



Comprehensive Approach to Infant RSV Protection

*Quality and Innovation
Collective (QuIC)*

Phase 1 **Virtual Meeting**
July 8, 2026





AMGA Quality and Innovation Collective (QuIC) Comprehensive Approach to Infant RSV Protection

Phase 1 Virtual Meeting

Respiratory syncytial virus (RSV) is a leading cause of lower respiratory infections in children one year and younger, with thousands of cases leading to emergency room visits and hospitalization each RSV season, which typically extends from September through April.ⁱ

Immunizing mothers late in pregnancy helps protect infants from RSV. In 2023–2024, the RSV Maternal Vaccine Preparedness Quality and Innovation Collective (QuIC) brought together 10 healthcare organizations to share best practices. Over three phases, participants discussed challenges, piloted a tailored intervention at their own organization, and reported results and next steps.

With the 2026–2027 RSV season fast approaching, eight healthcare organizations similarly convened a new program, AMGA’s Comprehensive Approach to Infant RSV Protection QuIC, with a focus on immunizing the infants themselves.

This program launched with a July 8 virtual meeting moderated by Senait Temesgen, senior manager, population health initiatives, with AMGA, and Uzma Shah, system chair of pediatrics and medical director of the pediatric service line at Henry Ford Health.

Participants represented roles and brought perspectives from across the healthcare ecosystem, including primary care and pediatrics, obstetrics, pharmacy, quality, operations, and immunization strategy.

Baseline Infant RSV Immunization Infrastructure and Success Stories

With the nirsevimab monoclonal antibody approved for infant RSV protection since July 2023,ⁱⁱ QuIC participants had many on-the-ground experiences to share.

“We were able to learn a lot from that first season, particularly how to manage shortages and move the product around to different practices,” one participant reported. “Getting people used to new workflows allowed us to accelerate efforts in our second season.”



ⁱ <https://www.amga.org/getmedia/c78e5c04-f4bd-4f38-b53f-053cab649d81/amga-rsv-maternal-interim-best-practice-guide.pdf>

ⁱⁱ <https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-prevent-rsv-babies-and-toddlers>



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“We had really good collaboration with our pharmacy in procuring the product and having it distributed equitably among our clinics based on patient volume,” another said about their organization’s 2025 efforts. “So, we were ready to go October 1.”

A variety of processes and tools factored into these efforts: templated notes to guide vaccination discussions during well-child visits, order sets that streamline pediatric workflows, and charts that put a mother’s immunization history at a provider’s fingertips. One set of electronic health record (EHR) upgrades involved pulling a mother’s immunization records directly into an infant’s discharge summary and developing a dot phrase to give busy primary care physicians more ease and consistency in infant RSV immunizations.

Participants praised the work done behind the scenes and by cross-functional teams. “I just have to click a button now,” one said about their new processes for ordering nirsevimab, citing “the committed clinical, pharmacy and operations leadership” to implement these improvements.

The group shared success stories. At one QulC organization last season, nearly two-thirds of qualified infants received nirsevimab before leaving the hospital, easing the burden on their ambulatory clinics. Another saw a 42% decrease in RSV admissions following implementation of a systemwide infant RSV immunization program.

Participation in programs like Vaccines for Children (VFC), which automatically covers Advisory Committee on Immunization Practices (ACIP)-recommended and Centers for Disease Control and Prevention (CDC)-approved immunizations,ⁱⁱⁱ has been key to uptake.

“Because we don’t have to figure out what insurance the patient has, we can just give nirsevimab to every infant who meets the indication,” said one participant from a state with full VFC coverage.

Another organization expanded nirsevimab administration beyond ambulatory centers to hospitals by expanding its VFC coverage.

“Many of our birthing hospitals were not registered with the VFC program, so they were not able to offer nirsevimab,” a representative from the organization explained. “In the second season, all of our birthing hospitals are now part of VFC.”

The Infant RSV Protection QulC: Closing Gaps While Transforming the Coordination of Care

The Infant RSV Protection QulC builds on this foundation, aiming to close critical protection gaps and protect even more infants from this potentially serious respiratory virus.

“The purpose of today’s meeting is to discuss infant RSV immunizations with a focus on the challenges new organizations are facing,” Temesgen said as she welcomed participants. “During this 90-minute discussion, we will identify key gaps and explore opportunities for future work.”

ⁱⁱⁱ <https://www.cdc.gov/vaccines-for-children/about/index.html>



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“Your insights will be directly informative to our November in-person collaborative workshop and will help develop best practices that can be scaled across a wide variety of healthcare settings,” said Joseph Domachowske, North America RSV field medical director, vaccines, for Sanofi.

“This isn’t just about improving immunization rates,” he continued. “It’s about transforming how we coordinate care across the entire patient journey from prenatal counseling through critical transitions, especially between hospital and ambulatory settings.”

