MetroCommon × 2050
Policy Recommendations

Equity of Wealth and Health

Improve quality of life and reverse the rising rate of chronic diseases, particularly among populations experiencing health inequities

MAPC

Recommendation: Improve quality of life and reverse the rising rate of chronic diseases, particularly among populations experiencing health inequities

Strategy 1

Help all people achieve a healthy start in life through improved health outcomes for birthing people and infants.

Women die from pregnancy related complications in the U.S. at a higher rate than any other high-income country. In 2019, the World Health Organization and United Nations estimated that the U.S. and the Dominican Republic were the only countries to see increases in the rate of maternal deaths between 2000 and 2017.[1] Black and Indigenous women in the United States are more than three and two times more likely to die from pregnancy-related complications, respectively. Infants born to parents who are Black, Indigenous, and people of color (BIPOC) are also more likely to experience birth risk factors that can have long-term impact on a child's development.[2] The factors driving these disparities are diverse and complex. They start early as barriers to accessing affordable, culturally competent care that is free from discrimination and continue to accumulate throughout families' lives in the form of social and environmental inequities. These factors are compounded by the legacy of intergenerational trauma experienced by BIPOC communities, which further exacerbates health disparities.

- **Action 1.1: Build a more diverse health workforce and require health practitioners to address racism and racial disparities in care settings.** Racism, not race itself, is the primary driving force behind disparately high death rates and complications at birth among BIPOC birthing people and infants. This crisis cannot be adequately addressed without first understanding and then dismantling racism and bias across systems of healthcare and public health. People of color, particularly Black, Latinx, Indigenous, and Asian and Pacific Islander women, consistently report experiencing bias and discrimination based on their race and gender in healthcare settings.[3] Racism in healthcare and public health has effects that extend beyond pregnancy and birth. It can lead to over- or under-diagnosis of certain conditions among BIPOC patients and can discourage patients from seeking care, which has consequences long after birth. For example, fat bias is deeply rooted in racism and is associated with health interventions that are now recognized as non-evidence based.[4] Additionally, studies have demonstrated the prevalence of the false notion among white

1 World Health Organization (2019). Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf

2 Artiga, Samantha et al. (2020). Racial Disparities in Maternal and Infant Health: An Overview. Kaiser Family Foundation. https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/

3 Taylor Jamila, et al. (2019). Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Blueprint. Center for American Progress. https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/

4 Maddie, Sofia. (2020). Fat Phobia and Its Racist Past and Present. National Public Radio. https://www.npr.org/transcripts/893006538

medical students that Black people are more pain tolerant, which can lead to insufficient pain treatment for Black individuals and reduced quality of care.[5]

National and state leaders should require practitioners to develop competency on racial equity and inclusion and to take actions to address the effects of racism in healthcare and public health settings. The Anti-Racism in Public Health Act, introduced by Senator Warren and Representative Pressley, would direct the Centers for Disease Control and Prevention (CDC) to declare racism a public health crisis and to improve data collection, research, and practices to promote anti-racist care and public health interventions. In 2019, California became the first state to require implicit bias training for healthcare professionals, a valuable first step to addressing discriminatory care. At the local level, a growing number of cities and counties have declared racism a public health crisis and begun to implement strategies to address racism across local governance and service delivery systems. These strategies should include placing members of groups most likely to experience health inequities in positions of influence on program development, implementation, ongoing monitoring, and determination of accountability measures. Research has also shown that BIPOC birthing people experience better outcomes when they receive care from a BIPOC health provider.[6] Leaders must also align workforce and education policies to support career pathways that result in a more diverse and inclusive health workforce.

Action 1.2: Expand access to full-spectrum pregnancy care, including coverage of post-partum care until one-year after birth or end of pregnancy. Cost should not be a barrier to accessing safe, comprehensive, and evidence-based pregnancy-related care. In Massachusetts, MassHealth covers about 40 percent of all births and provides essential care for people while they are pregnant, during delivery, and up to 60 days post-partum. While most maternal deaths are preventable, nearly a third occur one week to one year after delivery.[7] Many more people suffer from post-partum physical or mental health conditions due to pregnancy-related causes. Limiting pregnancy care to 60-days post-partum leaves many birthing people without critical access to care, including chronic disease management and behavioral and mental health screenings. Section 1115 Medicaid waivers can provide matching funds to help states extend post-partum care. MassHealth is currently seeking federal approval to extend post-partum coverage from 60 days to 12 months for the remainder of the state's 1115 waiver period, which expires in 2022. The next waiver must continue this expansion of post-partum care beyond 2022.

