Participants:
Holly Carmichael
Michael Murray
Andy Imparato

[Audio Length: 0:38:19]
RECORDING BEGINS

Introduction:
A garrison is a safe place where an army gathers. In the same way, the *Disability Garrison Podcast* is a place for the army of disability rights advocates to gather and discuss complex issues. We are unafraid to identify problems in our world and have difficult conversations about them. But we are not just here to complain. We spend our time brainstorming solutions with generals in the disability rights movement. Together, we take action to make positive change and lead the fight for justice and equality.

Holly Carmichael:
My name is Holly Carmichael.

Michael Murray:
My name is Michael Murray. This is the Disability Garrison.

Thank you everybody for joining the Disability Garrison today. Today we're going to talk about healthcare disparities. Healthcare disparities are differences in access to or availability of medical facilities and services and variation in rates of disease occurrences and disabilities between population groups. So communities of color, populations of lower socioeconomic status, rural communities, people with cognitive and physical disabilities are often disproportionately exposed to conditions and environments that negatively affect health risks and outcomes. One historical example of this is the health disparities in the AIDS crisis of the 1980s. But more recently, we've experienced this kind of disparity when it came to the rationing of ventilators for those of us with disabilities during the COVID-19 pandemic.

So today this is what we want to look at directly in the eyes, is the healthcare disparity that we see throughout our country and how we can positively impact that disparity and ensure that everyone has equal access to the kind of healthcare that we all deserve and have a right to within our country.

Holly Carmichael:
All right. Well, we are thrilled at the Disability Garrison to have with us Andy Imparato, the Director of Disability Rights California, the largest protection agency in the country. And we're going to chat a little bit today about some of the health inequities that have that have existed all along but really I think a spotlight on them occurred with COVID, and as we saw some of the rationing. And this disability rights issue is still ongoing because we're not out of this pandemic yet, and as I said, it existed before. We've talked previous episodes about organ transplant discrimination, but we're thrilled to invite Andy on our podcast to chat with us more about it today. Welcome, Andy.

Andy Imparato:
Thank you, Holly. It's great to be here.

Holly Carmichael:
Well, let's dive in a little bit about, really kind of lay the situation for folks. Because I think one of the pieces is people don't even know that this is happening. And so I don't know if you want to share just from your experience in California or even seeing the news around the country what we mean by rationing of healthcare or supplies in this pandemic.

Andy Imparato:
Sure. Well, let me start by just sharing some of the hats that I wear in this conversation. So I was appointed by President Biden as one of 12 public members on the COVID-19 Health Equity Task Force. Health equity is a big concept, but the way I think about it it's trying to learn lessons from the pandemic that will improve our ability to treat everybody fairly and that we'll try to address some of the long-term inequalities that we've allowed to go on that make us less able to respond effectively during a pandemic.

So I like the way the chair of the task force put it at one of our meetings. Her name is Dr. Marcella Nunez-Smith. She's from Yale. She's a clinician at Yale. But she said, “Our job as a task force is to disrupt the predictable patterns of who will be harmed first and who would be harmed worst during a pandemic.” One of the things that happens in a pandemic is you have periods of scarcity. You don't have enough ventilators or you don't have enough hospital beds or you don't have enough direct care workers. I mean there's scarcity in lots of different ways. And trying to navigate the scarcity where you don't reinforce prejudice and reinforce inequity is not easy, and that's something that we have to do better as a society. And the pandemic showed us that if we don't do it well, people die.

Holly Carmichael:
Yeah. And we saw some of these states, and even nationally I think, put forth these plans of how they would use resources in a pandemic. And many of those plans include not allowing them for somebody with a disability. And so I mean did you have that happen in California?

Andy Imparato:
Yeah. So in California, our California Department of Public Health came out with guidelines that were supposed to be useful for hospitals and other people that were making decisions during the pandemic. They came up with their guidelines in April of 2020, so pretty much like six weeks into the pandemic. And they were a draft, and they basically said when we're trying to make decisions about who gets a ventilator and who doesn't or other kind of life or death decisions, when we're in a surge and we're having to do rationing, the people who are not going to get priority are people who are too old or too disabled to benefit from whatever the thing is. And the Justice and Aging Disability Rights Education Defense Fund, Disability Rights California, and a number of other groups said this is illegal. What you just put out as guidance is a violation of federal civil rights laws. And I mean the people who put out those guidelines were not malicious. They weren't bad meaning in any way. They were trying to be helpful, and in their

mind, it was a no-win situation. They were trying to put some parameters out there that could help people make very difficult decisions.

