vulnerability, was what ensured she received the care she needed. The fact that it was required at all describes the gap.

4.3.7 Administrative Systems Disrupt Care

For many participants, the administrative layer surrounding maternal care was not a background inconvenience. It was an active and recurring source of disruption that affected whether care was accessible, whether it could continue, and whether the support programs participants were entitled to ever actually reached them. Insurance coverage changed mid-pregnancy, sometimes without notice and without any clear explanation of what had changed or what it meant. Participants described discovering these transitions not through a letter or a call but at the point of service, at the front desk or at the pharmacy, when something they had counted on was suddenly unavailable. For those with medically complex pregnancies who were being seen frequently and who had built care relationships over months, an unexpected plan change was not a minor administrative matter. It was a disruption to the care structure that had been keeping them stable.

Several specific administrative challenges emerged across the dataset with enough consistency and specificity to be named directly. One was the transition from pregnancy to newborn care. Participants in two separate groups, one a mother and one a father, independently described encountering confusion about their newborn's Medicaid enrollment in the days and weeks after delivery. The coverage their baby needed was not automatically in place. Parents were expected to contact the DC Department of Human Services, identify which plan the baby had been assigned to, confirm a provider within that plan, and resolve any billing discrepancies, all while recovering from delivery, managing a newborn, and in some cases dealing with complications. Neither parent had been told in advance that this transition would require their active management. Both described the process as something that fell on them unexpectedly at exactly the wrong moment.

A second point of disruption involved the administrative processes for accessing food and income support programs. Multiple participants across two groups described the SNAP application process as multi-step, technically unreliable, and in some cases resulting in denial or deferral on income grounds even though their actual financial circumstances, once fixed expenses like rent, car payments, and utilities were considered, left them without adequate money for food.

> *"I really don't like that one. It's so much that you call this number, they transfer you to this number, you go over there, you have to wait, you have to make an appointment, they have to do an interview. It's a lot, but the WIC was really, really easy."*

The contrast with WIC, which was described by participants in both groups as fast, same-day, and requiring only proof of pregnancy, was not incidental. Two programs addressing similar underlying needs delivered dramatically different experiences, and the difference came down to how they were designed.

A related point of disruption was the accuracy of resource information provided to participants by their care teams. As discussed in the information gaps theme, participants in multiple groups described receiving resource lists or referrals that no longer reflected what was actually available. In the administrative context, the issue was not only that information was outdated, but that no clear system appeared to exist for keeping those resources current. When participants were handed lists of programs that had lost funding, ended partnerships, or no longer existed, the care system extended the appearance of support without ensuring the substance of it.

Spanish-speaking participants and English-speaking participants experienced administrative disruptions differently, though both encountered them. Spanish-speaking participants more often described discovering gaps at the point of service, without having been notified in advance. English-speaking participants more often described the sustained ongoing labor of tracking coverage, managing transitions, and staying ahead of a system that moved without warning. One group worth particular attention is

participants who were navigating these systems for the first time. Those in subsequent pregnancies described administrative processes as still exhausting but more manageable than the first time, because experience had taught them what to expect. First-time parents had no such experience to draw on. The administrative layer of maternity care is not self-explanatory. It does not explain itself. And participants who had not previously learned it through necessity were the most likely to discover its failures at the worst possible moments.

4.3.8 Support Outside the Clinic Makes Care Possible

Across all groups, participants were clear that clinical care alone did not determine whether they could stay healthy during pregnancy and recovery. What happened outside the clinic mattered just as much: whether there was a ride to an appointment, food that supported a medically appropriate diet, a home that was safe and stable, and someone available after delivery when the clinical system had stepped back. When these supports were present and reliable, participants described them not as supplements to their care but as the conditions that made care possible at all.

Several types of support were described as having made a real difference. In-home postpartum was credited by multiple participants with being among the most meaningful resources they received. Delivered meal support was described by one participant as among the best things that had happened to her during her pregnancy. Medicaid-covered ride services were described as essential for participants without access to reliable transportation. For those who had been assigned a caseworker through their Medicaid plan, that relationship often proved to be one of the most valuable in their care network. The value was not that the caseworker provided clinical services, but that she connected participants to programs, followed up when referrals did not move, and advocated when something was falling short.

Those programs worked when they functioned as intended. When they did not, the consequences were immediate and sometimes startling. Transportation services were described as unreliable in ways that went beyond occasional delays. Multiple participants described rides that arrived with vehicles that smelled of cigarette smoke or marijuana, conditions that were not appropriate for someone recovering from delivery or traveling to visit a newborn in a NICU. One participant described the particular difficulty of having just given birth at a same-day discharge clinic, having no car, and facing the possibility of putting a newborn who was hours old into a vehicle that she was not comfortable entering herself. Childcare was another gap that the clinical system did not address. Several participants described missing or delaying appointments because they could not find someone to watch their other children and noted that clinic policies restricting children in waiting rooms made this barrier harder rather than easier to manage. These were not peripheral inconveniences. They were the practical conditions under which care either happened or did not.

Housing was the most consistently unresolved practical need in the dataset, and the participants who tried to address it through formal channels described a process that was fragmented in ways that a pregnant person was especially poorly positioned to manage. The architecture of DC housing assistance required multiple stops: an appointment at a central intake location, a referral to a second organization, a resource list to work through, and then a self-directed apartment search before any conditional assistance could be offered. The structure positioned help as something that arrived only after the hardest step had already been completed independently. One participant who had navigated this process described both the frustration and the design problem with unusual clarity.

> *"I think maybe if they have a more a system that will communicate better in terms of the person information, because me, I remember I had to go to Virginia Williams, set the appointment there, and then they send me to another organization, and then they send me resources, and then I have to go and look myself for apartment, and then hopefully if I find something, then they can help. So, I feel like it's a lot."*

She went further and offered a direct comparison. WIC and transportation, she noted, do not require participants to move across agencies. They come to the participant. Housing assistance, in her view, should work the same way. That is a participant-generated design observation grounded in comparative experience, and it points toward what a more integrated support model would require.

Participants' contrasting experiences with WIC and SNAP showed how much the design of a program shaped whether support was actually within reach. WIC was described across two separate groups as fast, easy, and practically helpful. Participants recalled being referred to the WIC office at the same appointment where their pregnancy was confirmed, receiving a benefits card the same day, and being asked for little beyond proof of pregnancy. SNAP, by contrast, was experienced as harder to access. Participants described a multi-step process that sometimes resulted in denial or delay, including income rules that did not account for fixed expenses such as housing, transportation, and other costs that shaped whether they could actually afford enough food. The contrast was not about need, it was about design: one program felt immediate and usable, while the other often required participants to prove need through a process that did not fully reflect the financial reality they were living in.

Some of the most valued support participants described did not come from a program at all. Group prenatal care, specifically the Centering model offered at several clinics, was described by participants who had attended it as something qualitatively different from both individual appointments and informal peer connection.

> *"Me, I did went in a few of them and I always went out of it satisfied because as I mentioned earlier, it helps you connect with other moms and they gave you mainly as a first time mom, it's very helpful because the*

other moms that have two, three kids already, they share their experience and the mistakes and also the nurses and the midwife that will guide even those moms through it. And it's really insightful, very interesting."

Another described the group sessions as the space where she first understood that she had a voice in her care and was entitled to use it. The absence of those sessions, when they were discontinued due to low attendance, was felt. One participant described feeling lonely in her pregnancy specifically because the group classes at her location had ended and named the focus group itself as meaningful because it gave her the peer connection that the clinical setting had withdrawn.

Home visiting was similarly valued, particularly by participants without nearby family support, who described the prospect of having someone come to them as both practically helpful and, for some, the only way they would feel comfortable asking certain questions. That same model was rejected firmly by some of the English-speaking fathers, who described home visiting as invasive and inappropriate for their households. Both responses belong in this report. Home visiting is not a universally desired model, and its success in practice will depend on how it is introduced, framed, and made accountable to the whole household rather than to the birthing parent alone.

Participants' experiences with doula support were meaningful, but uneven. Those who had doula support often described it as valuable, particularly when the doula was able to advocate, communicate with providers, or provide support during a difficult birth or postpartum period. At the same time, access was not consistent. Some participants were connected through specific community programs, while others were not offered the option, could not afford private doula care, or learned about doulas only after asking. Spanish-speaking participants, in particular, often had little or no prior awareness of what a doula was before the role was explained. In a few cases, participants had been assigned a doula, but the doula did not arrive in time, did not show up, or was limited by hospital policies that restricted who could be present. These experiences suggest that doula care cannot be treated only as a resource that exists somewhere in the system. It requires intentional referral, coverage, participant education, reliability, and integration into hospital and clinical settings.

Finally, what currently pregnant participants described wanting most in the postpartum period was not a specific clinical service. It was an hour. An hour to step out of the house and focus on themselves, not on the baby and themselves simultaneously. That framing, support as individual time and identity rather than only as treatment, points toward something the current system does not reliably provide.

4.3.9 Identity, Language, and Insurance Status Shape Trust, Safety, and Treatment

How participants were treated in clinical settings was shaped not only by what they said and what they needed but also by characteristics they carried into the encounter: the language they spoke, the insurance they held, their race, their age, and how they were

perceived. These characteristics influenced whether providers listened carefully, whether communication was thorough, whether care felt respectful, and whether participants felt safe enough to be honest about their experiences and concerns. The findings in this theme do not describe isolated incidents. They describe patterns that participants named directly and that cut across multiple groups, language communities, and care settings. These characteristics did not operate separately in participants' accounts. For many, language, insurance status, race, age, pregnancy history, and financial context overlapped in ways that shaped how much they had to explain, prove, repeat, or defend in order to receive care.

For Spanish-speaking participants, language was the most immediate and consequential characteristic shaping their care experience. Interpreter access was not always proactively offered. In some cases, participants described having to ask for interpretation rather than having it arranged before they arrived, and in some settings the option was not available at all. When providers communicated in ways that participants could not fully follow, the effect was not only informational. It shaped the entire quality of the interaction and the degree to which participants felt present in their own care rather than managed through it. The clearest evidence of language as a clinical variable rather than only a preference appears in the complications data: a same-language provider was credited by a Spanish-speaking participant as having made a material difference to her outcome during a medical complication, in a setting where other providers had not responded appropriately. Cultural expectations also shaped trust in ways that were specific and consistent. Respectful interpersonal treatment, genuine attentiveness, warmth, and being given time to explain, these were not described as preferences but as conditions for feeling safe in a clinical setting. Their absence produced fear, embarrassment, and in some cases withdrawal from care. For many Spanish-speaking participants, trust built through a relational and culturally responsive encounter was what made everything else in the clinical interaction possible.

English-speaking Black participants described a different but structurally related pattern in which insurance type and perceived demographic characteristics shaped how providers engaged with them. Participants described being looked at differently when they mentioned government assistance programs, being deprioritized in favor of patients with private insurance, and having clinical questions put to them in ways that reflected racial or age-based assumptions rather than neutral inquiry. One participant described a provider repeatedly questioning whether she was certain this was her first pregnancy, whether she had ever had an abortion, and expressing what the participant experienced as disbelief at her answers.

> *"I don't know if it's because I was a Black woman, because I was young or what it was. They kept asking me, 'Are you sure this is your first pregnancy? You never had an abortion or nothing?' I'm like, no. It was very offensive."*

Another participant described patient privacy being handled carelessly in ways she associated with being on Medicaid, including receiving another patient's personal and medical paperwork at the end of an appointment and overhearing provider conversations about patients that were not appropriately confidential. These accounts do not describe careless individuals. They describe patterns of differential treatment in which a participant's visible characteristics changed the standard of care applied to her.

