INVESTIGATIVE REPORT | HEALTHCARE LEADERSHIP SERIES

The Spreadsheet Decision

Why America Is Closing the Hospital Beds Its Sickest Children Need

Nearly 30 percent of pediatric inpatient units closed between 2008 and 2022, a rate seven to eight times faster than adult units. In the past twelve months, pediatric intensive care units have closed in Montana, Oregon, and Missouri, while pediatric wings have closed in Illinois and California. The hospitals call it low volume. The physicians call it a spreadsheet issue. This report examines who makes the decision, why the math rewards closure, what distance costs a critically ill child, and what leaders can do before the next respiratory season tests a system with fewer beds than last time.

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Researcher Summary

On a Tuesday in October 2026, Community Medical Center in Missoula, Montana, stopped admitting children to its pediatric intensive care unit. Lifepoint Health, a for-profit operator with more than $10 billion in annual revenue, owns the hospital. Its leaders said the unit saw about two critically ill children a month, that no pediatric intensivist had lived in Missoula since the last one retired eight years ago, and that the closure would affect roughly 25 patients a year. The next pediatric ICU in the state is about 150 miles north, in Kalispell.

Missoula is not an outlier. It is the latest entry in a ledger healthcare leaders have quietly kept for nearly two decades. Between 2008 and 2022, the number of U.S. hospitals operating a pediatric inpatient unit fell from 1,749 to 1,226, a nearly 30 percent decline, and pediatric beds fell 19.5 percent. Adult units and beds fell 4.4 percent and 3 percent, respectively, over the same period. Three-quarters of American hospitals now have no pediatric inpatient service at all. In rural areas, more than half of the pediatric units that existed at any point in that window are gone.

This report argues that the pediatric bed problem is not a demand problem, a quality problem, or a rural problem, although people routinely describe it as all three. It is a payment-and-workforce problem that creates a geography problem, and it will only get worse. Roughly half of American children are covered by Medicaid or CHIP, which pays hospitals about 30 percent less than Medicare and far less than commercial insurance. Pediatric subspecialists earn 24 to 96 percent less than their adult counterparts in the same field, and in the 2026 fellowship match, no pediatric subspecialty filled every training slot. The One Big Beautiful Bill Act's Medicaid financing changes hit a children's hospital sector where state-directed payments make up 38 percent of Medicaid revenue. Child enrollment in Medicaid and CHIP has already fallen by about two million in a year.

The findings that follow are organized around five questions: what closed, why the arithmetic favors closure, what the regionalization bargain actually delivers, what distance costs a critically ill child, and what leaders in community hospitals, hub systems, and state capitals can do about it. The report closes with the Pediatric Access Risk Index (PARI), a six-factor scoring tool for executives and boards asked to approve the next spreadsheet decision.

> *"You can't expect that people will be fine if the next-closest children's hospital is a flight away or an eight-hour drive." Elizabeth Mack, MD, American Academy of Pediatrics*

Part One: What Closed, and Who Closed It

The KFF Health News investigation published October 28, 2026, and co-published by CBS News, documented pediatric intensive care closures in three states in a single year and general pediatric unit closures in two more. Reporting from Becker's Hospital Review, local news outlets, and state regulatory filings fills in the picture. The table below is not exhaustive, but it is representative, and the pattern across ownership types is the first finding worth stating plainly: this is not a private-equity story or a nonprofit story. It is happening everywhere.

Table 1. Representative pediatric unit and PICU closures, 2025 to 2026

Hospital and location	Owner	What closed	Stated reason
Community Medical Center, Missoula, MT (Oct 2026)	Lifepoint Health (for-profit)	Pediatric ICU; NICU and general pediatrics retained	About 2 ICU-level children per month; no local intensivist since

Hospital and location	Owner	What closed	Stated reason
			2018; about 25 patients per year affected
University of Kansas Health System, Kansas City, KS (closed by June 2026)	Academic nonprofit	6-bed pediatric ICU; 19 general pediatric beds retained	About 150 PICU patients in 2025 out of 542,000 treated; unit empty 25 percent of the time; beds redirected to over-capacity NICU
Providence St. Vincent, Portland, OR (Nov 2025)	Providence (nonprofit, 7 states)	4-bed pediatric ICU	Unit often empty; low volume cited, not finances
Saint Joseph Medical Center, Joliet, IL (suspended Apr 2025, permanent filing June 2026)	Prime Healthcare (for-profit)	13-bed pediatric inpatient unit; Joliet is Illinois' third-largest city	Fewer than one patient per day; 12.2 transfers per month to Naperville, about 20 miles away
Santa Rosa Memorial, Santa Rosa, CA (Mar 2026)	Providence	8-bed children's unit converted to adult beds	Low volume and financial challenges
Los Robles Regional, Thousand Oaks, CA (Jul 2025)	HCA Healthcare	12-bed pediatric unit	Fewer than two patients per day
Connecticut Children's unit at St. Mary's, Waterbury, CT (2025 filing)	Pediatric system within community hospital	Inpatient pediatric unit	Staffing shortages, low volume, financial challenges

