REQUEST FOR FORMAL FEDERAL REVIEW

THE PEOPLE'S DOSSIER: PART I

Parasitic Diagnostic Access, Allocation Alignment, and Procedural Integrity

Submitted by

Billie Glazier
Levi's Mom

In memory of **Suzie Hitch** and on behalf of
Affected Americans & Concerned Families Nationwide:

Purpose of Submission

Request for documented federal review and

structured evaluation of parasitic diagnostic access and

public health allocation practices.

Let's Save Some Lives

#Stand_and_Roar

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I. EXECUTIVE SUMMARY

This dossier represents the first in a planned series of submissions documenting not only disproportionate parasitic disease burden among Americans, but a broader pattern in which profit-driven health structures have eclipsed patient protection as a central organizing principle. When diagnostic access, surveillance capacity, and workforce investment are shaped primarily by short-term financial incentives rather than by the imperative to detect and interrupt emerging threats, the result is not just preventable harm to individual families—it is the quiet accumulation of systemic blind spots that weaken national resilience. In this context, gaps in parasitic and environmental health detection function as gaping vulnerabilities in the nation's homeland security landscape, because they allow biological and ecological hazards to spread and consolidate before they are seen, named, or addressed.

In this part of the series, readers will find a structured, data-driven evaluation of parasitic disease burden relative to national health expenditure among peer high-income nations. Using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) rates and World Bank 2022 health expenditure per capita (PPP) data, this analysis examines whether U.S. healthcare investment aligns proportionately with infectious disease burden outcomes.

Key Finding:

The United States spends more per capita on healthcare than any peer nation examined. Within an OECD high-income comparison group (n = 7), regression analysis demonstrates a positive association between per-capita health expenditure and parasitic DALY burden ($R^2 = 0.5481$; standardized $\beta = 0.7403$; $p = 0.0571$). The direction and magnitude of this association raise a performance-alignment question appropriate for structured review.

Contrary to common assumptions that higher expenditure corresponds with lower infectious disease burden, this peer comparison indicates that higher aggregate spending within this sample was associated with higher reported parasitic DALY rates. The United States ranks near the upper bound of parasitic burden among comparator nations despite leading in per-capita healthcare investment (Z-score = 1.94). This pattern warrants examination of allocation structures, diagnostic access pathways, surveillance sensitivity, and workforce capacity.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including difficulty obtaining ova and parasite testing, limited access to parasitology specialists, fragmented referral pathways, and absence of documented acknowledgment when evidence is submitted to federal agencies. Rather than being dismissed as isolated anecdotes, these reports reflect consistent access concerns that merit structured, transparent evaluation.

Longitudinal comparison (1995–2023) further demonstrates that the United States has not maintained the lowest parasitic burden trajectory among its economic peers, despite sustained high expenditure levels. This persistent differential strengthens the case for allocation-alignment review.

This analysis identifies a structural performance-alignment question within a high-resource system. The appropriate response is formal review grounded in measurable protection of American lives and stewardship of federal health investment.

Requested Federal Actions:

- Formal confirmation of evidence intake and identification of reviewing authority.
- Independent evaluation of parasitic diagnostic access pathways and testing criteria.
- Assessment of parasitology workforce capacity and federal training pipelines.
- Review of laboratory continuity-of-operations safeguards.

- Establishment of transparent, conflict-free reporting mechanisms for citizens raising parasitic or environmental health concerns.

This submission seeks structured oversight, measurable alignment, and restoration of transparent diagnostic pathways. The objective is not confrontation. The objective is proportional alignment between national health expenditure and infectious disease detection outcomes—so that American families may rely on systems designed to protect them.

Respectfully submitted,
Let's Save Some Lives,

Billie Glazier

Billie Glazier, Levi's Mom

II. In Commitment to Levi: The Human Cost of Structural Misalignment

There is a young man at the center of this dossier—Levi Jordan Glazier is seventeen years old. Levi is not extraordinary in his vulnerability. He is extraordinary only in that his story is written here. There are countless other young people whose names are not.

Like many of America's youth, Levi is brilliant, thoughtful, deeply compassionate, mature beyond his years and instinctively protective of others. His teachers describe him as disciplined—he has been the class President for three consecutive years. His friends describe him as steady- and sometimes quirky, maybe a little nerdy. Strangers describe him as kind, charming, and a joy to meet.

