

**LEVELS OF MATERNAL CARE AMONG HOSPITALS IN FLORIDA:
AN IMPLEMENTATION EVALUATION**

**Report Submitted to the Florida Department of Health
by**

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EXECUTIVE SUMMARY

BACKGROUND

Severe Maternal Morbidity and Maternal Mortality Rates in the US and Florida

Severe maternal morbidity (SMM) and maternal mortality are alarming public health issues in the United States (US) (Ahn et al., 2020). In the 10-year span from 2011 to 2020, SMM rates in the US increased from 69.8 to 88.2 women per 10,000 hospital deliveries (Agency for Healthcare Research and Quality [AHRQ], 2023). In 2021, the U.S. maternal mortality rate was 32.9 per 100,000 births, an increase from 23.8 per 100,000 births in 2020 (Hoyer, 2021). SMM rates in Florida increased from 68.6 to 98.4 women per 10,000 hospital deliveries from 2011-2020 (AHRQ, 2023). While the 2019 pregnancy related maternal mortality rate in Florida was slightly lower (19.5 per 100,000 births) than the national average (20.1 per 100, 000 births), the increase in the national rate after 2019 indicates that the rates in Florida are also likely to have increased. The rates of adverse maternal health outcomes are even higher across the U.S. and in Florida when examining racial and ethnic differences.

Several system-level factors contribute to poor maternal health outcomes, including those at the patient-level (e.g., advanced maternal age, pre-pregnancy obesity, other pre-existing health conditions, cesarean delivery) (Creanga et al., 2013); community-level (e.g., lack of access to care, poverty, education, racism, housing instability, rurality) (Davis et al., 2017; Janevic et al., 2020); and medical care and health system-level (e.g., lack of standardized approaches and differences in quality of care; obstetric complications) (Davis et al., 2017; Peterson et al., 2019a).

LOMC Pilot Program in Florida

Risk-appropriate care is an approach to enhance perinatal health outcomes by providing tailored care to pregnant people and newborns in healthcare facilities that have the necessary resources and expertise to meet their specific health needs (ACOG, 2015; 2019; Desisto et al., 2023). It involves assessing each patient's risk factors and providing care that addresses their individual needs. In response to the need for risk-appropriate care, ACOG and the Society for Maternal-Fetal Medicine developed the *Levels of Maternal Care (LOMC) framework* to standardize care and improve maternal health outcomes (ACOG, 2015; 2019). The LOMC framework is composed of four levels (I-IV), that reflect the complexity of care required for pregnant and postpartum patients. ACOG collaborated with the Joint Commission to develop a verification process that is modelled after certification programs, with national standards and on-site survey processes (The Joint Commission, 2023).

The Florida Maternal Mortality Review Committee found that insufficient preparation by the hospitals for pregnancy-related complications was a key contributing factor to the deaths of mothers in Florida and recommended that Florida hospitals should participate in the LOMC verification program in order to provide risk appropriate care (Hernandez & Thompson, 2021). Beginning in 2022, the Florida Perinatal Quality Collaborative (FPQC), alongside the Florida Department of Health (FDOH), piloted the Joint Commission verification program for ACOG's levels of maternal care in Florida hospitals. With funding from FDOH, the FPQC paid the first-

year verification fees for any hospital that applied for the pilot program. Hospitals will pay for the second and third year verification fees. Following their commitment to the program, hospitals worked with the Joint Commission to prepare for, and subsequently schedule an on-site verification visit within 90 days of completing the LOMC application. These visits are conducted by experienced obstetric practitioners and can be completed in 1 or 2 days depending on the level of care in the hospital's application (Joint Commission, 2023). At the end of the visit hospitals receive a preliminary report of any findings. Hospitals have 60 days to submit evidence of compliance summary after which they will receive an official report that they have been verified for a particular level. The verification is good for 3 years (Joint Commission, 2023). Additionally, hospitals were required to participate in FPQC's evaluation, which occurred post-verification and included an (1) online survey and (2) interview (Florida Perinatal Quality Collaborative [FPQC], 2022).

PURPOSE

The Joint Commission verification program of ACOG's Levels of Maternal Care (LOMC) was offered as a pilot program to Florida hospitals through the FPQC. As a result, the potential impact of LOMC verification in improving maternal quality of care in the state is unknown. Therefore, the overall purpose was to conduct an implementation evaluation of the Levels of Maternal Care (LOMC) verification process for hospitals that selected to be in the pilot program. Specifically, this evaluation was comprised of the following three aims:

1. Assess hospitals' experience of LOMC verification.
2. Document factors influencing the implementation of LOMC verification program.
3. Share lessons from early adopting hospitals to guide future implementation.