Additionally, high out-of-pocket medical costs and coverage limitations, such as those on midwife or doula care, undermine access to evidence-based pregnancy care and create financial hardships that disproportionately impact women.[8] There is evidence to demonstrate improved outcomes associated with providing doula care to birthing people, including reduced likelihood of birth complications and having a low birth weight baby.[9] There are several bills proposed in the Massachusetts Legislature to expand

5 Hoffman, Kelly et. al (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proceedings of the National Academy of Sciences of the United States. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/.

6 Taylor, Jamila et al. (2019). Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Blueprint. Center for American Progress.

7 MA COVID-19 Perinatal Coalition (2020). Giving Birth in a Pandemic: Policy Recommendations to Improve Maternal Equity During COVID-19. https://static1.squarespace.com/static/5ec9763f4215f5026a66f967/t/5f0f1ee598c70c766f32bea9/1594826470104/Maternal+Equity+Coalition+Report+FINAL.pdf

8 Pregnant and newborn care are the top reason why women between ages 19 and 44 spend 62% more per capita on healthcare costs than their male counterparts. Centers for Medicare and Medicaid Services (2014). U.S. Personal Health Care Spending by Age and Gender 2010 Highlights. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/AgeandGenderHighlights.pdf

9 Gruber, Kenneth J. et. al. (2013). Impact of Doulas on Healthy Birth Outcomes. The Journal of Perinatal Education. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

access to full spectrum, low- to no-cost pregnancy care. For example, the Legislature should pass H.1196/S.673, An Act ensuring access to full spectrum pregnancy care, filed by Representatives Lindsay Sabadosa and Ruth Balser and Senator Cindy Friedman. This bill would require all Massachusetts regulated plans to cover pregnancy-related care, including abortion care, prenatal care, childbirth, and postpartum care without any cost-sharing. The Legislature should also pass H.2372/S.1475, An Act relative to Medicaid coverage for doula services, filed by Representatives Liz Miranda and Lindsay Sabadosa and Senator Joan Lovely, which expands Medicaid coverage to doula services. At the federal level, Congresswoman Ayanna Pressley is the leading sponsor on a new bill, known as the MOMMIES (Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Service) Act, that would extend Medicaid coverage to a full year after childbirth and increase access to community-based services like doulas and midwives.

- **Action 1.3: Expand access to home visiting programs for expecting parents and families with infants and young children.** Home visiting is an evidence-based program that provides a variety of in-home services to expecting parents and families with infants and young children (up to pre-K). Most models involve parental support, skills training and education, health screenings, and linkages to community resources provided by a nurse or health educator. Research has shown that home visits can yield real benefits for child development and family health outcomes, including by increasing connections to adult education, employment, nutrition supports, and mental and behavioral health services.[10] Several evidence-based home visiting models exist in Massachusetts, including Welcome Family, Early Head Start, Healthy Families America, and Parents as Teachers. The federal government provides funding for home visiting through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, three percent of which is set aside for home visiting programs in American Indian and Alaska Native communities. Current funding allows the program to only serve a small fraction of families who could benefit. The federal government should expand this funding through the program's next authorization. The state can supplement home visiting funding (as other states have done) and assist programs in securing insurance reimbursement. Communities should consider innovative home visiting partnership models that have emerged among schools, social service providers, and local public health providers. Municipalities can also play an important role in coordinating services relevant to home visiting and by addressing access gaps for marginalized communities, including immigrant families.

10 Dodge, Kenneth et al. (2014). Implementation and Randomized Controlled Trial Evaluation of Universal Postnatal Nurse Home Visiting. American Journal of Public Health. Vol 104, No. S1

Best/emerging practice: Public Health Nurses (PHNs) in the North Shore have a long history of partnership and mutual aid. In 2018, PHNs from Beverly, Gloucester, Hamilton, Newburyport and Peabody came together to begin the North Shore Mother Visiting Program (NSMVP). Modeled on the Massachusetts Department of Public Health's (DPH) Welcome Family program, the NSMVP offers a free one-time home visit to any new mother or caregiver, ideally within 12 weeks (but up to one year) of giving birth or adopting a baby. The program is universal; there are no income, insurance, or other eligibility restrictions. Since the first home visit, PHNs have visited 90 parents in the participating communities. During these visits, they conduct a clinical assessment of the mother and infant's health, provide breastfeeding guidance, screen for emotional health issues, such as postpartum depression or substance abuse, and connect new mothers or caregivers to vital health and family support services.