But none of them, none of the people at that table developing those guidelines had any training in disability rights or discrimination against older adults. They didn't know the Age Discrimination Employment Act. They didn't know the Americans with Disabilities Act. So they just gave a science view of what should be done, and the science view happened to be ableist and eugenesis. So we pushed back hard. Our Secretary of Health and Human Services for California, Dr. Mark Ghaly listened to us, and we ended up with dramatically better guidance. They issued new guidelines in June, and they were dramatically better. So one of the lessons there for me is that state and local public health agencies don't have enough grounding in disability civil rights. They don't understand. Civil rights laws are not part of their training. So we have to bridge the divide between medical ethics and civil rights. And the people who are professionals in medical ethics are rarely exposed to disability civil rights laws, and the people that do disability civil rights work often don't understand the complicated medical terminology that gets used in healthcare rationing situations.

The other thing that we can't lose sight of is we were in a rationing situation because we weren't prepared. If you prepare, and California actually had a history of buying a lot of ventilators and then like getting rid of them. But if you prepare for these kinds of things as like part of this new normal that we're all living through, then we shouldn't have rationing. And if we do have rationing, it shouldn't last for very long. So we shouldn't miss the other parts, like why is a country with all of our resources in a healthcare rationing situation in the first place?

Holly Carmichael:
Yeah. Well, and I think even you talked about the medical ethics folks not having disability rights, but I think there's even a deeper just bias amongst a lot of people that if you're disabled, your life is worse, and it's not as worth saving as a non-disabled person. In fact, we were able to pull a quote from a 2021 study that over 80% of U.S. physicians surveyed thought that people with disabilities have a worse quality of life. So they're judging this person's value and their quality of life based on a single stat. And it could be a single stat such as your hair color, your eye color. It just happens to be your disabilities.

Andy Imparato:
I wanted to bring up the early use of quality adjusted life years in the state of Oregon. I don't know if you all know this. So the Americans with Disabilities Act was passed in 1990, and one of the first tests of the ADA was when the state of Oregon tried to use quality adjusted life years to decide who was going to get a procedure paid for by Medicaid. And the scheme that they came up with is they said, look, we're Oregon, we want to make sure that we're paying for efficient use of healthcare resources. So we're going to decide whether you get a procedure based on the quality adjusted life years you're going to have after the procedure. So if after the procedure you're going to have a pretty significant disability, we're going to score you down on the quality. And even if you're going to live another 30 years, because your quality of life is so low, you may not get the procedure. And the other interesting thing is the way the state of Oregon Medicaid program decided they would decide your quality of life was by polling the general public in

Oregon. So if people in Oregon said if you have one leg versus two legs, your quality of life is 20% worse or if you can't think as well or if you have chronic migraines. Like they were asked to like decide, not having had that living experience, what was valuable and what was not valuable.

Holly Carmichael:
And did they include non-disabled things, like being bald?

Michael Murray:
I don’t know. I think my quality of life is great. I love being bald.

Holly Carmichael:
But you can't use all the beautiful shampoos.

Michael Murray:
That's so ridiculous.

Holly Carmichael:
You miss out on that.

Andy Imparato:
I think you've played your baldness very well.

Michael Murray:
Thank you, thank you.

Andy Imparato:
But it's interesting. So people challenged that. This was 1991. It was the Bush administration, Republican administration. People challenged the state of Oregon under the ADA, and it was one of the first tests of whether the ADA had any teeth. And the Secretary of Health and Human Services under Bush said, this is a violation of the Americans with Disabilities Act and we’re not going to stand for it. So it's interesting. One of the first tests of the ADA was this idea that your life is less valuable and you're not going to get a medical procedure that you need because of your life is less valuable. So there's a long history of this, and it's not Democrat or Republican. Like there are powerful Democrats that believe in quality adjusted life. Ezekiel Emanuel is probably the most powerful, and there are powerful Republicans that think that this is a good way to decide how scarce resources get allocated. And the pro-life community can be one of the strongest voices in support of the inherent value of disabled people's lives, and that was part of the reason the Office of Civil Rights under President Trump started pushing back on blue and red states that were using disability against people on whether they would get ventilated. So it's just interesting politics. You can't really predict who's an ally and who's not an ally just based on ideology on these issues.