METHODOLOGY

Conceptual Framework

This mixed methods implementation evaluation was guided by two implementation science frameworks: *Exploration, Preparation, Implementation, and Sustainment (EPIS) Framework*; and the *Consolidated Framework for Implementation Research (CFIR)*. The EPIS Framework provides a conceptual framework that assess influential factors during the implementation of a program at four key stages/phases during the implementation process: (1) *Exploration* which involves assessing the intervention's fit and feasibility; (2) *Preparation* which focuses on preparing stakeholders, resources, and systems for implementation; (3) *Implementation* which involves executing the intervention and monitoring its fidelity and outcomes; and (4) *Sustainment* which addresses the long-term integration and maintenance of the intervention (Aarons et al., 2011). CFIR is a comprehensive framework that can be used to: assess the context of program implementation, examine implementation process and progress, and explain program findings (Damschroder et al., 2009). CFIR contains several constructs across five domains that have been found to influence implementation and outcomes: (1) *Innovation factors* (e.g., complexity, relative advantage); (2) *Outer setting factors* (e.g., market pressure, funding); (3) *Inner Setting Factors* (e.g., culture, compatibility); (4) *Individual factors* (e.g., High level leaders,

implementation leads); and (5) *Implementation Process factors* (e.g., planning, teaming) (Damschroder et al., 2022a). The use of multiple frameworks made it possible to explore key implementation factors at each phase (as guided by EPIS), with CFIR constructs providing more in-depth assessment of the multidimensional factors at play during the LOMC verification process.

Instruments

A quantitative online evaluation survey was developed based on evaluation questions, EPIS phases and constructs, CFIR constructs, previous literature on LOMC verification program, and input from key stakeholders (e.g., LOMC advisory committee). A semi-structured interview guide was developed based on evaluation questions, EPIS phases and constructs, CFIR constructs, previous literature on LOMC verification program, and input from LOMC Advisory Committee. The guide included open ended questions structured under the four phases of EPIS, and additional questions on barriers, facilitators and lesson learned since these factors were expected to be present in all the four phases. A hospital/participant profile sheet was also created to collect descriptive information to describe and reflect on the diversity of experiences among the participants in the interview sample.

Procedure

Sampling and Recruitment. All 13 hospitals that applied for the LOMC verification program were recruited for the online evaluation survey. Hospital leads for the LOMC program completed the survey. Purposive sampling was employed to recruit participants for the in-depth evaluation interview based on the level of care a hospital applied for to ensure a diversity of experience. Using snowballing techniques, the hospital program lead was invited to include 2-3 key team members, such as nurse managers and nurse educators, who were instrumental in the implementation process.

Data Collection. A request to complete the online evaluation via Qualtrics was sent to the hospital LOMC verification program lead within a week of completing the verification site visit. Once the evaluation was completed, the evaluation team contacted the hospital lead to invite them and 2-3 key implementation team members for an in-depth interview. Interviews were conducted through Microsoft Teams, guided by the semi-structured in-depth interview instrument and were recorded and professionally transcribed. The evaluation was determined by the University of South Florida Institutional Review Board (IRB) as not constituting research involving human subjects as defined by DHHS and FDA regulations due to the project being an evaluation for a quality improvement initiative. Although this evaluation did not require IRB approval and oversight, the activities were still conducted in alignment with ethical principles and practices.

Data Analysis. *Quantitative data* from the evaluation surveys and hospital/participant profile sheet from the interview were analyzed in Qualtrics and Excel. The evaluation reported the frequencies (n) and proportions (%) to describe hospitals and participants. The evaluation also reported proportions (%), means, and standard deviations for constructs measured in the survey.

Qualitative data from the de-identified interview transcripts were uploaded into MAXQDA which is a program for qualitative data management and analysis. Deductive codes based on key research aims, EPIS phases, and CFIR constructs were used to develop the initial codebook. Two evaluation team members revised the codebook, by collaboratively coding 10% of the data, including inductive codes (those that are derived from the data), and resolving any differences by mutual agreement.

