



GROUP PRENATAL CARE IN RURAL SETTINGS: EXPERIENCES FROM RURAL MATERNAL HEALTH NETWORKS

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The Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) funds rural maternal health networks to improve health care access and outcomes. These networks commonly develop and implement initiatives to increase access to both clinical and supportive care in the prenatal period, often through innovative models designed for the rural setting. One such model is group prenatal care. This issue brief draws

HRSA funds rural maternal health networks through two programs: the Rural Maternity and Obstetrics Management Strategies (Rural MOMS) program and the Delta Maternal Care Coordination (Delta MCC) program. Networks are typically comprised of obstetric hospitals, prenatal and postpartum care providers, and support service agencies.

upon networks' experiences with group prenatal care and service delivery in rural settings. It describes a group prenatal care model implemented by a Rural MOMS 2021 Cohort network in northern Minnesota, the Families First: Rural Maternity Health Collaborative ("Families First"). It also shares lessons learned from other group-oriented maternal health services provided by HRSA-funded networks.

GROUP PRENATAL CARE IN THE UNITED STATES

Prenatal care is specialized primary care for pregnant women. For optimal health of the mother and baby, prenatal care should begin during the first trimester and include regularly scheduled visits, clinical assessments, and maternal education.¹ In the United States, prenatal care is most often delivered in a one-on-one, provider-to-patient setting, with additional support and education provided as needed and where available.

As an antidote to rising costs, lack of availability of obstetric and perinatal care providers, and high need for patient education during and after pregnancy, a group prenatal care model was first piloted in 1993.² In this model, prenatal care is delivered in a group setting and facilitated by a health care provider, such as a physician, midwife, or nurse. Group prenatal care integrates clinical assessments, education, and social support and may include culturally tailored content or support specific health conditions.

In group prenatal care, sessions typically begin at the end of the first trimester or early in the second trimester. Group meetings, which generally include 8-10 patients with similar due dates, occur approximately monthly and may last 90-120 minutes. Each participant also receives the standard one-on-one assessments she would get in individual prenatal care (e.g., weight checks, physical and behavioral health screenings) in an adjacent room or other private setting with a certified provider.³

Group prenatal care allows more time for maternal education and gives pregnant women a space to make friends and grow their social support networks. This can be particularly valuable for pregnant women with high needs or chronic health conditions.³ Evaluations have found that women who participate in group prenatal care feel more ready for and knowledgeable about labor and delivery, initiate breastfeeding more often, and are more satisfied with their prenatal care experiences.⁴

Despite these benefits, group prenatal care models are uncommon in rural settings. Small patient populations, transportation issues, and workforce shortages complicate implementation in rural areas.⁵ For example, non-rural clinical settings that serve larger populations may start one or more prenatal care groups each month, allowing patients to learn and build community with others who share similar due dates. It can be difficult or impossible to enroll pregnant women with similar due dates in communities with low birth rates. Rural areas may also lack providers or staff to facilitate the groups and sessions.

FAMILIES FIRST: CASE STUDY OF GROUP PRENATAL CARE IN RURAL MINNESOTA

Families First serves a six-county region in northern Minnesota. Led by Sanford Bemidji Medical Center, the network aims to increase access to care, enhance care coordination among network partners, and improve maternal and neonatal outcomes. The Families First network includes three prenatal clinics; two of those are at Indian Health Service (IHS) non-delivery hospitals and the third is at Sanford Bemidji.

Foundation of the Model

Families First implemented group prenatal care at two network partner clinics to increase prenatal care utilization and provide services that create community and address participants' educational and health-related social needs. The model's foundation is based on the characteristics below.

Leadership Support

Any new service initiative requires buy-in from leaders and decision-makers. At Families First, an obstetrics provider championed the effort based on her previous experience with group prenatal care. She valued the opportunity to build relationships with her patients, understand their complex educational needs, and foster a supportive social network through group participation. She felt a group prenatal care model would be beneficial in the Families First service area given its geographic, economic, and social barriers to care.