Holly Carmichael:
No. I mean we talked about this on another episode too where it's not necessarily a red or a blue. Disability rights are human rights, are civil rights. These are things that—and we could all, I think it's like 70% of us are likely to need some type of support as we age. The longer you live, the more likely you are to encounter a disability. And I know in my years, especially started off working in a group home, met several people who became disabled from an accident and a fluke thing that you wouldn't expect. It's a critical piece regardless of your political ideology that life is valuable and that your life, should you become disabled, is still valuable.

Michael Murray:
Well, and I think at the root of a lot of this perception of how valuable your life is when you have a disability is based in a deeply rooted fear that I don't want to become them, that out of all the people in the world that you could become like, you don't want to be bald, and you don't want to have a disability. I'm just kidding about the bald part. But I think that we as people with disabilities have an opportunity to change that and just to recognize that disability is a natural part of the human experience. The longer you live, the more likely you are to acquire a disability. And that it is nothing to be scared of, and that by reducing that fear, it also opens up our perception of the quality of life that you can have as a person with a disability that we have as people with disabilities.

Andy Imparato:
But also, if you think about the professional training of physicians and many healthcare workers, they're not exposed to the idea that disability is a natural part of human experience. They're not exposed to the perspectives of people with lived experience with long-term disabilities. They're exposed to the pathology of disease. And so I think in many ways—

Michael Murray:
For our listeners, can you explain what you mean by pathology?

Andy Imparato:
They're exposed to the biology of how does the disability manifest. What are all the bodily functions that are impacted and what's the prognosis? What can we hope to achieve with this patient? And it's all very ableist. Obviously, it's a medical model that they're getting trained in a medical model. And they have a blind spot to the idea that disabled people could have amazingly positive lives with their disabilities, and they might actually be happier with their disability than they were if they didn't have their disability. That's just not within the comprehension of medical training.

Michael Murray:
Right. And that's the first person. Oftentimes when you acquire a disability or even if you were born with it, the first person that you're going to interact with is someone who has been trained to see your disability in the light that you just described.

Andy Imparato:
Yeah. So I feel like that got exposed during this pandemic in a lot of different ways. In Los Angeles at different points during the surge, ambulances were refusing to pick people up if they didn't think they would make it to the hospital. So that's a form of healthcare rationing that there's no record of other than reports of it in the *Los Angeles Times.* But just think about all the health healthcare ration that goes on behind closed doors that we don't know about.

Michael Murray:
Absolutely.

Holly Carmichael:
Yeah. Well, that's a good question for our listeners. With your background and knowledge of your position, I know when we brought to light even like the organ transplant issues or even some of these when these rationing issues are happening, you're like, that's not legal. The ADA should protect against that. Well, how do they get away with this? Is this legal?

Andy Imparato:
Well, I think part of the challenge is that ADA is not self-enforcement, right? Like when I worked at the National Council on Disability, we did studies of federal enforcement of the Americans with Disabilities Act, the Special Education Law, the Fair Housing Act, the Healthcare Access. I've looked at lots of federal civil rights laws. And the big takeaway that I had from all those studies is the federal government is never going to be big enough to enforce all these disability rights laws everywhere where they're being violated. And the way that you get enforcement of these laws is by having a well-educated, protected class. The people who enforce the Special Education Law are parents who know their children's rights and assert those rights in a classroom. People who enforce the Healthcare Access Act are people who have disabilities who know their rights and educate people they have to educate in order to get their rights enforced.

So in the context of crisis standards of care or healthcare rationing, we need consumers to be well-educated about what is and is not discrimination, and they need to be able to advocate for themselves. But if they have COVID and they need a ventilator, they're not in a great position to do that. So another fight we had was to get people to be able to bring people with them to the hospital, and we got our Department of Fair Employment and Housing to issue guidance that the Department of Public Health was supportive of that said, if you have a disability and you need that support in order to get quality healthcare, you have a right to bring that person with you to the hospital. But again, the person you bring needs to know your rights and needs to be comfortable asserting your rights or they're not likely to be honored or respected. I wish that we could count on hospitals to just do the right thing, but I think we've learned over and over that's not how it works.