Strategy 2

Invest in and expand access to programs that support families' basic needs.

In addition to providing more affordable and accessible care, efforts to improve equity in public health outcomes must also include fostering the conditions that help prevent disparities from the outset. Disparate access to healthy food, safe and stable housing, and adequate mental health care can all exacerbate inequities in public health outcomes. While programming and resources exist to help these basic needs, they often lack sufficient funding and can be inaccessible to residents who are proficient in languages other than English. Investing in these programs and making services more accessible not only improves the quality of life for more residents of the Commonwealth, but can also alleviate public health disparities and reduce healthcare costs in the long term. Efforts to reduce community violence (see "**Ensure all residents are provided equal protection and support by law enforcement agencies and within the justice system**.") and improve wealth equity and economic stability (see "**Enable wealth creation and intergenerational wealth transfer**") should work in tandem with the ideas presented in this strategy.

- **Action 2.1: Adopt universal free school meals to allow every student to access the nutrition they need during the school day. Food insecurity touches every community in Massachusetts.** Today, one in five households with children are food insecure, with Black and Latinx families disproportionately impacted.[11] Children have always been one of the groups most impacted by food insecurity and its long-term consequences, and COVID-19 has exacerbated this issue.[12] School meals can account for half of the meals a child eats and are a critical source of nutrition. These meals help kids learn and be active in the short term, and thrive academically, physically, and emotionally in the long term. School meals also establish lifelong healthy eating habits that can reduce the risk of type 2 diabetes, heart disease, and obesity, along with the cost associated with these diseases.[13]

11 Definition of Food Insecurity: Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. Source: USDA referenced definition from Life Sciences Research Office, S.A. Andersen, ed., "Core Indicators of Nutritional State for Difficult to Sample Populations," The Journal of Nutrition 120:1557S-1600S, 1990.

12 One in 10 households with children were food insecure before the COVID-19 pandemic. Source: Project Bread

13 Source for Background: Project Bread Feed Kids, Solve Hunger website: https://feedkidsma.org/

Passing legislation requiring universal free school meals in Massachusetts would recognize food as a basic need and right and allow every student access to the nutrition they need during the school day. H.714/S.314, An Act relative to universal school meals, filed by Representative Andy Vargas and Senator Sal DiDomenico, would ensure all children are offered school meals (breakfast and lunch) at no cost to students or their families. This would be accomplished by maximizing federal funds available to schools participating in the National School Lunch or Breakfast Program, supplemented through state funds. To take the effort several steps further, the Commonwealth should look to a similar proposal in California and the Universal Schools Meal Program Act, introduced by Senator Bernie Sanders and Representative Ilhan Omar in Congress, which provide incentives for local food procurement and supplement the summer Electronic Benefits Transfer (EBT) program to help families meet children's nutritional needs when school isn't in session. The federal proposal additionally increases resources for meals in childcare settings.

- **Action 2.2: Improve families' housing stability by increasing the number of rental vouchers directed to families with children and eliminating barriers to the development of new homes for families.** Families with children face unique obstacles to accessing stable, healthy housing. Across the region, exclusionary zoning practices limiting the number bedrooms and age of occupants in new developments effectively prohibits housing for families with children. Child and family related discrimination collectively represented the third most common type of housing discrimination cases in Massachusetts between 2013 and 2018.[14] This and other factors have contributed to Massachusetts experiencing one of the highest increases in family homelessness in the country.[15] In an effort to direct limited housing assistance to people in greatest crisis, many housing programs have oriented preference policies to prioritize assistance for people experiencing homelessness, most often single individuals. However, research shows that unstably housed families have similar health outcomes to those experiencing homelessness. Taking a prevention approach by increasing the overall availability of housing assistance and directing more vouchers to support family housing stability can have long-term positive effects on the health of children and their caregivers.[16, 17] Local resident preferences in communities that impose other barriers to housing for low-income families and families of color should also be scrutinized alongside the elimination of development policies that reduce housing opportunities for families with children. See the recommendations in **"Ensure that people of all races and income levels have equal access to affordable housing through homeownership and rental opportunities in every community."** for more details.