Efforts to Make Prenatal Care Visits More Interesting and Attractive to Patients

Given the importance of prenatal care to a healthy pregnancy, delivery, and beyond, encouraging and incentivizing regular visits is essential. Families First offered group prenatal care at the network partner IHS sites in Red Lake and Cass Lake. The development process took nearly two years and involved extensive input and consensus from Families First partners and community members. Tribal maternal and child health staff, who are respected members of each nation but not formal Families First network partners, collaborated with the IHS providers to develop content for the model that would be meaningful to patients. The result was a group prenatal care experience that incorporated Ojibwe cultural elements and motivated patients to attend. Customized group activities, presentations, and small pregnancy- or infant-related gifts for attendance made the model attractive and valued in the community.

Established Prenatal Care Curriculum

Several models of group prenatal care, such as Centering Pregnancy, Expect with Me, Pregnancy and Parenting Partners, and The March of Dimes' Supportive Pregnancy Care, have been implemented in the United States.³ Families First chose the March of Dimes curriculum because it is less oriented toward “due date groups” than other models and allows for comprehensive education across many relevant topics. This model helped address concerns that there would not be enough Families First participants to form groups of adequate size based on due date.

Families First Group Prenatal Care Model Overview

Characteristic	Description
Frequency of group start dates	Four times a year; a new group starts about once a quarter
Frequency of meetings	Monthly
Length of meetings	Two hours
Size of groups	Five to eight participants
Enrollment process	Clinic staff present the group option at the first prenatal visit. Patients who try group prenatal care but decide it is not right for them are quickly re-integrated into the individual prenatal care calendar. Other patients, usually those who have given birth before, may join the group for later sessions that focus less on pregnancy and more on infant care.
Process to join a group	At one site, enrollment is rolling; a patient joins an existing group when she enters care. At the other site, enrollment is fixed; she joins the next group that is starting, and everyone there will be in their first group meeting.

During the first year of implementation, about **80 percent** of eligible patients opted into the group prenatal care model.

Attendance was robust with approximately **5-8 patients** in each meeting.

Components of Group Prenatal Care Sessions

On the day of a group prenatal care meeting, providers review patient charts and order laboratory tests and any other necessary clinical services for each patient they expect to see in the group. During a session, patients participate in a group activity and receive the full complement of screenings and clinical services that they would receive in individual prenatal care appointments, as described below.



First, patients arrive and **check in**.



Patients then go to the **lab** for tests that might be indicated for that visit, such as bloodwork, a urine sample to check for protein (a sign of preeclampsia), and screening for gestational diabetes.



Then, patients report to the group meeting room and measure and report their own vital signs with the assistance of the clinic nurse. Each patient goes to a **private exam room with the nurse practitioner** who assesses fundal height and fetal heart tones and gives the patient an opportunity to ask any questions she might not want to raise in front of the whole group. At this time, the nurse practitioner also reviews any home monitoring results she has received from her patients with high blood pressure or diabetes and makes sure their medications and recommendations for diet and physical activity are in order.



While the clinical assessments are taking place, the **group interacts with a community health worker** about other maternal and child health supports, such as home visiting, that they may be eligible to receive through tribal health services. At that time, the nurse also checks in with each patient to assess whether there have been any changes to their social needs, often offering a pregnancy- or infant health-related gift or perk to promote attendance.



Each group session allows time for a **community-building activity**. A tribal facilitator opens the activity with a lesson about traditions and/or a shared meal with ingredients that are meaningful to the community, such as wild rice and maple syrup. Patients learn about cultural traditions and beliefs, including how to hand-craft baby items like a cradleboard (baby carrier), moss bag, and moccasins; traditional practices for the baby's first bath; the first words that should be spoken upon the baby's birth; and touching the baby's feet to the earth. Later sessions may focus on baby-naming ceremonies and traditional lullabies.