Two details in this table deserve attention. The first is the ratio in Kansas City: 150 critically ill children in a year inside a system that treated 542,000 patients. That is 0.03 percent of volume occupying six licensed beds while the neonatal unit next door ran over capacity nearly every day. When the hospital's own faculty warned in a formal letter that eliminating the PICU would delay definitive care and worsen outcomes, the decision stood. The second is Joliet, where a city of 150,000 lost its only inpatient pediatric service two months after a new owner took possession, and where the hospital's own filing reported that it was already transferring 12 children a month before the unit formally closed.

The KFF reporting also captured the honest rationale. Elizabeth Mack, a pediatric critical care physician who consults with hospitals on quality, described cutting children's services as, for most hospitals, a spreadsheet issue. She called the endeavor very pricey and unsustainable, and said there isn't a great answer. The Missoula CEO, Greg Cook, framed it differently: quality more than dollars. His spokesperson later clarified that low volume and staffing, not concerns about care quality, drove the decision. Both can be true at once, and that is the point. The spreadsheet and the quality argument converge on the same answer because the economics produced the staffing problem that produced the quality risk.

Part Two: The Arithmetic of Closure

Four peer-reviewed analyses from the same research group, led by Kenneth Michelson of Lurie Children's Hospital of Chicago, Anna Cushing of Children's Hospital Los Angeles, and Emily Bucholz of Children's Hospital Colorado, form the quantitative spine of this report. Published in Pediatrics (2021 and 2026) and JAMA Pediatrics (2025), they use American Hospital Association survey data and the Kids' Inpatient Database to track pediatric capacity over two decades.

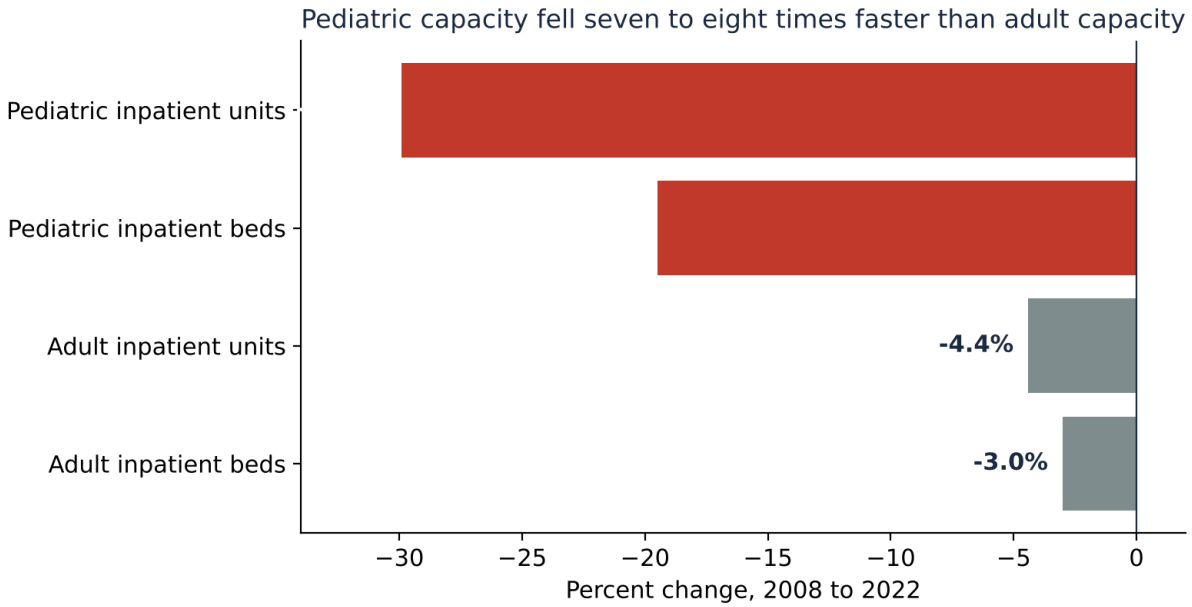


Figure 1. Change in pediatric and adult inpatient capacity, 2008 to 2022. Source: Bucholz, Cushing, Michelson et al., JAMA Pediatrics, 2025.

