CHARTIS

The future of children's hospitals

SEPTEMBER 2026



CHAPTER 1:

Compounding pressures are reshaping what's next for child health

The changing needs of children and families, together with major shifts in the broader healthcare environment, are calling on children's hospitals to lead in new ways.

In many markets, declining birthrates are reducing the base of routine pediatric volume, even as children's needs are becoming more complex. Pediatric discharges involving two or more complex chronic conditions have increased 123%, and more children are experiencing behavioral, developmental, and social challenges that compound medical complexity.[1]

At the same time, advances in treatment are enabling more children with serious and previously life-limiting conditions to survive and thrive, increasing demand for sustained support over longer periods.

This evolving pediatric profile is placing new demands on a care delivery model already challenged by scarce pediatric expertise and mounting financial pressure. Site-of-care shifts and declining community capacity are concentrating more high-acuity, resource-intensive care in children's hospitals. Meanwhile, some of the fastest-rising needs require support beyond the hospital and are not consistently funded through traditional reimbursement.

Children's hospitals will play a unique role, redefined by new capabilities

Rapid advances in artificial intelligence (AI) and other technology, research, and care delivery are creating new possibilities for how children's hospitals can respond to these pressures. These emerging capabilities can help extend scarce expertise, connect care more effectively across settings and over time, and accelerate discovery—allowing children's hospitals to improve care while broadening their impact.

Children's hospitals have always been distinguished by highly specialized pediatric expertise, research capabilities, and trusted relationships with families and communities. As care becomes more distributed and technology-enabled, children's hospitals are uniquely positioned to serve as trusted stewards of pediatric information, evidence, and expertise across a wider network of care and support—ensuring that new models of care remain grounded in the distinct needs of children.

While not every children's hospital will play the same role in the coming years, each will need to determine where it is best positioned to lead across three imperatives.

Partnerships will be critical. The next era of care will require deeper and more intentional collaboration to extend pediatric expertise, combine capabilities and investment, and address needs that increasingly span organizations and sectors.

Three strategic imperatives		
1. Build an integrated pediatric care platform that orchestrates care.	**2. Lead the next generation of pediatric discovery and innovation.**	**3. Mobilize a broader child health ecosystem.**

▲ Partnership enablement ▲		
Care delivery partnerships: Extend pediatric expertise across settings and create shared pathways for coordinated care.	***Innovation and data partnerships:*** Pair pediatric expertise with external capabilities to develop and scale solutions designed for children.	***Ecosystem partnerships:*** Align organizations around unmet needs and build shared approaches to funding, advocacy, and accountability.

Governance | Shared data and technology | Clear roles and pathways | Trust and privacy | Funding models | Measurement and accountability

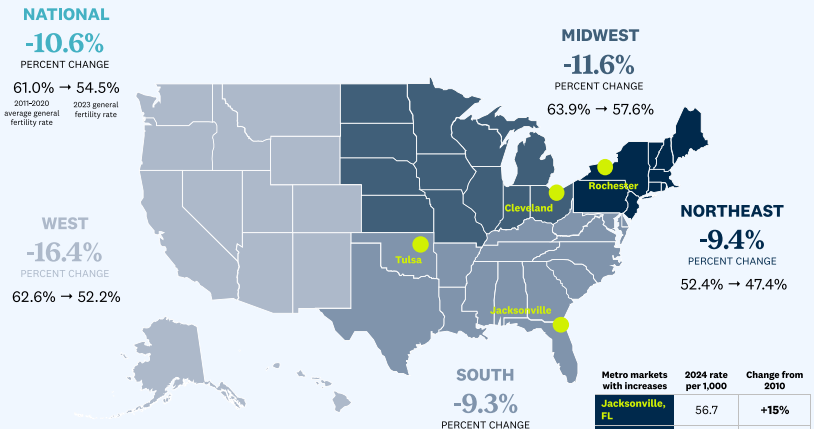
Chapter 2 explores how children's hospitals can lead across each imperative, and Chapter 3 explores what types of partnerships will help put these strategies into practice.

Children's hospitals are facing intensifying headwinds

Pediatric needs are becoming more complex, specialized capacity is growing more constrained, and the economics of caring for children is becoming harder to sustain.

THE PEDIATRIC NEED PROFILE IS CHANGING

FERTILITY RATES ARE DECLINING ACROSS ALL US REGIONS, WITH SELECT METRO EXCEPTIONS



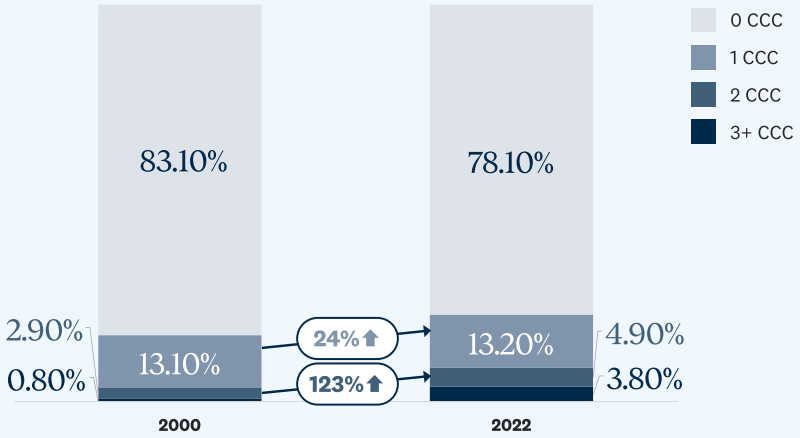
Metro markets with increases	2024 rate per 1,000	Change from 2010
Jacksonville, FL	56.7	+15%
Tulsa, OK	58.7	+9%
Rochester, NY	49.9	+7%
Cleveland, OH	52.6	+5%

Source: "How Record-Low Fertility Rates Foreshadow Budget Strain," Pew, July 2025.

US birthrates and fertility continue to decline, reducing the base of routine pediatric volume in most markets, although population growth and in-migration are sustaining pediatric populations in select areas. Fertility rates are declining broadly across all regions, with rates staying flat or increasing in only six of the 50 largest metro markets.[2]

PEDIATRIC INPATIENT CARE IS BECOMING MORE COMPLEX AS CHILDREN WITH MULTIPLE CHRONIC CONDITIONS ACCOUNT FOR A GROWING SHARE OF DISCHARGES

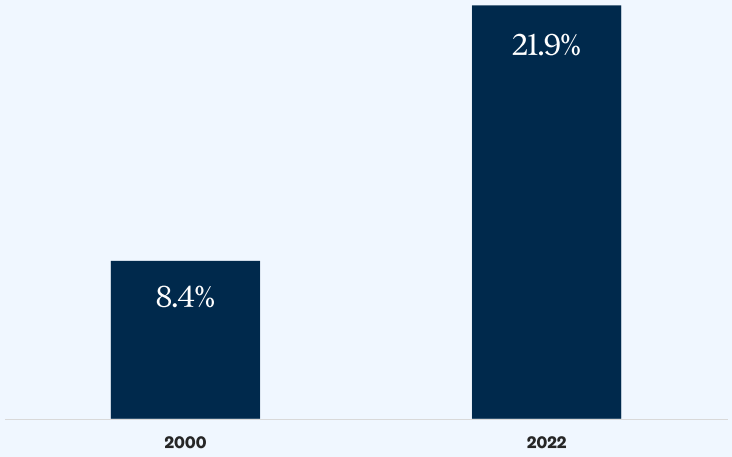
Discharge rates for children with complex chronic conditions (CCCs)



Source: "Trends in Hospital Resource Use for Children With Complex Chronic Conditions," JAMA Network Open, December 2, 2025.
Note: Annual percentages are modeled extrapolations.

The care needs of hospitalized children are also becoming more complex. The discharge rate for children with at least one chronic condition increased by 24%, while the rate among children with two or more chronic conditions grew by more than 120%.[3]

CHILDREN WITH CCCs ARE INCREASINGLY PRESENTING WITH MENTAL HEALTH COMORBIDITIES



Source: "Trends in Hospital Resource Use for Children With Complex Chronic Conditions," JAMA Network Open, December 2, 2025.

Greater medical complexity is increasingly accompanied by behavioral health needs. Diagnosed behavioral health conditions among adolescents have grown nearly 40% since 2016. Mental health comorbidity among children with complex chronic conditions (CCCs) increased from 8.4% in 2000 to 21.9% in 2022.[4]

At the same time, remarkable improvements in treatment mean more children with once-fatal or severely life-limiting conditions are surviving and thriving into adolescence and adulthood. This is increasing the need for long-term, multidisciplinary care across developmental stages.[5]

SURVIVORSHIP GAINS ARE CREATING LONGER-TERM CARE NEEDS

SELECTED INDICATORS OF PROGRESS

Measures and time periods differ by condition; each is a directional proof point.