But what defines Levi most is his heart.

From infancy, gratitude came naturally to him. As a baby, before he could sit up on his own, he would whisper *"thank you"* when a bottle touched his lips. That instinct never faded. He is the young man who gave his New Orleans beignet money to a homeless stranger because someone else needed it more—he was really looking forward to tasting his first beignet, too. He prays for others, passionately, when he thinks no one can hear. He steps aside so others may shine. He opens doors — literally and figuratively.

He feels other people's joys and sorrows out loud.

But now, he feels something else.

Levi does not trust tomorrow.

He is experiencing the same constellation of symptoms his mother endured months earlier on her detrimental journey — symptoms that progressively weakened her, altered daily life, and introduced

uncertainty into every decision.

He watched her deterioration up close. He saw exhaustion replace strength. He saw confidence replaced by uncertainty. He saw fear settle into places where resolve once stood.

When Levi looks into his mother's eyes, he does not just see concern for him. He sees a reflection of what his own future might become.

~He sees the same trajectory he has already witnessed.

~He fears the inevitable decline he has watched his parents endure may now become his own--because his doctors, too, do not look-but then write that they "did not see."

~This fear is informed — not imagined.

Levi chose to pursue his education online out of caution while unresolved health concerns remain without documented institutional review—cautious—to be certain he does not infect an innocent classmate. That decision was not made lightly. It was made after observing what happens when diagnostic pathways stall and deterioration advances without answers.

Teenagers should not be reorganizing their lives around uncertainty created by procedural barriers. But there is a force behind Levi that is as real as his fear and as powerful as his love:

There is a Mama Bear in this story.

A mother whose devotion is boundless, whose determination is unshakable, and whose love refuses to accept barriers as impassable.

There is no obstacle too heavy, no procedural labyrinth too complex, and no institutional inertia too rigid to stop a mother who is committed to carving a path for her son to see tomorrow—in the absence of unnecessary ailments.

This dossier is not driven by outrage. It is driven by **maternal resolve** — and by the refusal to allow preventable deterioration to repeat itself.

Families across this nation — from both sides of the aisle, from every community, regardless of education or political affiliations — report similar barriers to parasitic diagnostic access, specialist evaluation, and meaningful review. That means these are not partisan issues. They are human issues. These are mothers' biggest fears transforming into realities.

When diagnostic pathways falter, children watch their parents decline. When surveillance sensitivity is inadequate, fear replaces stability.

When expertise exists but remains procedurally inaccessible, young people lose confidence in the systems--the trusted figure heads-- meant to protect them. Like Levi, they do not trust tomorrow.

Levi's story is not included for sympathy.

It is included for clarity.

Public health policy is **not abstract.**

Allocation alignment is **not theoretical.**

Surveillance integrity is **not bureaucratic language.**

It is whether a seventeen-year-old has reason to believe tomorrow will come — with promise, not fear.

Levi once believed without hesitation that tomorrow would be full of possibility.

Now he measures tomorrow cautiously — because he has already seen what unchecked uncertainty can become.

Again, **this dossier is not driven by outrage**. These words exist so that LEVI — and THE MANY OTHER AMERICAN YOUTH LIKE HIM — may once again ***TRUST TOMORROW.***

- So all American youth, may believe in the futures they deserve.
- So every **Mama Bear's devotion** — *fierce, precise, and unwavering* — can be met with accountability, action, and measurable protection.
- So no obstacle — no matter how heavy — stands between a young life and the answers it deserves.
- So people are pulled back to the pyramid's peak, and human lives are once again valued by our national leaders.
- This compilation of facts and figures, and all those that will follow, **are penned for all Americans** to have paths to well-being, but it **is inspired by Levi's search for hope**.

~Levi's Mom

III. BACKGROUND AND CONTEXT

This submission arises from a convergence of empirical data, documented access barriers, and recurring patterns reported by affected American families. The purpose of this section is to establish factual context for the statistical findings and policy recommendations that follow, and to clarify why these patterns have direct implications not only for public health, but for homeland security.