- **Action 2.3: Help meet individuals' social-emotional needs by facilitating access to mental health services and by investing in opportunities for social connection.** Even before the pandemic, health and social service providers were concerned about the high and increasing rates of mental health conditions and social isolation. These conditions affect people of all

14 MA Department of Housing and Community Development (2019). Analysis of Impediments to Fair Housing Choice. https://www.mass.gov/doc/analysis-of-impediments-to-fair-housing-choice-2019/download

15 Rog, Debra et al. (2017). The Growing Challenge of Family Homelessness. The Boston Foundation. https://www.tbf.org/-/media/tbforg/files/reports/homlessness-report_feb2017r.pdf?la=en

16 Fischer, Will et al. (2019). Research Shows Rental Assistance Reduces Hardship and Provides Platform to Expand Opportunity for Low-Income Families. Center on Budget. https://www.cbpp.org/research/housing/research-shows-rental-assistance-reduces-hardship-and-provides-platform-to-expand

17 Gaitan, Veronica (2019). How Housing Affects Children's Outcomes. Urban Institute. https://housingmatters.urban.org/articles/how-housing-affects-childrens-outcomes

ages, but are particularly prevalent among BIPOC, LGBTQ, and low-income individuals, while social isolation affects older adults disproportionately. Mental health and social isolation are closely associated with chronic disease. They often co-occur and each increases risk for the others.[18, 19, 20] The universal impact of these conditions indicates a need for intergenerational approaches to social emotional support. For example, increasing access to pregnancy-related care, home visiting, and affordable housing resident service coordinators can be an effective strategy for screening and then connecting young children and their caregivers to mental health resources. Flexible work hours and stability in the workplace also has an impact on the mental health of parents and children (see recommendations in Action 3.3). State funding and support for workforce development in the mental health provider field can help ensure there are adequate mental health providers for all age groups.

Physical and social environmental factors also play a role in development of mental health conditions. Social connections affect health in a variety of ways, including by promoting positive health behaviors and collective action on health issues and by counteracting feelings of stress and isolation.[21] The Commonwealth and cities and towns should incentivize the development of housing with social connectivity aspects (e.g., common spaces, courtyards, and resident services coordination) and implement measures, such as joint-use agreements and multi-function facility design, to develop intergenerational community spaces in school buildings and recreation and senior centers. School buildings should be equipped to operate year-round to serve multiple community needs, including through weatherization and efficiency measures to ensure thermal comfort through the summer.

Action 2.4: Dismantle structural barriers to immigrants' integration and access to vital health-promoting resources. One in six Massachusetts residents is an immigrant, and one in seven US-born residents has at least one immigrant parent, including a third of all children aged five and under.[22, 23] The contributions of documented and undocumented immigrants as neighbors, workers, business owners, and taxpayers help make diverse, resilient, and thriving communities across the region. The disproportionate toll of the pandemic on these communities has highlighted the cost of excluding immigrants from basic protections and tools for survival. Eligibility rules that determine access by immigration status have their foundation in racist ideas of deservingness, rather than evidence of what works to achieve a healthy society. Even before adoption of the public charge rule, which made it easier for the federal government to deny legal status to immigrants who were "likely to use public benefits," in February 2020, the announcement of its proposal reduced enrollment in children's safety-net programs, including an enrollment decline of 260,000 children in Medicaid.[24] The rule has since been rescinded by the new administration, but the fact that fewer people were able to access critical health resources during a public health crisis exacerbated the impact of the pandemic and surely led to unnecessary suffering and spread of the virus.

When immigrants are excluded or discouraged from accessing preventative

18 National Institute of Mental Health. (2021). Chronic Illness and Mental Health: Recognizing and Treating Depression. National Institutes of Health. https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/index.shtml

19 National Alliance on Mental Health. (2021). Mental Health By the Numbers. https://www.nami.org/mhstats

20 Holt-Lunstad (2020). The Double Pandemic of Social Isolation and COVID-19: Cross-Sector Policy Must Address Both. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20200609.53823

21 Cockerham, William et al. (2017). The Social Determinants of Chronic Disease. American Journal of Preventative Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5328595/

22 https://www.americanimmigrationcouncil.org/research/immigrants-in-massachusetts

23 https://www.miracoalition.org/wp-content/uploads/2020/02/MIRA-MPI-young-children-of-immigrants-Jan2020.pdf