Pediatric cancer[1]

5-YEAR SURVIVAL FOR ALL CANCERS

63% → 87%

Mid-1970s vs. 2015-2021

521K+

US survivors in 2022

270K in 1997
>580K projected 2040

Critical heart defects[2]

4-YEAR SURVIVAL RATE FOR INFANTS WITH CRITICAL CHD

67% → 93%

1979–1993 vs. 2014–2017

2.4M

people living with CHD (2010)

1.4M were adults

Cystic fibrosis[3]

MEDIAN PREDICTED SURVIVAL FOR INFANTS WITH CF

34 yrs → 66 yrs

2000–2004 vs. 2021–2025

3,337

living with CF in 2025

increase from 3,035 in 2024

Sickle cell disease[4]

MEDIAN PREDICTED SURVIVAL FOR INFANTS WITH SCD

14 yrs → 61 yrs

1973 vs recent academic medical center cohorts

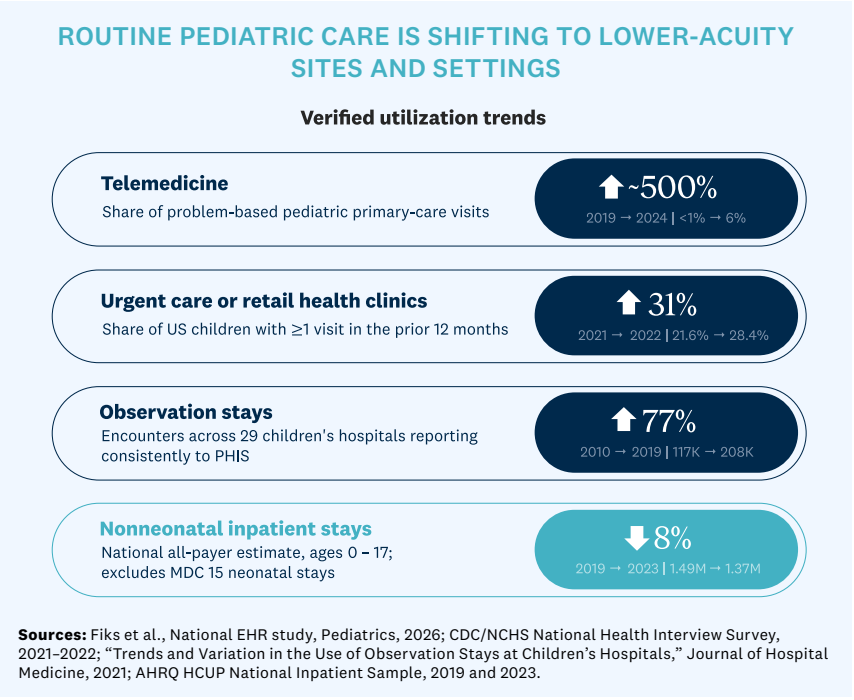
> 95%

US newborns with SCD reach adulthood

~100K living with SCD in US

Source: 1. Pediatric cancer: "ACCR Pediatric Cancer Progress Report 2025," American Association for Cancer Research. 2. Critical heart defects: "Survival From Birth Until Young Adulthood Among Individuals With Congenital Heart Defects: CH STRONG," CDC Stacks, August 2023. 3. Cystic fibrosis: 2025 Patient Registry Highlights, Cystic Fibrosis Foundation, 2025. 4. Sickle cell disease: "Management of Older Adults with Sickle Cell Disease: Considerations for Current and Emerging Therapies," Drugs & Aging, March 2023. "Data and Statistics on Sickle Cell Disease," Centers for Disease Control and Prevention.

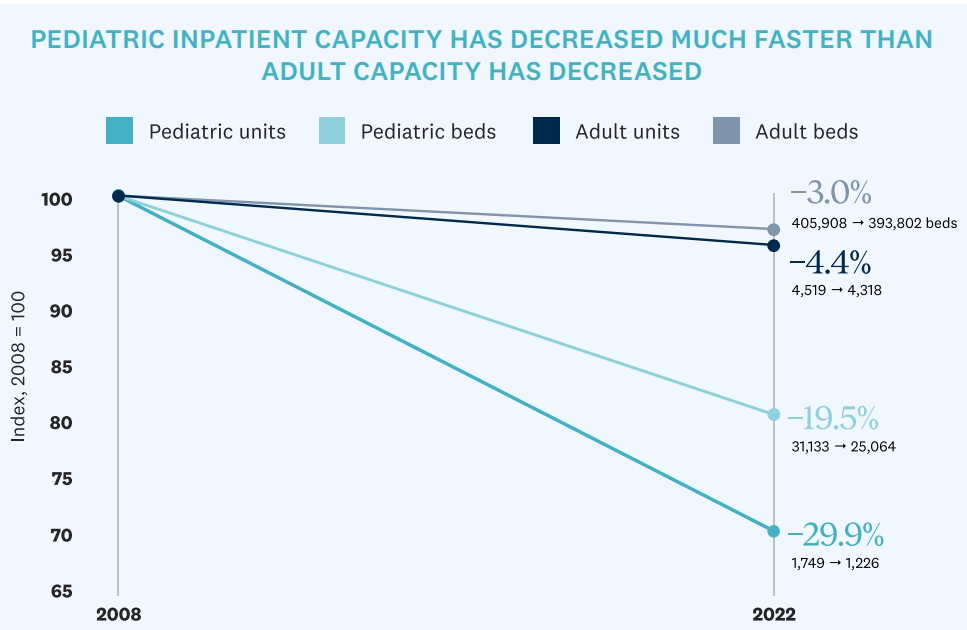
More routine pediatric services are moving to ambulatory, home, and virtual settings, while community pediatric inpatient capacity is declining. Together, these shifts are concentrating a greater share of complex, resource-intensive care in children's hospitals.



Sources: Fiks et al., National EHR study, Pediatrics, 2026; CDC/NCHS National Health Interview Survey, 2021–2022; "Trends and Variation in the Use of Observation Stays at Children's Hospitals," Journal of Hospital Medicine, 2021; AHRQ HCUP National Inpatient Sample, 2019 and 2023.

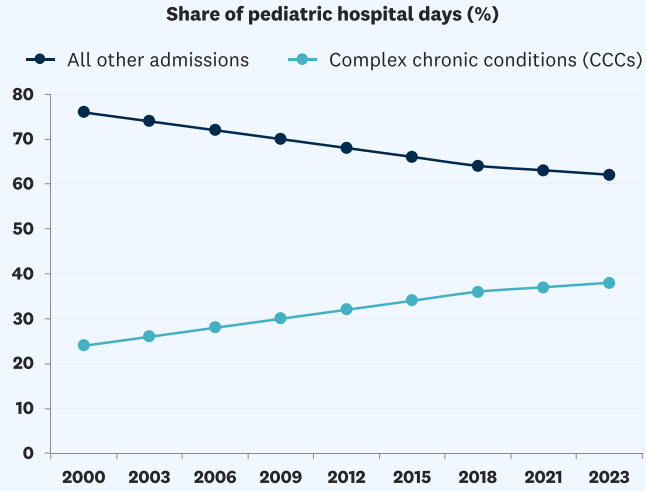
Routine care is increasingly shifting out of traditional inpatient settings to distributed, lower-acuity alternatives. Telemedicine use for problem-based pediatric primary care visits increased approximately 500%, from less than 1% in 2019 to 6% in 2024. Urgent care and retail health clinic use increased 31% from 2021 to 2022. And observation stays increased 77% from 2010 to 2019 across 29 children's hospitals.[6]

Community pediatric inpatient capacity is contracting, with pediatric units closing seven times faster than adult units within the same hospitals.[7]



Source: "National trends in pediatric inpatient capacity," JAMA Pediatrics, 2025.
Note: Based on American Hospital Association annual survey, 2008–2022, across 2,074 hospitals that reported ever having a pediatric inpatient unit.

PATIENTS WITH COMPLEX CHRONIC CONDITIONS (CCCs) REPRESENT A GROWING SHARE OF PEDIATRIC HOSPITAL DAYS



3-5X
higher LOS vs. non-complex patients

38%
of hospital days driven by CCCs (2023)

7-10X
greater resource use per admission episode

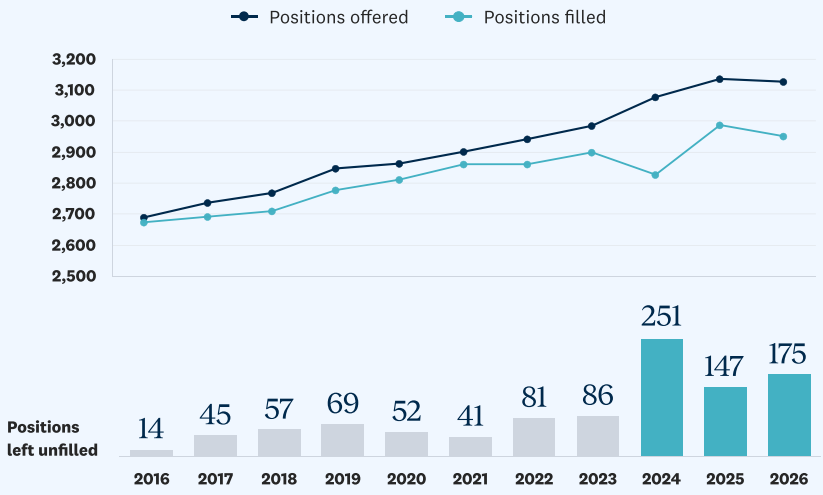
50%
of hospital costs tied to 20% of patients

Source: Chartis analysis. Assumptions derived from Feudtner et al. (BMC Pediatrics, 2014); Berry et al. (JAMA, 2011); and Cohen et al. (Pediatrics, 2012). Annual percentages are modeled extrapolations.

Children with multiple chronic conditions often require more intensive inpatient support, including longer stays, more frequent intensive care unit (ICU) care, and more complex medication management. Traditional reimbursement often does not fully reflect this higher case-mix intensity.