FINDINGS

Quantitative Findings

All 13 pilot hospitals in the program completed the evaluation survey. The total median number of years participants (n=13) who completed the survey had been with the current hospital was 7 years (Range 0-37). The median number of staff involved in the LOMC verification program per hospital was 24 (Range 13-51). These staff represented various departments (e.g., obstetrics, NICU, ICU, pharmacy, radiology, emergency department) and roles (e.g., high-level leadership, unit managers, unit staff) within the hospital. All participating hospitals involved both the chief medical officer and the perinatal unit director as key leadership stakeholders in this initiative. Most hospitals (n=8) in this pilot applied for higher levels of care (levels III and IV). All but one hospital were verified for the level of care that they applied for. Interestingly, none of the hospitals sought a higher level of care than what they were already providing.

A summary of the quantitative findings is organized below according to the EPIS Framework phases (Exploration; Preparation/Implementation; and Sustainment).

Exploration Phase

Exploration phase examined **hospitals readiness, leadership support, and several key factors influencing decision to participate** in the LOMC verification.

Most hospitals reported:

- Having *little* (23%) or *some* (38.5%) **knowledge** of LOMC guidelines before applying for the verification program
- Being *almost* (38.5%) or *fully* (38.5%) **ready** to adopt the LOMC program
- Having **leadership** that was *fully supportive* (85%), *involved/fully involved* (84%), and who made LOMC verification a *high priority* (85%)

On average, most participants *agreed* or *strongly agreed* that the following **factors influenced their hospital's decision to participate** in the LOMC program (5-point Likert scale from 1-Strongly Disagree and 5-Strongly Agree):

- Validates current level of care provided (mean 4.85, SD 0.36)
- Improves overall quality of maternal care in Florida (mean 4.77, SD 0.42)
- Funding available through FPQC to participate in the LOMC verification process (mean 4.75, SD 0.43)
- Improves patient outcomes (mean 4.46, SD 0.75)

- Helps decide which components of maternal care are missing or needed (mean 4.38, SD 0.49)
- Increases marketability for the hospital (mean 4.31, SD 0.99)
- Gives hospital a competitive advantage (4.23, SD 0.90)
- Recommended by hospital's leadership (4.08, SD 1.21)

Preparation/Implementation Phase

Preparation/Implementation phase examined **hospital readiness, activities and resources used during verification process, program complexity, and other factors influencing their experience** during this phase.

Most hospitals reported:

- Already having internal guidelines that were similar to the LOMC guidelines (85%)
- Interestingly, participants assessment of their **readiness level** (23.1% fully ready) **was lower** after completing the verification preparation process, **than what originally perceived it to be** (38.5% fully ready) prior to completing the verification preparation process.

On average, most participants *agreed* or *strongly agreed* with the following statements regarding **activities and resources used** during the LOMC verification process (5-point Likert scale from 1-Strongly Disagree and 5-Strongly Agree):

- FPQC was available and responsive (mean 4.85, SD 0.36)
- The Joint Commission was available and responsive (mean 4.62, mean 0.62)
- The application process for FPQC funding was easy (mean 4.46, SD 0.63)
- The preparation that my hospital had to do was time-intensive (mean 4.15, SD 0.86)
- The Joint Commission's standards were easy to use for assessing my hospital's practices (mean 4.00, SD 0.68)

Although perceived program complexity varied across hospitals, on average, most participants did not perceive the verification process to be complex. The *least complex* stage of the program was **post-site visit follow up** (mean 1.46, SD 1.08) and the *most complex* stage was **preparation** (mean 3.15, SD 1.23).

As guided by CFIR, a variety of **system-level factors** were found to influence implementation experiences. On average, most participants *agreed* or *strongly agreed* that the following factors were important during this phase of the program (5-point Likert scale from 1-Strongly Disagree and 5-Strongly Agree):

- *Innovation*
 - LOMC is *better* than other available options for addressing maternal risk (mean 4.31, SD 0.61)
 - LOMC has *robust evidence* supporting its effectiveness (mean 4.46, SD 0.63)
- *External Setting*
 - *Competing with and/or modelling after peer hospitals* drives implementation of the LOMC (mean 4.0, SD 1.00)