Table 2. National pediatric and adult inpatient capacity, 2008 to 2022

Measure	2008	2022	Change	Annual rate (pre-pandemic)
Pediatric inpatient units	1,749	1,226	-29.9%	-2.2% per year
Pediatric inpatient beds	31,133	25,064	-19.5%	-1.4% per year
Adult inpatient units	4,519	4,318	-4.4%	-0.4% per year
Adult inpatient beds	405,908	393,802	-3.0%	-0.3% per year

Pediatric units closed at a rate seven to eight times higher than adult units. The decline was steady rather than episodic: the pandemic's only measurable immediate effect was a 3.4 percent drop in pediatric beds as units were converted to adult COVID capacity, and many of those conversions were never reversed. The earlier 2021 study found that between 2008 and 2018 alone, an average of 34 pediatric units closed and 407 pediatric beds disappeared every year, and that nearly one in four American children experienced an increase in the distance to their nearest pediatric inpatient unit. Low-volume units and units without an attached PICU were most likely to close, meaning closures compound: a general pediatric unit that loses its PICU becomes a candidate for closure itself.

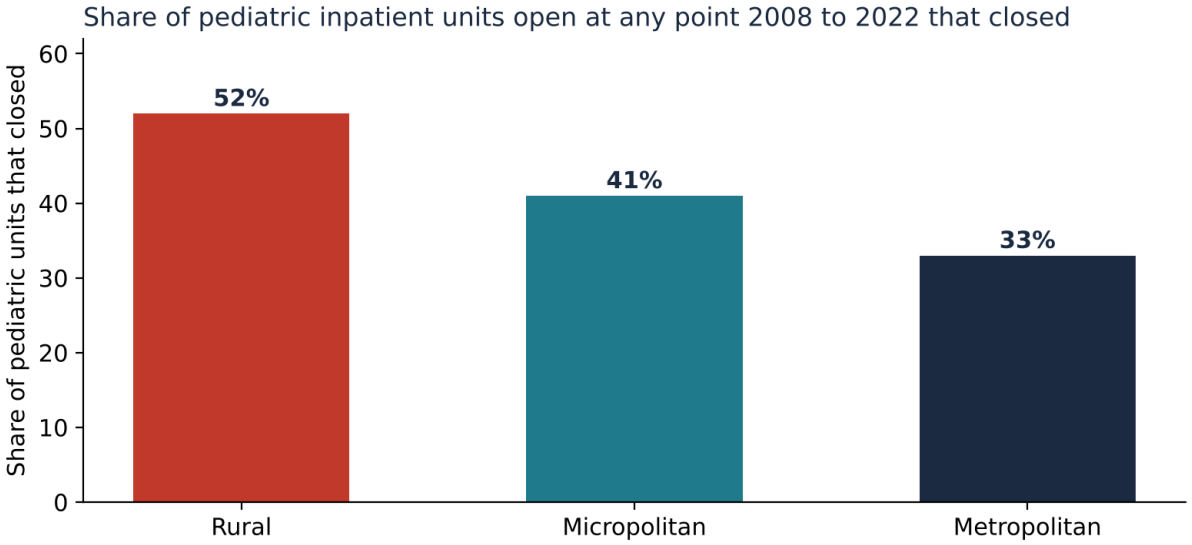


Figure 2. Share of pediatric units that closed by geography, 2008 to 2022. Source: JAMA Pediatrics, 2025.

Geography turns arithmetic into a public health problem. Among pediatric units that were open at any point between 2008 and 2022, 52 percent closed in rural areas, compared with 41 percent in micropolitan and 33 percent in metropolitan areas. Michelson summarized it in one sentence: more than half of rural units closed over a fifteen-year period. The 2021 analysis found rural pediatric bed losses of 26.1 percent, compared with 10.0 percent in urban areas.

The capability cascade

The January 2026 Pediatrics analysis extended the question from beds to capability. Using the Kids' Inpatient Database, which includes an average of 3,927 hospitals per year from 2003 to 2022, Michelson's team classified hospitals by the intensity of pediatric services they delivered. The share of hospitals at the lowest pediatric capability level rose from 26.7 percent to 65.0 percent, an adjusted increase of 137 percent. Seventeen of 24 measured capabilities were available at fewer hospitals in 2022 than in 2003.