The United States leads the world in per-capita healthcare expenditure. According to World Bank 2022 data, U.S. health expenditure per capita (PPP) substantially exceeds that of peer OECD high-income nations. At the same time, Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized DALY data indicate that the United States does not demonstrate proportionately lower parasitic disease burden relative to several comparator nations. This contrast raises a legitimate allocation and diagnostic access question: Does current infrastructure align proportionately with infectious disease burden within a system of unprecedented resource investment? It also raises a security question: when a high-resource nation sustains elevated parasitic disease burden despite leading expenditure, critical gaps in detection and response can become exploitable vulnerabilities within the homeland security landscape.

In parallel with the quantitative data, families across multiple states report consistent challenges in obtaining parasitic diagnostic evaluation. These reports include difficulty accessing parasite testing, limited availability of parasitology specialists, fragmented referral pathways, and lack of documented acknowledgment when concerns are submitted to federal agencies. These same barriers that prevent timely evaluation for individual patients also impair early warning at the

system level, allowing parasitic and environmental threats to circulate without being fully seen, coded, or counted. In a context where biological and ecological hazards are recognized as threat multipliers, under-detection of these conditions weakens national resilience and leaves avoidable blind spots in homeland security planning and preparedness.

Importantly, these reported patterns are not presented as conclusive proof of systemic failure. They are presented as recurring access concerns that merit structured evaluation. When multiple geographically dispersed families describe similar barriers, the issue becomes one of procedural transparency and institutional responsiveness, as well as a question of whether security-relevant health information is reaching the federal agencies responsible for safeguarding the nation.

An expanding population of Americans whose families are experiencing the impacts reflected in the enclosed data recognize that these findings represent only one component of a broader structural analysis. The material submitted here is intended as an initial analytical layer. Additional documentation and contextual information will be provided to support comprehensive federal review, including review that explicitly integrates public health surveillance with homeland security risk assessment.

At the center of this issue are American families seeking evaluation and care. In some cases, individuals have reorganized education, employment, and daily life around unresolved health concerns that have not received documented institutional review. These circumstances underscore the urgency of restoring clear diagnostic pathways and visible evidence-review mechanisms, both to protect families directly and to ensure that emerging biological and environmental threats are detected in time to inform national preparedness and security decisions.

This background establishes the foundation for the statistical analysis and policy recommendations that follow. The objective is not confrontation. The objective is structured review, measurable alignment, and leadership grounded in the protection of American lives and the quality thereof—and in closing the preventable gaps where failures in health protection can become failures in homeland security.

IV. Statistical Analysis and Findings

A linear regression analysis was conducted to evaluate the relationship between age-standardized parasitic disease burden (DALY rate, 2023) and per-capita health expenditure (PPP, 2022) among seven OECD high-income peer nations. The resulting regression equation was:

$$DALY = 0.003572 \times Spending - 11.6112.$$

The model demonstrated moderate explanatory capacity ($R^2 = 0.5481$), indicating that approximately 30 % of the variation in parasitic disease burden among the peer countries was statistically associated with variation in per-capita health expenditure within this comparison group. The standardized association coefficient ($\beta = 0.7403$) reflects a strong positive relationship between national health spending and reported parasitic DALY burden within this high-income sample.

While it is often assumed that higher health expenditure would correspond with lower infectious disease burden, the observed association in this peer comparison was positive. Within this OECD high-income sample, countries with higher per-capita health spending tended to report higher parasitic DALY rates.

Z-score analysis further contextualizes national positioning. The United States' parasitic DALY burden was approximately 1.94 standard deviations above the peer mean, placing it near the upper bound of the distribution among the comparator nations. This positioning indicates that the United States does not exhibit a proportionately lower parasitic burden relative to its level of expenditure.

Collectively, these findings show that within this high-income peer group, higher aggregate health expenditure does not correspond to proportionately lower parasitic disease burden. The analysis raises a performance-alignment question appropriate for structured oversight review: whether national health expenditure is optimally aligned with infectious disease detection, diagnostic infrastructure, and surveillance capacity.