24 https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00763

care, nutrition supports, public safety, education, and workforce development resources, our society's collective wellbeing suffers. The concept of "deservingness" must be disassociated from resources that are critical for public health. The Commonwealth should start by recognizing language access as a critical link to health-supporting resources and opportunities. The Legislature can make language accessibility a priority in government services and decision-making processes by adopting H.3199/S.2040, An Act relative to language access and inclusion, introduced by Representative Adrian Madaro and Senator Sal DiDomenico, and by investing in adequate resources for translation, interpretation, and outreach. These efforts should be complemented by increasing resources for English classes (ESOL), including by leveraging workforce and childcare development funds. State agencies and cities and towns should create roles for designated immigrant liaisons to help immigrants navigate communities' resources and programs. Additionally, the Legislature should adopt the Work and Family Mobility Act (H.3456/S.2289, filed by Representative Tricia Farley-Bouvier and Christine Barber and Senator Brendon Crighton), the Safe Communities Act (H.2418/S.1579, filed by Representatives Ruth Balser and Liz Miranda and Senator Jamie Eldridge), and other bills to expand MassHealth and in-state tuition eligibility to immigrant children and youth.

Strategy 3

Foster a caregiver economy with dignity and access for all.

Everyone needs care at some point in their lives, and quality caregiving provides dignity for workers while enhancing both immediate and long-term health outcomes for people receiving care. Yet, it is consistently undervalued and underpaid. According to the Domestic Workers Alliance, the pre-pandemic average salary of a childcare worker was $25,510. Wages for residential care workers and home care workers are similarly low, contributing to high rates of turnover and vacancies. Care workers are disproportionately women, immigrants, and women of color. The devaluing of and inadequate public investment in care underscores the gendered, racialized, and ableist assumptions baked into our economic and political systems, and contributes to lesser quality care for children, older adults, and people with disabilities who rely on these services. We need an inclusive approach to all care work.

- **Action 3.1: Increase reimbursement for childcare providers and in-home caregivers, creating mechanisms to support higher pay and benefits for care workers.** The pandemic has highlighted how affordable childcare is essential infrastructure, providing critical support for working families and enabling women, in particular, to remain in the workforce. However, childcare providers are chronically underpaid. A report from the Center for the Study of Child Care Employment found that the median wage for childcare workers in 2019 was $14.11/hour in Massachusetts, below what would be considered a living wage for one adult with no children.[25] Reimbursement rates for home- and community-based care should be increased through Medicaid and other public and private payers, with requirements that employers improve wages, benefits, training, and other pillars of job quality.

25 https://cscce.berkeley.edu/workforce-index-2020/states/massachusetts/.

We also need to increase investment in Head Start and Early Head Start to establish childcare affordability through sliding scale subsidies that require no family to pay more than 7 percent of their income on childcare. Furthermore, funding to childcare providers should be allocated based on capacity (rather than attendance), whether providers accept families that use subsidies, and investments in educator salary and benefits. The Legislature should pass H.605/S.362, An Act Relative to Affordable and Accessible High Quality Early Education and Care. Filed by Representatives Kenneth Gordon and Adrian Madaro and Senator Jason Lewis, the bill aims to make high quality early education and childcare affordable to all Massachusetts families.

Sustainable improvements in caregiving access and wages ultimately requires significant federal investment. A Biden administration proposal released in March 2021 proposed $400 million for home- and community-based care. Local governments could help address cost drivers for childcare providers by incentivizing development of affordable commercial spaces for childcare centers and targeting small business assistance to home-based childcare providers. Communities can also support Affordable Housing development that is inclusive of care workers alongside development targeted to older adults. See the "**Ensure that people of all races and income levels have equal access to affordable housing through homeownership and rental opportunities in every community**" recommendation for more details.

- **Action 3.2: Strengthen and expand tax credit programs to alleviate financial hardships for family caregivers, including those assisting with the care of adults.** Our nation's emphasis on individual responsibility in caregiving places heavy financial and emotional demands on family caregivers. The US is the only wealthy country in the world that does not guarantee paid parental leave and is not among at least 17 countries that provide child allowances for most parents. Caring for an older parent or loved one with a disability can also take a heavy financial toll.[26] Almost a million Massachusetts residents assist with the care of an adult. The Earned Income Tax Credit (EITC) and Child Tax Credit (CTC), which families can claim when they file taxes, help alleviate financial hardship for families by boosting incomes and have been shown to improve health outcomes for children and their caregivers.[27] The 2021 American Rescue Plan Act enhanced the EITC and CTC and made the tax credits fully refundable, which expands benefits to families who previously earned too little to owe federal income tax. The enhanced benefits are projected to cut child poverty in half, but the measure is effective for just one-year. Making the enhanced benefits permanent is important to sustaining this impact. H.2871/S.1841 An Act providing a guaranteed minimum income to all Massachusetts families, filed by Representatives Marjorie Decker and Andy Vargas and Senator Sal DiDomenico, would enhance the state's EITC program, increasing the state match to 50 percent of the federal EITC, establishing a minimum $2400 credit for every eligible households, and expanding the credit to unpaid caregivers of adults and individuals filing with an Individual Tax Identification Number (ITIN).[28] Similar legislative efforts are discussed