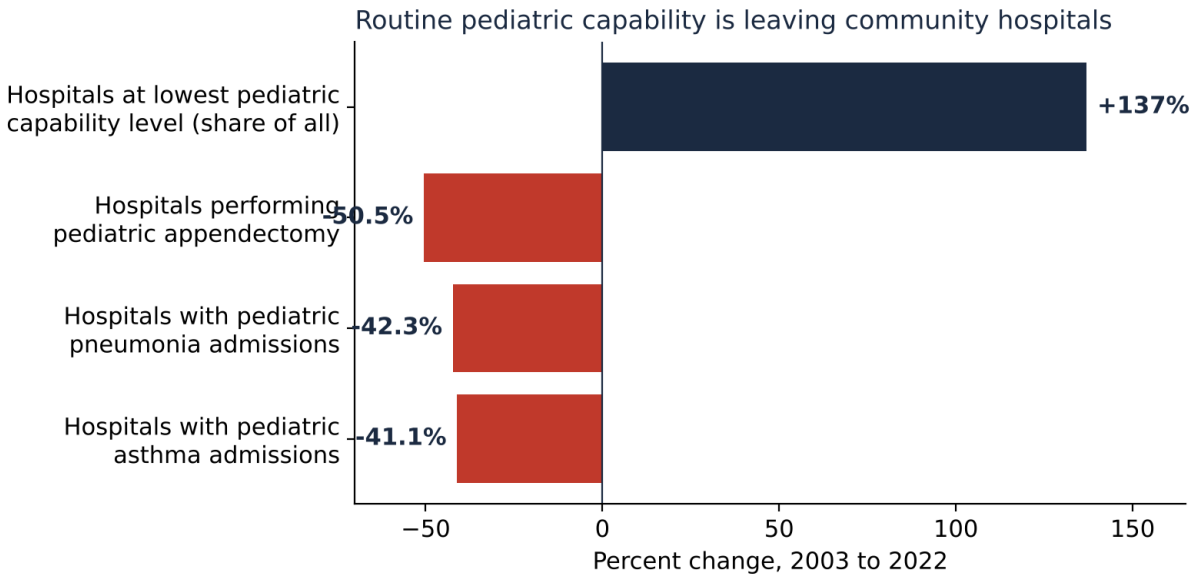


Figure 3. Change in hospital pediatric capability, 2003 to 2022. Source: Michelson et al., Pediatrics, January 2026.

The steepest losses were in moderate-intensity services, those that require an inpatient pediatric unit or pediatric surgical coverage but not a children's hospital. The share of hospitals performing pediatric appendectomy fell 50.5 percent. Pediatric pneumonia admissions fell 42.3 percent, and asthma admissions fell 41.1 percent. This finding reframes the PICU story: when the intensive care unit goes, the pediatric surgeon and the pediatric-trained nurses who justified the unit often go with it, and routine care unrelated to intensive care follows them out the door. An appendectomy is not a rare event. It is the most common emergency abdominal surgery in children, and half the hospitals that used to do it no longer do.

Part Three: Why the Spreadsheet Always Says Close

Hospital leaders cite three reasons for pediatric closures, usually in this order: too few patients, too few clinicians, too little money. Each is accurate. The investigation question is why all three point in the same direction at the same time, and the answer is structural.

1. Volume is low, and getting lower, for good reasons

Fewer children need hospital beds than a generation ago. The U.S. birth rate has declined. Vaccines eliminated most hospitalizations for diseases that once filled pediatric wards. Outpatient management of asthma, diabetes, and infections has improved. Admission criteria tightened. These are achievements, and they mean a community hospital that admitted 20 children a day in 1995 may admit two today. A six-bed PICU that is empty one day in four is operating at a census no adult unit would survive.

But low volume cuts the other way. Raj Basu, chief of critical care at Lurie Children's, noted that better medicine means more children survive complex conditions that once were fatal, so the children who do need intensive care are sicker and more complicated than they were. Rarity and acuity are rising together. That is the worst possible combination for a low-volume unit: it is hard to justify financially and hard to staff safely, and the clinical argument for regionalization strengthens exactly as the access argument against it does.