V. Scatterplot and Explicit SS Calculations

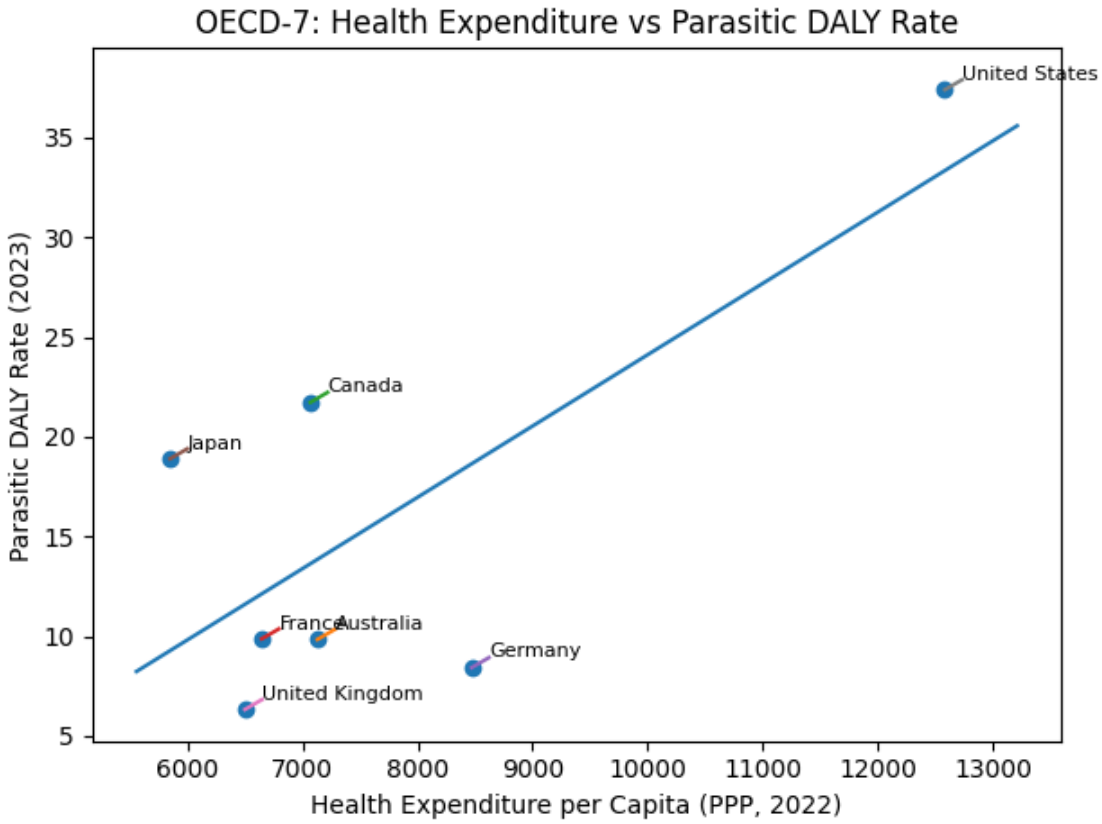
OECD-7: Health Expenditure vs Parasitic DALY Rate (Exact Data)
Regression Equation: DALY = 0.003572 × Spending -11.611173

$R^2 = 0.548075$

F-statistic = 6.063794

p-value (slope) = 0.057055

n = 7



Explicit Sum of Squares Calculations
SS Total = 725.936221
SS Regression = 397.867843
SS Residual = 328.068378

Verification: SS Regression + SS Residual equals SS Total (within rounding precision).

VI. POLICY IMPLICATIONS AND ALLOCATION REVIEW

This section translates the statistical findings and comparative visual analysis into concrete policy considerations. The objective is to evaluate whether current diagnostic allocation, workforce capacity, and surveillance structures align proportionately with national health expenditure and documented parasitic disease burden.

A. Allocation Imbalance in a High-Expenditure System

The United States invests more per capita in healthcare than any peer nation examined. Comparative analysis demonstrates that within OECD high-income peers, higher per-capita spending is associated with higher parasitic disease burden in this sample. This pattern indicates that expenditure magnitude alone does not ensure optimized infectious disease detection or burden reduction. High aggregate expenditure does not automatically translate into optimized infectious disease detection. Allocation within the healthcare system is distributed across numerous sectors, including chronic disease management, oncology, cardiology, pharmaceutical development, and administrative overhead. The findings indicate that parasitic diagnostic capacity may not be receiving proportional structural support.

B. Diagnostic Infrastructure and Access Pathways

Reported barriers to parasitic diagnostic access raise important structural questions regarding laboratory availability, specialist workforce capacity, and referral mechanisms. When individuals report difficulty obtaining ova and parasite testing or specialist evaluation, the issue may reflect limited infrastructure rather than clinical decision-making alone. Policy review should examine

whether parasitology expertise, laboratory continuity-of-operations safeguards, and referral pathways are proportionately maintained relative to system resources.