After a break, providers and guests, such as pediatricians, obstetricians, dieticians, gentle exercise leaders, and social service providers, give **presentations about a topic of clinical importance**, such as labor pain management, infant feeding, postpartum nutrition, and healthy exercise habits during and after pregnancy. Providers noted that these sessions enable far more maternal education than is possible during individual prenatal care. Because providers are delivering information to several patients at a time and individual clinical or social needs have already been addressed, they can delve more deeply into a topic, facilitate group discussions, and introduce the providers that families might work with later.

Impacts and Next Steps

Families First partners were unanimously enthusiastic about the initiative and its future, as most patients opt into the prenatal care groups. Providers reported that the increased visibility and extended time with patients, being “human” rather than simply clinical, builds trust and encourages patients to remain more engaged in their families’ health after their babies arrive. Providers also

“[Group prenatal care] adds a lot. We’re able to spend so much more time with our patients and get to know them on a more even playing field. They’ve expressed that they feel more comfortable asking for certain things or being an advocate for themselves.”

- Families First provider

reported that patients seem to enjoy building community with others who will have babies around the same age as theirs. The collaborative effort to develop and implement a group prenatal care model led to

new relationships among providers at Sanford, the IHS clinics, and the tribal health organizations at Red Lake and Leech Lake. In turn, the prenatal care groups led to increased efforts by providers at Sanford, where deliveries take place, to respect and accommodate patient requests around delivery. Staff and providers across the network reported that this model was one of the biggest “wins” for Families First.

Providers worked toward efficient solutions to unanticipated barriers encountered in implementation, such as rescheduling a patient who did not attend her planned group meeting but needed a prenatal visit or connecting patients who lived near each other for ridesharing to group sessions. Childcare was also a barrier for some families, so Families First explored community resources to accommodate childcare needs during group meetings and the possibility of offering onsite childcare in the future.

“For diabetic moms,... they can get support from each other, we can have nutrition come visit or someone to talk about exercise, or to talk about diabetes risk over the lifetime. There’s so much power in what you could do with this.”

- Families First provider

The larger community also embraced the initiative. As of August 2025, the end of the Rural MOMS award period, tribal health providers planned to continue collaborating with network partners to sustain the group prenatal care model. Conversations about offering a group prenatal care option at Sanford had also begun.

Staff indicated that they looked forward to additional opportunities for patient education and streamlining high-risk care coordination and referrals to relevant programs.

OTHER NETWORK GROUP SERVICE DELIVERY MODELS

Other HRSA-funded rural maternal health networks^a have also implemented group prenatal care and offered opportunities for service delivery in group settings (Table 1).

Table 1: Network Group Prenatal Care or Service Delivery as of June 2025

	Group Prenatal Care	In-Person Group Childbirth Classes	Virtual Group Childbirth Classes	In-Person or Virtual Postpartum Support (Moms’ Groups)
Families First	●			
ROAMS				●
WV-RMOMS	●*	●		
GA’s Maternal Village	●			
AZ MOMS	Under development			
RMOM-SMP		●		●
AR MOMS		●	●	
AlaRISE			●	

*Group prenatal care was developed as a local hospital initiative, not a formal Rural MOMS initiative.

^a These networks included the Rural OB Access & Maternal Services Network (ROAMS) in New Mexico, West Virginia Rural Maternity and Obstetric Management Strategies Collaborative (WV-RMOMS), GA’s Maternal Village (Mississippi), AZ MOMS (Arizona), RMOM-Southeast Missouri Partnership (RMOM-SMP) in Missouri, AR MOMS (Arkansas), and Alabama-Resources Information Support Empowerment Maternal Health Coordination Project (AlaRISE).

A hospital network partner of WV-RMOMS (Rural MOMS 2021 Cohort) implemented a group prenatal care program in 2024, outside of but complementary to the hospital's Rural MOMS involvement. AZ MOMS (Rural MOMS 2023 Cohort) and GA's Maternal Village (Delta MCC Cohort) have also made progress on group prenatal care models. As of August 2025, the AZ MOMS program was still in the planning stage, relying on the Centering Pregnancy model, and GA's Maternal Village had held one session.