Among English-speaking fathers, a different dimension of the same underlying problem appeared. Several described hospital-based care as operating in a standardized way that did not account for who they were, where they came from, or what they trusted.

> *"Hospitals and universal. They are performing universal. They don't care what race you are. They're going to do the same thing for anybody and everything not the same."*

This is not a rejection of medical care. It is a critique of care that treats sameness as neutrality, when in practice it functions as a failure to see the people it is meant to serve. The experience of SNAP eligibility determination illustrates one more form of the same structural pattern. Participants described being told that their fixed expenses, mortgage payments, car payments, utilities, did not factor into the eligibility calculation. Only the income number counted.

> *"They just look at the number, which is pretty sad."*

Being told that one's actual financial circumstances are irrelevant to how the system assesses need is a form of institutional dismissiveness with the same underlying mechanism as the differential treatment described elsewhere in this theme: a characteristic of the participant is processed rigidly, her context is made invisible, and she is informed that nothing can be done. These experiences, across language groups and across care and program settings, share a common thread: who a participant is perceived to be, changed what care and support she received.

4.4 Subgroup Summaries

This section briefly summarizes the major patterns that emerged within each subgroup: prenatal participants, postpartum participants, participants navigating a subsequent pregnancy, participants with SUD, behavioral health, or perinatal mental health experiences, participants with medically complex pregnancies or deliveries, and fathers and non-birthing caregivers.

These subgroup summaries are included in the main report because the same system-level issues were often experienced differently depending on participants' circumstances. Language, pregnancy stage, prior pregnancy experience, medical complexity, behavioral health needs, and caregiver role all shaped how participants encountered care, understood information, built trust, and navigated support systems.

The summaries below provide a concise view of those subgroup-specific experiences. The more detailed subgroup theme tables, including theme descriptions and illustrative excerpts, are included in Appendix A.

4.4.1 Prenatal

Across three groups, one tension emerged clearly and consistently: the relational experience of care was often positive, but the system surrounding it was not reliably clear, coordinated, or easy to move through. Women described providers who were warm, responsive, and attentive, and then described, in the same conversations, insurance changes that happened without explanation, information gaps that no one filled, and social needs that were visible to everyone but addressed by no one.

Familiarity with the system made a significant difference. Women who already had clinic relationships, who had been pregnant before, or who had connections to community health centers moved through care with less friction. Those who were new to the system, navigating it in a second language, or encountering it during a first pregnancy were more likely to experience confusion, fear, or delay and to work around those gaps on their own.

What participants were asking for, across language and experience, was not more of everything; it was care that felt connected: providers who explained things and followed up, systems that communicated changes rather than expecting patients to discover them, and support that extended beyond the clinical visit into the real circumstances of their lives.

4.4.2 Fathers and Non-Birthing Partners

Across both groups, fathers were more present, more invested, and more emotionally engaged than the care system around them seemed to expect or accommodate. They were showing up, learning on their own, managing their partners' emotional needs, handling practical logistics, and navigating their own fear and exhaustion with very little formal support.

What they were not receiving was recognition of that role or information directed specifically at them. Care systems continued to treat fathers as peripheral figures, present during key moments but not consistently included in the information, planning, or emotional support that shaped those moments. The gap was not a matter of indifference on the fathers' part. It was a structural feature of how care was organized.

Both English-speaking and Spanish-speaking fathers arrived at similar conclusions through different paths. For Spanish-speaking fathers, the gaps were often about information and formal inclusion. For English-speaking fathers, the gaps were more often about mental health support, postpartum preparation, and a sense that the system's attention faded once the baby arrived. In both cases, fathers were left to fill

those gaps on their own, drawing on family knowledge, internet searches, and sheer willingness to figure things out.

In practice, participants were describing a need for more family-centered care. What they were asking for was not complicated. They wanted to be included in the conversations their partners were already having. They wanted someone to explain what was coming, not just to their partners but to them. And they wanted the system to recognize that the postpartum period was not just hard for mothers. It was hard for everyone in the household, and fathers were managing their own version of it largely in silence.

4.4.3 Postpartum

Across all three groups, the postpartum period emerged as a time when care could make an extraordinary difference and often fell short of doing so. When support was present, consistent, and practically grounded, women described recovering with something that resembled confidence. When it was absent, fragmented, or obstructed by administrative problems they had not caused, they described navigating one of the most demanding periods of their lives largely on their own.

What women across all three groups were describing was not a failure of any single provider or program. It was a structural gap between what the postpartum period requires and what the systems around it reliably deliver. Care that mattered most came through relationships that held, information that arrived before it was too late to use, and support that showed up at the door rather than waiting for women to find their way to it. What women were asking for, in their own words and with remarkable consistency across language and experience, was for care that took seriously the reality of their daily lives, not just the clinical window of the appointment.

4.4.4 Subsequent Pregnancy

Experience brought clarity and competence to subsequent pregnancies, but it did not remove the barriers. Women in this group knew what they needed, pursued it quickly, and advocated effectively. What they ran into was a system that had gotten harder to navigate since their last pregnancy: fewer providers accepting DC Medicaid, longer waits, more administrative complexity, and ongoing disruptions to the provider relationships they had worked to build.

What they were asking for was not unfamiliar. They wanted care that recognized their history, insurance processes that did not treat recertification as reapplication, and providers who could stay consistent across a pregnancy rather than rotating in and out. They also wanted their stated preferences and choices to be respected. Some participants described situations where preferences were not simply missed but not honored once stated. One participant described expressing discomfort with a male student being present during a hands-on procedure and not having that preference

honored. The same participant described nearly having birth certificate paperwork processed in a way she had not agreed to, with correction occurring only because a family member intervened. These examples point to the issues of participants not only asking to be heard; but that they were asking for their consent, choices, and prior experience to matter in practice. They had learned, through experience, how to make the system work for them. The question the system had not answered was why they should have had to.

4.4.5 Medically Complex Pregnancy or Delivery

Medical complications revealed not just individual failures but the structural gaps that those failures depended on. When symptoms were present but not recognized, when diagnoses existed in charts but were not communicated, when care teams changed at the moment of delivery and no one knew the patient's history, the consequences were not just uncomfortable. They were sometimes life-threatening.

These breakdowns are especially consequential because medically complex pregnancies are not distributed evenly across populations. Black and Brown birthing people, Medicaid-enrolled patients, immigrant families, and people with fewer financial and social supports often experience structural conditions that can increase risk during pregnancy and make complications harder to prevent, identify, and manage. In that context, a missed warning sign, delayed escalation, or poorly managed handoff does not occur in isolation. It occurs within a broader maternal health landscape in which the people most likely to need coordinated, responsive care may also be least able to absorb the consequences when that care breaks down.

What protected women was not always the system. It was a doula who spoke up, a partner who said something was wrong, a Spanish-speaking doctor who happened to read the chart, or the woman herself who knew her body well enough to call 911 when the headache would not stop. That self-generated protection was real and, in several cases, decisive. It was also not what the system should have required of people who were already managing serious medical conditions while pregnant.

Across both language groups and both clinical contexts, participants described a system that worked best when providers were attentive, proactive, and willing to communicate. It worked worse when those qualities were absent. And for women with complex pregnancies, the stakes of that inconsistency were highest precisely when consistent, responsive care was most needed.

4.4.6 SUD/Behavioral Health/Perinatal Mental Health

Across this group, the system's capacity to support mental health and behavioral health during pregnancy was real but unevenly distributed. It depended on which provider a woman had, whether that provider stayed consistent, whether care was coordinated

across behavioral and maternal health, and how much of the system's complexity the woman had prior knowledge or energy to manage.

Women who had come through multiple pregnancies, who had connections to community health organizations, or who had developed their own strategies for self-advocacy moved through the system more successfully. Women who were newer, more isolated, or navigating for the first time missed programs, benefits, and support they had never been told existed.

What this group was describing was not a system without resources. It was a system that placed the burden of accessing those resources almost entirely on the people who needed them most, at a moment in their lives when they were least positioned to carry that burden alone.

Across these subgroup analyses, several broader patterns emerged consistently. The nine cross-cutting themes below synthesize findings across all twelve focus groups while preserving meaningful differences by language, care context, pregnancy stage, and participant role. Together, these themes describe how participants experienced maternity care as a set of interconnected systems: relationships with providers, access to information, administrative processes, clinical safety, mental health support, practical resources, and trust.

V. Cross-Cutting Implications for the TMaH Model

The findings from this study are not simply a description of what went wrong. They are also a description of what worked, and of the conditions under which it worked. Taken together, the findings point toward a set of design and implementation considerations that are directly relevant to the three pillars of the Transforming Maternal Health model. The observations below are organized by pillar, but they are not discrete. Relational care, administrative coordination, mental health support, and community-based resources are deeply connected in the lives of the participants who described them, and they should be addressed as a system, not as separate components.

5.1 Pillar One: Access, Infrastructure, and Workforce

Access to care, as participants described it, was not primarily determined by whether a clinic existed nearby or whether a person was formally enrolled in Medicaid. It was determined by whether participants knew how to reach the system and whether the system was designed to carry them through it. For participants navigating a first pregnancy without prior experience, without a named provider they could call directly, or without family members who had navigated the same system before, entry was harder, delays were longer, and continuity was more precarious. TMaH implementation should treat proactive navigation support for first-time parents as an access intervention in its own right, not as an enhancement to clinical services.

Relational care and knowing who to contact directly were not, in participants' accounts, simply features of a pleasant experience. They were structural facilitators of access. Participants who had a midwife they could call directly encountered fewer barriers to scheduling appointments, followed through more consistently, and remained engaged in care during disruptions. Participants who felt seen and heard by their care teams disclosed more, trusted more, and asked for what they needed. Workforce investment that builds relational capacity, reduces provider rotation, and enables direct contact with a named care team member is an investment in the access infrastructure of the TMaH model. The same principle applies to Medicaid caseworkers and care coordinators: where those relationships were strong, they connected participants to programs, resolved gaps, and served as a practical layer of navigation the clinical system alone could not provide.

The administrative transition from pregnancy to the postpartum period was a consistent gap point. Newborn Medicaid enrollment, coverage continuity through plan changes, post-delivery paperwork, and the shift from prenatal to pediatric care all arrived at the same time that participants were recovering from delivery and adjusting to newborn care. These transitions require proactive support at the system level, including automated or staff-assisted enrollment processes, written confirmation of completed administrative tasks, and orientation to what to expect at each transition point. Designing around transition points, rather than assuming participants will manage them

independently, is a concrete infrastructure investment with measurable downstream effects on whether postpartum care is accessed and sustained.

5.2 Pillar Two: Quality Improvement and Safety

The findings in this study point toward quality gaps that are not primarily about clinical knowledge. They are about communication, coordination, and cultural and language responsiveness. Spanish-speaking participants described conditions that went unrecognized, diagnoses that were not communicated, and care that did not escalate until a situation had become dangerous. English-speaking participants more often described reactive monitoring that began after a complication had already been identified. Neither pattern describes proactive, preventive engagement with risk. TMaH quality improvement efforts should include measures of early warning sign recognition, communication across care settings during complications, and language-concordant care as a patient safety variable, not only as a patient satisfaction variable. The evidence in this study is direct: a same-language provider was credited by one participant as having made a material difference to her clinical outcome.