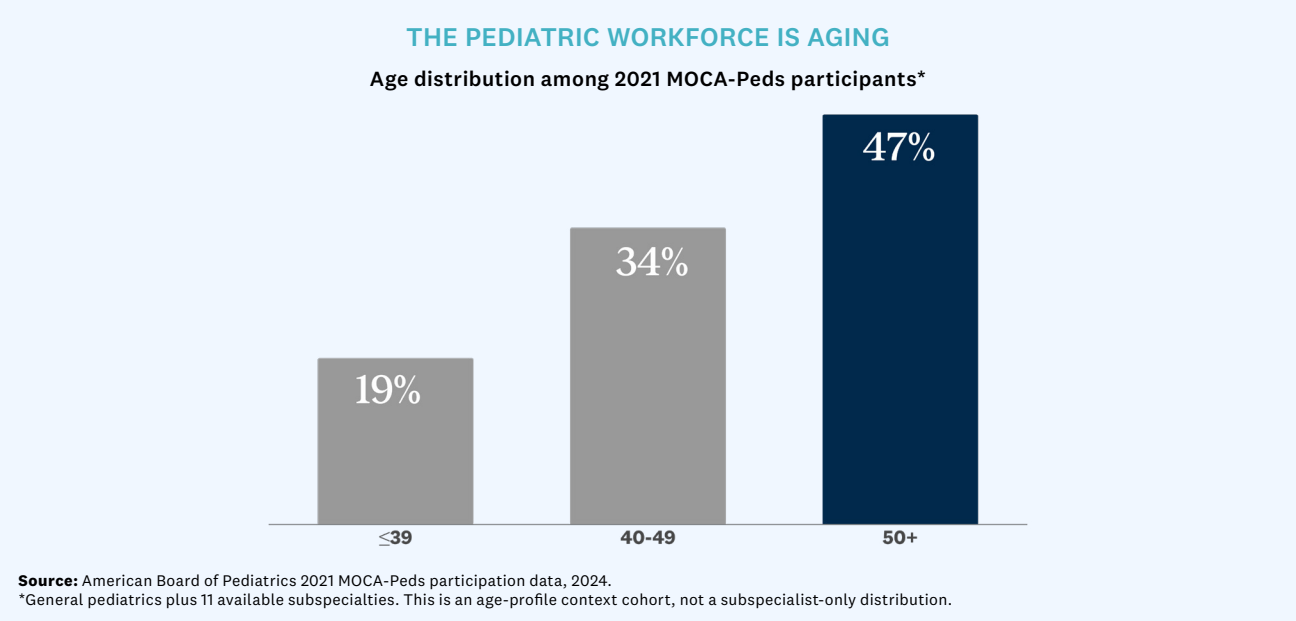
THE EXPERTISE REQUIRED TO MEET THESE NEEDS IS INCREASINGLY CONSTRAINED

PEDIATRIC RESIDENCY FILL RATES ARE DECLINING



Source: National Resident Matching Program (NRMP), Results and Data: Main Residency Match, 2016–2026 (Pediatrics, categorical), and NRMP Match Day press releases.
Note: Match results reflect positions filled through the Main Residency Match algorithm before the Supplemental Offer and Acceptance Program (SOAP). Unfilled positions may subsequently be filled through SOAP.

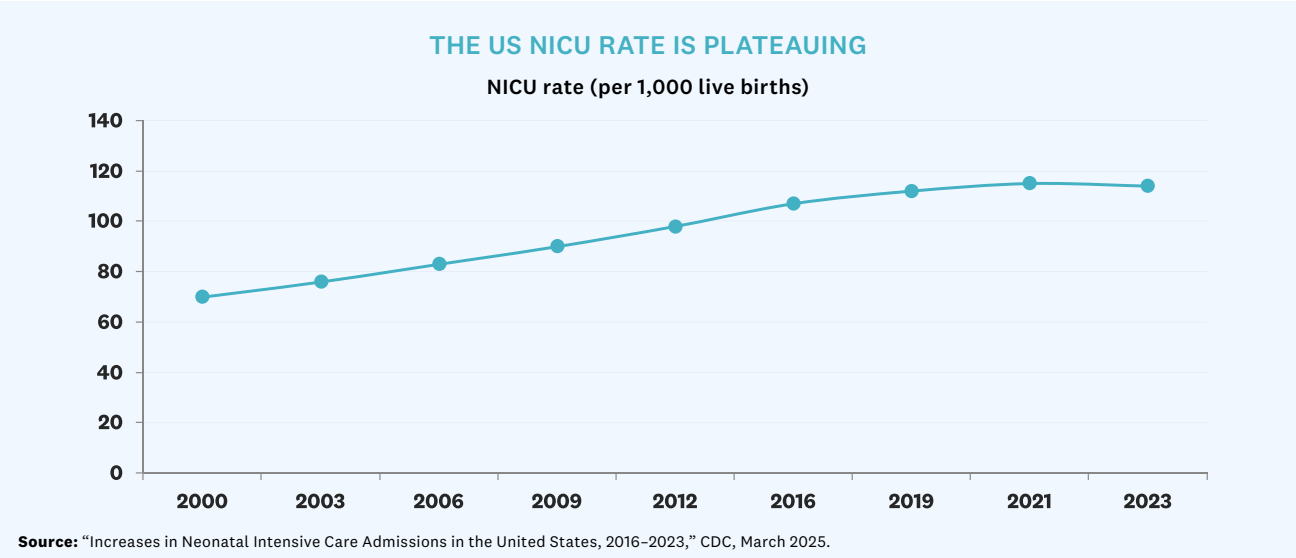
Interest in pediatric specialties has weakened, even as demand for specialized expertise grows. Training capacity has expanded, but more pediatric residency positions are going unfilled, signaling a growing challenge in attracting physicians into the field. Current training trends will take years to reverse because of the long pipeline required to train pediatric specialists.[8]



Source: American Board of Pediatrics 2021 MOCA-Peds participation data, 2024.
*General pediatrics plus 11 available subspecialties. This is an age-profile context cohort, not a subspecialist-only distribution.

The mismatch of expertise and access is especially acute in fast-growing areas, such as behavioral health, where shortages of child and adolescent psychiatrists are compounded by an aging workforce.[9]

THE ECONOMICS OF PEDIATRIC CARE ARE BECOMING HARDER TO SUSTAIN

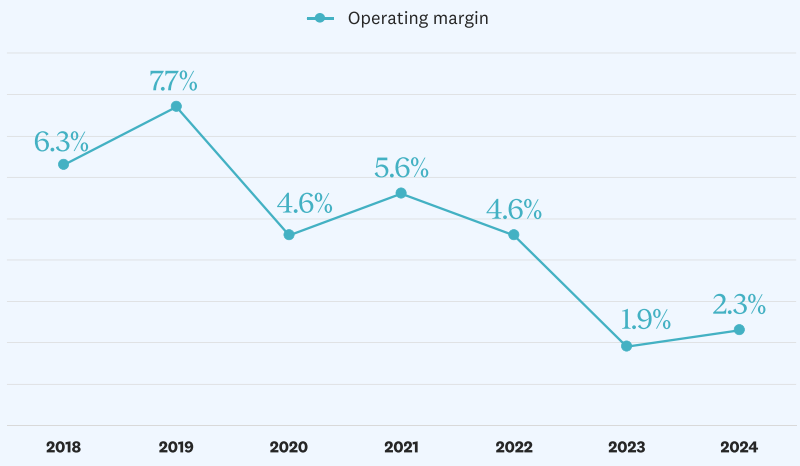


Source: "Increases in Neonatal Intensive Care Admissions in the United States, 2016–2023," CDC, March 2025.

As routine pediatric volume declines in many markets, neonatal intensive care unit (NICU) admission rates are also flattening after rising steadily for two decades. While this is a positive health trend, it also reduces an important financial offset for many children's hospitals.[10]

CHILDREN'S HOSPITAL OPERATING MARGINS ARE TIGHTENING

Children's hospital operating margin medians (2018–2024)



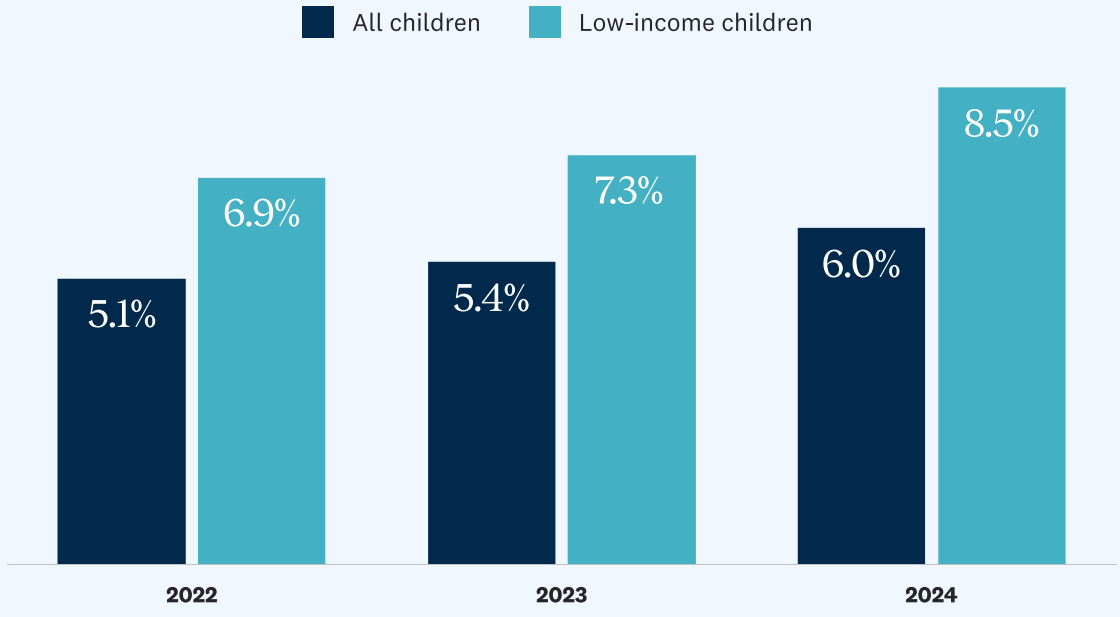
Source: Moody's MFRA data-children's hospital (n=24), Moody's, May 2026.

Broader financial pressures are also intensifying. Children's hospitals highly depend on Medicaid and other public coverage. They also face rising costs associated with highly specialized care, putting further strain on operating margins.