- *Availability of funding from FPQC* influenced hospital's decision to participate in LOMC (mean 4.38, SD 0.92)
- *Quality or benchmarking* metrics drive implementation of LOMC (mean 4.54, SD 0.63)
- *Internal Setting*
 - *Organization of tasks and responsibilities* within and between individuals and teams, and general staffing levels for the LOMC verification process were adequate (mean 4.31, SD 0.82)
 - *Resources are available* (e.g., funding, space, materials, equipment) to implement the LOMC (mean 4.54, SD 0.75)
 - Implementing the LOMC is *aligned with the overarching commitment, purpose, or goals* of our hospital (mean 4.92, SD 0.27)
- *Individual*
 - *Individuals of high level of authority* in our hospital, including C-suite members, *support* the LOMC process (mean 4.85, SD 0.53)
 - Hospital *staff are committed* to implementing LOMC (mean 4.85, SD 0.36)
 - *Individuals of moderate level of authority*, such as department heads, *support* LOMC process (mean 4.92, SD 0.27)
 - *Implementation teams leaders were available* (i.e., individuals who collaborate with and support LOMC verification process) (mean 5.00, SD 0,0)
- *Implementation Process*
 - Our hospital was able to *coordinate and collaborate* to implement LOMC (mean 4.85, SD 0.36)
 - Our hospital was able to *plan in advance* to identify roles and responsibilities, outline specific steps and milestones, and define goals and measures for implementation success (mean 4.85, SD 0.36)
 - Our hospital was able to *attract and encourage participation* in implementing LOMC (mean 4.85, SD 0.36)

Sustainment Phase

Considering the future, most hospitals reported that they:

- Were committed to **reconsidering reverification in 3 years** (62%)
- Would **recommend other peer hospitals to apply for the LOMC verification** (85%)

However, only half (54%) indicated that they would **consider *changing* their current level of care**.

Suggestions for Future Implementation

Participants provided the following suggestions and recommendations for hospitals seeking to adopt LOMC verification.

1. **Conduct a gap analysis.**
 - Assess your hospital capabilities, discuss with leadership, and only apply for levels of care confirmed by leadership.
2. **Preparation starts before application.**
 - Have everything ready before the application, you will do the bulk of the work before the site visit and turnaround time is quick.
 - Create an ongoing repository shared with all team members outlining all activities, tasks, responsibilities, and timelines.
 - Have a point person to coordinate all verification activities.
3. **Obtain buy in from everyone (staff, leadership, other departments).**
 - Encourage and engage staff to commit to LOMC processes and standards.
 - Obtain buy in from all ancillary departments and have them involved in the process.
 - Check-in with the implementation team frequently.
 - It's a lot of work, but if the team works together, you will be successful.
4. **Follow the Joint Commission Guide.**
 - Follow the guide step by step to help you prepare your process.
 - Use the guide to develop presentations for site visit.
5. **Talk to other hospitals who have gone through the experiences.**
 - Set up webinars with early adopters to speak to your team on how to prepare.
6. **Make quality maternal care a habit.**
 - Set high quality standards as normal practice.

Qualitative Findings

Nine hospitals participated in the interviews. A total of 20 participants participated across the 9 interviews (1 per hospital): 5 nurse managers, 13 OB services directors, (nursing, quality, perinatal, women's health, and MFM), 1 perinatal nurse educator, and 1 associate vice president for women's health.

A summary of qualitative findings is organized below based on themes that emerged at the different stages of the program according to EPIS framework: Exploration (decision to participate); Preparation (*preparation for verification*); Implementation (*site visit experience*); and Sustainment (*post -site visit experience*).

Decision to Participate

Key factors influencing the decision-making process included having a *hospital champion*, *quality improvement (QI) experience*, wanting to *validate the level of care* already being provided and other motivations to participate such as *role modelling exemplary service* as noted by one participant:

“Hey, we have to do this, this is really important to verify that we really do have all the services in place needed to provide the level of care we think we're providing and be a role model and set that example.”

Preparation for Verification

Several activities and responsibilities were undertaken during the preparation phase for the LOMC verification. The main components included **(1) gap analysis; (2) team formation; (3) readiness for site visit; (4) collaboration;** and the use of available **(5) resources**. Beyond getting ready for the site visit, the preparation process helped hospitals exhaustively review and extensively learn about all their policies and processes related to maternal care. As one participant mentioned, the visit by Joint Commission was an advantage to maternal care team.

“We got to say, "Joint Commission's coming, so we need this. People were like, "Okay. We're doing it," and we we're like, "Oh, this is all we had to say when we started." That was good. There was a lot of stuff on the back end that we had sitting there waiting in process, but it's a hospital and there are other departments that take priority, and other things and projects, and resources are limited, and particularly so since post-COVID. It's not just nursing that's having a shortage, all other areas in healthcare are having shortages, IT have issues. I think that piece really having the word Joint Commission behind us, expedited a lot of stuff, were to our benefit.”