Respectful treatment is a quality measure. Participants described experiences of dismissiveness, humiliation, discriminatory assumptions, and careless handling of personal information, and they described these experiences as having shaped whether they disclosed concerns, whether they returned for care, and in some cases their clinical safety during medical complications. Quality improvement frameworks that do not include measures of respectful and non-discriminatory treatment are missing a dimension that participants named directly as affecting their clinical safety. Patients should not have to name their right to respectful care in the middle of a medical emergency to receive it.

Mental health is a quality and safety domain. Perinatal mental health screening that covers only the most severe endpoints, that is conducted once and not revisited, or that occurs in settings where provider rotation makes sustained therapeutic relationships impossible, does not constitute adequate mental health support. Quality standards for the TMaH model should include the warm handoff as a baseline expectation, not as a best practice: when a patient discloses distress, the pathway to support should be immediate and not require the patient to complete another intake process on her own. Screening consistency throughout the perinatal period, and not only at the initial appointment, should also be included as a quality indicator.

5.3 Pillar Three: Whole-Person Care

Participants across all groups described the non-clinical dimensions of their care, such as housing, food, transportation, childcare, mental health support, and peer community, as conditions for accessing and sustaining everything else. These are not add-ons to whole-person maternity care. They are its foundation. TMaH implementation should treat programs like community-based maternal health supports, meal assistance,

Medicaid-covered transportation, and community case management as part of the care system rather than as supplemental resources. When those supports were reliable, participants described being able to attend appointments, manage their health, and recover after delivery. When they were not, the consequences were immediate. This means that resource list maintenance is not an administrative detail; it is a care quality issue. Participants who followed referrals to defunct programs did not receive the support those referrals represented, and some stopped seeking help altogether as a result.

Mental health support for the whole family system belongs explicitly in the whole-person care pillar. Postpartum depression does not only affect the person who gave birth. Fathers and non-birthing caregivers in this study described navigating their partners' postpartum depression without any preparation, support, or framework from the care system. They were present throughout pregnancy and delivery and in the home during the postpartum weeks. They were not reached. TMaH whole-person care should include structured opportunities to prepare non-birthing caregivers for the postpartum period during pregnancy, including psychoeducation about postpartum depression and practical guidance about how to support a partner through it. The prenatal period itself should be used more actively as a window for postpartum mental health preparation, since participants who were still pregnant described anticipating postpartum mental health challenges and wanting to prepare before delivery. That motivation is present and does not need to be created. It needs to be met.

Alternative care models, including group prenatal care, home visiting, doula support, and peer community programming, were described by participants as meaningful in ways that individual clinical appointments often were not. Group prenatal care provided peer connection, preparation, and a sense of voice and agency that some participants described as foundational to how they advocated for themselves in other care settings. Home visiting was valued by participants with limited family support as a way to receive help in an environment where they were more comfortable asking for it. Doula support, where it was accessible, was associated with a sense of advocacy and accompaniment during labor and delivery. All of these models have evidence of impact in existing literature, and the participant accounts here reinforce that evidence. Implementation should attend to the specific conditions under which they work: home visiting requires household-level consent and framing, not only birthing parent consent; group prenatal care requires programmatic commitment to sustain sessions even when attendance is variable; and doula access requires addressing the geographic and insurance-based inequities that currently shape who receives it. Whole-person care, at its fullest, is also care that adapts to who a participant is, where she comes from, what she trusts, and what her household needs, rather than care that delivers the same thing to everyone and calls the sameness equitable.

Strengthening these areas will require financial models that recognize the work participants described as essential to care. Many of the supports that made the greatest difference, including care coordination, warm handoffs, transportation, housing

navigation, meal support, home visiting, doula support, group prenatal care, interpreter access, and father-inclusive education, are not always treated as core reimbursable components of maternity care. Yet participants described these supports as central to whether care was accessible, safe, and sustained. For TMaH implementation, payment and financing strategies should account for the labor, infrastructure, and community-based partnerships required to deliver whole-person care so that these supports are not left underfunded, inconsistently available, or dependent on short-term grants.

VI. Limitations and Analytic Considerations

The findings in this report describe patterns of experience rather than prevalence. They reflect what participants said, in their own words, about navigating maternal care as Medicaid beneficiaries in Washington, D.C. They are not statistically representative of all DC Medicaid beneficiaries, and they should not be read as estimates of how commonly any given experience occurs across the population. Their purpose is to offer depth and specificity that survey data cannot provide and to surface the kinds of design, practice, and policy questions that quantitative measures alone are unlikely to raise.

Focus groups are by nature small. Individual groups in this study included between three and ten participants, and some discussions were shaped substantially by the accounts of a few highly engaged participants. Where a finding rests on a single account or a small number of similar accounts, it is presented as illustrative rather than as evidence of a widespread pattern. Throughout the findings, language such as "several participants," "across multiple groups," and "in one case" is used deliberately to signal the weight of evidence behind each observation. Readers should attend to that language when assessing the strength of individual findings.

Several findings are specific to particular subgroups and should not be generalized across all participants or all care settings. The positive clinical care accounts that appear across the prenatal groups, in particular, were concentrated among participants connected to community health settings. These accounts describe what care can look like when delivered by midwife-led teams in community-based models, and they are meaningful as examples of promising practice. They are not representative of the experience of every DC Medicaid beneficiary accessing prenatal care. Findings from the fathers and non-birthing caregiver groups should similarly be interpreted within their context. Both the English-speaking and Spanish-speaking fathers groups contributed to this report, and comparisons between the two are made cautiously throughout. The groups were conducted at different points in time and with participants at different stages of the perinatal experience, which limits direct comparison.

Some findings related to resource availability, particularly the accounts of defunded programs, defunct resource lists, and organizations that no longer accepted referrals, reflect conditions that were present at the time of data collection in early to mid-2026. The resource landscape in Washington, D.C. has been changing, and some programs mentioned by participants as unavailable may have since been restored, restructured, or replaced. Conversely, programs described as available at the time of the sessions may have since lost funding or capacity. The findings on resource availability should be understood as reflecting a moment in time and verified against current program status before being used for referral or planning purposes.

None of these considerations diminish the value of what participants shared. The consistency of certain patterns across twelve groups, two language communities, multiple care contexts, and both birthing parents and non-birthing caregivers is itself

analytically meaningful. Where the same experience, barrier, or concern was described independently by participants who had no contact with one another and were served by different providers and systems, that convergence points toward structural features of the care environment rather than individual circumstances. The findings are offered in that spirit: not as a census of experience, but as a grounded account of what the current system asks of the people it serves, and where it falls short of what they need.

VII. Conclusion

Across twelve focus groups and two language communities, a consistent picture emerged. Participants did not ask for perfect care. They asked for care that felt like care: providers who listened, systems that communicated, information they could use, and support that was actually there when they called for it. The experiences that participants described as most meaningful -- a midwife who kept track of missed appointments and followed up, a caseworker who stayed on a problem until it was resolved, a group of other mothers who understood what they were going through -- were not complicated to describe. What made them exceptional was simply that they were not common enough.

The greatest gaps in care appeared not during routine appointments but at the places where participants had to move across systems, transitions between plans or providers, referrals that did not follow through, the days after delivery when a newborn needed enrollment and a mother needed recovery at the same time. They appeared when information was absent, inaccurate, or delivered only to the birthing parent and not the household. They appeared when complications required coordination that the system was not equipped to provide, and when mental health challenges arrived in a postpartum period that the formal support structure had already abandoned. The participants who navigated these moments did so largely on their own, carrying a burden the system should have shared.

The TMaH model offers a genuine opportunity to address what participants described. Not by adding programs to a system that is already asking too much of the people it serves, but by redesigning the conditions under which care is delivered: building continuity into provider relationships, streamlining the administrative transitions that fall on patients at the worst moments, extending mental health support beyond the first weeks of the postpartum period, preparing families rather than only birthing parents, and treating language access and respectful treatment as patient safety requirements rather than service enhancements. The non-clinical supports participants described, including housing navigation, meal delivery, transportation, peer community, and case management, should be treated as part of that redesign, as integral components of the care model rather than as supplemental resources available only to those who happen to find them.

The participants in this study were generous with their time and candid about their experiences. They described care that fell short and care that was deeply supportive. They also named, often with striking clarity, what would have made care feel more respectful, coordinated, and complete. The work ahead is to take that clarity seriously. TMaH offers an opportunity to do that by using participant experience to strengthen not only access to care, but the relationships, supports, and follow-through that make care work in real life.

Appendix. Themes by Subgroup

Table A1. Prenatal

Theme #	Theme Title	Description	Illustrative Quotes
1	Getting into care was possible, but not equally easy for everyone	Most women were able to find prenatal care, but how quickly and easily that happened depended heavily on whether they already had a clinic relationship, had been through pregnancy before, or knew where to look. Women with prior connections moved through entry with little friction. First-time mothers, those navigating an unfamiliar system, or those reaching out during disruptions like snowstorms described significantly more uncertainty. High-risk cases added another layer, with some waiting months for a specialist appointment while their clinic continued to see them in the meantime.	"I called Monday and by Wednesday I had the appointment. They said, 'We have this date at this time. Would you like it?' I said yes, of course. It didn't take long at all. Because my two daughters have been seen there before, at that same clinic. Maybe that's why it was fast for me." (Spanish-speaking participant) "Since it's my first pregnancy, I was scared. I tried calling Monday, but no one answered because of the snow. I've seen things like embryos not implanting in the uterus. So, I told my boyfriend to take me to the ER so they could at least do an ultrasound and confirm everything was okay." (Spanish-speaking participant) "Some of them weren't really helpful with giving me other resources or they were like, 'Okay, it is what it is type thing.'" (English-speaking participant)
2	Insurance confusion was a constant background burden	Across both English and Spanish-speaking groups, Medicaid was part of nearly every conversation about care, and it was rarely straightforward. Plan changes happened without explanation. Benefits were tied to pregnancy timelines that providers did not	"For me, I don't know if it fully covers the birth or if we have to pay a percentage." (Spanish-speaking participant) "At the beginning of my pregnancy, they took my insurance away but gave me another one. I assume it covers the birth, but I'm not sure. No

Theme #	Theme Title	Description	Illustrative Quotes
		communicate clearly. Women found out about coverage lapses at pharmacies or at the front desk of clinics rather than in advance. Spanish-speaking participants more often described quiet uncertainty, not knowing what their plan covered but continuing on trust. English-speaking participants more often described frustration with processes that felt arbitrary and required constant monitoring to navigate.	one helps me understand it." (Spanish-speaking participant) "They don't specify certain things. Certain things that they offer, it'd be like, oh, this is only while you're pregnant, or this is only while the baby's one month, two months, three months. Sometimes you find out until it's too late, literally too late." (English-speaking participant)
3	Relational care was the primary measure of quality	Across all three groups, women evaluated the quality of their care first through the quality of how they were treated as people. Being greeted, listened to, and given time mattered as much as the clinical content of the visit. Spanish-speaking participants were especially consistent in describing interpersonal treatment as the central measure of a good provider. English-speaking participants more often framed relational quality in terms of whether providers took them seriously and respected their stated concerns and boundaries. In both cases, when that relational standard was not met, women noticed and responded, either by speaking up, switching providers, or disengaging.	"That they're kind, that they greet you, that they look you in the eyes, that they listen and take time with you." (Spanish-speaking participant) "I'm one of those people who respects others to get respect. But especially when it comes to my body, if I go to someone to attend to me, it's because I need their opinion, not for them to come and tell me what to do without respect. If they don't speak to me respectfully, I leave. If I have to file a complaint, I will." (Spanish-speaking participant) "They kept asking me, 'Are you sure this is your first pregnancy? You never had an abortion or nothing?' I'm like, no. It was very offending." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
			"Without community help, I probably would've never even known some of the options to do some of the things even existed." (English-speaking participant)
4	Cultural context and provider trust were intertwined	Trust in providers was not only about clinical skill. For Spanish-speaking participants in particular, it was shaped by cultural expectations around professionalism, warmth, and gender. Several described discomfort with male providers that was specific to this context, noting that the same would not have bothered them at home. This was not a universal position within the group: others described moving past the question once they were in labor. What the variation revealed was that trust is built through cues that are culturally shaped, and that those cues are not always present in U.S. clinical settings.	"In my country, my gynecologist is a man, and I feel completely comfortable with him. But here, I don't feel the same. I don't feel that trust." (Spanish-speaking participant) "Here there's something. They don't give you that confidence or security. Instead of feeling trust, you feel embarrassment and even fear." (Spanish-speaking participant)
5	Midwives were associated with more time, communication, and confidence	Midwives stood out across both language groups as providers who offered more explanation, more reassurance, and more of a sense that the patient's preferences shaped what happened. Spanish-speaking participants described midwives as taking time, giving details, and helping them feel calm during uncertain moments. English-speaking participants described midwives as providers who held the birth plan and could protect it when hospital staff made	"The midwife gives you more confidence. She talks to you more and explains things better." (Spanish-speaking participant) "The midwife gave me more confidence and told me it was better to try for a natural birth and that only if the baby were very, very big would I need a C-section. She assured me that natural was better because the baby wasn't that

