adults than Michigan, so they would receive proportionately larger increases in federal Medicaid funding, but their lower state tax rates would generate less revenue. Nonetheless, a 2013 review of the projected economic impact of Medicaid expansion in 10 states predicted all positive effects.[5]

Our results indicate that continuing Michigan's Medicaid expansion in 2017 and beyond will have clear economic benefits for the state. The state-budget gains outweigh the added costs for at least the next 5 years — and probably longer, when additional Michigan-specific taxes and contributions for Medicaid expansion from health plans and hospitals are included. Similar economic benefits are almost certainly accruing to the other 30 states that have expanded Medicaid, but not to the 19 states that haven't done so. State policymakers can consider these benefits along with health and financial effects for enrollees as they decide whether to continue or initiate Medicaid expansion.

An audio interview with Dr. Ayanian is available at NEJM.org

The views expressed in this article are those of the authors and do not represent official positions of the Michigan Department of Health and Human Services or the Centers for Medicare and Medicaid Services.

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Caring for Children by Supporting Parents

Mark A. Schuster, M.D., Ph.D., and Elena Fuentes-Afflick, M.D., M.P.H.

A mother brings her toddler in for a well-child visit. When the pediatrician asks how things are going, the mother says everything's fine. The pediatrician asks whether she's getting enough support at home, to which she cautiously responds that some days can feel like more than she can handle. Delving a little deeper, the pediatrician learns that the mother recently lost her father, is having trouble sleeping, and hasn't been engaging and playing with her child. After the pediatrician determines that the mother is not at immediate risk for harming herself or her child, the clinic nurse helps her make an appointment with her primary care provider.

A single father brings his 6-year-old child to a family physician for increased wheezing. When the physician asks about asthma triggers, the father responds that he and his child have been sleeping in the car some nights and at a friend's apartment other nights. A social worker who works in the physician's office refers them to a shelter that can help with temporary housing as well as food, clothing, and job counseling.

Supporting children's health and development often starts with supporting the parents. Children's brains develop rapidly during their first few years of life, and acquisition of knowledge and skills during early childhood sets the stage for future health and well-being. Parents shape children directly through the environment they create at home and indirectly through their choices of community, childcare, and schools. Studies have consistently documented the importance of the parent–child relationship for children's well-being and healthy development. Researchers have identified a wide range of parenting practices associated with improved child outcomes in areas such as social–emotional and cognitive functioning, school performance, and mental and physical well-being (see table).

Physicians (and other clinicians providing primary care) are expected to offer parents of young children anticipatory guidance ad-

Selected Parenting Practices and Outcomes.

Parenting Practice	Outcomes
Obtaining prenatal care	Reduced risk of poor birth outcomes; management of pregnancy complications
Ensuring adequate nutrition and physical activity	Ability to regulate food intake and weight status; promotion of normal growth and development
Monitoring (supervising children's activities and being aware of where they are and whom they are with)	Limited exposure to potential hazards; reduced risk of psychological and physical harm
Promoting household and vehicle safety	Reduced risk of unintentional injury; reduced risk of vehicle-related injury or death
Using appropriate discipline	Improved child emotional and behavioral health; reduced child aggression
Showing warmth and sensitivity	Enhanced social and linguistic competence; positive child–parent interactions
Engaging in contingent responsiveness (an interaction approach in which a parent is sensitive to a child's needs or cues and responds appropriately)	Secure attachment between child and parent; development of children's sense of self
Establishing routines and reducing household chaos	Development of self-regulatory skills; improved sleep and oral health
Reading books with and talking to children	Enhanced language development; stimulation of children's cognitive development

dressing many of these topics. For example, physicians can discuss appropriate discipline and positive parent–child interaction techniques, which have been shown to reduce children's behavior problems and improve social competence.[1] They can also help parents reduce childhood injuries by encouraging home-safety practices such as installation of fitted stair gates and safe storage of cleaning products.[1] And they can foster positive parenting behaviors by implementing clinic-based programs such as Reach Out and Read, which can improve early language development.[2]

Despite the abundance of research on parenting, there is little consensus on which parenting behaviors most effectively promote children's well-being. Physicians, educators, and policymakers haven't consistently incorporated research findings into policy and practice, so it's unclear how physicians can best support the parents of young children. Furthermore, changing demographics and increasing diversity of family structures in the United States underscore the need for a nuanced and updated approach to supporting parents and others who serve in parental roles, such as grandparents, adult siblings, and foster parents.

The Department of Health and Human Services and the Department of Education, along with other agencies and foundations, commissioned a National Academies of Sciences, Engineering, and Medicine report to inform the development of a national framework for policies, practices, and research to strengthen parents' capacity to nurture children from birth to 8 years of age. We served on the multidisciplinary committee that was charged with identifying parenting knowledge, attitudes, and practices that are associated with positive parent–child interactions and child outcomes; outlining strategies to support widespread adoption of effective parenting approaches; and exploring ways of strengthening parenting capacity and facilitating parents' participation in programs and services.[1]

Our committee recognized that parents are not alone in having a strong influence on children's healthy development. Local and national organizations, schools, and government agencies provide programs and services that address children's health and well-being and support parents in attending to children's needs. Studies have reported broad social and economic benefits associated with providing parents with such help.