Median operating margins for children's health systems have fallen sharply, declining from 6.3% in 2018 to 2.3% in 2024 and remaining well below pre-pandemic levels.[11]

CHILD UNINSURED RATES ARE RISING AS COVERAGE DECLINES

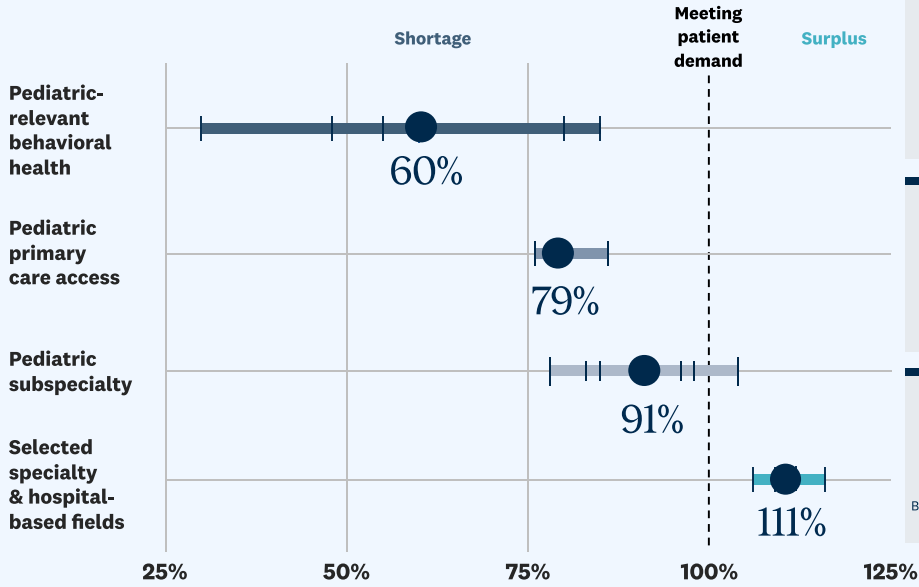
Uninsured rates among US children (2022–2024)



Source: "Children's Health Insurance Coverage: Uninsured Rates Rise for Second Straight Year as Public Coverage Decreases," SHADAC, October 2025.

Uninsured rates among children are rising, with the increase especially pronounced among low-income children, whose uninsured rate reached 8.5% in 2024, compared with 6.0% for children overall.[12]

EMERGING PEDIATRIC NEEDS REQUIRE EXPERTISE THAT IS IN THE SHORTEST SUPPLY



Only 61% of demand met*

Child and adolescent psychiatry by 2038

Projected supply will meet only 61% of demand.

10.3% projected decline†

Pediatric primary care, 2025–2037

Pediatrician supply will decrease from 62K to 55K, while demand will grow 2%.

1.8x regional gap‡

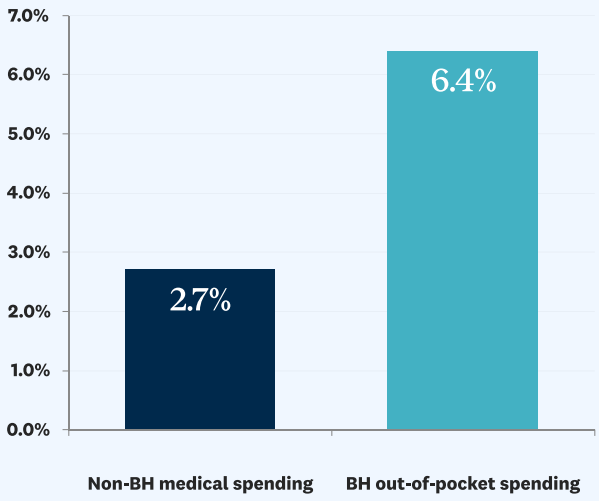
Developmental-behavioral pediatrics

By 2040, the Northeast is projected to have ~1.8x the clinical workforce density of the South.

Source: Chartis analysis based on HRSA/NCHWA 2038 status quo workforce projections, Behavioral Health Workforce Brief 2025, Physician Workforce Projections factsheet, and Workforce Projections Dashboard. *HRSA/National Center for Health Workforce Analysis, State of the Behavioral Health Workforce, 2025. †Workforce Projections on the Supply and Demand of General Pediatricians Across the United States: Identifying Deficiencies to 2037, Academic Pediatrics, April 2026. *Child Health Needs and the Developmental–Behavioral Pediatrics Workforce Supply: 2020–2040, Pediatrics, 2024.
Note: Each small tick is an underlying occupation; the dark dot is a draft category-level roll-up in which FTE gap and adequacy allow recalculation.

Pediatric expertise is highly concentrated, creating access barriers for families and capacity pressure at major pediatric centers. Just 59 freestanding children's hospitals, less than 1% of US hospitals, support 57% of pediatric medical and surgical specialty residents and fellows.[13]

ANNUAL GROWTH IN PEDIATRIC OUT-OF-POCKET HEALTHCARE SPENDING, 2011–2022



Behavioral health (BH) share of pediatric medical spending

22% → 40%

US CHILDREN AGES 6-17 | 2011 - 2022

Total pediatric BH spending

$41.8B

US CHILDREN AGES 6-17 | 2022

Family out-of-pocket BH spending

$2.9B

US CHILDREN AGES 6-17 | 2022

Source: "Expenditures for Pediatric Behavioral Health Care Over Time and Estimated Family Financial Burden," JAMA Pediatrics, December 2025.

Some of the fastest-growing needs, including behavioral health, complex care management, navigation, and longitudinal support, do not align well with traditional encounter-based reimbursement, making these services difficult to scale sustainably.

- Behavioral health accounted for approximately 40% of total pediatric healthcare spending in 2022.[14]
- Families are also bearing more of the cost directly, with out-of-pocket spending for pediatric behavioral health growing more than twice as fast as spending for other pediatric medical care, increasing from $2.1 billion in 2011 to $2.9 billion in 2022.[15]

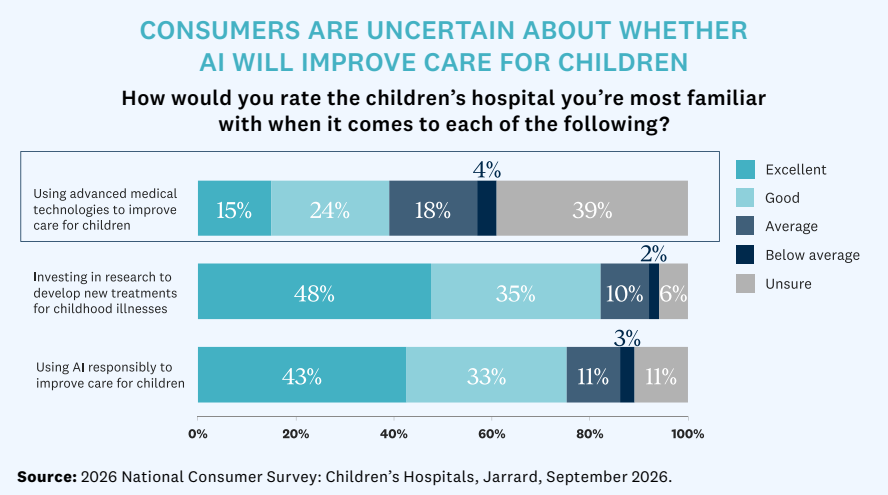
As children's hospitals care for a more concentrated mix of high-acuity and resource-intensive patients, the cost of maintaining specialized pediatric capabilities is becoming increasingly difficult to absorb within traditional reimbursement models.

Highly specialized services require substantial fixed infrastructure, staffing, and around-the-clock capabilities that must be maintained regardless of patient volume.

New capabilities are expanding children's hospitals' options for responding to these mounting pressures

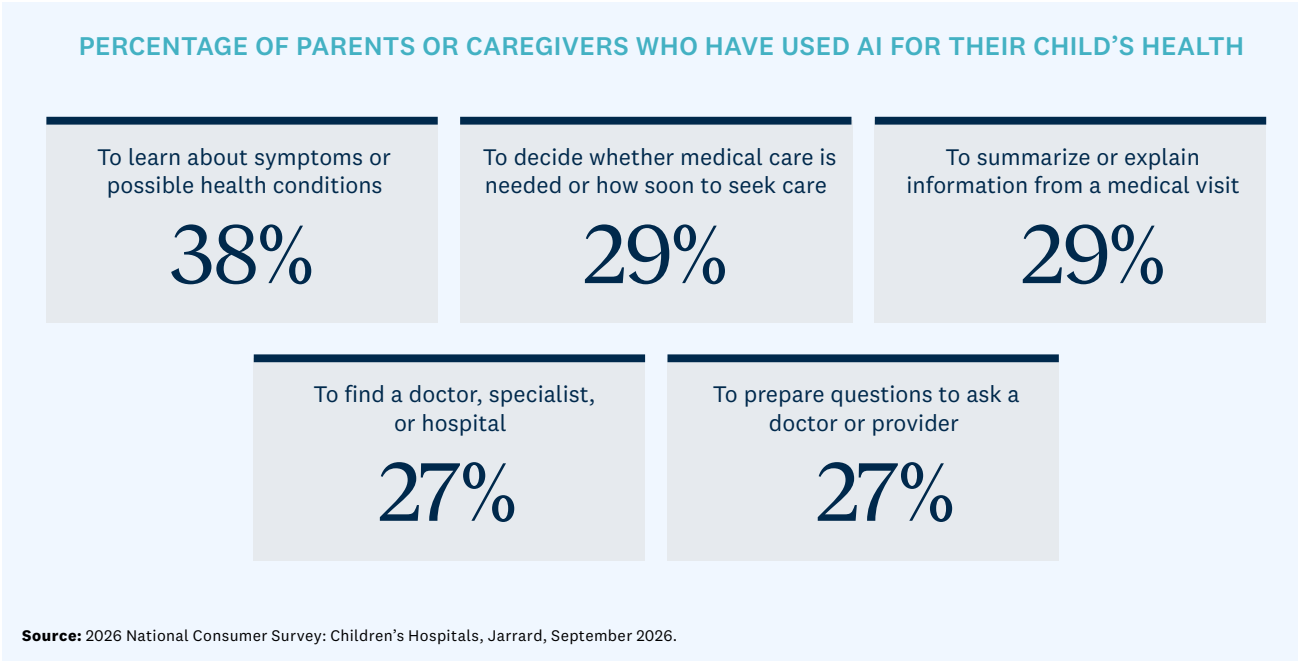
AI, advanced analytics, remote monitoring, and digital tools can support a more connected model of care by extending clinical expertise and helping children receive more proactive support across settings and over time.