Theme #	Theme Title	Description	Illustrative Quotes
		different assumptions. Doulas, by contrast, were almost entirely unfamiliar to Spanish-speaking participants and were not consistently offered or explained to English-speaking participants, representing a gap in how support roles reach the people who could benefit from them.	big. So, I felt confident." (Spanish-speaking participant) "A midwife is always good because they have to go off of your midwife's plan. They can't just do whatever to you or give you whatever type of medication and things like that." (English-speaking participant)
6	Information gaps about birth and the care system left women navigating uncertainty	Even when women were engaged in prenatal care, key information was often missing. What to expect during labor and delivery, how to understand insurance coverage, what services existed and when they applied: these were things women more often learned through informal networks, prior experience, or their own searching than from providers. Spanish-speaking participants more often described uncertainty and reliance on trust. English-speaking participants more often described frustration at discovering resources too late. First-time mothers in both groups were at a consistent disadvantage, with no prior experience and no informal network to fill the gaps providers left.	"They don't say much to me because it's automatic when the moment of birth comes. They can say it will be normal, but complications can arise and everything changes." (Spanish-speaking participant) "They don't specify certain things. Certain things that they offer, it'd be like, oh, this is only while you're pregnant, or this is only while the baby's one month, two months, three months. Sometimes you find out until it's too late, literally too late." (English-speaking participant)
7	Social needs were visible but rarely addressed within prenatal care	Women across all three groups were managing housing instability, financial stress, food access challenges, and other practical pressures alongside their pregnancies. These needs came up in conversations but were rarely addressed	"Things that they promised would happen never happened, real life never happened." (English-speaking participant) "The 12 weeks of maternity leave are not paid, and that has me worried about housing

Theme #	Theme Title	Description	Illustrative Quotes
		during clinical visits. Spanish-speaking participants described asking clinic staff about housing resources and being told they did not know. English-speaking participants described promises that never materialized and programs that were available but never mentioned until it was too late. WIC and food assistance programs were valued when they worked, but logistical frustrations, including checkout errors and recertification cycles, created additional friction.	because I'm a single mother." (Spanish-speaking participant) "I asked if they could help me with housing, and they said they didn't know about those resources." (Spanish-speaking participant)
8	Mental health was checked inconsistently and follow-through was rare	Mental health came up as a topic across all three groups, but the depth and consistency of that engagement varied considerably. Women at community health centers with established provider relationships described mental health conversations that felt genuine and ongoing. Women at larger facilities or with rotating providers described screening that happened once and was not revisited. Spanish-speaking participants described emotional difficulties around isolation, homesickness, and fear that often went unaddressed, not because they were not present but because the environment did not feel safe enough to share them in, or because they did not recognize what they were experiencing as something they could ask for help with.	"Me being a sensitive person, I'm really scared that I might get more sensitive than what I am already. And not having somebody to talk about it, you might go really, really depressed." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
9	Telehealth was acceptable for routine visits; home visiting drew genuine interest	Responses to alternative care models were practical rather than ideological. English-speaking participants were more open to telehealth for routine check-ins, particularly when in-person visits were brief and logistically demanding to attend. Spanish-speaking participants consistently preferred in-person care and were skeptical of virtual visits. Home visiting drew interest across both groups, particularly among women who were isolated, had transportation challenges, or felt more comfortable in their own settings. The appeal was less about the format and more about the idea of someone coming to them, meeting them where they were, rather than requiring them to manage the logistics of getting somewhere else.	"The appointments be so quick, I'd rather them be telehealth." (English-speaking participant) "I don't like virtual appointments. It doesn't feel like a real medical appointment. They don't check you." (Spanish-speaking participant) "That's very good, especially with snowstorms, it's hard to go to the clinic." (Spanish-speaking participant) "There are women who would really benefit from that because they don't have family here." (Spanish-speaking participant)

Table A2. Fathers and Non-Birthing Partners

Theme #	Theme Title	Description	Illustrative Quotes
1	Becoming a father was a profound emotional shift, often navigated without guidance	Across both groups, men described fatherhood as one of the most significant transformations of their lives. The moment of birth, in particular, carried enormous emotional weight: a mix of fear, wonder, and a sense of responsibility that did not fade. For Spanish-speaking fathers, this shift was often described in terms of a complete reorientation of priorities. For English-speaking fathers, it came through in visceral accounts of labor and delivery, the stress of being present, the difficulty of holding themselves together while watching their partners go through something intense. What neither group described receiving was any structured preparation for what that experience would actually feel like, or any support for processing it afterward.	"At the beginning, I felt very nervous. I didn't know what to do. But after my daughter was born, I felt something incredible. I didn't think I would have the strength to witness that. I felt a different kind of love that I had never felt before. I saw someone come out of the womb, and I felt very happy. And to this day, I feel like my way of thinking and living keeps changing. I no longer think only about myself; I think about my family, about how to take care of my baby." (Spanish-speaking participant) "The two natural ones, I feel like it was a little bit smoother than the C-section one because the cutting and the process... that was a crazy experience." (English-speaking participant) "It was something different for me. It was my first time experiencing it. So, it took me for a loop, but it was beautiful." (English-speaking participant)
2	Fathers understood their support role as active and practical, and took it seriously	Men in both groups described their role during pregnancy not as passive presence but as active support: managing the household, responding to their partner's emotional shifts, attending appointments when possible, and taking on whatever daily tasks needed to happen. Spanish-	"For me, the most important role is being attentive. Always being attentive when my wife needs something. Especially emotionally. A pregnant woman is very different. Their emotions change in a drastic way. As a man, you have to know how to speak to your partner, know when to say things, and

Theme #	Theme Title	Description	Illustrative Quotes
		speaking fathers described this in particularly concrete terms: staying calm, giving space, going out of their way to fulfill cravings, and adjusting their own behavior to protect their partner's stability. English-speaking fathers described a similar sense of responsibility, including ensuring their partners got to appointments, tracking what was happening, and being prepared for whatever might come. The investment was real, consistent, and largely invisible to the care system.	up to what point. It's about understanding her." (Spanish-speaking participant) "I had to park and walk two blocks to get the mangoes. And in the end, she only ate one mango." (Spanish-speaking participant) "Wake up early, get her to the appointments, make sure she's on the appointments on time, everything, man." (English-speaking participant)
3	Inclusion in care was uneven and often faded after delivery	Some fathers described being actively involved: included in conversations, shown how to care for a newborn, invited to cut the umbilical cord, and treated as a legitimate part of the care team. Others described a much more marginal experience, particularly when work schedules prevented them from attending appointments or when providers directed all communication toward the mother. Even men who felt well-included during labor and delivery noted that the attention they received from the care system narrowed significantly in the postpartum period. The delivery room was often where fathers felt most visible. What came after was far less	"They involved me a lot. They let me watch the birth, cut the umbilical cord. They explained how to care for her. Even though the focus is the mother and baby, they involved me a lot and didn't leave me out." (Spanish-speaking participant) "Initially I felt heavily involved and things of that nature. Coming out of the hospital, I feel like the doctors and stuff put a heavy responsibility on the father. But as time went on, things dimmed down. They started to kick you out of the picture. I stopped getting as much information as I wanted to." (English-speaking participant) "I showed my ID and the insurance information and everything, but she still said the mother had to come.

Theme #	Theme Title	Description	Illustrative Quotes
		consistent. Spanish-speaking fathers more often described being left out of clinical conversations from the start. English-speaking fathers more often described an initial sense of inclusion that faded over time.	I didn't make a big issue of it, but I felt bad because I'm the father." (Spanish-speaking participant) "Kept me in the loop with everything. Didn't hold nothing back. And if I was doing something wrong as a father or made a mistake, they were teaching me and learning and I loved going through the sessions." (English-speaking participant)
4	Information for fathers was consistently limited and rarely proactively offered	Across both groups, fathers described a care system that directed nearly all of its explanations toward the mother and assumed that whatever she understood would reach the father through her. In practice, this left men with significant gaps. Spanish-speaking fathers were especially direct about this: they described not knowing what to do in an emergency, not understanding key aspects of the pregnancy, and feeling that direct guidance addressed to them would have made a real difference. Men in both groups filled these gaps independently, through online searches, videos, family knowledge, and in some cases AI tools. The information was available but accessing it required personal initiative rather than being part of standard care.	"In my case, during the pregnancy I think I was missing information. They mostly focus on her and tell her what to do. But I think it would also be important to give more information directly to us. How to act if something happens, what to do in an emergency." (Spanish-speaking participant) "They give you paperwork where everything is written, but I don't remember someone explaining it verbally to me." (Spanish-speaking participant) "After waiting so many years, I started researching before the baby was born. Researching and researching. So, when the time came, it wasn't that difficult because I'm the kind of person who learns quickly when I focus on something." (Spanish-speaking participant) "TikTok, Google, and YouTube was my favorite thing that I watched for a whole nine months straight in case anything happened." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
			"She wanted me very loaded with all that information I could get. She was the one sitting there asking about this, telling me to ask rather than her asking, knowing the answer already. Just showing me just in case it came a time where I had to take my son to the doctor by myself." (English-speaking participant)
5	The postpartum period brought real demands that fathers managed largely alone	Sleep deprivation, emotional strain, physical exhaustion, and the difficulty of balancing work with a newborn's unpredictable schedule came up immediately in both groups as the defining features of the postpartum period. Several men also described the emotional impact of watching their baby or partner go through painful or frightening experiences, including blood draws, NICU stays, and complications. These were not small moments. They described them as things that stayed with them. Yet neither group received any structured support for their own experience of the postpartum period. They managed it the way they had learned to manage most things: by figuring it out.	"The hardest thing is the lack of sleep. Babies don't have schedules. You go to sleep and then they wake up again at two, then at four. In the end you go to work exhausted, especially if you start very early." (Spanish-speaking participant) "They were drawing blood from her little foot, from her hand. With my first daughter, it was very difficult for me to see her go through that. Obviously, it hurt her, and it hurt me to see it." (Spanish-speaking participant) "You go to work having slept maybe three or four hours and knowing the next day will be the same. That's the hardest part." (Spanish-speaking participant) "Sleeping, getting sleep." (English-speaking participant) "The most challenging thing was just keeping up with building a new regimen, scheduling, appointments, just making sure you're beating everything to the punch." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
6	Mental health support for fathers was nearly absent	When asked directly whether anyone from the care system had addressed their emotional wellbeing or mental health, nearly every man in both groups said no. This included fathers who had witnessed serious pregnancy complications, emergency deliveries, and NICU stays. The one clear exception was a Spanish-speaking father who was connected to a peer support group for first-time fathers through the hospital, and who described that experience as genuinely helpful. That exception stood out because it was so rare. In the English-speaking group, the absence of mental health support was named directly and responded to with immediate recognition. When asked what services would have helped, men described counseling, family development programs, and the simple acknowledgment that the postpartum period was difficult for them too.	"In my case, no. They didn't say anything to me." (Spanish-speaking participant) "We deal with it the way that we had to deal with it." (English-speaking participant) "Mental health is real, man. We got to continue to find time for ourselves. We give so much time, we give so much energy, we give so much effort that we forget ourselves. Just finding something that you love to do. If we got 365 days out the year, at least five of those days got to be just for us." (English-speaking participant) "They gave me information about a group for first-time fathers. I went to several of their meetings. I went a couple of times, and honestly it helped. It was pretty good." (Spanish-speaking participant) "No, no, no, no. And I went through that, man." (English-speaking participant, in response to being asked whether anyone had discussed postpartum depression with him) "Some family development classes, man. Classes where they teach strong family development environments and how to create the environment. Give us more opportunities. Give us more tools." (English-speaking participant)
7	Awareness of doulas and alternative care	Doulas were unfamiliar to most men in both groups. In the Spanish-speaking group, nearly no one had heard the	"I think they're good because sometimes couples don't have much family around. Those people can help by talking with the mother, having