Before the Phase I meeting, participants completed a detailed survey ranking their organization’s top challenges and barriers to infant RSV protection. Shah led them through an interactive discussion of the top four.

Motivating Need #1: Patient Education and Outreach

With multiple RSV seasons behind them to get initial infrastructure and workflows set up, participants said they are currently grappling with patient education and outreach.

“The most burning issue that we have now is reluctance,” one shared.

Even though parents and caregivers are aware of, and fear, the disease, “they are still worried about the idea of giving a shot to a very young baby,” was one observation. “We’re seeing a lot of heavy refusals, and that’s rising at an exponential rate.”

Immunization rates have varied, sometimes within one community. One organization reported 66% nirsevimab acceptance at one hospital and 23% at another—only 20 miles apart.

Patience and persistence are key to battling these trends. “If you refuse at one visit, we’ll ask you again,” one participant declared. So are a wide range of educational materials, including printed handouts, messages through the Babyscripts™ smartphone app, and talking points for nurses, clinicians, obstetricians, and other members of the care team who have immunization conversations with these patients.

Some discussions require specialized expertise. “If parents have a lot of questions, and if these discussions go beyond a nurse or pediatrician’s comfort level, we have pediatric infectious disease providers who are willing to have those conversations with parents,” one participant shared.

AMGA QulC Advisory Committee

Uzma Shah, MD, FAAP, FAASLD, System Chair of Pediatrics, Medical Director, Pediatric Service Line, Henry Ford Health

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Andrea Polkinghorn, BSN, RN, Lead Immunization Strategist, Sanford Health

Joseph Domachowske, MD, North America RSV Field Medical Director, Vaccines, Sanofi



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Healthcare organizations participating in the 2026-2027 Infant RSV Protection QulC include:

- Advocate Health Care
- Henry Ford Health
- Northwell Health
- Sanford Health
- Skagit Regional Health
- Summit Health
- UW Health
- WellSpan Health

Sometimes a family and specialist have a meeting focused solely on immunizations and vaccines, with nirsevimab and vaccines available right there. “That way, after that conversation, we can give them the shot.”

The seasonal nature of RSV complicates matters. One participant talked about “people trying to time the season. They know that the protection only lasts for a certain period of time and they think, ‘Well, it’s October, but nobody’s getting sick yet, and in some years, people don’t get sick until March.’ So, they try to push it off. They trying to gamble and play the game.”

Immunization teams are also looking at their calendars. Their goal: to increase immunization rates.

“We use our electronic medical record to reach out to all of the newborns who were born outside of the season, to get them in in October,” one participant said.

Another example might be a six-month-old who just had their well visit in September. When their next regular visit as a pediatric patient happens at nine months, this child will be ineligible for nirsevimab. In such a situation, one participant said, “I’ll tell the front desk that I want to schedule them the first week of October instead of September 28.”

Extra efforts like these are particularly important for high-risk infants and patients of NICU. “We had one of our IT people build a high-risk report,” said one participant. “The primary care providers can run this, as can the pediatricians and family docs, and we actually run it, too. It says: Here are kids that need outreach, and so they have someone in the offices do that outreach to get these kids in right away in October.”

Hospital discharge is another key touchpoint for patient outreach, with newborn nursery, labor, and delivery nurses serving as critical conduits of vaccination information. “They provide that message right after delivery.”

Motivating Need #2: Clinician and Staff Education

To deliver such a message, care team members need to know about infant RSV protection in the first place, which isn’t always guaranteed.

“We found out that we had an entire clinic not giving nirsevimab because they weren’t aware of it,” one participant revealed.

“Nirsevimab was seen as new,” another remembered from the early days after Food and Drug Administration approval, reminding the group that “this came on the heels of a COVID vaccine, mRNA, very novel technology. Even some of our nurses were saying, ‘No, I wouldn’t take it. It’s too new.’”

Shah asked what organizations were doing to keep their staff apprised of the latest RSV knowledge.

One uses grand rounds as an opportunity to disseminate RSV information. Another engaged clinicians and non-clinicians alike into a vaccine hesitancy task force. This group creates and shares a variety of educational materials,



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including videos, PowerPoint slides, and documents highlighting the latest literature and statistics, from trusted external sources and inside the organization.

“One thing that we found effective was regularly sharing the data with our providers: how our immunization rates are tracking seasonally, where we were compared to last year, rates of RSV cases,” one participant said. “This way our providers are prepared and able to say things to their patients, like they’d seen an uptick in RSV in the last two weeks.”

Participants underscored the importance of educating and engaging all members of the immunization team. “I think I really underestimated the role of nursing support, especially for families who are hesitant,” one admitted. “People are more likely to ask nurses questions, as opposed to getting intimidated by a physician’s presence and not being as open as they otherwise would be.”