The health care system and

health care providers play an important role in supporting parents. Primary care providers are the only professionals who have ongoing contact with virtually all young children and their parents starting in infancy. Over their first 3 years, children are supposed to have 12 preventive health visits, with annual visits thereafter, and they tend to have an even higher number of sick visits. Child care providers and teachers, religious leaders, and social workers and community health workers interact with many children and parents, but primary care providers are expected to interact with all children and their parents. They are specifically charged with teaching parents about raising healthy children, and they serve as a resource to help parents with their concerns and challenges related to parenting.

Our report recommends that physicians support parents through one-on-one interactions, practice- or clinic-based programs, referrals to community programs, and partnerships with public- and private-sector initiatives. Physicians can provide parents with anticipatory guidance related to their child's development and prepare them to respond to children's behaviors in ways that promote health. Physicians already educate parents about a wide range of topics such as eating habits, discipline, and firearm safety. Our report also calls for physicians to assess parents' needs, especially related to the parent–child relationship, so they can intervene before serious problems develop and make referrals for additional sources of support.

Within the constraints of the typical 15-to-30-minute pediatric visit, physicians may find it challenging to expand the amount of counseling they provide to parents. However, physicians can adopt team-based approaches to care through which nurses, social workers, community health workers, and other professionals assist with eliciting parents' concerns, provide education and counseling, and help with referrals to clinic- or community-based programs.

Physicians can provide parents with anticipatory guidance related to their child's development and prepare them to respond to children's behaviors in ways that promote health.

Evidence regarding strategies for incorporating parental education and counseling into pediatric visits is limited. However, our committee identified several evidence-based programs that provide support to parents, teach effective parenting practices, and offer guidance about children's development. Our committee recommends that physicians incorporate some of these programs into their practices and refer families to community-based programs. For example, Healthy Steps for Young Children trains nonphysician pediatric health workers to offer enhanced anticipatory guidance and referrals through office-based interactions and home visits. Randomized trials have shown that the program is associated with improvements in vaccination rates and the timeliness of well-child visits.[3] A newer program, Parent-Focused Redesign for Encounters, Newborns to Toddlers, incorporates a health coach into well-child care. A randomized study revealed that participating children had fewer emergency department visits and that their parents were more receptive to psychosocial assessment and health information.[4]

Our report further recommends evaluation of clinic- and community-based programs and interventions, including programs that target the needs of specific demographic groups. Evaluations could be undertaken by a clinical practice or network, public health department, academic center, or other entities. Our report also highlights the importance of large-scale policies that support parents, such as family-leave benefits and legislation[5]; physicians can inform parents about such policies and how to make use of them. They can also advocate for parent-focused policies within their communities and engage in broader advocacy through professional organizations, the media, or collaborations with legislators.

Parents have substantial influence on their children during early childhood, but they may be uncertain, misinformed, overwhelmed, or depressed. Physicians who care for children are uniquely positioned to identify and address families' needs. Although their interactions with families are intermittent, the support, education, and counseling that they offer parents can have lasting ef-

fects on both the parent and the child. Indeed, physicians' greatest effect on the health of children may, at times, be the result not of what they do for children, but of what they do for parents.

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Learning to Drive — Early Exposure to End-of-Life Conversations in Medical Training

Stephen P. Miranda, B.A.

As I drove to Carol's home, I couldn't help but notice that even her location seemed terminal: it was the last exit off the freeway, at the end of a winding village road, in the bulb of a quiet cul-de-sac. This was the first of three home visits I would make to Carol, part of an assignment for my primary care clerkship in medical school. There was a task for each hour-long visit with my chronically ill patient: an in-depth medical and psychosocial history; a geriatric screen, functional assessment, and quality-of-life review; and a values history to inquire about advance care planning.

Carol lived alone in a split-level house, a fact that might not have meant much on its own. But when you considered her history of spinal fractures (due to osteoporosis) and her recurrent urinary tract infections (caused by long-term immunosuppression), the split-level design meant that when her urinary problems were at their worst, Carol had to negotiate a set of stairs several times a night with a bad back to get from her upstairs bedroom to the bathroom. Not only did that put her at great risk for falls (she'd already had one hip replaced), but anxiety about these nightly trips robbed her of sleep.

Just by walking around Carol's home, I gained insight into her health, despite my limited clinical knowledge. As I left on the first day, I wondered how much more I would have learned from Carol had I stopped worrying about asking the "right" questions about her history. So on my next visit, I left my white coat in the car and let Carol take the lead. She showed me photos of her grandchildren, and we discovered our shared love of Chopin. But when I asked about her plans for the future, to my surprise, Carol said she knew she'd long outlived her prognosis. "I do my own studying online, too, you know," she said. I looked around the room crowded with books and photographs and the piano she could no longer play, and I wondered what it must be like to sit in the stillness, making peace with the end that awaits us all.

I then asked Carol about death. A year earlier, I'd been too nervous to ask a standardized patient about his chief symptom, but here I was asking Carol how she envisioned the end of her life. Which is not to say that I knew what I was doing — I even struggled to read the suggested prompts off my worksheet. But by sharing her story so candidly with me, Carol seemed to have given me permission.

She revealed that she had her death all planned out, right down to the spot where her daughters would spread her ashes. "Mind you, I haven't told them all this yet," she confided. "I don't think they'd want to hear it." I asked her how much she'd be willing to go through in order to gain more time. She told me how difficult her last taper of prednisone had been. "If I had to go through something like that again just to stay alive, I don't think I would," she said. "No, in fact, I wouldn't."

Every now and then as I lis-