26 According to a 2016 AARP report, the average family caregiver spent almost $7,000 on out-of-pocket costs – all to help their loved ones remain at home and in their communities. Those caring for adults with dementia spent an average of $10,000.

27 https://childrenshealthwatch.org/wp-content/uploads/CHW-EITC-2020-web.pdf

28 This bill is also known as S.1852, An Act providing a guaranteed minimum income to all Massachusetts families, which was filed by Senator Jamie Eldridge.

in the **"Enable wealth creation and intergenerational wealth transfer"** recommendation. Other legislative proposals have alternatively sought to reimburse caregivers for care-related expenses, including AARP's proposed tax credit of up to $1500.

- **Action 3.3: Help family caregivers balance work and caregiving responsibilities by requiring employers to provide workers with greater flexibility and more predictable, stable hours.** When workers have predictable, stable hours with life-sustaining wages and flexibility, they are better able to meet basic expenses and plan for caregiving responsibilities. However, many people work in essential, but low-paying jobs in retail, food service, hospitality, and other industries where employees receive little notice of work schedules, experience shift fluctuations, and work an inconsistent number of hours. Black and Latinx workers, particularly women, are much more likely to be assigned irregular schedules.[29] This volatility contributes to poor mental health outcomes among workers and low or unstable incomes, and makes it difficult to impossible to arrange childcare to assist with care for an adult friend or relative. Research shows that children of parents with erratic schedules are less likely to use formal childcare centers, more likely to exit childcare subsidy programs after being enrolled, and switch childcare providers more often.[30] Income volatility can also make it more difficult for families to budget and maintain eligibility for means-tested programs. If adopted, the Massachusetts Fair Workweek Bill (H.1974/S.1236, filed by Representatives Sean Garballey and Maria Robinson and Senator Pat Jehlen, link to legislative text) would provide workers greater stability for themselves and their families by requiring employers to give advance notice of employee schedules, predictable pay, and adequate rest between shifts, and to offer existing employees new shifts before hiring new staff. The bill also provides access to unemployment for workers who leave a job because their employer failed to comply with the Fair Scheduling practices. In 2019, business leaders and the Executive Office of Elder Affairs formed the Massachusetts Caregiver Coalition to assess and address the needs of unpaid family caregivers. The Coalition's Employer Toolkit is mainly targeted to private employers but contains many recommendations that can be adopted by state and municipal employees as well, including providing workers with greater scheduling flexibility.

Best/emerging practice: Since 2014, San Francisco's Family Friendly Workplace Ordinance has allowed family caregivers to request greater schedule flexibility or more predictable work arrangements to help make caregiving responsibilities more feasible. The ordinance applies to San Francisco employees at workplaces with 20 or more employees, if the person making the request has been employed for six months or more by their current employer and works at least eight hours per week on a regular basis. Employees may request schedule flexibility or predictable arrangements to assist with care for a child or children under the age of 18, a family member with a serious health condition, or a parent aged 65 and older.[31]

29 Cain Miller, Claire (2019). How Unpredictable Work Hours Turn Families Upside Down. New York Times. https://www.nytimes.com/2019/10/16/upshot/unpredictable-job-hours.html?smid=nytcore-ios-share&fbclid=IwAR39cNFKn9eVp8y2UGAFrqLynUkVk0r0Os0CouSlbRTCWQbhSBhnNglFI6k

30 Human Impact Partners and Center for Popular Democracy. (2016). Scheduling Away Our Health: How Unpredictable Work Hours Affect Health and Well-Being. https://humanimpact.org/wp-content/uploads/2018/10/Scheduling-Away-Our-Health_rev3.pdf

31 https://sfgov.org/olse/family-friendly-workplace-ordinance-ffwo