A Delta MCC network (AlaRISE) and four Rural MOMS networks (ROAMS in the 2019 Cohort, RMOM-SMP and WV-RMOMS in the 2021 Cohort, and AR MOMS in the 2022 Cohort), offered group classes that have been well-received by their patients. AlaRISE holds monthly virtual classes where pregnant women can learn about local resources, share their pregnancy experiences, and discuss birth plan options. In AR MOMS, families are invited to one four-hour session, and the provider who administers the sessions pre-screens them into a group that will be most applicable to them. These groups might focus on first-time moms or offer "refresher" content for those who have given birth before. RMOM-SMP supports several programs that offer group sessions, including the Young Parent Mentoring Program that helps moms under the age of 25, and Recycling Grace, a treatment program for people with substance use disorder (SUD). The ROAMS network offered a postpartum education series with classes on nutrition, navigating the fourth trimester, and other lesser-discussed topics.

Networks cited both general and rural-specific barriers to implementing group-oriented programs, especially for small populations of rural pregnant women. There simply are not enough people in similar stages of pregnancy to fill many group classes. Large geographic distances, limited childcare availability, and transportation challenges are additional barriers. Women may be willing to travel long distances for a single birthing class, but not for regular group sessions. Virtual models may help address these challenges for women and families while also offering convenience and cost-effectiveness for networks; for example, one network noted that virtual meetings enable guest speakers to join from anywhere in the state. Women may also have privacy concerns or, according to one provider, prefer "figuring it out" themselves and the efficiency of one-on-one clinical encounters. Additional barriers in rural areas include provider shortages and limited capacity of providers to facilitate groups outside of or in addition to regular clinic hours. In areas where prenatal care providers are few in number or are limited by scope of practice, there may be less provider availability to implement and sustain a group model.

CONSIDERATIONS

The decision to offer prenatal care and pregnancy-related services in a group setting requires careful consideration about the service population's unique needs and the resources that are available to best meet those needs. Some women find it hard to fit a fixed monthly meeting into their schedules; others may be averse to sharing personal details of their pregnancy experience with co-inhabitants of a small town or tribal community.

However, with a coordinated vision, administrative support, and broad community input into curriculum design, the group prenatal care model can be successful and beneficial in rural settings. Importantly, encouraging enough patients to opt in to the group model is critical in a rural setting. Group models can be especially effective for populations with high educational and service needs, such as in areas with high rates of chronic disease or unmet health-related social needs. In these high-need settings, providers may appreciate both the opportunity a group prenatal care model offers to strengthen their relationships

with patients and the efficiency of delivering in-depth, relevant health information to several patients at one time. Keeping participation optional and allowing patients to return to individual care may encourage hesitant patients to try the group model without feeling locked in. In addition, providers can consider offering attractive group activities or incentives to promote participation. Families First's successful implementation of a group prenatal care model serves as encouragement that rurality alone should not be a deterrent to this approach.

REFERENCES

1. American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). Guidelines for Perinatal Care. 8th edition. Elk Grove Village; 2017. Accessed March 31, 2025. <https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care>
2. Centering Pregnancy: An Interdisciplinary Model of Empowerment - Rising - 1998 - Journal of Nurse-Midwifery - Wiley Online Library. Accessed March 31, 2025. <https://onlinelibrary.wiley.com/doi/abs/10.1016/S0091-2182%2897%2900117-1>
3. Group Prenatal Care | ACOG. Accessed March 31, 2025. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/03/group-prenatal-care>
4. Group prenatal care and perinatal outcomes: a randomized controlled trial - PubMed. Accessed March 31, 2025. <https://pubmed.ncbi.nlm.nih.gov/17666608/>
5. Centers for Medicare and Medicaid Services. Improving Access to Maternal Health Care in Rural Communities: Issue Brief. Published online September 3, 2019. Accessed January 2, 2020. <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>