Children's hospitals' ability to realize that potential will depend on how well they integrate these capabilities into care delivery. Children's hospitals will need to redesign workflows, engage clinicians and staff, build trust with parents and caregivers, and make deliberate investment choices. Those choices will be especially important given the substantial capital required for AI and advanced technology in an already constrained financial environment.



Source: 2026 National Consumer Survey: Children's Hospitals, Jarrard, September 2026.

Survey findings show that many members of the public remain uncertain about whether AI will improve care for children, underscoring the need for proactive education and communication about how these tools are being used and where they can improve access to expertise and high-quality care.[16]



Source: 2026 National Consumer Survey: Children's Hospitals, Jarrard, September 2026.

Parents and caregivers who have used AI for questions and information related to pediatric health report greater trust in the technology's benefits, suggesting that familiarity and experience may help build confidence over time.

Children's hospitals should take a leading role in how AI and advanced technology are applied to child health. As trusted centers of pediatric expertise, research, and innovation, they can help define appropriate expectations and safeguards—and ensure that new care models are designed around the distinct needs of children and families.

Not every children's hospital will play the same role

The right strategic position will be unique to each institution and market, but each children's hospital should be evaluating where it is best positioned to lead across three imperatives:

1. Build an integrated pediatric care platform that orchestrates care across settings and time.
2. Lead the next generation of pediatric discovery and innovation.
3. Mobilize a broader child health ecosystem around the unmet needs reshaping children's health.

CHAPTER 2:

Three imperatives to lead the next era of child health

Leading in the next era will require children's hospitals to focus on three strategic imperatives. Partnerships will be essential to translating strategy into practice—enabling children's hospitals to extend care, scale innovation, and respond to the unmet needs of children and families.

This chapter explores the three imperatives and the associated considerations for children's hospitals.

Three strategic imperatives		
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▲ Partnership enablement ▲		
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Governance | Shared data and technology | Clear roles and pathways | Trust and privacy | Funding models | Measurement and accountability

1. Build an integrated pediatric care platform that orchestrates care across settings and time

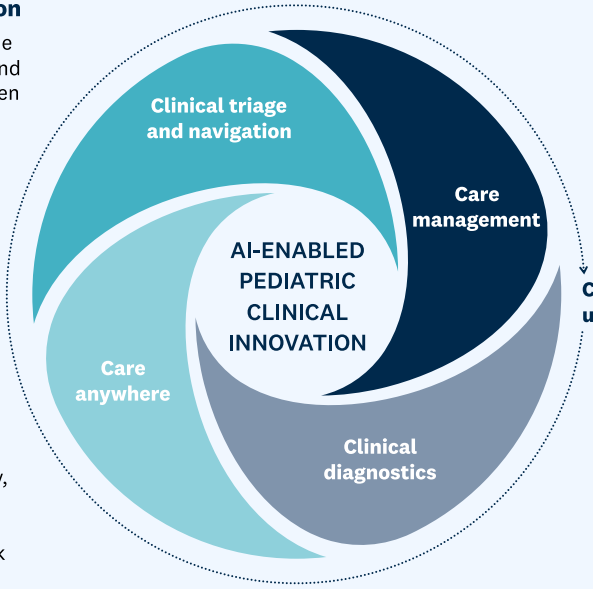
Children's hospitals have multiple avenues for building a more integrated model of care, and many are already investing in new ways to connect care across settings. AI, integrated data, and advanced technology can help improve how needs are identified, extend pediatric expertise beyond the hospital, and support more continuous care over time.

The four core capabilities in the following graphic can work together to extend the reach and impact of children's hospitals, even within the realities of constrained clinical capacity.

AN INTEGRATED PEDIATRIC CARE PLATFORM CONNECTS ACCESS, DIAGNOSIS, DELIVERY, AND ONGOING SUPPORT

Clinical triage and navigation

Identify what a child needs, guide families to the right next step, and help care teams prioritize children who require more urgent or specialized support.



Care management

Support children with ongoing needs through longitudinal monitoring, coordinated follow-up, shared care plans, and earlier intervention when a child's condition or circumstances change.

Care anywhere

Extend pediatric expertise beyond the hospital through virtual, home-based, community, school-based, and partner-supported models, while maintaining clear pathways back to specialty care when needs escalate.

Clinical diagnostics

Enable earlier identification, risk stratification, and more precise clinical decision-making, particularly where pediatric expertise is scarce or highly specialized.

These capabilities are most powerful when they operate as a connected platform rather than as isolated technologies or programs. Continuous unified data flow across triage, diagnostics, care delivery, and longitudinal management can help families and clinicians move more seamlessly across settings and stages of care while making better use of limited specialist capacity.

Children's hospitals should serve as clinical stewards of the information that enables this model. As data increasingly flows from providers, schools, devices, and families, children's hospitals will play an important role in ensuring that information is interpreted and used in ways that reflect the distinct needs of children.

Two design priorities are especially important as children's hospitals build a more connected model: (1) Connecting children and families to the right care in the right setting at the right time and (2) supporting children as their needs evolve over time.

CONNECT CHILDREN AND FAMILIES TO THE RIGHT CARE IN THE RIGHT SETTING AT THE RIGHT TIME

Children's hospitals have expanded access through ambulatory sites, telehealth, digital tools, and regional partnerships. These options create more ways to reach children, but the challenge is to manage these access points and delivery channels as one connected system. Integrated referral pathways, supported by AI and shared data, can help assess needs earlier, guide children to the appropriate setting, and preserve scarce specialty capacity for the patients and services that need it most.

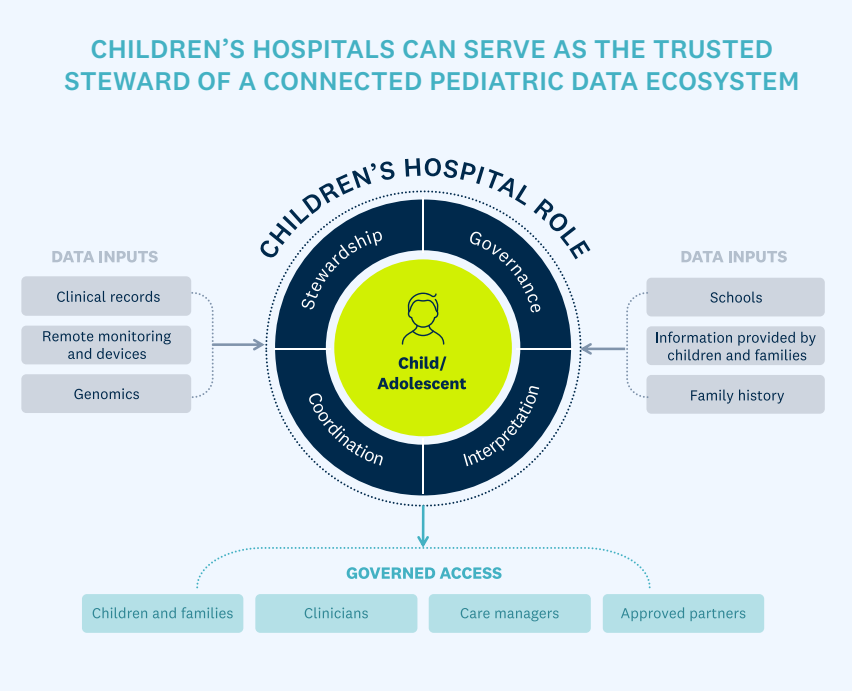
Key considerations include:

- Tailor the reach model by clinical program. Rare conditions and infrastructure-intensive services may need to remain concentrated in a limited number of centers. More routine specialty care may be supported through regional, virtual, home-based, or partner-enabled models.
- Match specialist capacity to the level of need. Children's hospitals should determine where direct subspecialist involvement is essential and where they can extend pediatric expertise through consultation, shared protocols, or decision support.
- Design distinct pathways for children with ongoing needs. Children with chronic conditions may benefit from more care delivered closer to home, which children's hospitals can support with remote monitoring and clear pathways back to specialty care as needs become more complex.
- Redesign workflows and roles across the network. Clinicians and staff will need clear responsibility for triage, follow-up, escalation, and handoffs. AI should support clinical judgment and reduce work rather than add another layer of complexity.
- Extend pediatric knowledge beyond the specialist center. Education, shared clinical guidance, and technology-enabled decision support can help community providers and partners manage appropriate care locally while recognizing when escalation is needed.
- Define and capture the economic value. The benefits may come through better use of specialist capacity, earlier intervention, fewer avoidable emergency visits, and a more manageable experience for families. Children's hospitals should consider how that value can be recognized through Medicaid managed care, value-based arrangements, and other funding models.

SUPPORT CHILDREN AS NEEDS EVOLVE OVER TIME

Many children with complex, chronic, behavioral, or developmental needs require support that changes over time, yet care remains largely organized around scheduled visits and manual follow-up. New capabilities, including remote monitoring, integrated data, and AI-enabled workflows, can support a more proactive model by helping care teams identify meaningful changes earlier and respond between encounters.

A key enabler is a longitudinal health profile that brings together the information needed to understand a child's health, development, and care needs over time. Clinical records can be enriched with relevant data from remote monitoring, genomics, family history, and information contributed by families and care partners. Organized around the child rather than the institution, this profile can become a durable source of information that travels with the child over time and supports more informed care as needs evolve.



CHILDREN'S HOSPITALS CAN SERVE AS THE TRUSTED STEWARD OF A CONNECTED PEDIATRIC DATA ECOSYSTEM

A longitudinal child health profile can create a more complete view of a child over time.

Digital health platforms that have gained traction primarily in adult healthcare are beginning to demonstrate how information from multiple sources can be organized around the individual rather than the institution. For children, the opportunity is particularly significant because the record can evolve with them across developmental stages and care settings. Well-curated longitudinal data can also support research, quality improvement, and other uses beyond direct care.