Site Visit Experience

The site visit was a **positive experience** and **opportunity to showcase hospitals' quality of care**. Most participants also viewed the site visit as an opportunity to get an external assessment and identify **opportunities to continue improving** maternal care.

“I might have a different story if it didn't go well. [chuckles] I felt like the nurses were so supportive of it too. You noticed nobody ran as soon as we came on the floor. Generally, when joint commission comes, people go scatter. Nobody did that. I think because they knew that they weren't trying to catch up anything. They were trying to see what great care we have and so they were happy to share.”

Post-Site Visit Experience

Once the site visit was completed, hospitals **revisited their policies and procedures** based on the recommendations of the Joint Commission surveyor. Hospitals **addressed any gaps** identified during the visit and **made future plans** considering their verified status. On reflection, the verification process invoked a sense of pride and accomplishment as participants were able to really take stock of all that they do to ensure quality maternal care.

“You have a sense of pride in what you do. I had a huge sense of pride in what I did, but when I heard the stories or the data that were put together by that team and I saw what we looked like sitting in a chair, just listening, I sat up straighter. I was like, "Our team needs to know what we do." How it looked, when you put it that way, it was very

affirming for me. I was like, "People need to know this. Our team needs to know this." I said, "Public need to know, but our team needs to know this."

"It was. It was also a proud moment too. It was a proud moment of seeing that we do have what we need. We learned a lot now. Things we did learn, we did learn during the process, but it was like, we do have what it takes to give great care to our community for moms and babies."

DISCUSSION

This evaluation employed a mixed methods approach to examine the LOMC verification program experiences among early adopting hospitals in Florida. Findings contribute to the limited current knowledge on LOMC designation as a strategy to improve the quality of maternal care. Having an established QI culture, availability of internal resources and personnel, and external structural support were noted as key pieces for implementation success. Given the relative novelty of the ACOG levels of care administered by the Joint Commission, uncertainty on the structure of the process was a frequently mentioned challenge. Furthermore because of the limited certification focus on maternal care, participants strongly recommended that all Florida hospitals should get verified and had already begun promoting the program in network hospitals. A summary of the strengths, early successes, barriers and future recommendations are provided below.

Strengths and Early Successes Experienced During Implementation

Based on triangulating findings related to hospitals’ experiences through the evaluation surveys and interviews, several factors were identified related to the strengths and early successes experienced during the LOMC verification (Table 13).

Table 13. Strengths and Early Successes During Implementation	
Strengths/ Early Successes	Description
Leadership Support	<ul style="list-style-type: none"> • Leadership supported the maternal care teams to go for the LOMC verification and provided the necessary support. • Leadership showed their commitment by being present on the day of the Joint Commission site visit.
Mission Alignment	<ul style="list-style-type: none"> • The participating hospitals realized that the Joint Commission had the same mission as their own hospital, which is to provide the best care to mothers and babies. • Hospitals had an understanding that this was a validation of the quality work that they were already doing.
Hospital Champion	<ul style="list-style-type: none"> • Having a person from the maternal care unit lead the LOMC verification preparation was a huge factor in the success of this initiative.

	<ul style="list-style-type: none"> • In many hospitals, someone from the maternal care unit took the initiative to convince the leadership for getting LOMC verified.
Motivated Staff	<ul style="list-style-type: none"> • Staff involved in direct maternal care played a significant role in the success of LOMC verification, as they were able to showcase their skills and expertise in patient care to the surveyors. • Staff were motivated to be part of an initiative that they could be proud.
Involvement of Ancillary Department	<ul style="list-style-type: none"> • The Joint Commission LOMC verification is based on holistic maternal care provision. Hence, ancillary departments such as emergency, blood bank, diagnostics, respiratory, etc., must be prepared for the visit.
Gap Analysis	<ul style="list-style-type: none"> • Conducting a detailed formal gap analysis of all the policies and procedures pertaining to maternal care is very helpful to prepare for the LOMC verification site visit.
Support of the FPQC	<ul style="list-style-type: none"> • Funding by the FPQC for the first round of the LOMC verification was a boost for participating hospitals. • FPQC's support through the LOMC initiative helped in understanding the verification process played an important role. • Hospitals with previous connections with FPQC felt comfortable applying for the LOMC verification.
Support of the Joint Commission	<ul style="list-style-type: none"> • Having a designated person from the Joint Commission to help with application process was helpful for the hospitals.