Theme #	Theme Title	Description	Illustrative Quotes
	roles was limited, but interest was real	term before it was introduced. When explained, interest was genuine and shaped by practical concerns: who would be there when they could not be, who could check in on their partner, who could fill the gaps created by work schedules and limited leave. One father who had had a doula through his partner's prenatal care described a positive relationship that functioned like ongoing emotional support. An English-speaking father described a more complicated experience, noting that he had not been involved in choosing the doula and sometimes felt excluded from the support structure she represented. Taken together, these accounts suggest that doulas could play a meaningful role for partners, but that how they are introduced and integrated into care matters for whether fathers feel included or further sidelined.	conversations, checking in on how she feels." (Spanish-speaking participant) "Sometimes they need help, and because of work you can't always be there. So, it's something good." (Spanish-speaking participant) "She said she would come to the hospital, but when the birth happened, she didn't show up." (Spanish-speaking participant) "It was a little aside, because I never experienced that one the first child. Second child, it was all right, because she was there to help my wife in case, I couldn't be there in case I had to go to work or do something else. She was there to support through the appointments." (English-speaking participant) "I wasn't involved in that process. I just seen the process and it was just there." (English-speaking participant)
8	Home visiting and telehealth drew mixed responses shaped by trust and circumstance	Both groups engaged thoughtfully with questions about alternative care models, but their responses differed in texture. English-speaking fathers described reservations about home visiting rooted in privacy and a preference for going to the clinic. Spanish-speaking fathers were more	"I think it would be excellent. If my wife were pregnant and called me at work saying she didn't feel well, and I couldn't leave because I was far away, it would be excellent if a nurse could go to her." (Spanish-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		ambivalent: some saw real value, particularly for situations where their partner was home alone and they were at work and could not leave. On telehealth, Spanish-speaking fathers who worked from home described seeing practical benefit in video appointments that could be joined quickly. English-speaking fathers were more skeptical, describing a preference for in-person care where they felt taken more seriously. Across both groups, the underlying preference was for care that felt direct, continuous, and built on relationship rather than transaction.	"It would be good because many people don't have transportation. It would make things easier for those families." (Spanish-speaking participant) "If I can go to the hospital, I would prefer to go to a health center." (Spanish-speaking participant) "That's a no-no. You don't have to come visit me. I'll come visit you if we need you." (English-speaking participant) "It wasn't too helpful. I'd rather get up and been going there and talking to them face-to-face rather than that over the phone." (English-speaking participant) "When you in their face, they kind of bring themselves down to the level that you want to give a different understanding. When you're doing things over the phone, you don't get the response that you really need." (English-speaking participant)

Table A3. Postpartum

Theme #	Theme Title	Description	Illustrative Quotes
1	Continuity with a trusted provider shaped the entire postpartum experience	Women who carried an established relationship with a provider into the postpartum period described that continuity as foundational. It shaped how they felt at appointments, how willing they were to disclose concerns, and how supported they felt overall. The contrast with fragmented or unfamiliar care was sharp. Many described delivery rooms populated by rotating staff they had never met, shift changes mid-labor, and in some cases being taken to hospitals they had not chosen. Spanish-speaking participants more often described trust built through attentive, ongoing contact from specific nurses or midwives. English-speaking participants more often described what it cost them when that continuity broke down at a key moment. In both cases, when a known provider showed up, it made a difference that was immediately felt.	"She was always looking out for me. Every time I arrived, she always made me feel good. She would always say, 'I'm going to check the baby's little heartbeat.' She would talk with me and always check my stomach. And I felt that... that's how midwives are." (Spanish-speaking participant) "She's the best. She's very understanding and she's a great listener. She doesn't force anything that you don't want to do or that you're not comfortable with. And even if you're not comfortable with getting a certain service or particular thing done, she will give you time to adjust to that. So, she's all about communicating." (English-speaking participant) "It was so many coming in and out. You don't know who you were talking to." (English-speaking participant)
2	Midwives offered a different kind of care that women valued and sought out	Midwives came up across all three groups as providers who communicated more, protected patient preferences more consistently, and stayed more present through the birth and postpartum process. English-speaking participants described midwives as a form of structural protection: because everything went through the midwife's plan, providers could	"Certain doctors and hospitals, they just do what they want. They don't have a plan. They don't know your pregnancy plan or your background history. So, a midwife is always good because they have to go off of your midwife's plan. They can't just do whatever to you or give you whatever type of medication and things like that." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		not simply impose interventions without her knowledge. Spanish-speaking participants connected midwife care to cultural familiarity, some having experienced home births with midwives in their countries of origin. What they described in U.S. clinical settings was a version of that role, though one they had to discover and advocate for themselves. In both cases, the value of a midwife was less about a particular set of clinical skills and more about having someone who already knew them, already held their plan, and was there when it mattered.	"She was a doctor, but she was also a midwife. When I had medical problems in the middle of my pregnancy, she stepped up more and gave me more plans. She was the one who handled all of that for me." (Spanish-speaking participant)
3	Doulas were rarely available and their effectiveness depended heavily on presence and integration	Doulas were largely unknown to Spanish-speaking participants before the moderator introduced the concept. In the English-speaking groups, use was limited and experience was uneven. Women who had wanted a doula described specific expectations: someone who would be present during labor, who knew their plan, and who could speak to providers on their behalf when they were in pain and unable to advocate for themselves. In some cases, the doula did not arrive in time, or their role was not coordinated with the care team in a way that made advocacy possible. The gap was not really about whether doulas are valuable in principle. It was about how they are introduced, accessed, and integrated into care in	"It's so crazy because I ended up having her before she even got upstairs. I texted her and let her know I was upset. She was downstairs and said, 'Hold on for me for a second.' I put the phone down and push them out." (English-speaking participant) "I think more information needs to be given to people when they are pregnant, so we have an idea of what's coming. Just imagine, there are so many things we don't know. I didn't know almost anything that's been mentioned." (Spanish-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		practice. Women who knew about them had often found out through informal networks or specific programs, not through providers.	
4	Insurance and administrative problems disrupted care at its most critical moments	The postpartum period was where administrative failures had their sharpest consequences. One woman arrived at her six-week appointment and was turned away because of an insurance error she had not caused. She had to resolve the problem herself before care could resume, and no one reached out in the interim. Spanish-speaking participants described a quieter version of the same problem: receiving letters saying coverage was active while being told at the clinic that it was not, leaving them uncertain about what was actually in place. For women whose physical and emotional health were both in flux, these disruptions did not just delay a single appointment. They introduced uncertainty, added workload, and sometimes meant going without care during weeks that mattered.	"They didn't reach out and check. I had to make sure everything was fixed, and then I set the appointment up myself. But as far as them, they were like, 'Oh, well, your insurance stuff is not fixed, so we're not going to see you.'" (English-speaking participant) "I would get letters at my house saying my insurance was active, but when I went there, they told me it wasn't active." (Spanish-speaking participant) "I keep receiving mail talking about maybe the coverage was denied or something like that. I'm not sure. I don't know what it means." (English-speaking participant)
5	Practical support after birth made a concrete difference, but reached	When postpartum support was coordinated and present, women described it in concrete terms: someone came to the house, helped with the baby, made it possible to eat and rest.	"They came out to check on the baby. Even though I didn't need it because I have a supportive partner, they'll come and stay at your house and help you with the baby so that you can be able to eat and get some rest and stuff

Theme #	Theme Title	Description	Illustrative Quotes
	too few women too inconsistently	Postpartum support programs were described with genuine warmth by participants who had accessed them. Spanish-speaking participants described similar appreciation for support that extended beyond the clinic visit, including home nursing visits, transportation assistance, and coordinated check-in calls from insurance navigators. What these experiences shared was that support arrived where women actually were, rather than waiting for them to seek it out. The problem was that these experiences were not common. Many women had never heard of these programs until well into their fourth or fifth pregnancy, or not at all, and had navigated earlier postpartum periods without them.	like that. And during my pregnancy, they came out and cooked for me and was being that extra support outside of my support that I already had in home." (English-speaking participant) "The nurses came by and gave me a lot of information, a lot of documents. Phone numbers I could call for nurses who weren't from the clinic where I was seen. They also called me on behalf of the insurance; they would call me offering nurses and asking if I needed them to come take care of me here at home. Or if I had an emergency, they gave me numbers I could call where they could come pick me up. And if I didn't have transportation for my clinic appointments, they also provided transportation for me." (Spanish-speaking participant) "They need to announce that out loud a little bit more. You'll find things out unless you go to the doctor and stuff like that. I didn't hear about [the program] until my fourth pregnancy ended." (English-speaking participant)
6	Transportation and childcare barriers made attending appointments harder than it should have been	Getting to postpartum appointments required navigating a set of logistical obstacles that were rarely acknowledged by the care system. Transportation through insurance was available for some, but the process of arranging it involved conflicting information, representatives who gave incorrect guidance, and the occasional no-show. For women with other	"They would tell you those extra kids... I don't think they care about the story, about you, about them being out of school. They say no kids or you reschedule." (English-speaking participant) "Some of the representatives like, 'Oh, we can't do that.' And I would be like, 'Yes, you can.' It literally says you have to give them a 72-hour notice or 24-hour notice, but they also do same-