2. The workforce is shrinking because the pay is wrong

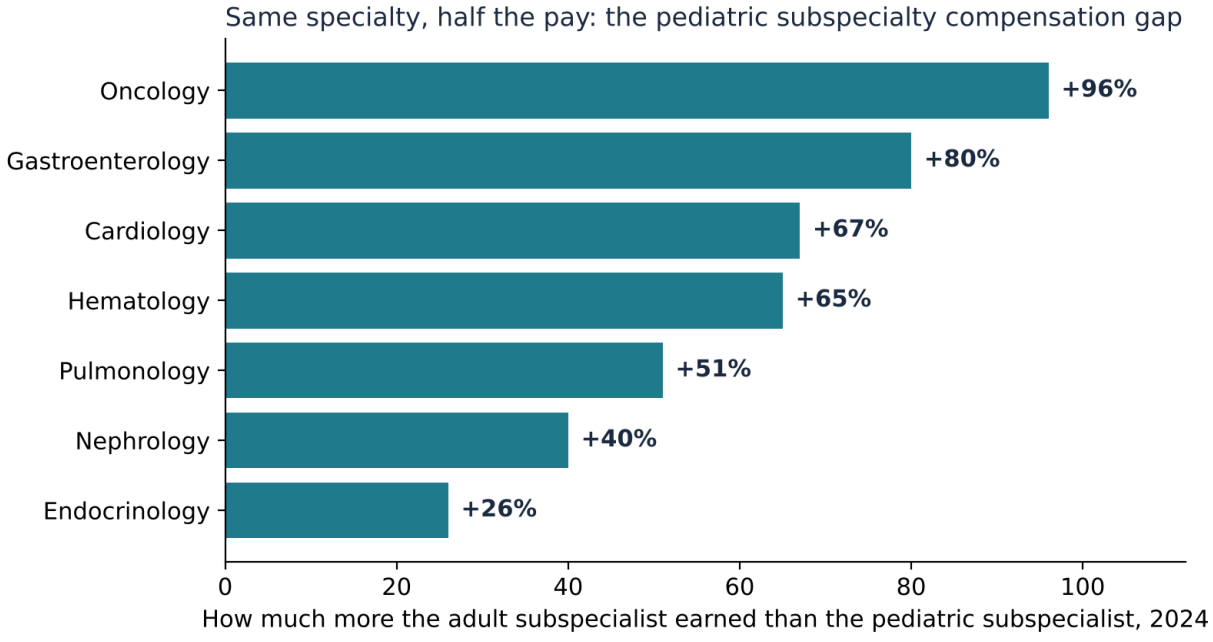


Figure 4. Adult versus pediatric subspecialist compensation gap, 2024. Source: Doximity Physician Compensation Report, 2025.

Pediatric subspecialists complete up to three additional years of fellowship training, often more than their adult counterparts, and then earn dramatically less. The 2025 Doximity report found pediatric subspecialists received at least 24 percent lower compensation than adult subspecialists in the same field in 2024. In oncology, adult specialists earned 96 percent more. In gastroenterology, 80 percent more. In cardiology, 67 percent. A Health Affairs analysis, adjusted for training length, still found adult-medicine physicians earning 19 percent more than pediatric physicians. The Children's Hospital Association reported that in the 2026 fellowship match, none of the pediatric subspecialties filled all available training slots, and in a survey of pediatric subspecialists, 69 percent said lower pay was making them consider a career change.

The mechanism is the relative value unit system, which was built around adult procedural medicine. A pediatric endocrinologist spends a 45-minute visit talking to a parent and a frightened child; the wRVU benchmark for that work is 47 to 56 percent of the adult equivalent in several subspecialties. Missoula could not recruit a pediatric intensivist to live in town for eight years. That is not a Missoula problem. It is the national pipeline, and it explains why hospitals increasingly staff pediatric critical care with fly-in rotations until the rotation itself becomes the reason to close.

3. Medicaid pays for half the children and covers a fraction of the cost

Children are the single largest Medicaid population. As of June 2026, 35.0 million children were enrolled in Medicaid or CHIP, 47.9 percent of all enrollees, and together the two programs cover close to half of all American children. In Louisiana, the share is 53 percent; in every state, at least 30 percent of children are on Medicaid. Medicaid pays hospitals roughly 30 percent less than Medicare for the same service and far less than commercial insurance. For freestanding children's hospitals, 50 to 80 percent of inpatients are typically Medicaid-covered, and 43 percent of Medicaid discharges involve a child with a complex chronic condition.

For a general community hospital, the comparison is not Medicaid versus Medicare. It is a pediatric bed versus the adult cardiac, orthopedic, or ICU bed that could occupy the same square footage. The Kansas City decision was explicit: the PICU space would go to the NICU, which was over capacity. Mount Sinai in Chicago planned to use its pediatric space for cardiac or medical intensive care or behavioral health. Tufts converted 41 pediatric beds to adult ICU and medical-surgical beds. A Louisiana pediatrician put it precisely in a 2023 essay: pediatrics is a loss specialty, and the beds have been transformed into paying beds serving other specialties.

4. Children need different equipment and different rooms

Pediatric care requires size-specific equipment across the entire range from a four-kilogram infant to a ninety-kilogram adolescent: airway devices, ventilator circuits, dosing systems, restraints, and monitoring. A hospital that sees two critical children a month must stock and maintain all of it, train staff on it all, and keep that competency current with almost no repetition. Adult ICUs amortize their equipment across a full census. Pediatric ICUs in community hospitals cannot.

Part Four: The Regionalization Bargain

The closures are not happening in a vacuum. They are the visible half of a deliberate strategy called regionalization: concentrating pediatric expertise in fewer large children's hospitals and academic centers and routing sick children to them. The 2021 Pediatrics data showed exactly this: while general pediatric beds fell, PICU beds rose 16 percent between 2008 and 2018, almost entirely at children's hospitals. Lurie Children's

added roughly 25 percent more beds after opening its downtown tower, nearly all of them intensive care, and in 2025 gained state approval for 44 more ICU beds. Children's Mercy in Kansas City announced a new tower days before KU closed its PICU.

The clinical case for regionalization is real. Basu warned that hospitals that take on complicated pediatric cases without the specialists or experience can put patients at risk. Volume-outcome relationships in pediatric critical care and surgery are well established. This report does not ask whether regionalization is wrong. The question is whether the regional network it presumes actually exists, and whether the hubs can absorb what the spokes send.