Michael Murray:
Yeah. I think the point that you just made around all of our listeners and having an army of disability rights advocates who are aware of their rights and able to assert those rights is so valuable. I also think that

there is part of the solution in this and changing people's mindsets is ensuring that those that get put in power have a proper mindset of the value that we have as people with disabilities. And I go back to, if we could maybe find the CDC director's quote, I think it's a valuable lesson in the fact that sometimes when people are in power, we can't assume just because they're running the CDC that they understand disability and those of us with disabilities. What was that quote?

Holly Carmichael:
Yeah. The overwhelming number of deaths, over 75%, occurred in people with at least four comorbidities. So it was shared almost as an exciting thing. And like you said, a lot of times people aren't being intentional about this, right? But it's this unconscious bias, that those deaths are more okay. And I'm just curious to get your thoughts on this leaders and their value set and understanding of the entire spectrum of people and why that's so critical in these leadership roles.

Andy Imparato:
Yeah. I mean I think the CDC director was trying to make the point that the vaccines were working for most people, and the people who were dying were people who were unwell and had a lot of healthcare problems before the pandemic and it's basically an acceptable outcome and that our job is to protect the healthy people as best we can and the best way to protect them is to get them to take vaccines. It was an incredibly, probably unconsciously ableist and offensive thing to say. And then it took her a long time to walk it back. She blamed the editing.

Michael Murray:
Did she really?

Holly Carmichael:
Yeah. Doubled down at first.

Andy Imparato:
And then we saw the full transcript, and it didn't get any better.

Holly Carmichael:
Yes, it was worse. Yes, yes.

Andy Imparato:
So it's easy to pick on political leaders, and it's easy to pick on physicians. But I think the disability community was so ready to have that fight because I think we felt over and over during this pandemic, our needs, our quality of life, our health was to take second fiddle. Think about all the disabled people who didn't get any medical treatment for over a year because nobody made it safe for them to go to a doctor. I mean if you had really serious negative consequences from getting exposed to COVID, you're just not going to go to a doctor.

Holly Carmichael:
Yeah, yeah. Or go many places. I mean I think that there was a lot of frustration too in the disability community with the different restrictions lifting and people being like, oh, it's good now, we have vaccines and it's not necessarily over for everyone.

Andy Imparato:
The other thing I've been thinking a lot about both in the context of when do you not have to wear masks or how do we make decisions about who gets a hospital bed, who gets a ventilator, who gets whatever scarce intervention is out there is who is the right person to make that decision and what is the right training? Well, you could say that's not really part of medical training. The medical training is do no harm. When you make a rationing decision, somebody's getting harmed. So is it better done by a panel of lay people? But if so, how do you account for bias, racial bias, disability bias, gender bias, all kinds, religious bias, all kinds of bias? So maybe it's an ecumenical group of faith leaders. Like who are the right people to make the decisions? And I don't know the answer, but I know that whoever's making those decisions, they need to be clear on what are their core values, what are the legal parameters around which they can make this, and they need to understand that science alone will not get you to the answer.

Michael Murray:
That's right.

Holly Carmichael:
Well, and sometimes it's not even backed by the science, but the overriding bias. I mean we saw that in the transplants episode where the science showed that they don't have a worse quality of life, that the success of the transplant is just as effective based on your IQ and whether or not you have an intellectual disability. But even though the science said that, that overwhelming bias is still to this day in several states around the country, limiting and rationing, again, with scarcity of organs, who can get one and whose life is worth it.

Michael Murray:
Yeah. Well, and I think that this isn't a recent issue. I think that we also have to recognize for those of us with disabilities, whether it was forced sterilization or Nazi Germany first impacting people with disabilities, it comes down to a fundamental perception that our lives are of less value. And so I think that we do have to address this in modern day issues, but we also have to begin and continue to help our fellow man no longer see those of us with disabilities as “them” but a realization that you are us and we are you.

Andy Imparato:
And I also think in the context of rationing with ventilators in California, there was a real combination of ageism, ableism, and racism. And the people that were going to lose if those April standards had become the kind of gold standard for rationing were people of color who were obese and old because everything was stacked against them. And the people making those decisions were not in that category. So I do feel like there's a broad kind of cross civil rights opportunity to learn from the pandemic and for the Office of

Civil Rights and the Department of Health and Human Services and the Department of Justice to really say these are the kinds of things that will never be okay and these are the kinds of things that are possible. And I think where they're going to land is if somebody is not going to survive an intervention, if you have good reason to believe that they're not going to survive an intervention, that is one legitimate way that you can distinguish. But when you start getting into well, how long will they survive and what will their quality of life be and will they understand, whatever it is that you're using to say they're lesser than, you're in very treacherous territory.