Theme #	Theme Title	Description	Illustrative Quotes
		children, clinic policies that did not allow children to accompany their mothers created an impossible situation: no childcare, no appointment, and rescheduled slots that were weeks out. These were not marginal inconveniences. For a woman in the early postpartum weeks, managing these barriers while recovering physically and adjusting emotionally was simply too much. Participants who had worked out the system described doing so through repeated experience, not because anyone had explained it to them.	day appointments." (English-speaking participant)
7	Mental health screening happened, but follow-through was uneven and often fell short	Mental health questions were asked across all three groups but asking the question and actually supporting someone through what came up were not the same thing. English-speaking participants described screening that felt routine and scripted, where a negative answer ended the inquiry. When referrals were offered, they did not always match what women actually needed. Spanish-speaking participants described emotional difficulty that was real and significant, including isolation, depression, and sustained distress, but also described reasons they had not disclosed it: not wanting the intrusion of support they did not trust, not having language for what they were experiencing, and not being sure the	"They just ask the questions. If you tell them no, then that's what it is. Don't follow up much deeper than that unless you, I guess, give them a reason. You let them know." (English-speaking participant) "I had to deal with my mental health on my own because I mean, they gave me different places and stuff, but you know what I'm saying? They didn't point me in a direction I wanted it to go in." (English-speaking participant) "I didn't even want to talk to anyone or see anyone. I wouldn't go out, and sometimes if I was in a meeting, I would just start crying. If I heard music, I'd just cry. I couldn't be around

Theme #	Theme Title	Description	Illustrative Quotes
		system would respond in a way that felt helpful. When mental health support was genuine and connected to ongoing care, it made a difference that women described clearly. When it was not, the burden of finding something adequate fell to them.	people. I just couldn't. That's why I didn't agree with it." (Spanish-speaking participant) "They set me up with someone so I could express myself, and yes, it helped me a lot." (Spanish-speaking participant)
8	Food and nutrition programs were valued but created their own frustrations	WIC was used across all three groups, and participants were genuinely grateful for it. But gratitude and frustration coexisted. Benefits that participants expected to increase after giving birth were sometimes reduced, without explanation. Breastfeeding mothers described receiving less support than they felt they needed, and discovering this only after their baby was not gaining weight as expected. The recertification process required regular re-engagement with a bureaucratic process even when nothing had changed, and in-person recertification requirements were a burden for women managing newborns and other children. These were programs that worked in principle and created avoidable friction in practice, at a time when women had very little capacity to absorb it.	"When I gave birth, they instead removed or reduced some of those benefits. The only thing that was increased was the fruits and veggies. But things like the juice, it got reduced to one yogurt. I don't even get any other stuff I usually get. And with the fact that I wasn't even getting formula because I exclusively breastfed, so I felt like I was supposed to get more." (English-speaking participant) "I eventually be like, 'Man, forget that.' But then I'm like, 'Dang, I need it.' But it would just be so annoying." (English-speaking participant)
9	Home visiting drew strong interest; telehealth was practical	Home visiting programs resonated strongly across all three groups. The appeal was consistent: support that came to women rather than requiring them to navigate logistics, childcare, and	"In those moments right after having a baby, you're left alone at home. The husband goes to work; the kids go to school. Sometimes you feel lonely, and if, say, a young woman came to the house, you could talk with them. For me, it

Theme #	Theme Title	Description	Illustrative Quotes
	for some and insufficient for others	transportation during one of the most physically and emotionally demanding periods of their lives. Women described the loneliness of the early postpartum weeks, the practical impossibility of leaving the house, and the value of simply having someone present. Telehealth drew more varied responses. English-speaking participants were divided: some found virtual visits convenient for routine check-ins when the baby was sleeping; others felt they did not substitute for in-person care. Spanish-speaking participants were largely unfamiliar with telehealth but expressed openness once it was explained, particularly for situations were reaching a provider quickly mattered but going in was not realistic.	would have been nice." (Spanish-speaking participant) "That would be a big help. And that could help with people's postpartum depression a lot too, because they feel like they can move around, they can get some stuff done without being tied to the baby." (English-speaking participant) "I think the convenience that comes with it, because sometimes the baby might be sleeping or you have things to do. So, the convenience that comes with it while your baby is sleeping, you can be on the phone, getting your appointment." (English-speaking participant)

Table A4. Subsequent Pregnancy

Note. This group was conducted with English-speaking participants only.

Theme #	Theme Title	Description	Illustrative Quotes
1	Experience made pregnancy more familiar, but not necessarily easier	Women entering a subsequent pregnancy described a shift in how they approached the process: less uncertainty, a better sense of what to expect, and in some cases a more positive outlook than they had with earlier pregnancies. Some described genuine excitement about starting over, especially when older children could share in the experience. At the same time, familiarity did not reduce the load. Women managing multiple children under age seven described the physical and emotional demands of this pregnancy as heavier, not lighter. Each pregnancy also felt physically distinct, with some women experiencing more nausea, more swelling, or different symptoms than before. The accumulated weight of experience and responsibility made subsequent pregnancy more complex, even when it was also more anticipated.	"More nesting and actually looking forward to having the baby instead of dreading and running around with my head cut off. It's been a lot better this time. More positive outlook and more happiness. Looking forward to it. Maybe because this is the last baby I'm ever having." "Having three other children that are younger than the ages of seven, it's a little difficult. I've just been working to keep my mind off prep, but it's in the back of my mind." "It feels regular to me. Maybe I done already went through this process before, but it feels like a regular appointment to me, honestly. Now it's just like I'm four or five kids in, so it's kind of like I'm used to routine."
2	Women sought care early but faced longer waits than in previous pregnancies	Most participants moved quickly to schedule their first prenatal appointment, often because prior complications, including ectopic pregnancies and preeclampsia, made early care feel urgent. What they encountered was a system that could not match that urgency. Wait times	"I made my appointment right away because in 2021, I had an ectopic pregnancy and that was my main concern. But the appointment took long to get, it took so long, I was like, oh my God. They were telling me if I don't get an appointment soon, just go to the ER."

Theme #	Theme Title	Description	Illustrative Quotes
		of two months for a first appointment were described as the norm, not the exception, and they applied across multiple providers. Unity, MedStar, and Planned Parenthood were all mentioned as fully booked. One participant managed to get an earlier slot only because another patient's cancellation opened up. For women who understood the importance of early prenatal care from personal experience, being told to wait or to go to the ER if symptoms worsened was both frustrating and alarming. This was a noticeable shift from what previous pregnancies had felt like.	"Normally when I would call to make the appointments, it is always smooth, but this time around, it just seemed like everything is so long. I tried with [one provider], I tried with [a second provider], and then I just ended up switching to [a third provider]." "If it was more places that accept Medicaid, that would've been a whole lot easier for prenatal care. A lot of places stopped taking DC Medicaid, so it was just so hard."
3	Medicaid processes created delays and disruptions that were difficult to manage	Navigating Medicaid was a recurring burden that created real disruptions in care. For some, the challenge was the 45-day approval wait when signing up for coverage during pregnancy. For others, it was the recertification process, which felt identical to reapplying from scratch and could result in being switched to a different plan or a different doctor without warning. One participant described having to call DHS every day and escalate to supervisors just to get her coverage reinstated. Another described missing a deadline to change her plan because she had not yet received her approval notification in time to act on it. Even women with stable coverage described the cognitive and logistical demands of staying ahead of a	"When I recertify, it's like you're reapplying all over again. They tell you have to wait up to 45 days, and sometimes they switch your insurance or switch your doctor. It's diabolical. Renewing is the same as applying." "You have to really be ahead of them. You have to really call every day to see if they even checked it or seen it or on your application. It's always something." "Having to wait the 45 days, it's like where they're like, well, do you have any insurance? And I'm like, not yet. And you don't even know if you're being approved for the Medicaid or not. You just know that you put in the application. So, it was really frustrating."

Theme #	Theme Title	Description	Illustrative Quotes
		system that required constant monitoring to function.	
4	Insurance changes forced women to rebuild relationships with new providers	Several participants had established trusted relationships with providers who had delivered previous children, and those relationships were severed when insurance changes made their doctors unavailable. Losing a provider who had delivered multiple babies was not experienced as a logistical inconvenience. It required starting over on trust, in a context where trust took time to build and mattered a great deal. At the same time, some participants described finding care that felt even better after switching, particularly when a new provider was more communicative, more direct, and more attentive to their full history. Whether the change resulted in a better or worse experience, it was a disruption women had not chosen and could not always anticipate or control.	"I've always gone to this doctor. He's delivered my last two to three babies. So, trying to go back and they're not accepting the insurance, now I have to try to build this trust and relationship with someone else who may not even care." "I had the same midwives, the same team, the same doctors. They like, 'Oh hey, it's been a long time.' Yep, I'm back." "This doctor, he pays more attention. If I miss an appointment, he will send a note in the portal quick. And he makes sure I get a sonogram every time I go, and it's a lot better."
5	Prior complications changed how women were monitored and how closely they followed their own care	Women who had experienced ectopic pregnancies, preeclampsia, or other complications in previous pregnancies described heightened vigilance in this one. Several described calling their care team for anything that felt unusual, documenting every symptom, and advocating proactively rather than waiting to see if things resolved on their own. In some	"Don't let these doctors gaslight you. Especially if you know your body, speak up for yourself. Because what they do is they be trying to brush any and everybody off. That's why anything that I feel going on wrong, I'm always on the phone with the midwives."

Theme #	Theme Title	Description	Illustrative Quotes
		cases, providers responded in kind, increasing monitoring frequency, following up on missed appointments, and treating the patient's history as context that shaped every clinical decision. This attentiveness stood out as a meaningful shift from earlier experiences. However, not all women with high-risk histories described that same level of responsiveness. For some, care felt adequate only after they had actively pushed for it.	"Even if I got a headache, I call just so they can make sure it is documented." "Especially for moms who have previous kids, they be trying to gaslight us the most. I'm like, I know my body. I know what's going on."
6	Childcare, transportation, and logistical barriers made attending appointments harder than it should have been	Getting to appointments required coordinating childcare for multiple children, securing transportation, and navigating clinic policies that did not always account for the realities of parenting several kids. Clinics that prohibited young children from accompanying their mothers created an impossible situation for those without family support or reliable childcare. Transportation coverage through insurance helped but was not always dependable: rides were sometimes arranged and then did not show up, requiring rescheduling and pushing appointments further out. Women with experience in the system had developed strategies, including knowing which transportation requests could be made same-day and which could not, and timing appointments around school holidays and	"I just think mainly somebody being able to watch the kids. Sometimes everybody doesn't have family support. So, it's like, if you don't have nobody to watch them, then what are you supposed to do?" "They were saying that they were coming and they didn't show up. And then I had to reschedule my appointment. It's like you're trying to do what you're supposed to do, and then things like that happen, and now you're pushed back again." "They tell you can't bring your kids unless they're a certain age. You have to be 12 and older. So, what if you don't have childcare?"