As the volume and variety of pediatric data grow, children's hospitals can play an important stewardship role. They can help determine what information is clinically meaningful, how it should be interpreted and shared, and how access should evolve as children mature. Privacy, consent, and changing rights to information will be especially important considerations.

Future-state example: A connected pediatric platform can identify needs earlier and bring the right expertise to the child

Building on regional specialty networks, remote monitoring, school-based services, and other models already emerging in pediatrics, a children's hospital could create a more integrated platform that follows a child's needs across settings and over time. With appropriate consent and safeguards, a longitudinal health profile could bring together relevant clinical information, monitoring data, and input from families and care partners, with the children's hospital serving as a trusted steward of that information.

A family might first experience the model when subtle changes suggest that a child needs additional support. For an adolescent with a chronic condition, for example, changes reported by the family, remote monitoring, or patterns identified through approved digital tools could signal rising anxiety or difficulty managing the condition before a scheduled visit or crisis occurs.

AI could help surface the change and guide the family toward the appropriate next step, whether that is virtual support, primary or specialty care, additional monitoring, or evaluation at the children's hospital. A human care team would remain involved when clinical judgment or more complex coordination is needed.

Over time, the child would move through one connected system rather than relying on their family to identify the right entry point each time the child's needs change. Pediatric expertise could reach further upstream and across settings, while highly specialized capacity remains focused on children who need it most.

2. Lead the next generation of pediatric discovery and innovation

Advances in research, technology, and data are creating new opportunities to accelerate pediatric discovery and improve care. Genomic platforms are generating more rapid insights into rare and complex diseases, opening new possibilities for treatments and cures. AI is expanding that potential by making it possible to analyze complex information, pursue questions involving smaller populations, and develop more tailored solutions.

Realizing that promise will require tools, evidence, and care models designed around the distinct needs of children. Yet many emerging technologies and research approaches still rely on generalized or adult-oriented data and assumptions.

Children's hospitals have a critical role in ensuring that this new era of discovery reflects the distinct needs of children. Just as they can serve as stewards of the clinical information that supports more connected care, they can serve as stewards of pediatric evidence, expertise, and discovery. Their role is to ensure that pediatric needs shape the direction of innovation, from the questions pursued to the standards organizations use to bring new solutions into care.

Not every children's hospital will invest to the same degree or in the same areas. Given the sustained investment required, organizations will need to focus on areas where they have distinctive strengths and the potential to create meaningful clinical and strategic value. Partnerships with academic medical centers and research institutions, technology and life sciences companies, and other pediatric healthcare organizations can amplify impact.

Two roles will be particularly important: (1) Setting the standards for pediatric AI and emerging tools and (2) directing investment toward unmet pediatric needs.

SET THE STANDARDS FOR PEDIATRIC AI AND EMERGING TOOLS

The market is already producing a wide range of AI-enabled tools, but they vary significantly in their readiness for pediatric use. Some were designed for children, while others were developed for adult populations and will require further adaptation and validation. Children's hospitals can help determine which tools are ready for use, where more evidence is needed, and when pediatric-specific solutions must be developed.

Leading institutions are beginning to evaluate these tools through staged testing and ongoing monitoring. A children's hospital considering an AI model to identify clinical deterioration, for example, could first test it retrospectively against pediatric patient data and assess whether performance varies by age, diagnosis, race, language, or care setting.

The children's hospital could then pilot the model with clinician oversight before refining workflows for broader adoption. Once deployed, continued monitoring would determine performance across different patient populations and clinical practices.

Importantly, as children's hospitals better adapt and validate these tools for pediatric use, these tools may also help lower the cost of discovery for institutions at the forefront of this work. That potential is especially important as traditional research funding becomes more constrained and children's hospitals face greater limits on their ability to subsidize discovery through operating dollars.

PEDIATRIC AI TOOLS REQUIRE DISTINCT EVIDENCE, VALIDATION, AND OVERSIGHT

READY/IN USE → **RESEARCH/DEVELOPMENT**

NATIVE PEDIATRIC AI Designed specifically for pediatric populations or pediatric care settings *Examples include:*	**Monitoring** AngelEye Health supports NICU family engagement through bedside cameras and virtual care capabilities. It is used by leading children's hospitals, including Children's Hospital of Philadelphia, Lucile Packard Children's Hospital Stanford, and Texas Children's Hospital.	**Diagnostics** Cognoa Canvas Dx is an FDA-cleared, AI-enabled diagnostic aid for autism spectrum disorder in children ages 18–72 months. Trained on pediatric data, it is used by pediatricians across the country.	**Virtual triage/ access** Blueberry Pediatrics provides 24/7 AI-enabled virtual pediatric care, connecting families with board-certified pediatricians and supporting care with at-home diagnostic tools. It is focused exclusively on pediatric care.	**Behavioral health** Hazel Health is a school-based telehealth tool for K–12 behavioral health. It is used in public school systems and partners with Children's Memorial Hermann Hospital to connect school-based care with pediatric services.	**Diagnostics** Researchers at UCSF Benioff Children's Hospitals are evaluating digital analysis of cough and respiratory sounds to support detection of RSV and other respiratory illnesses. These approaches are not yet commercially deployed.
AI VALIDATED/ DEPLOYED IN PEDIATRIC CARE Broader AI platforms being adapted, evaluated, and used in children's hospitals *Examples include:*	**Ambient documentation** Abridge is a broader-market ambient clinical documentation AI platform that has been adapted for pediatric workflows. Many children's hospitals now use it, including UPMC Children's Hospital of Pittsburgh, Seattle Children's Hospital, and Boston Children's Hospital.	**Diagnostics** Fabric Genomics uses AI-enabled genomic analysis to support diagnosis of rare genetic diseases in children. Pediatric genomics programs use this technology, including Rady Children's Institute for Genomic Medicine, Intermountain Primary Children's Hospital, and Cincinnati Children's Hospital Medical Center.	**Operations** LeanTaaS iQueue is used at Monroe Carell Jr. Children's Hospital at Vanderbilt to improve scheduling, patient flow, and nurse workload distribution in pediatric infusion care.	**Precision medicine** Tempus is a precision oncology and genomics company partnering with UCLA Mattel Children's Hospital through its TIME for Kids program. It matches pediatric and adolescent/ young adult oncology patients to biomarker-driven clinical trials.	**Diagnostics** AMIE is a conversational diagnostic AI platform initially developed for adult primary and specialty care settings. It is being evaluated for pediatric-specific design and application.
AI REQUIRING PEDIATRIC VALIDATION Tools developed primarily for adult care that need children's hospital partnership to adapt *Examples include:*	**Clinical decision** Hippocratic AI has created safety-focused AI care agents for patient and caregiver engagement. Pediatric-specific caregiver and family interactions and communications are being actively tested.	**Clinical decision** Viz.ai is an adult stroke/cardiac detection AI tool. Pediatric use would require additional validation and workflow design for pediatric and congenital conditions.	**Monitoring** Biofourmis provides AI-enabled remote monitoring for cardiac and respiratory conditions in adult populations. Pediatric application would require validation of algorithms and escalation protocols for children.	**Documentation** Regard is an AI-powered clinical documentation and automated diagnosis coding tool. It has an adult hospital focus and does not have a confirmed pediatric validation or deployment roadmap.	**Predictive analytics** Research-stage pediatric models are using EHR data to predict deterioration, readmission, length of stay, avoidable admissions, and NICU/PICU risk. These models show promise but require validation before broader clinical deployment.

DIRECT INVESTMENT TOWARD UNMET PEDIATRIC NEEDS

As investment in AI and digital health accelerates, much of it naturally flows toward larger adult markets. Pediatric innovation remains more difficult because populations are smaller, data is fragmented, and validation requirements are high.

Children's hospitals can help overcome those barriers by directing research funding, partnerships, and innovation capacity toward questions that are unlikely to attract sufficient commercial investment without active pediatric leadership. This role may be particularly important for independent children's hospitals whose mission and specialized capabilities allow them to sustain focus on needs that larger healthcare and technology markets may overlook.

Future-state example: A more connected pediatric discovery model can accelerate the path from insight to treatment

Building on advances already emerging in rare disease, genomic medicine, and pediatric AI, a children's hospital could help create a shared discovery platform that connects clinical care with research across institutions. Pediatric data from multiple sources could be continuously reanalyzed as scientific knowledge advances, allowing promising signals to surface earlier and making it easier to pursue questions that individual organizations or small patient populations could not support alone.

A child with a rare or poorly understood condition, for example, might initially receive extensive testing without a clear diagnosis or treatment path. As new evidence emerges, AI could help identify patterns across pediatric datasets and flag a potential diagnosis or therapeutic target. Clinicians and researchers could then work with partner institutions and life sciences organizations to validate the finding and determine whether an existing therapy, clinical trial, or highly tailored treatment could be appropriate.

The children's hospital would play a critical stewardship role throughout, helping determine which questions warrant investment, ensuring that pediatric evidence and validation standards guide development, and translating promising discoveries safely into care. Over time, a model like this could make discovery more continuous, collaborative, and economically feasible for pediatric populations that have historically been difficult to study at scale.

3. Mobilize the broader child health ecosystem around the unmet needs reshaping children's health

Many of the most pressing unmet needs affecting children's health and well-being begin well before a child reaches the hospital. Many of these needs depend on systems outside traditional clinical care. Behavioral and developmental health, food and housing insecurity, transportation barriers, and access to trusted health guidance all require a broader response than healthcare institutions alone can provide.

Children's hospitals are well positioned to help shape a broader response by taking pediatric expertise and trusted leadership beyond the hospital. Digital tools and partnerships can extend their reach, helping to identify needs earlier and connect families to appropriate support across settings.

Survey findings consistently show that parents and caregivers view children's hospitals as trusted sources of information and as institutions that act in the best interests of their communities.[17] This provides a foundation for two important roles: (1) Bringing trusted pediatric expertise into the channels families already use and (2) leading on the issues that require a broader child health response.