C. Workforce Capacity and Surveillance Sensitivity

Published literature has documented decline in parasitology laboratory capacity within the United States. Workforce contraction can affect surveillance sensitivity, diagnostic turnaround time, and clinical familiarity with parasitic conditions. A system with diminished specialist capacity may inadvertently create barriers to timely diagnosis. This warrants formal review of workforce training pipelines, laboratory distribution, and federal support for infectious disease expertise.

D. Surveillance and Data Transparency

Age-standardized DALY modeling and expenditure data indicate allocation imbalance at a structural level. This raises legitimate questions regarding surveillance sensitivity and case detection completeness. Federal review should assess whether parasitic conditions are consistently captured through national reporting systems and whether diagnostic coding practices align with contemporary epidemiological realities. To achieve this without conflicts of interest costing American lives, federal review processes must incorporate the documented experiences of people who encounter barriers that prevent reporting.

E. Recommended Federal Review Actions

1. Conduct an independent evaluation of parasitic diagnostic access pathways and testing criteria.
2. Review parasitology workforce capacity and federal support structures for infectious disease training.

3. Assess laboratory continuity-of-operations safeguards to prevent diagnostic disruption.
4. Evaluate reimbursement alignment relative to infectious disease detection and evaluation.
5. Establish transparent evidence intake and documented review protocols for citizens raising environmental or parasitic health concerns.

F. Structural Leadership Imperative

The findings presented identify structural misalignment within a high-resource system. The appropriate response is structured review, proportional adjustment where necessary, and measurable alignment between expenditure and infectious disease burden. Federal leadership grounded in transparency, evaluation, and measurable public protection strengthens institutional credibility and reinforces the principle that American lives—and the quality thereof—remain central to public health policy. This section concludes that allocation imbalance, as identified through comparative analysis, warrants formal federal review. Such review should prioritize diagnostic accessibility, workforce reinforcement, surveillance sensitivity, and transparent citizen engagement mechanisms.

VII. REQUESTED FEDERAL ACTIONS

This section outlines specific, structured federal actions recommended in response to the allocation imbalance and diagnostic access concerns identified in the preceding analysis. These actions are procedural and structural in nature. They are not punitive, and they do not assume institutional misconduct. Their purpose is to restore alignment, transparency, measurable public health protection, and to close the homeland security vulnerabilities created when environmental and parasitic threats are under-detected.

A. Formal Confirmation of Evidence Intake and Reviewing Authority

Federal agencies, in coordination with homeland security and public health partners, should establish and publicly document clear intake procedures for parasitic and environmental health concerns. Each submission of supporting documentation should receive confirmation of receipt, identification of reviewing authority, and an estimated timeline for evaluation. Transparent intake processes that are visible across the health and homeland security enterprise strengthen institutional credibility, public trust, and situational awareness.

B. Independent Evaluation of Parasitic Diagnostic Access Pathways

An independent review, with participation from relevant homeland security and biosecurity entities, should assess current criteria governing parasitic diagnostic testing, including ova and parasite testing, serologic evaluation, and specialist referral pathways. The review should examine whether qualifying criteria, reimbursement policies, and laboratory availability align proportionately with infectious disease burden and with the need to detect threats before they escalate into security events.

C. Parasitology Workforce Capacity Assessment

A federal assessment of parasitology workforce capacity should be conducted to determine whether specialist training pipelines, laboratory staffing, and geographic distribution are sufficient to maintain surveillance sensitivity. Declines in workforce capacity may directly affect diagnostic accessibility and turnaround time, and thereby weaken the nation's ability to detect, attribute, and respond to biological threats that have direct implications for homeland security.

D. Laboratory Continuity-of-Operations Safeguards

Federal review should evaluate whether parasitic diagnostic assays and reference laboratory capabilities are protected through continuity-of-operations safeguards to prevent disruption during public health emergencies, cyber incidents, or deliberate attacks. Diagnostic infrastructure that can be rapidly degraded or taken offline creates an exploitable gap in national biosurveillance and response capacity.

E. Reimbursement and Allocation Alignment Review

CMS and related federal oversight bodies should evaluate whether reimbursement frameworks and allocation patterns support appropriate infectious disease detection. Aggregate health expenditure should translate into proportionate diagnostic accessibility and into resilient surveillance systems that contribute to national preparedness and homeland security objectives.