Theme #	Theme Title	Description	Illustrative Quotes
		closures. For those without that knowledge, logistics alone could become a barrier to consistent care.	
7	Midwives provided continuity and advocacy that women sought out and valued	Midwives were consistently described as providers who offered more sustained support, listened more carefully, and functioned as a consistent point of contact when other parts of the system were harder to access. One participant described her midwife as someone she considers family, who has seen her through multiple pregnancies and remained a trusted resource even between them. Others described midwives as willing to escalate concerns to physicians when needed and more likely to catch things that could otherwise be overlooked. Doulas were largely out of reach for this group. Several participants had wanted one and been told it was not covered by their insurance. Others described costs that made private options unaffordable. The few who had accessed doula support described mixed experiences, with availability and presence at the moment of delivery being the central concern.	"I already knew my team. I already knew who I was expecting to see. And they are good for support. Always let them know what's going on. If the doctors don't listen, they will listen." "I feel like the midwives are part of my family. They gave me advice; they made sure I stay on track with my appointments. It's just overall been good." "I tried to price a doula and it was too pricey for me to even think about."
8	Mental health preparation and planning made a	Participants who had planned for mental health support ahead of delivery described a qualitatively different postpartum experience than those who had not. One participant drew a direct contrast between	"The difference now is having the extra mental health support in the background instead of depending always on the doctor. So that way if I do miss my six-week appointment, I still have a therapist or a psychiatrist or someone from the

Theme #	Theme Title	Description	Illustrative Quotes
	meaningful difference postpartum	her last postpartum period, when she struggled in isolation without formal support, and this pregnancy, where she had a therapist and psychiatric support already in place. She described this preparation as the single most important change she had made. Others described mental health screening that happened but felt routine rather than responsive, and some described being screened in a moment when they were managing well, without follow-up when things got harder. Trust in the source of a mental health recommendation also mattered: some participants described being more willing to seek help when it came from someone they knew personally rather than from a clinical checklist.	assurance people that will be able to come and help with that part." "I feel like before, I didn't really have that set up, and I probably should have. So, this time, I made sure I got that settled ahead of time, because I already know what can happen after." "Hearing it from your loved one is different than hearing it from a professional. Sometimes you feel as though professionals are always trying to push something on you."
9	Support beyond medical care was offered but not consistently communicated or accessed	Several participants described meaningful non-clinical support connected to their prenatal care: transportation, parenting classes, WIC, food programs, housing referrals, breastfeeding resources, and in some cases home visiting programs. When these were offered, they were genuinely helpful. But participants often described learning about available programs through their own networks, from other mothers in the focus group, or from community-based organizations rather than from their providers. Women who had navigated the system multiple times had accumulated	"They offer transportation, parenting classes, arts and crafts to reduce stress, numbers to call if you're depressed, WIC. They always asked if you have enough food, do you feel safe, are you going through anything dealing with domestic violence." "I feel like that's one less thing you would have to worry about. They come out with their equipment, do everything they need to do, check on you, and any questions you have, you can just let them know right then and there."

Theme #	Theme Title	Description	Illustrative Quotes
		knowledge that newer or younger mothers might not have. Home visiting programs drew consistent interest, with several participants describing the appeal of having support come to them rather than requiring them to manage the logistics of getting somewhere else. Telehealth was also viewed positively by most participants, particularly for routine check-ins when leaving the house with a newborn or young children felt difficult.	"I actually like the virtual visits, just being tired and not trying to leave the house. I think they were really helpful."

Table A5. Medically-Complex Pregnancy or Delivery

Theme #	Theme Title	Description	Illustrative Quotes
1	Complications were often not recognized, communicated, or treated early enough	Across both groups, participants described symptoms that worsened over time without being identified, explained, or acted upon. Swelling that began at five months and went untreated for weeks. Recurring headaches that were told to take aspirin. Preeclampsia diagnoses that were never communicated to the patient until after delivery. In multiple cases, complications had been documented in the chart without anyone telling the woman she had a diagnosis. The pattern was consistent: something was wrong, participants either knew it or eventually had to figure it out themselves, and the system did not respond until the situation had already become urgent. Spanish-speaking participants more often described conditions going completely unaddressed until crisis point. English-speaking participants more often described symptoms being acknowledged but minimized, leaving them to push for recognition themselves.	"I started swelling in my body starting at five months of pregnancy. I did not receive medication. I did not receive a notification where they told me you have to follow a diet. I received nothing. My delivery was complicated to the point that I almost died." (Spanish-speaking participant) "The truth is, I didn't know I had been diagnosed with pre-eclampsia. I didn't find out until after I had the baby. They called the doctor and he told me, 'Yes, you have preeclampsia.' But I tell him, 'But I didn't know.'" (Spanish-speaking participant) "My doctor never said, this is preeclampsia. They kind of brushed it off actually until I'm like, this headache is not going away. That's when I took it upon myself to call 9-1-1." (English-speaking participant)
2	Complications escalated rapidly when early warning signs were not addressed	Across both groups, what began as manageable symptoms became emergencies in a matter of hours or days because early signals were not acted upon. Women described being sent home while still visibly unwell, returning by	"They sent me home even though I was swollen all over my body. I couldn't walk. At dawn my husband called the ambulance. They came to take me out on a stretcher. I was going to have an embolism." (Spanish-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		ambulance. They described blood pressure readings of 220 that nurses had not flagged as urgent. They described laboring for three days on repeated rounds of medication before a provider stepped in and named what was obviously wrong. The moments when care finally shifted into action were often not the moments when intervention was first needed. Delays in recognition created cascading complications, some of which could have been prevented.	"When I went into labor, I felt her flip. She was head down since 22 weeks, but I felt her flip back the opposite way. They weren't taking this seriously. It took for my child's father to speak up about the bleeding I was having for them to actually check me. And they realized her heart rate was dropping." (English-speaking participant)
3	Providers did not consistently listen to patients when they reported symptoms	Whether the complication was preeclampsia, fetal positioning, an allergic reaction, or surgical injury during a C-section, a recurring experience across both groups was describing what they were feeling and not being believed. Women said they felt them cutting and were told no, that's just pressure. Women said they couldn't breathe and were told that was normal. Women said something was wrong and were asked to wait. In several cases, it was only when someone else stepped in, a doula, a partner, a different provider who happened to read the chart, that the situation was finally addressed. The phrase "they weren't taking it seriously" appeared in nearly identical terms across multiple participants and both language groups.	"When I was stating that I couldn't breathe on the table, they weren't taking it serious. It literally took for my doula to advocate on my behalf, and I ended up passing out on the table." (English-speaking participant) "No, I don't feel like I had a say, and I don't feel like they were listening to me at all." (English-speaking participant) "From the moment they started to humiliate me, I said, 'No. It's a right, I have a right to my health.' When they treated me badly and I didn't know how to speak English, I asked for an interpreter." (Spanish-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
4	Language, race, and discrimination shaped how care was received during complications	Both groups described experiencing dismissal, but it took different forms depending on language and racial context. Spanish-speaking participants described overt discrimination: rough physical handling, being spoken to harshly, comments about their age or circumstances that were inappropriate, and feeling that not speaking English meant their concerns were taken less seriously. One participant's recovery from a near-fatal complication was attributed in part to a Cuban doctor who spoke Spanish finally reading her chart and intervening. English-speaking Black participants described a pattern of being heard but not listened to, of feeling that providers performed attention without actually acting on what was said. Race was named directly as a factor in at least one account, and the pattern across the group supported what that participant described.	"There are nurses who look at you terribly. They discriminate against you. She grabbed my arm hard. My child had autism. It's too much what they do to you." (Spanish-speaking participant) "They told me, 'How do you get pregnant at your age if you know it's a risk.' Those are things that are not encouraging and that no doctor has any reason to say to any patient." (Spanish-speaking participant) "When it comes to doing surgery, it's basically all white people. They'll hear you, but with them listening, I don't think that's a choice. They try to do their best. But I feel as though when things are going on and things are going wrong; they should let us know what's going on and hear us more. The child still needs a parent." (English-speaking participant) "I need y'all to talk to me not holding that degree. It was kind of like, we're talking to you, we think you understand, but they didn't break it down for me to really understand it." (English-speaking participant)
5	Doulas played a critical advocacy role, but access was limited and presence was not guaranteed	Participants who had a doula during a complication or emergency described the doula as the person who made the difference. In one account, it was the doula who saw the participant crashing, spoke up when nurses were not responding, and invoked legal accountability in a way that	"It literally took for my doula to advocate on my behalf. When that was mentioned, it's like their whole attitude changed and they were being a lot more responsive and attentive." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		finally shifted the team's attention. In another, the doula was not permitted in the room because hospital policy restricted who could be present. In the Spanish-speaking group, one participant had been assigned a doula through her clinic, expected her to be there during delivery, and discovered she did not show up when it mattered most. Across both groups, doulas were largely unknown to women who did not already have one, and access was often determined by connection to a specific program rather than by being routinely offered.	"I had a doula. But they didn't let her in the room. They let her in for the first maybe ten minutes, because it was my child's father there and the doula. So, they both couldn't be in a room at the same time." (English-speaking participant) "The doula didn't show up. My husband called and called and messaged her. She was supposed to be with me at the hospital. And no, she never showed up." (Spanish-speaking participant) "With what took place, I wish I had one. I'm really open to it. I feel like they might've been able to advocate for me more than what actually happened." (English-speaking participant)
6	Provider continuity mattered especially when complications made care more complex	The moment when a complication emerged was often also the moment when the care team changed. Shifts ended. Vacations started. A different doctor read the chart and became the first person to say what was actually happening. Participants who had built relationships with their providers during pregnancy described those relationships as interrupted at exactly the point when they mattered most. Several described arriving for delivery with a completely different team than the one that had managed their pregnancy, and feeling the cost of that discontinuity acutely when complications	"When it was time to go back, it was a completely different team. Shifts had changed. I ended up delivering during a week where they allowed a lot of the OBs and midwives to take a little vacation. So, I ended up going to it with a completely different team." (English-speaking participant) "This doctor pays more attention. If I miss an appointment, he will send a note in the portal quick. He makes sure I get a sonogram every time I go, and it's a lot better." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
		arose and no one in the room knew their history. In contrast, participants who had established high-risk monitoring relationships with consistent providers described those experiences as more attentive, more responsive, and markedly different from earlier pregnancies.	
7	Mental health and emotional support after complications were inconsistent and often absent	The emotional aftermath of a near-fatal complication, a NICU stay, or a traumatic delivery was rarely addressed in a way that felt adequate. Spanish-speaking participants described experiencing intense distress: crying constantly, not wanting to be around people, wanting to run away. In some cases, a social worker called twice a month and offered reassurances that were not enough. In others, promises of home visits never materialized. One participant described having postpartum depression that went unvisited, even though she was told follow-up would happen. English-speaking participants described being told about counseling resources but not connected to anything that matched what they needed. The women who received support that made a difference described it as coming through specific programs or through providers who were genuinely present, not through routine clinical follow-through.	"I felt like crying, I couldn't be alone. I felt really bad. I wanted to run away. You don't know how awful I felt." (Spanish-speaking participant) "I did have postpartum depression. It always stayed pending that they were going to visit me, but nobody ever came." (Spanish-speaking participant) "For me, my baby spent six days in the NICU. I was discharged the day after my C-section. Had I known that initially, I would've never signed to be discharged, because now I'm home without my baby, and that didn't have to be the case." (English-speaking participant) "I also had a caseworker. She treated me pretty good. She checked in on me all the time, made sure I was okay." (English-speaking participant)

Theme #	Theme Title	Description	Illustrative Quotes
8	Home monitoring devices were useful when provided and explained, but were not consistently offered	Participants with blood pressure and blood sugar complications were sometimes sent home with monitoring equipment and shown how to use it and described those tools as genuinely helpful. In one account, a participant continued to monitor her blood pressure, reported consistently high readings, and was told repeatedly that she was doing it wrong, until she stopped monitoring and relied on medication alone. Others with similar conditions were not offered devices at all. The availability of home monitoring equipment was experienced as inconsistent and dependent on which provider a woman was working with, rather than as a standard component of high-risk care.	"They gave me the little blood sugar machine to check three times a day. They also gave me a notebook where I was going to be recording my sugar. Before eating, I had to write down how it came out. A nurse was in charge of talking with me and preparing me on how I was going to use them." (Spanish-speaking participant) "I would call and tell them, but they would tell me, 'No, you're doing it wrong, it's not like that.' So, I stopped doing it." (Spanish-speaking participant)
9	Self-advocacy was necessary and exhausting, but the burden fell entirely on patients	Across both groups, participants described learning to advocate for themselves as a response to systems that had not protected them. This included demanding interpreters, pushing back on dismissive diagnoses, documenting symptoms to ensure they were on record, asserting rights when being treated badly, and, in some cases, researching their own diagnoses in real time because no one had explained what was happening. Several participants described the work of self-advocacy as something they had developed out of necessity, not something that should have been required. The	"Don't let these doctors gaslight you. Especially if you know your body, speak up for yourself. Because what they do is they be trying to brush any and everybody off." "Now I have already learned to educate myself a little and to defend myself." (Spanish-speaking participant) "They thought I was a nurse by the time I finished in that hospital because I had obtained my own knowledge. I just wanted to understand what they were doing every step of the way." (English-speaking participant) "I would like them to also realize the kind of doctors and assistants they put in the job to

Theme #	Theme Title	Description	Illustrative Quotes
		burden of staying alive, in some cases literally, fell on patients who were already managing serious medical conditions.	attend to you. Because sometimes depression is killing us. And sometimes they don't listen to us either." (Spanish-speaking participant)

Table A6. SUD/Behavioral Health/Perinatal Mental Health

Note. This group was conducted with English-speaking participants only.