Holly Carmichael:
Yeah, yes. Well, and you brought up your work on the Health Equity Task Force and the first and worst. And often people with disabilities on any policy decisions for rationing or making a change are impacted first and worse and as are people of color that we see. And I mean how do we move beyond—you talked about that really who gets these things enforced are the people themselves being educated. Is that sustainable though? How do we get this education, like you said, physicians need? They learn about this deficit-based medical model. How do we need to change the education of physicians to make sure they learn about the value of disability and disability rights? And how do we build a society and a culture that respects and values everyone?

Andy Imparato:
Yeah. I mean I wish I had kind of clarity on the best way to do that. I think part of it is having more disabled people everywhere. So we had the concept of nothing about us without us for a long time. Now, a lot of people are just saying nothing without us.

Holly Carmichael:
I like that. I like it.

Michael Murray:
That's so good. Yeah.

Andy Imparato:
We need to be in medical schools. We need to be on the faculty. We need to be students. We need to be in every role. We need to be on hospital boards of directors. We need to be the CEO of hospitals.

Holly Carmichael:
On the Supreme Court.

Andy Imparato:
We need to be everywhere, and we need to make sure that every conversation about cultural and linguistic confidence, health equity, disparities, that disability is always part of that conversation. And for many years, it wasn't part of the conversation.

Holly Carmichael:
Yeah.

Andy Imparato:
I also just want to say I think the coalition building opportunity between advocates who are primarily focused on older adults and advocates who are primarily focused on people with disabilities, this is an issue where those two worlds come together very clearly. You can't really separate out the ageism from the ableism. They go together when you're trying to decide who's going to get an intervention, who’s collateral damage. Look at all the people who died in nursing homes. They were old, disabled people. And as a society, we let that happen.

Holly Carmichael:
Yeah. And really it's like this, I mean we've talked about this idea of what is your quality of life and valuing one person's quality of life over another. And even just the idea of congregate settings in general are certainly an advancement from where we started where we ignored people with disabilities, then we had institutions and we thought oh, we're going to take care of them. Then we've shifted to those congregate settings. We haven't really truly gotten to people with disabilities are fully inclusive and part of our communities and part of our own homes and communities.

Michael Murray:
Nothing without us.

Holly Carmichael:
Yes, exactly. And so I think that just highlighted that, how many people we have put into congregate settings, just if you look at the percentage of deaths that are based in congregate settings.

Andy Imparato:
And I also think when you start talking about the inherent value of every human life, it's hard to talk about that without thinking about faith and spirituality. And I would like for us to think about an unusual coalition of progressive religious voices from lots of different denominations and more fundamentalists religious voices from lots of different denominations locking arms around the idea that every life is valuable. We need more people like that, people who are lay leaders, people who are clergy, but who just have that deep love for disabled people because there's just not enough of that. There's so much avoidance of disabled people. If you think about the typical faith community and how they deal with accommodations for disabled people, it's very grudging. It's very unusual to be in a church that has American sign language, captioning, full wheelchair accessibility, audio descriptions. Why is that so hard especially with these mega churches and the budgets that they have?

Michael Murray:
Totally.

Andy Imparato:
It's because the leadership is not leaning into the fact that these are the most important people in our congregation. And most congregations are old. They all need it. My mother attends church now over Zoom or over the television because she can actually hear what's going on.

Michael Murray:
So good, so good.

Holly Carmichael:
Yes, yes. Well, and the crazy thing is a lot of those accommodations would help somebody who doesn't have a disability too, might help the mom whose baby’s crying in her ear. She can read the closed captioning and follow along their eyes.

Michael Murray:
So good.

Holly Carmichael:
it helps everybody.

Michael Murray:
I hear a whole separate podcast just on faith and disability that we got to have.

Andy Imparato:
it I really do think you can't talk about healthcare rationing and life or death issues without having some concept that the faith community has a role to play. I'm not saying we have to insert faith into people who don't have a religious. Belief. But I mean when I compare a physician or a rabbi, who do I want making a decision about whether I'm going to get a ventilator? I'll take the rabbi.

Michael Murray:
That's so good.