F. Conflict-Free Reporting and Review Mechanisms

A conflict-free reporting pathway should be established for individuals raising environmental or parasitic health concerns. This mechanism should operate independently of local clinical gatekeeping structures to ensure impartial review and should include clear routes for information

sharing with federal public health and homeland security stakeholders so that credible early-warning signals are not lost.

G. Structured Federal Review and Public Reporting

Following review, agencies should provide structured public reporting outlining findings, identified gaps, and measurable corrective actions, including those relevant to national resilience and security. Such transparency reinforces institutional accountability, informs Congressional oversight, and demonstrates a unified commitment to protecting both public health and homeland security.

These requested actions are designed to ensure that national health expenditure aligns proportionately with infectious disease burden, that American families have access to transparent, structured diagnostic pathways, and that preventable gaps in detection do not mature into avoidable homeland security vulnerabilities. The objective is not confrontation—it is measurable alignment, aggressive risk reduction, and the preservation of American lives and the quality thereof.

VIII. LIMITATIONS OF ANALYSIS

This section defines the scope and boundaries of the comparative and statistical analyses presented in this submission. Clarifying these parameters preserves analytical integrity and ensures that the findings are interpreted as system-level signals appropriate for federal oversight and review.

A. Ecological (Country-Level) Analysis

The statistical comparisons in this dossier are conducted at the country level. National health expenditure and DALY data are used to evaluate structural patterns across high-income peers, not to assess individual patient experiences. No claim is made about specific physicians, facilities, or single institutions; the findings speak to how systems allocate resources and perform at scale.

B. Modeled Disease Burden Estimates

Age-standardized DALY rates are modeled estimates produced by the Institute for Health Metrics and Evaluation (IHME), an internationally recognized, peer-reviewed source for global burden of disease data. These estimates incorporate standard modeling assumptions and data constraints. They represent the strongest comparable burden estimates currently available for cross-national policy review.

C. Aggregate Health Expenditure Data

World Bank health expenditure data capture total national per-capita healthcare spending and do not isolate line items devoted specifically to infectious disease detection or parasitic diagnostics.

Accordingly, the expenditure comparisons in this dossier evaluate overall system investment in relation to observed parasitic disease burden.

D. Limited Peer Sample for Regression Modeling

The regression model includes seven high-income peer nations. This defined comparison group represents countries with broadly similar economic capacity, and within that group the analysis identifies a clear positive association between per-capita health spending and parasitic disease burden. The results are used to frame structural performance and allocation questions appropriate for Congressional and federal review.

E. Cross-Year Data Alignment

Health expenditure data reflect 2022 values, and parasitic DALY data reflect 2023 estimates. These measures are temporally adjacent and methodologically compatible for the purpose of structural comparison. Short-term annual fluctuations are not the focus of this analysis; the emphasis is on broader alignment between sustained expenditure and disease burden.

F. No Assessment of Clinical Coding or Substitution

This dossier does not examine psychiatric diagnostic coding, insurance claim files, or individual medical records. It does not attempt to determine whether specific diagnoses were substituted, miscoded, or concealed. The conclusions are limited to questions of national allocation alignment, surveillance sensitivity, and the presence of system-level warning signals.

G. Interpretive Boundaries

The findings identify structural misalignment within a high-resource system and demonstrate that the observed burden patterns warrant structured federal review and oversight. They are

grounded in comparative national data and confined to the measures available; questions that require individual-level clinical investigation or case-by-case adjudication fall outside the scope of this analysis and would require additional inquiry by the appropriate federal entities.

IX. LEADERSHIP CORRESPONDENCE

This section contains the full formal correspondence prepared for executive, agency, oversight, and congressional leadership. Each letter requests documented review, identification of reviewing authority, and structured evaluation of parasitic diagnostic access, allocation alignment, and surveillance sensitivity.

President Donald J. Trump
The White House
Washington, D.C.

Dear Mr. President,

I write on behalf of affected American families seeking structured federal review of parasitic diagnostic access and allocation alignment within the United States healthcare system.

Recent comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized DALY data and World Bank 2022 health expenditure per capita (PPP) data reveals a measurable performance concern: although the United States leads the world in per-capita healthcare spending, it does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample. This counterintuitive relationship raises a legitimate fiscal-performance question.