Theme #	Theme Title	Description	Illustrative Quotes
1	Getting prenatal care took more effort than it should have, especially for Medicaid recipients	Participants who had established clinic relationships moved through the first prenatal appointment without significant difficulty. Those who were newer to the system or had not yet built those connections encountered fully booked schedules, providers unwilling to offer alternatives, and the experience of being treated differently once Medicaid was mentioned. One participant described calling five to ten places before finding care. Others described arriving at providers and feeling that staff treated them as less deserving of attention or information because of their insurance status. First-time mothers in particular described missing benefits they never knew existed, finding out about programs and resources through word of mouth from other mothers rather than from providers or insurance companies.	"I had to call literally maybe over five to 10 places to find an appointment. When I mentioned government assisted programs, they just look at you a little funny. They act like it's coming out of their own pocket." "Without community help, I probably wouldn't ever even know some of the options to do some of the things even existed. They really do try to gatekeep certain things." "They don't specify certain things. Certain things that they offer, it'd be like, oh, this is only while you're pregnant, or this is only while the baby's one month, two months, three months. Sometimes you find out until it's too late, literally too late."
2	Medicaid coverage was confusing, inconsistently explained, and required constant management	Insurance changes happened without clear communication. Mid-pregnancy plan switches from one Medicaid insurer to another disrupted care continuity and left participants uncertain about what was still covered. Coordinating coverage for a newborn required navigating multiple	"I had AmeriHealth at first, then it ended up getting changed to WellPoint. Just because of the name change, I ended up not being able to see certain people or get certain things. It still isn't really clear to me what exactly happened."

Theme #	Theme Title	Description	Illustrative Quotes
		agencies that did not communicate with each other, and the burden of making that coordination happen fell on the mother. Benefits had time limits that were not disclosed upfront. Processing delays meant that even when coverage existed on paper, it was not always active when appointments happened. Participants described calling DHS repeatedly, being transferred, getting hung up on, and eventually losing access to programs they would have used had anyone explained them in time.	"DHS, they do not communicate all the way across the board. You go to the appointment and you don't have it. Or you got it, but the baby doesn't have it. So, it is very frustrating when you're trying to get your baby an appointment and it's not covered." "It was a lot of stuff that I had to end up doing myself that I know for a fact that they could have done. They just said, 'Here's the number for this. You got to call them and say this and say that.' I'm like, 'That don't really seem like it's my job.'"
3	How mental health was asked about shaped whether women felt safe answering honestly	Across the group, the quality of mental health screening varied dramatically depending on the provider and the setting. When questions were asked with genuine interest and warmth, participants responded openly and described receiving real support. When questions were delivered in a scripted, rote manner without empathy, participants did not answer truthfully, even when they were struggling. One participant described experiencing postpartum depression with her first child and not recognizing it until she was pregnant again, partly because the screening process had given her no framework for understanding what she was feeling. Several described the fear of losing their children as a reason women she knew had lied to their providers about	"Very frequently throughout my pregnancies, I did not see the same provider. So that was kind of a hindrance with my comfortability with speaking about things like that. When I would see these other providers and they would ask the script of questions, there was no empathy, no tone of concern. So, I didn't feel comfortable answering truthfully." "Especially with my first pregnancy, I didn't know what I was feeling because it's the first time. I wasn't really offered the resources or tools to really identify that within myself. It would either be the extreme points of postpartum like, 'Are you having thoughts of hurting yourself or hurting baby?' But not really inclusive about the spectrum."

Theme #	Theme Title	Description	Illustrative Quotes
		their mental state. The dynamic was clear: the approach to asking mattered as much as the asking.	"They can be more reassuring that it's okay to tell us how you feel. We're not here to take your child. Because a lot of women don't tell them that they feel in all these different ways because of the stigma of if you tell them you're suicidal, you overwhelmed, you feel this, they're going to take your children."
4	Genuine mental health support made a meaningful difference, but wait times and provider continuity limited access	Participants who received mental health support they described as genuine and consistent named it as one of the most important parts of their care. Being connected directly to someone in the moment, rather than handed a phone number, made a real difference. Having a caseworker through insurance who followed the pregnancy end-to-end and could advocate when other services fell short also made a difference. What limited access was not always a lack of willingness to get help: it was wait times for mental health appointments, difficulty maintaining consistent attendance postpartum when schedules became overwhelming, and the challenge of staying connected when rotating providers meant starting over every time. Participants who stayed engaged described it as a deliberate effort they made on their own behalf, not something the system made easy.	"For me, my provider at Community of Hope, they always been pretty good. Anytime they did ask about my mental health and I told them anything concerning, they would definitely connect me with someone immediately. Now, sometimes the wait could be iffy. Sometimes it could be right away, other times it could take weeks." "They were big on mental health for me too. They really cared and I knew it was genuine actually. They would be like, 'Here, this is my personal number just in case you don't want to put it on the record.' They were genuinely very, very helpful." "I chose to take a step back from my therapy only because of scheduling wise with a newborn baby, my other kids and stuff like that. It's sometimes overwhelming to try to make all of the appointments. I have to remember that I have to take care of myself too."

Theme #	Theme Title	Description	Illustrative Quotes
5	Care coordination across maternal and behavioral health providers made a measurable difference when it happened	When behavioral health and maternal health providers communicated with each other, had each other's contact information, and coordinated scheduling to reduce burden, participants described the experience as qualitatively different. One participant described her support team as going further than required: checking in with each other when they had not heard from her, coordinating appointments around one another so nothing conflicted, and following up on referrals that had not been used. Another described providers who had an existing relationship, so referrals landed with someone already familiar with her context. In contrast, when coordination was absent and participants had to relay information between systems themselves, the experience was burdensome and created gaps.	"My support team, they all personally asked for each other's contact. If they didn't hear from me, they would reach out to them and vice versa for mental health and physical health. They used all the resources I gave them. I generally say that they did more than what they needed to do." "They were familiar with each other. They were making my appointments around each other, and so I wouldn't be too frustrated. It was less stress on me."
6	Non-medical supports were helpful when they worked, but unreliable delivery undermined their value	Food programs, transportation assistance, and referrals to housing and community resources were meaningful when they functioned as intended. One participant described a meal delivery program through a caseworker as one of the best things that happened to her during her pregnancy. Transportation through insurance was used regularly and helped participants make appointments they would otherwise have missed. But the systems around these supports were not	"[Meals delivery program]: one of the best things that happened to me. They gave 21 meals for I think six months, and then I ended up getting an extension. It helped me out a lot." "The [transportation assistance] to and from appointments, I probably wouldn't have made it to most of my appointments without those rides." "Things that they promised would happen never happened, real life never happened. I did

Theme #	Theme Title	Description	Illustrative Quotes
		consistently reliable. Rides did not show up or arrived with conditions that were uncomfortable or unsafe for a postpartum woman or newborn. Housing support that had been promised and tracked never materialized. Programs ended at six weeks, when some participants described still being in the midst of recovery. The gap between what was offered and what actually arrived was a consistent feature of how practical support was experienced.	everything I needed to do on my end. After I had my baby, I ended up having to move out of state with my mother and father because we had nowhere to go, literally." "It comes off very strong support within the six weeks and before. But it's like after the six weeks, it's not as strong as when the six weeks and before."
7	Stereotyping based on race, age, and insurance status created barriers to honest engagement	Several participants described interactions where providers made assumptions about their history, their choices, and their circumstances that felt rooted in stereotype rather than in what they had actually said. One participant described being repeatedly asked whether she had smoked, whether she was really a first-time parent, and whether she had ever had an abortion, in a tone that suggested the provider had already decided the answer. She connected this experience to her race and to the institutional culture at that particular facility. Others described feeling looked down upon for having Medicaid, treated as less deserving of full information or engagement. These experiences did feel disrespectful. They directly affected whether women trusted providers enough	"They would ask me, 'Do I or have I smoked in the past?' And I'm like, 'Oh no.' And they would be like, 'Oh, are you sure?' And I'm like, 'What do you mean I'm not sure?' They were just really insulting sometimes and they were also very stereotypical. They kept asking me, 'Are you sure this is your first pregnancy? You never had an abortion or nothing?' I'm like, no. It was very offending." "I don't know if it's because I was Black, because I was young or what it was that they kept asking me things like that. They act like they wanted me to fall into another category or something. It was very annoying, honestly."

Theme #	Theme Title	Description	Illustrative Quotes
		to share what was actually happening with them.	
8	Midwives, doulas, and group care models offered relational support that clinical visits often could not	Participants who had midwives described them as accountability partners who checked in beyond what the appointment required, had direct contact information available, and built the kind of continuity that made disclosure more natural. One participant described her midwife as someone who checked in more frequently than family. A participant with a doula described the relationship as lax and non-formal in a way that made it easier to ask the small but nagging questions that did not feel worth a clinical appointment. Group prenatal care was described by one participant as feeling like group therapy: a space where shared experience, normalizing, and community reduced isolation in a way that one-on-one clinical visits had not.	"My midwives did check on me more frequently than sometimes my family even did. They were accountability partners. As pregnant women, we need someone to remind us, keep us accountable, to make sure we're caring for ourselves and baby throughout pregnancy and even after." "My doula, I didn't feel as structured or too formal with her. It helped me feel more comfortable expressing when I had those little nagging concerns or was confused about something. Just having that support in a lax kind of manner." "Centering and hearing from other moms really helped me. It helped ground me. It felt like affirmations. The whole group experience just felt like it was reaffirming everything that I felt, encouraging me, building my voice, strengthening my voice."
9	Self-advocacy was necessary but unevenly distributed, and experience made a significant difference	Participants who had been through multiple pregnancies or who had experience navigating the healthcare system described advocating for themselves as second nature. They knew which questions to ask, when to escalate, how to document, and where to look for resources. Those who were newer to the	"Even though we have Medicaid, we are still human and our babies are human. Do they always listen? No. Can you get a second opinion? Yes. And can you report them? Definitely. So, you always going to have a say so."

Theme #	Theme Title	Description	Illustrative Quotes
		system, including first-time mothers and those without strong informal networks, described missing out on benefits, programs, and supports simply because they had not known to ask. The knowledge required to navigate the system effectively was not provided by the system. It was passed between women informally, through group prenatal visits, through peer connections, and through community health workers. That knowledge gap was experienced as cumulative: the less you knew going in, the more you missed.	"I think for a young girl or woman who's pregnant for the first time, she might miss out because she doesn't have that background knowledge or know to advocate." "I would say just better customer service in general. When I got connected to [provider], it was so many things that they enlightened me on that I could have done that I didn't find out till later on. I'm happy I found out in general because, honestly, without community help, I probably wouldn't ever even know some of the options existed."