Key Barriers and Future Recommendations

Based on triangulating findings related to hospitals' experiences through the evaluation surveys and interviews, key barriers and corresponding recommendations are provided in Table 14.

Key Barriers	Future Recommendations
Access to Providers' Credentials	<ul style="list-style-type: none"> • Keep the credentials of all the concerned authorities ready along with any certifications received by them.
Limited Internal Support	<ul style="list-style-type: none"> • Involve leadership and other key stakeholders from the beginning. • Involve the ancillary departments and prepare them with the same vigor as the maternal care unit. • Make a presentation on the LOMC verification and its benefits to get their buy-in.
Staff Turnover	<ul style="list-style-type: none"> • Involve the staff that can be present at the time of LOMC verification site visit.
Burden on Staff	<ul style="list-style-type: none"> • Form a larger team and delegate tasks.

	<ul style="list-style-type: none"> • Relieve anxieties by informing them that this is the validation of work they do on an everyday basis.
Technology Issues	<ul style="list-style-type: none"> • Involve the IT department from the beginning of the process. • Have a designated IT person for the day of the Joint Commission site visit. • Understand beforehand that uploading documents is a relatively lengthy process. • Inform the signing authority beforehand that they would need to sign the application before submission.
Limited Information	<ul style="list-style-type: none"> • Participate in the information sessions by FPQC and the Joint Commission. • Contact other hospitals that have undergone the LOMC verification. • Refer to FPQC's evaluation (this technical report) to learn from the experiences shared by participants.
Timeline	<ul style="list-style-type: none"> • Understand that after the submission of the application, the Joint Commission site visit happens in 90 days, hence prepare beforehand. • Keep track of all the discussions and processes conducted for verification preparation as meeting minutes to avoid repetition of activities.

Limitations and Strengths

Although the mixed methods approach of this implementation evaluation allowed for many aspects of the LOMC verification process to be examined among the pilot sample in Florida, limitations must be considered. First, findings may not be representative of all hospital stakeholders who contributed towards LOMC verification as only a few representatives from each hospital shared their experiences. Second, hospitals had started planning to participate several months prior to the time of the evaluation and thus there is a possibility of recall bias given the busy and dynamic nature of the hospital setting and with other priorities and initiatives. Third, most hospitals were part of a network, were a larger hospital, and/or were applying for a higher level of care; thus, findings may not be generalizable to smaller hospitals or those hospitals who desire a lower level of care designation. Fourth, given the relationship of the evaluation team with FPQC, social desirability by participants could have led to information bias.

Nonetheless, there are several strengths of this evaluation. This evaluation employed mixed methods and was guided by two prominent implementation science frameworks. In addition, the evaluation survey and interviews were administered online (via Qualtrics and Microsoft Teams), which may have facilitated comfort and convenience among hospital participants. Lastly, the

evaluation team had the opportunity to observe several verification site visits. Although observational data was not collected, this experience provided them with critical context and a deeper understanding of the process which assisted in designing evaluation instruments and when interpreting evaluation findings.

Conclusion

This implementation evaluation examined the experiences of hospitals that participated in the pilot LOMC verification program in Florida. This report documented the factors influencing hospitals' decision to participate in the verification, and facilitators and barriers experienced during all phases of the process. This evaluation also elicited lessons learned and developed recommendations to guide future iterations of the LOMC verification program implementation. Overall, the evaluation found that although funding from FPQC played a significant role in hospitals' decision to participate, supportive hospital leadership, having an in-house champion, willingness to get validation for quality work, and experience with QI initiatives played significant roles in applying for the LOMC verification. Many participants agreed that more information from the Joint Commission about the application and timelines would help hospitals to prepare for the verification. Having a formal team, conducting a gap analysis to review policies and procedures, and involvement of the ancillary departments were identified as key factors in the success of LOMC verification. Hospitals appreciated the knowledgeable and amiable nature of the Joint Commission surveyors. These findings may help future hospitals in preparing for the LOMC verification and provide elements for the Joint Commission and the FPQC to consider in their roles in this process. Ultimately, the LOMC verification should lead to improvement in maternal healthcare delivery, including preventing severe maternal morbidity and mortality across the state of Florida.