This identifies structural misalignment that warrants formal executive-level review. This is not simply a disease burden issue — it is a budget integrity issue.

When federal healthcare expenditure reaches historic levels, yet measurable outcomes do not align proportionately with investment, it becomes appropriate to examine whether allocation structures, surveillance sensitivity, and diagnostic pathways are functioning efficiently.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including difficulty obtaining parasite testing, limited access to parasitology specialists, fragmented referral pathways, and the absence of documented acknowledgment when medical

concerns are submitted to agencies. These reports are consistent and geographically dispersed. They raise questions not only about individual clinicians, but also about system-level design, responsiveness, oversight, and tax-dollar allocation decisions that are contributing to preventable health decline and significant financial harm to American families. The concern is straightforward: **Are taxpayer dollars generating measurable public health improvements, or are structural inefficiencies undermining both health outcomes and financial security for American families?**

Ensuring that federal health expenditures translate into measurable improvements in both the health and financial stability of American families is not partisan. It is a matter of stewardship. When allocation misalignment or procedural bottlenecks delay early detection and effective treatment, the consequences are not merely clinical — they are economic. Families absorb preventable medical costs, lost wages, educational disruption, and long-term instability. In such circumstances, federal investment is not achieving its intended return in either health outcomes or fiscal responsibility.

These failures also have direct homeland security implications. Environmental and parasitic threats that go under-detected because of diagnostic barriers, surveillance gaps, or refusal to review citizen evidence become blind spots in our national defense posture. When families report aggressive, spreading contamination and deteriorating health and cannot secure even basic investigatory engagement, the nation is effectively flying without radar in sectors where biological and environmental hazards can accumulate, cross borders, and destabilize communities. That is not only a public health breakdown; it is a vulnerability in our homeland security architecture.

This pattern is compounded by the response of key political figures who have been publicly endorsed by you and who campaign on protecting American families. Despite repeated outreach and documented evidence of deterioration, the offices of Congressman Barry Moore, Congressman Robert Aderholt, Senator Katie Britt, and Governor Kay Ivey have refused to ask substantive questions or review the evidence we have offered, even when we are begging them to help save our dying children. We have a recorded call with an assistant to Congressman Aderholt offering nothing more than a brief well-wish, with no request for documentation and no follow-up. From Senator Britt and Congressman Moore, we have received no meaningful engagement at all. When we attempted to loop in Governor Ivey's office, her assistant shouted "go to the hospital" and ended the interaction; further communications have been blocked. Our political leaders are, in practice, ignoring dying children and declining even to look at the evidence of a potential environmental and parasitic threat. That abandonment by those closest to the ground underscores the need for direct presidential attention and federal executive action.

This request represents one analytical layer within a broader structural review. Additional documented layers will follow, addressing diagnostic criteria, workforce capacity, surveillance sensitivity, intake mechanisms, and allocation modeling — each examined through the dual lens of public health impact, taxpayer accountability, and national preparedness. A comprehensive solutions packet will be provided upon completion. If it would assist your administration, we are prepared to submit solutions concurrently with each analytical layer.

We respectfully request:

- Formal confirmation of evidence intake for citizen-submitted documentation. Identification of the federal reviewing authority responsible for parasitic diagnostic oversight.
- Executive-level evaluation of allocation alignment relative to infectious disease detection outcomes, measurable family impact, and homeland security vulnerabilities.
- Assessment of laboratory continuity-of-operations safeguards as they relate to early detection, cost avoidance, and national resilience.
- Review of parasitology workforce capacity and surveillance sensitivity in relation to federal expenditure and long-term public health stability.

The litigation referenced by affected families exists not to confront institutions, but to preserve life and secure lawful evaluation where procedural barriers persist. It is protective in purpose and reflects the intersection of health protection and financial survival for affected families.

At its core, this matter concerns whether federal spending is delivering measurable benefit to American families — in improved health, preserved livelihoods, reduced long-term economic strain, and strengthened protection against biological and environmental threats.

Fiscal responsibility requires that tax dollars be spent in favor of Americans' positive health outcomes and overall well-being — not merely absorbed into systems that fail to produce proportional results or leave exploitable security gaps. Structured review strengthens public health performance, public trust, and homeland security.