Holly Carmichael:
No, that's true. That's almost like a bad joke. A physician, a rabbi walk into a bar and decide your fate. And yeah. What you also were talking earlier about kind of like what we also have to accept, what are we put on this earth to do? We kind of expect well, what value are you going to add? That's how these decisions are being made. Well, what can you contribute? And we're here to just be. We have to let go of this expectation that everybody has to—of course, we all make contributions and it feels good to contribute and share things and people with disabilities and all types of people.

Michael Murray:
Does my title mean that I have a greater value to society than someone without a particular title?

Holly Carmichael:
Yeah. So your life. Yes, this life. And I mean I think that's a real change, and I think a lot of the disability rights pieces or barriers that are faced are somewhat of that attitude too. Like well, pull yourself up from your bootstraps. You have to contribute and do something.

Andy Imparato:
But this idea that we're all measured by how much salary we can commit or what we can contribute at a meeting or whatever is valued, it is ableist, and it does exist in the disability movement. We have ableism baked into our own movement. It's very counter-cultural to see everybody as inherently valuable, no matter who they are, no matter what they do. So I just feel like we have to check each other as a movement when you start to play into that narrative.

Michael Murray:
That's so good.

Holly Carmichael:
Yeah. Well, I'm curious. Closing thoughts on this concept. We talked today about health equity and the scarcity and rationing and how people with disabilities and the elderly are often the first to get cut.

Andy Imparato:
I mean, for me it's a through line from eugenics, what happened in the Holocaust to people with disabilities and the idea that during this global crisis, the people who disproportionately died were older folks, folks with disabilities, people of color, low-income populations globally. I'm hoping that we can have a never-again moment and say, okay, this happened, it's horrible, it's still going on. What did we learn and what are we going to do to make sure that this never happens again or certainly never happens again on this scale? And for me, I was raised Catholic, but it starts with some *mea culpa*. People need to acknowledge the role that we all played in letting this happen.

Michael Murray:
Yeah, yeah. But I think you're right. The takeaway is insomuch as we all and our listeners included have the power to do something about this, we're going to leave you with some things that you can do. But I think we should all walk away from this saying never again.

Andy Imparato:
And every hospital has an ethics committee that has community representation. We can all connect with our local hospitals and try to bring a disability-affirming perspective to those committees.

Michael Murray:
That's a great idea.

Holly Carmichael:
Yeah. Representation like we talked about is key. I mean your never again comments reminds me of a Maya Angelou quote. “We do the best we can until we know better. And when we know better, we do better.” And we know better.

Michael Murray:
Thank you everyone for joining this powerful episode of the Disability Garrison. I know many of you are probably wondering, what can I do to impact health disparities and to make the world a more equitable place? Well, we have a few suggestions for you of actions that you can take. Again, we always like to give you our listeners three really specific actions that you can take. One is an action that you can take as an individual. Secondly is an action that you can take that will have a broader systematic issue. And then last, we want to give you an organization that's doing great work around these issues and give you an opportunity to donate to that organization.

So let's start with the first action, something that you as an individual can do. Make yourself aware. There are health disparities all around us. How does it affect your community? How does it affect your hospital? What are the ethics committee at your local hospitals? Is your church accessible to people with disabilities? These kinds of healthcare disparities are things that we can become aware of and then talk about and make sure that we are addressing them in our local communities and that the conversation is being had.

So we also want to give you a systematic thing that you can do to have an impact on healthcare disparities. In Section 1557 of the Affordable Care Act, entities are prohibited from discriminating based on race, color, national origin, sex, age, or disability. It is expected that in 2022 the Biden administration will look to update these provisions to advance racial equity even further. We're not exactly sure what this is going to look like or what's going to happen around it, but the federal government plays a big part in ensuring that health equity is available to everyone. So we'd encourage you to contact the Department of Health and Human Services and encourage them to take a look at these regulations and ensure that the Affordable Care Act and specifically Section 1557 continue to have a positive impact on healthcare disparities.

Lastly, we want to make sure that you have an organization that you can donate to. As you know, Andy Imparato, our guest today, is the Executive Director of Disability Rights California. They are an awesome organization that defends and advocates and strengthens the rights of those of us with disabilities. We really encourage you to go check them out. If you go to disabilitygarrison.org for the links to donate to this incredible organization, and we encourage you to do that. As always, we are super grateful for each one of you that listen in every month. We know that we are having an incredible impact throughout the country, and we are honored to join you in this fight for justice and equality.

RECORDING ENDS