The 2022 stress test

In November 2022, the Children's Hospital Association and the American Academy of Pediatrics wrote to the President and the HHS Secretary asking for a national emergency declaration. More than three-quarters of pediatric hospital beds nationwide were full, seventeen states reported more than 80 percent occupancy, and seven states exceeded 90 percent. Children's hospitals in Arizona, Colorado, Kentucky, Maine, Minnesota, Rhode Island, Utah, and the District of Columbia were at or near capacity. Oregon declared a state emergency. Comer Children's in Chicago had been full for two months. The federal government declined to declare an emergency. Michelson recalled community emergency departments calling 10, 15, or 20 hospitals to find one that would accept a child, and said flatly: that's probably going to happen again.

The 2022 surge was RSV, influenza, and COVID arriving together on top of a mental health crisis that was already boarding adolescents in emergency departments. It hit a system that had lost roughly 20 percent of its pediatric beds over the prior decade. The system has lost more since. The early 2026-27 influenza season, which this author examined in a separate report, is arriving weeks ahead of schedule. Regionalization works in ordinary years. It hasn't yet been shown to work in a surge year, and surge years are the ones that matter.

> *"There's a case to be made that we don't need this capacity, but this can't be viewed as a typical good that we get from, like, a grocery store. This is people's lives, children's lives."*
> *Kenneth Michelson, MD, Lurie Children's Hospital*

Part Five: What Distance Costs

When a hospital closes its PICU, it does not stop seeing critically ill children. They still arrive in the emergency department, by ambulance or in a parent's arms, and the hospital's new job is to stabilize and transfer. The outcome of that model depends on one variable studied more rigorously than almost anything else in pediatric emergency medicine: the receiving emergency department's pediatric readiness.

The National Pediatric Readiness Project, a federal program run with the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association, scores emergency departments from 0 to 100 on their preparedness to care for children. Over 30 million children visit emergency departments each year, and more than 97 percent of EDs that treat children are not in children's hospitals. The evidence on what the score predicts is consistent across multiple cohorts:

- A 2019 study in Pediatrics of critically ill children across five states found in-hospital mortality of 11.1 percent at low-readiness EDs (scores below 59) versus 3.4 percent at high-readiness EDs (scores above 88). Children were roughly four times more likely to die at the least-ready hospitals.

- A 2023 JAMA Network Open study of 796,937 children in 983 EDs found both short-term and one-year mortality were lower at high-readiness EDs, and estimated 1,442 deaths over the study period could have been prevented if every ED had been high-readiness. Injured children treated at high-readiness EDs had 30 percent lower mortality out to one year.
- A 2023 analysis of 790 U.S. trauma centers found the highest-readiness quartile (scores of 93 or greater) had 17 to 27 percent lower adjusted odds of death than any other quartile. Lower-scoring centers most often lacked a pediatric emergency care coordinator, a pediatric-specific quality improvement plan, and a pediatric disaster plan.

The readiness evidence matters for the closure debate because it identifies what is actually lost when a PICU leaves. It is not primarily the beds. It is the pediatric intensivist in the building, the pediatric-trained nurses who staff the ED on the night shift, the pediatric champion who keeps the protocols current, and the institutional reflex that treats a sick child as a core competency rather than an exception. Hospitals that close pediatric units and keep that infrastructure intact can stabilize and transfer safely. Hospitals that let it erode will not know they have a problem until a child arrives who cannot wait 150 miles.

Siobhan Waldbillig was not quite two years old when she stopped waking up one morning in Helena in 2022. Bacterial meningitis. A local emergency department started antibiotics and flew her 100 miles to Missoula, where she spent more than a week in the PICU that closed this month. Her mother believes those doctors are why she lived. The next child from Helena will fly past Missoula to Kalispell, Spokane, or Seattle. Basu described the front-line concern precisely: a creeping sense that kids are showing up a little bit sicker, without enough data yet to prove it. The data will come. The question is whether anyone is collecting it, and that is one of the recommendations below.

Part Six: What Comes Next

The Medicaid financing shock

Children's hospitals outperformed adult hospitals financially in 2024 and 2025, but profitability fell to a five-year low, and every major analyst now flags the same headwind. The One Big Beautiful Bill Act cuts roughly $1 trillion from Medicaid over ten years. Work requirements don't apply to children, but the law changes provider taxes and state-directed payments; a Manatt Health analysis commissioned by the Children's Hospital Association found that state-directed payments account for 38 percent of total Medicaid funding for pediatric hospitals. Phoenix Children's, where 65 percent of patients are on Medicaid, projected a $75 million annual reduction. Children's Hospital of The King's Daughters in Virginia relies on more than $11 million a year in directed payments to close the gap between Medicaid rates and the cost of advanced care. A Fitch Ratings director called the cuts a long-term headwind. The Children's Hospital Association's CEO said in March 2026 that hospitals are already making financial decisions today based on the expected cuts.