BRING TRUSTED PEDIATRIC EXPERTISE INTO THE CHANNELS FAMILIES ALREADY USE

Families and adolescents are increasingly seeking health guidance outside traditional clinical settings. Eight in 10 parents of young children report using social media for parenting information, including topics such as nutrition and sleep. More broadly, nearly 4 in 10 US adults, and about half of adults under the age of 50, get health and wellness information from social media, even though many prominent health influencers lack professional health backgrounds.[18]

Adolescents facing behavioral health challenges may also turn to conversational AI agents when trusted human support is unavailable, with recent cases showing the potential for serious harm.[19]

Children's hospitals can help bring credible pediatric guidance into this increasingly fragmented information environment. Their expertise should be visible in the digital channels where families and adolescents are already seeking answers, with information that helps them understand the level of concern and identify an appropriate next step. Children's hospitals can also help shape the pediatric content and decision pathways embedded in AI-mediated tools so that users are directed toward safe and appropriate support.

LEAD ON THE ISSUES THAT REQUIRE A BROADER CHILD HEALTH RESPONSE

Children's hospitals have routinely focused their leadership and advocacy platforms on issues where pediatric expertise, public credibility, and coordinated action can make the greatest difference.

Children's hospitals can help define a model that identifies needs earlier and extends support into the settings where children already receive care and spend their time. For instance, rather than identifying a behavioral health concern in primary care and referring a family into an already constrained specialty system, an alternate model can place behavioral health clinicians directly in schools to assess and treat children, coordinate with families and school staff, and connect children with more complex needs to psychiatric or crisis services.

The same role applies to developmental health, vaccine confidence, and other needs that depend on coordinated action across healthcare, schools, community organizations, public agencies, and families. Children's hospitals can bring pediatric evidence and clinical insight to these efforts while helping clarify roles, establish shared outcomes, and ensure that children can move more seamlessly between levels of support.

Children's hospitals' firsthand view of unmet needs also gives them an important advocacy role. Survey findings show that parents and caregivers are willing to support children's hospitals' advocacy efforts by contacting elected officials and supporting public funding and tax measures, especially when they see hospitals as good community partners.[20]

That willingness gives children's hospitals an opportunity to mobilize families and communities around policy change and investment in children's health.

What is changing is the ability to pair that longstanding leadership role with deeper partnerships and new technology. Together, these capabilities can help children's hospitals move from convening around a problem to building more coordinated and sustainable responses across the broader child health ecosystem.

Future-state example: A shared navigation model can connect families to support across the healthcare ecosystem

Building on emerging school-based and cross-sector partnership models, a children's hospital could help create a shared navigation model for families whose needs span clinical and community services. Rather than building another standalone program, the hospital could provide pediatric stewardship and navigation infrastructure while partners contribute funding, services, and access to community resources.

A family might enter the model because a child is struggling with anxiety, missing school, and having difficulty managing a chronic condition. Instead of receiving separate referrals from different organizations, the family could be connected to one coordinated pathway that identifies the most pressing needs and organizes support around a shared plan. AI could assist with routine matching and follow-up, while a human navigator steps in when the situation requires judgment or coordination across organizations.

Because the benefits of better navigation accrue across multiple organizations, the funding model could also be shared. For instance:

- A Medicaid plan might invest because better navigation can reduce avoidable utilization.
- Public agencies could support connections to educational or social services.
- Philanthropy could help fund startup costs or services not covered by reimbursement
- The children's hospital could convene stakeholders and contribute infrastructure, clinical oversight, or staff.

Sharing investment across the organizations that benefit from better outcomes could create a more durable model than relying on one institution to fund and operate the full response.

CHAPTER 3:

Integrated partnerships will power innovation and impact

Partnerships will be central to how children's hospitals deliver on the three strategic imperatives.

Children's hospitals have relied on partnerships as an important part of their strategies for decades. The future will require them to build on those relationships and pursue new forms of collaboration that can help them continue to fulfill their missions in a changing environment. Delivering on the three imperatives described in Chapter 2 will require a more intentional partnership portfolio that extends pediatric expertise, advances discovery and responsible innovation, and mobilizes broader action around children's health.

Three strategic imperatives		
1. Build an integrated pediatric care platform that orchestrates care.	**2. Lead the next generation of pediatric discovery and innovation.**	**3. Mobilize a broader child health ecosystem.**

▲ Partnership enablement ▲		
Care delivery partnerships: Extend pediatric expertise across settings and create shared pathways for coordinated care.	***Innovation and data partnerships:*** Pair pediatric expertise with external capabilities to develop and scale solutions designed for children.	***Ecosystem partnerships:*** Align organizations around unmet needs and build shared approaches to funding, advocacy, and accountability.

Governance | Shared data and technology | Clear roles and pathways | Trust and privacy | Funding models | Measurement and accountability

The next era will require more integrated and intentional partnerships to extend pediatric expertise and impact

Historically, many partnerships centered on referrals or research collaborations. Today, financial pressures and the growing scarcity of specialized pediatric expertise are increasing the need for broader and more integrated models. Across markets, children's hospitals are exploring arrangements that range from shared clinical capabilities and combined programs to joint ventures and full organizational integration.

Several forces are making deeper partnerships more important. Care increasingly spans organizations and settings, while many of the most urgent needs affecting children cannot be addressed through healthcare alone. Simultaneously, constrained resources are making it harder for any one organization to build and sustain every capability independently.

Partnerships can help spread investment, combine complementary capabilities, and create more financially sustainable models. In many cases, the strategic question is not whether a children's hospital can build a capability alone but whether partnership can extend its impact more effectively and sustainably.

Three types of partnerships will be especially important because they correspond to the areas where children's hospitals will need to expand their role most significantly:

1. Clinical partnerships can extend pediatric expertise and sustain capabilities that are difficult to maintain independently.

2. Innovation and data partnerships can combine pediatric expertise with capabilities needed to accelerate discovery and bring new solutions into care.

3. Ecosystem partnerships can bring organizations together around needs that no single institution can address alone.

1. Clinical partnerships can extend pediatric expertise and sustain scarce capabilities

Clinical partnerships are becoming a core part of the care delivery operating model rather than functioning primarily as referral relationships. Shared pathways, common clinical standards, and technology-enabled support can help partners determine what care should remain local, when specialty input is needed, and when a child should move to a higher level of care. This allows children's hospitals to broaden access to pediatric expertise without requiring every site to replicate the full depth of specialized capabilities.

These arrangements can also make pediatric access more sustainable. Organizations can distribute services more deliberately, reduce unnecessary duplication, and preserve capabilities that might be difficult for an individual institution to support alone.

The appropriate structure will vary by clinical need and market. Relationships with adult health systems can bring pediatric specialty capabilities into regions that lack sufficient scale to sustain them independently. Other models can connect specialty centers more closely with primary care and community providers.

Whatever the structure, the central challenge is creating an operating model that allows partners to function as a clinically coherent system. Clear roles, common standards, escalation pathways, and accountability for quality must be accompanied by an economic model that defines how costs and value are shared. Technology can strengthen connections across the network, but it cannot substitute for underlying alignment.

2. Innovation and data partnerships can accelerate pediatric discovery and expand access to new capabilities

The next wave of pediatric discovery will increasingly depend on capabilities that sit across institutions. Children's hospitals bring pediatric clinical expertise, data, and understanding of unmet needs, while external partners can contribute technical expertise, research infrastructure, capital, and pathways to broader development and adoption.

These collaborations are particularly important in pediatrics because smaller populations and markets can make it difficult to generate the scale or investment required to develop new solutions independently. Partnership can make that work more feasible while ensuring that pediatric priorities remain central.

As trusted stewards of pediatric information and evidence, children's hospitals help establish the standards under which new tools are developed, validated, and adopted. Agreements should address performance expectations, data governance, and accountability. They also should address how the organizations will share value from new intellectual property or commercial products produced from the partnership.

The stewardship of pediatric data is particularly important as information collected in childhood raises important questions about consent, caregiver access, privacy, and future use. These considerations need to be built into the partnership itself rather than addressed after a technology has already been developed.

3. Ecosystem partnerships can align organizations around needs no single institution can address alone

Many of the most pressing needs affecting children are beyond the reach of a single health system. Behavioral health, developmental needs, and the conditions in which children live and learn often require sustained action across healthcare, schools, government, and community organizations.

Children's hospitals already play an important role in bringing pediatric evidence and clinical insight to these efforts while helping partners organize around shared priorities and outcomes. The need for these efforts is becoming more important, and children's hospitals can play a critical role in both convening organizations around a common response and clarifying where different organizations can contribute and how progress will be measured.

Funding is often one of the largest barriers, particularly because the organization that invests in earlier intervention may not be the one that realizes all the resulting benefits. That makes shared investment especially important. Different partners can contribute according to their roles, helping sustain services whose benefits reach across care, education, and other supports for children and families.

Better behavioral health support, for example, may reduce emergency utilization, improve school attendance, or lower future public spending. More sustainable models can bring together the organizations that share responsibility for those outcomes and align resources around a common goal.

Funding could come from a combination of hospital investment, Medicaid plans, public agencies, philanthropy, employers, or community organizations. By pooling resources around shared priorities, these partners can help sustain services such as navigation, screening, virtual support, and resource connection without relying primarily on short-term grants or one institution's operating budget.

Collaboration can help sustain highly specialized pediatric capabilities that are increasingly difficult to support alone

Children's hospitals are developing new forms of collaboration to sustain high-volume, high-quality congenital heart programs as the clinical, workforce, and financial requirements of these programs become increasingly difficult for individual institutions to support alone.