Motivating Need #3: Clinical Workflow Integration

“Which EHR alert systems and clinical decision support tools have been most effective?” Shah asked. “What standing orders and protocols work best in your workflows?”

One organization implemented pop-up reminders for well-child visits, along with built-in order sets that streamline this step of the process down to a simple click.

At another organization, however, a new feature toggling infant RSV protection within the template infant and well-child visits, surfaced a new obstacle—one that’s technology-related as well.

“The toggle only works if the provider is actually charting during the visit. A lot of our providers use DAX Copilot and other AI tools.”

Many challenges circled back to the EHR.

“As integrated as Epic might be, it still relies on a lot of manual intervention,” said one participant, citing specific problems with documentation for patients medically homed outside of the system.

“We do take their immunization history at our birthing centers and we’ll record it, but it doesn’t always get charted correctly.” While charting for infant RSV immunization is mentioned during employees’ Epic training, “it’s not part of their routine workflow. And because it’s so rarely done, it’s not done correctly. And then it kind of falls through the cracks.”

Another participant noted how the care gap or health maintenance trigger for RSV in their EHR “initially wasn’t reading in the mother’s charts. So even if a mom got a vaccine, they would still show up as overdue,” spurring needlessly repetitive conversations to encourage immunization.

“So we worked with our team to turn off that trigger if the maternal vaccine was done within our system. That was very helpful for us.”

Even as such ingenuous fixes addresses problems, some participants were frustrated with having to troubleshoot these issues in the first place.



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“It’s been three seasons,” one bluntly declared. “We’re looking for ways to make this better, but so far, Epic really hasn’t come up with any brilliant solution that will support our clinical workflow and make our clinical teams work less burdensome.”

Motivating Need #4: Reimbursement and Financial Sustainability

“Has anyone found successful strategies for reimbursement?” Shah asked about the final motivating need discussed in this meeting.

Participants reported that their organizations have been busy on this front, linking efforts to total cost of care, engaging population health and managed care contract leaders, and adding infant RSV immunization to newborn bundle payments.

“We’ve worked with our payers on the bundled care part of it to make sure that we’re getting something. I don’t know if we’re getting everything, but we are getting something back,” was one experience.

But organizations have encountered obstacles as well. One doesn’t know if an infant is VFC-eligible until after a child discharged from the hospital—missing a touchpoint and opportunity for RSV immunization. At another, the seasonal nature of infant RSV protection poses a barrier, as reimbursement teams only review bundles once a year.

“It’s complicated knowing what your system’s cost is versus what the average wholesale, or list, price is,” was one observation.

One organization has assembled a list of payers most likely to cover nirsevimab right now, data that Sanofi has available for local markets, they pointed out. “Giving providers that list helps remove the barrier of which patients I can actually give this to. When you see patients, access and coverage should be a no-brainer.”

Conclusion and Next Steps

At the time of the meeting, RSV season was just a few months away, so the discussion ended with nuts-and-bolts questions and concerns.

“We’re really looking for guidance on timing,” was one example. Do you go ahead and immunize infants late in the season, say late April, even if that means they’re not eligible for a shot in the upcoming fall? And how long should organizations make infant RSV protection available, give the seasonal nature of the disease?

One organization initially halted availability in late January. This was too soon, they later discovered, based on still-high case numbers measured in the community. “With some coordination, we were able to extend nirsevimab until the end of April.”

All of these variables—seasonality, fluctuating disease rates, age-based eligibility, family and caregiver resistance—also complicate inventory and supply chain decisions behind the scenes.

“How much should we stock? How much should we order? It’s going to be wasted if it’s not used. How do you trend for that?”



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With the connections and discussions of the Phase I virtual meeting as their foundation, participants will have the opportunity to seek answers in the weeks ahead. They will also begin implementing their tailored interventions for the QuIC, based on top motivating needs. The next step: meeting in person on November 17–19 in the Washington metropolitan area to share more perspectives and insights.

PHASE 1

Listen: Virtual Discussion Forum

July 8, 2026

Virtual Discussion Forum:

- Engage in a virtual discussion forum moderated by a national advisor.

PHASE 2

Share: Two-Day In-Person Meeting

November 17–19, 2026

In-Person Meeting:

- Participating organizations will share in educational sessions and interactive activities, collaborating with one another in a structured learning environment.

Implementation:

- Discuss barriers and plans for implementation of tailored interventions. Healthcare organizations will share successes and challenges with their tailored intervention implementation.

PHASE 3

Create: Two-Day Virtual Meeting

July 14 & 15, 2027

Virtual Meeting:

- Participating organizations will engage in interactive learning with a qualitative focus, breakout rooms, general session. Participants will share successes and challenges with their infant RSV protection program development and enhancement.

AMGA Infant RSV Protection QulC Team

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