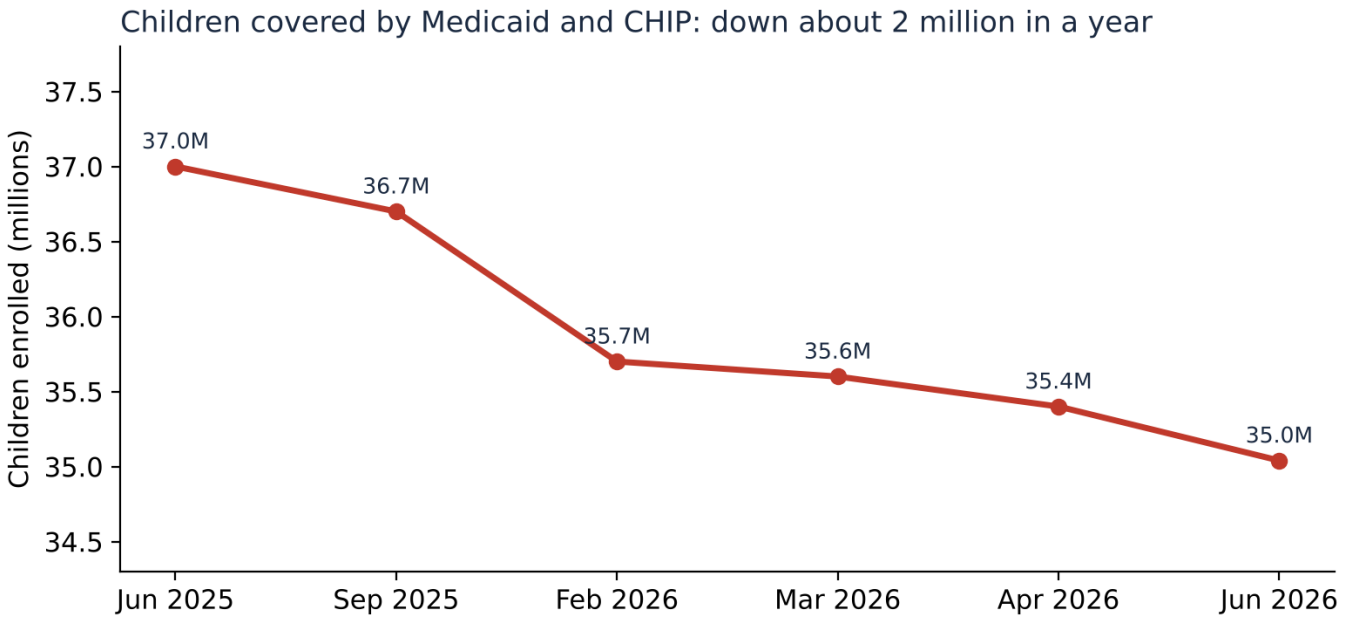


Figure 5. Children enrolled in Medicaid and CHIP, June 2025 to June 2026. Source: CMS Medicaid and CHIP Enrollment Data Highlights.

Enrollment is already falling. Children in Medicaid and CHIP numbered 37.0 million in June 2025 and 35.0 million in June 2026. KFF reports that child enrollment dropped below pre-pandemic levels for the first time in February 2026 and has fallen 7.4 million since the April 2023 peak. Adults are losing coverage faster than children, but public-aid researchers have long documented that when a parent is tangled in paperwork, the child's coverage lapses with it. The medical frailty litigation and the January 1, 2027 work-requirement rollout will accelerate adult churn, and every uninsured parent is a child whose hospital visit becomes uncompensated care.

The projection

Combine a 2.2 percent annual pre-pandemic unit closure rate with lower Medicaid enrollment, reduced supplemental payments, a fellowship pipeline that cannot fill its own slots, and a demographic trend that keeps thinning community pediatric volume, and the direction is clear. At the historical rate alone, the 1,226 hospitals with pediatric units in 2022 fall to roughly 1,100 by 2027 and under 1,000 by 2032. The financing changes make the historical rate a floor, not a forecast. Pediatricians quoted in the KFF investigation expect more cutbacks; the research group that produced the capacity studies is now designing a study to measure whether the closures already made have affected outcomes and costs. That study did not exist when leaders approved the closures.

Part Seven: What Leaders Can Do

The closures described in this report were made by capable executives looking at accurate numbers. The problem is not that they read the spreadsheet wrong. The problem is that the spreadsheet doesn't include the variables that determine whether a child survives, and no one has required it to include them. The recommendations below are organized by who holds the decision.

For community hospital executives and boards considering a closure

- Separate the bed decision from the readiness decision. Closing a PICU can be defensible. Letting ED pediatric readiness drop below the high-readiness threshold (an NPRP score above 87) is not. Require a documented readiness score before and 12 months after any pediatric service reduction, and report it to the board.
- Name a pediatric emergency care coordinator and fund the role. The absence of a PECC is the single most common deficiency at low-readiness hospitals and the cheapest to fix.
- Negotiate the transfer agreement before the closure, not after. The agreement should specify acceptance time, transport mode and funding, a tele-critical-care consult line staffed by the receiving PICU, and a surge clause that addresses what happens when the hub is full.
- Model the surge case, not the average. A unit that averages two patients a month and is empty 25 percent of the time will also be asked for six beds at once in a 2022-style season. Present the board with both numbers.
- Count the downstream services. Before closing a pediatric unit, list every service that depends on the pediatric-trained staff it supports: ED pediatric coverage, pediatric surgery, sedation for imaging, child life, pediatric pharmacy. The capability data show these leave together.