Children born with severe forms of congenital heart disease require highly specialized, coordinated care supported by an extensive clinical and physical infrastructure. Successful programs bring together pediatric specialists across cardiology, cardiac surgery, anesthesiology, neonatology, and intensive care, along with specialized nurses, pharmacists, advanced practice providers, respiratory and physical therapists, and technical teams supporting cardiac operating rooms, ICUs, and catheterization labs. The physical requirements are equally significant, requiring ongoing investment in state-of-the-art facilities, technology, and equipment.

Maintaining that depth of capability is particularly important because, for the most complex congenital heart procedures, volume is associated with outcomes. Congenital heart surgery cases are categorized from STAT 1 to STAT 5 based on complexity. A recent study found that, after adjusting for patient and case complexity, lower-volume hospitals had higher operative mortality for STAT 4 and 5 procedures.[21] Yet only approximately 5,000–6,000 of these highly complex cases are performed annually, with roughly 30% concentrated in the 20 largest pediatric congenital heart programs.

These requirements are becoming more difficult to sustain amid the broader headwinds facing children's hospitals, including financial pressure and growing workforce constraints. Congenital heart programs are among the most capital- and workforce-intensive pediatric services, requiring continued investment in specialized facilities, equipment, and clinical teams.

Workforce pressures are particularly acute in pediatric anesthesia and even more pronounced in pediatric cardiac anesthesia. Declining Match rates are creating recruitment and retention challenges.

CONTINUED ON NEXT PAGE

Meanwhile, more than half of practicing pediatric cardiac anesthesiologists are over age 55, which increases the potential for further shortages as physicians retire over the coming decade.[22]

Together, these pressures are driving children's hospitals toward new forms of collaboration to sustain high-volume, high-quality programs while making better use of scarce expertise and infrastructure.

Collaborative models include independent children's hospitals partnering with pediatric programs within larger integrated delivery networks, as well as independent children's hospitals working together across geographies. Some organizations are moving beyond traditional affiliations to shared governance, financial alignment, and deeper clinical integration. Technology, remote connectivity, and evolving data-sharing models can further enable these networks by allowing scarce expertise to extend across organizational and geographic boundaries.

For highly specialized services, such as congenital heart care, these models can provide a bridge to the future by concentrating the capabilities that benefit from scale while extending expertise and appropriate elements of care closer to patients.

Leading the next era of child health

Children's hospitals have consistently helped define a better future for the health and well-being of children. These essential institutions within the fabric of US healthcare will face new challenges and intensifying pressures in the years ahead, but they also have a unique opportunity to reimagine how they deliver care, advance discovery, educate, and extend their impact.

Partnerships, long a mainstay of pediatric organizations, are also entering a new phase of deeper collaboration and a broader view of what is possible. Changing demographics, rising pediatric complexity, and growing economic pressure will demand new approaches. At the same time, advances in technology, research, and care delivery are expanding what is possible for children's hospitals.

Children's hospitals that act now can take a leading role in shaping the next model of pediatric care and ensuring it is built around the evolving needs of children and families.

Sources

1. Nathaniel D. Bayer et al. “Trends in Hospital Resource Use for Children With Complex Chronic Conditions,” Dec. 2, 2025, JAMA Network Open, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2842166.

2. Joanna Biernacka-Lievestro et al., “How Record-Low Fertility Rates Foreshadow Budget Strain,” The Pew Charitable Trusts, https://www.pew.org/en/research-and-analysis/articles/2025/07/08/how-record-low-fertility-rates-foreshadow-budget-strain.

3. Nathaniel D. Bayer et al. “Trends in Hospital Resource Use for Children With Complex Chronic Conditions,” Dec. 2, 2025, JAMA Network Open, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2842166.

4. Nathaniel D. Bayer et al. “Trends in Hospital Resource Use for Children With Complex Chronic Conditions,” Dec. 2, 2025, JAMA Network Open, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2842166.

5. “AACR Pediatric Cancer Progress Report 2025,” American Association for Cancer Research, Dec. 4, 2025, https://cancerprogressreport.aacr.org/pediatric/pcpr25-contents/.

   Karrie F. Downing et al., “Survival From Birth Until Young Adulthood Among Individuals With Congenital Heart Defects: CH STRONG,” Aug. 15, 2023, Circulation, https://stacks.cdc.gov/view/cdc/133846.

   Charity I. Oyedeji et al., “Management of Older Adults with Sickle Cell Disease: Considerations for Current and Emerging Therapies,” April 2023, Drugs & Aging, https://pubmed.ncbi.nlm.nih.gov/36853587/.

   “Data and Statistics on Sickle Cell Disease,” Centers for Disease Control and Prevention, https://www.cdc.gov/sickle-cell/data/index.html.

   “2025 Patient Registry Highlights,” Cystic Fibrosis Foundation, 2025, https://www.cff.org/medical-professionals/2025-patient-registry-highlights.

6. Alexander G. Fiks et al., “Telemedicine Use in Primary Care for Children: 2019–2024,” Pediatrics, 2026, https://doi.org/10.1542/peds.2025-075498.

   “2021 NHIS Questionnaires, Datasets, and Documentation,” National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention, 2021, https://www.cdc.gov/nchs/nhis/documentation/2021-nhis.html.

   “2022 NHIS Questionnaires, Datasets, and Documentation,” National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention, 2022, https://www.cdc.gov/nchs/nhis/documentation/2022-nhis.html.

Yao Tian et al., "Trends and Variation in the Use of Observation Stays at Children's Hospitals," Journal of Hospital Medicine, July 21, 2021, https://doi.org/10.12788/jhm.3622.

"National Inpatient Sample," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, 2019 and 2023, https://hcup-us.ahrq.gov/nisoverview.jsp.

7. Kenneth A. Michelson et al., "National Trends in Pediatric Inpatient Capacity," JAMA Pediatrics, December 2024, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2826774.

8. "Results and Data: 2016–2026 Main Residency Match," National Resident Matching Program, 2016–2026, https://www.nrmp.org/data-topic/results-and-data/?post_type=match-data.

   "NRMP Releases Results for the Main Residency Match," National Resident Matching Program, 2016–2026, https://www.nrmp.org/data-topic/residency-match-soap/?post_type=match-data.

9. Chartis analysis based on "Workforce Projections," National Center for Health Workforce Analysis, Health Resources and Services Administration, data as of Dec. 18, 2025, https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections; "State of the Behavioral Health Workforce, 2025," National Center for Health Workforce Analysis, Health Resources and Services Administration, 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf; and "Physician Workforce: Projections, 2023–2038," National Center for Health Workforce Analysis, Health Resources and Services Administration, December 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf.

10. Joyce A. Martin and Michelle J.K. Osterman, "Increases in Neonatal Intensive Care Admissions in the United States, 2016–2023," NCHS Data Brief No. 525, Centers for Disease Control and Prevention, March 2025, https://www.cdc.gov/nchs/products/databriefs/db525.htm.

11. Moody's MFRA data-children's hospital (n=24), Moody's, May 2026.

12. Zoe Pringle, "Children's Health Insurance Coverage: Uninsured Rates Rise for Second Straight Year as Public Coverage Decreases," SHADAC, Oct. 21, 2025, https://www.shadac.org/news/childrens-health-insurance-coverage-2024-uninsured-rates-rise.

13. Chartis analysis based on "Workforce Projections," National Center for Health Workforce Analysis, Health Resources and Services Administration, data as of Dec. 18, 2025, https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections; "State of the Behavioral Health Workforce, 2025," National Center for Health Workforce Analysis, Health Resources and Services Administration, 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf; and "Physician Workforce: Projections, 2023–2038," National Center for Health Workforce Analysis, Health Resources and Services Administration, December 2025, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf.

14. Ashley A. Foster et al., "Expenditures for Pediatric Behavioral Health Care Over Time and Estimated Family Financial Burden," Dec. 15, 2025, JAMA Pediatrics, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2842604.

15. Ashley A. Foster et al., “Expenditures for Pediatric Behavioral Health Care Over Time and Estimated Family Financial Burden,” Dec. 15, 2025, JAMA Pediatrics, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2842604.

16. 2026 National Consumer Survey: Children’s Hospitals, Jarrard, September 2026, https://jarrardinc.com/resources/2026-childrens-survey/.

17. 2026 National Consumer Survey: Children’s Hospitals, Jarrard, September 2026, https://jarrardinc.com/resources/2026-childrens-survey/.

18. Dylan Scott, “Do health influencers actually know what they’re talking about?,” Vox, May 7, 2026, https://www.vox.com/good-medicine-newsletter/487970/health-and-wellness-social-media-influencers-pew-report.

    Joanna Biernacka-Lievestro et al., “How Record-Low Fertility Rates Foreshadow Budget Strain,” July 8, 2025, The Pew Charitable Trusts, https://www.pew.org/en/research-and-analysis/articles/2025/07/08/how-record-low-fertility-rates-foreshadow-budget-strain.

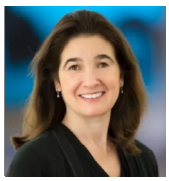
19. Kate Payne, “An AI chatbot pushed a teen to kill himself, a lawsuit against its creator alleges,” Oct. 25, 2024, AP News, https://apnews.com/article/chatbot-ai-lawsuit-suicide-teen-artificial-intelligence-9d48adc572100822fdbc3c90d1456bd0.

20. 2026 National Consumer Survey: Children’s Hospitals, Jarrard, September 2026, https://jarrardinc.com/resources/2026-childrens-survey/.

21. Karl F. Welke et al., “Contemporary Relationship Between Hospital Volume and Outcomes in Congenital Heart Surgery,” December 2023, The Annals of Thoracic Surgery, https://www.annalsthoracicsurgery.org/article/S0003-4975(23)00904-9/fulltext.

22. Lindsey Loveland and Susan Nicolson, “Back to Basics: A Curriculum to Address the Pediatric Cardiac Anesthesia Workforce Crisis,” November 2025, Pediatric Anesthesia, https://www.researchgate.net/publication/397298644_Back_to_Basics_A_Curriculum_to_Address_the_Pediatric_Cardiac_Anesthesia_Workforce_Crisis.

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