For hub children's hospitals and regional systems

- Treat the community hospitals in the catchment as part of the delivery system, not as referral sources. The Society of Critical Care Medicine and AAP are developing models in which specialty centers establish regional training and transfer protocols with community hospitals. Lead one.
- Publish regional PICU capacity in real time to referring EDs during respiratory season. A community ED should never have to call 20 hospitals.
- Staff tele-critical-care consultation as a service line with its own budget, not as an informal favor. Missoula's remaining pediatricians will consult with distant intensivists to stabilize children; that arrangement should be contractual and measured.

For state and federal policymakers

- Raise pediatric Medicaid reimbursement toward Medicare parity for inpatient and critical care, the single recommendation every study in this report converges on.
- Protect state-directed payments to pediatric providers in the implementation of the OBBBA financing provisions, and require states to report the pediatric share of any reduction.
- Designate low-access pediatric units as critical access services with cost-based or supplemental payment, as the Pediatrics authors have proposed, rather than relying on the market to keep an unprofitable but necessary service open.
- Fund the pediatric subspecialty pipeline directly: loan repayment tied to pediatric critical care and rural pediatric practice, and RVU reform that stops pricing a child's visit at half an adult's.
- Require a child-access impact statement, including distance-to-care and readiness scores, as part of any certificate-of-need or state approval for closing a pediatric unit. Illinois and Massachusetts already require filings; the filings should require the data.

The Pediatric Access Risk Index (PARI)

Executives and boards need a way to evaluate a proposed pediatric closure that is more rigorous than the volume number and less abstract than a mission statement. The Pediatric Access Risk Index scores six factors from 0 (low risk) to 3 (high risk). It is designed to be completed in one meeting using data the hospital already holds, and it is intended to accompany the financial case, not replace it.

Table 3. The Pediatric Access Risk Index: six factors, 0 to 18 points

Factor	0 points (low risk)	1 to 2 points	3 points (high risk)
Distance to next PICU	Under 30 miles or under 45 minutes	30 to 100 miles	Over 100 miles, or air transport required in winter
ED pediatric readiness (NPRP score)	Above 87 with a named PECC	70 to 87	Below 70, or no PECC
Transfer agreement quality	Written, surge clause, tele-consult line, transport funded	Written but no surge clause	Verbal or none
Hub surge capacity	Hub reported under 80 percent peak occupancy last season	80 to 90 percent	Hub exceeded 90 percent, or declined transfers last season
Pediatric Medicaid and uninsured share	Under 35 percent of pediatric volume	35 to 55 percent	Over 55 percent
Dependent services at risk	None; pediatric surgery and ED staffing independent	One or two services share staff	Pediatric surgery, sedation, or ED coverage depend on unit staff

A score of 0 to 5 indicates a closure that can proceed with monitoring. A score of 6 to 11 indicates a closure that should be conditional on named mitigations: a readiness plan, a funded transfer agreement, a surge arrangement with the hub. A score of 12 or higher indicates that closing the unit will shift risk onto children and the receiving system, neither of which has agreed to absorb it, and the board should treat the decision as it would a service closure with a known mortality consequence. Missoula, with a 150-mile transfer distance, an eight-year specialist vacancy, and a rural Medicaid-heavy population, scores in the top band on at least three factors. Kansas City, with Children's Mercy under three miles away and the hub expanding, scores near the bottom. Both hospitals closed their PICUs this year. The index does not say they were wrong. It says they weren't the same decision and shouldn't have been evaluated the same way.

Author Conclusion

The pediatric bed is the canary in American hospital finance. It pays the worst, staffs the hardest, and is needed least often, so it is the first to go when a system is under pressure. Every structural force identified in this report — Medicaid retrenchment, the specialist pay gap, demographic decline, the regionalization doctrine — points toward more closures. None of them is going to reverse on its own.

What can change is how we decide. Right now, a PICU closure is a facility decision justified by a census number. It should be a regional decision justified by a readiness score, a transfer plan, a surge model, and a distance map, and it should be evaluated against the one question that the spreadsheet never asks: when the next Siobhan arrives at two in the morning, who is in the building, and how far is she going to have to go?

Hospitals that closed their pediatric units this year will tell you they made the right call, and in many cases they did. The test will come in the first hard respiratory season, when hubs are full, and community emergency departments start making their calls. Leaders who want a different outcome have about one season to build the network regionalization assumed already existed.

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