We respectfully request leadership grounded in measurable protection of American lives — and the economic and personal stability that must accompany that protection — through outcome-

based accountability, budget integrity, and decisive federal action where others have refused even to look.

With *Tremendous* Respect,

Billie Glazier

Billie Glazier
Levi's Mom

Robert F. Kennedy, Jr.
Secretary of Health and Human Services
U.S. Department of Health and Human Services
Washington, D.C.

Re: Request for Documented Review – Parasitic Diagnostic Access and Allocation Alignment

Dear Secretary Kennedy,

I write on behalf of affected American families seeking structured federal review of parasitic diagnostic access pathways and allocation alignment within the United States healthcare system.

We recognize and appreciate your stated commitment to improving healthcare transparency, reducing regulatory capture, and restoring accountability across federal health agencies. It is in that spirit of measurable reform that this correspondence is submitted.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data indicates that the United States, despite leading in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This counterintuitive relationship identifies structural misalignment that warrants formal review under HHS authority.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including difficulty obtaining ova and parasite testing, limited access to parasitology specialists, fragmented referral pathways, and the absence of documented acknowledgment when evidence

is submitted to agencies. These concerns fall directly within HHS jurisdiction through oversight of CDC, CMS, and related public health programs.

Parasitology is a specialized scientific discipline requiring advanced training in morphology, life cycle differentiation, and species-level identification. Accurate species identification is not a generalist function. It directly determines treatment pathway, medication selection, dosing considerations, and clinical risk assessment.

Species identification should not be delegated to individuals who have not received focused parasitological training. This is intended to serve as a recognition that parasitology, like pathology or oncology, requires discipline-specific expertise. When identification is conducted without that expertise, the probability of misidentification or delayed recognition increases. Currently, Americans are lacking this expertise, and the small percentage of medical providers who have the training leave species identification and diagnostics to untrained PCPs before accepting patients. It is a never-ending battle for Americans to find science-backed and meaningful care as it stands now.

The CDC itself demonstrates that expert parasitologists are capable of evaluating image-based submissions for species identification in research contexts. If such review is scientifically valid in research channels, then it is reasonable to evaluate whether comparable expertise should be structurally accessible in clinical contexts when parasitic disease is possible or a concern of the patient(s).

Accordingly, species identification should be performed or confirmed by qualified parasitologists whose training is directly aligned with morphological and species-level

evaluation. This function can and should be clearly distinguished from clinical treatment authority.

Following expert identification, collaboration with physicians trained in infectious disease management is essential. Therapeutic decisions—including prescription of antiparasitic medications—must remain within the scope of medical doctors operating under evidence-based, peer-reviewed, globally recognized treatment standards—elements that are leaving many people across the country in ongoing medical decline.

This is a call to align each stage of evaluation with the appropriate level of specialization: identification by parasitologists; treatment by medically trained physicians informed by patient-trusted and reputable data. When expertise exists but is procedurally inaccessible, preventable deterioration claims lives and destroys families. Structural alignment between specialization and responsibility is foundational to patient safety.

We believe that true and meaningful healthcare reform must begin by hearing the patients' voices. Structural reform cannot succeed if lived experiences are procedurally filtered before evaluation. Families across the country are communicating consistent patterns of access barriers. Those voices should be heard and never omitted by the reform process.

We respectfully suggest that any formal review include independent subject-matter experts and patient-informed representation. Reliance solely on institutional stakeholders may present inherent conflict-of-interest risks or, at minimum, create the appearance of financial or reputational self-interest. Even where no misconduct exists, evaluation conducted exclusively

within existing funding and regulatory structures can undermine public confidence. Independent participation strengthens transparency, credibility, and the integrity of reform efforts.

To rebuild trust among affected Americans who have experienced prolonged dismissal, HHS may also consider structured dialogue with independent clinicians who are regarded by these families as credible and experienced in complex parasitic and infectious disease evaluation. For example, Dr. Thomas Lodi, Founder of An Oasis of Healing, is viewed by many affected individuals as a trusted voice on related subject matter. We, the People, recommend that HHS consider collaborative communication with such clinicians as part of a broader listening and review process. This recommendation is not an endorsement of any single provider, nor a substitute for formal institutional evaluation. Rather, it reflects the importance of including trusted external perspectives to bridge gaps between institutions and the communities they serve. Furthermore, any such engagement should include clear assurances that participating clinicians are protected from professional retaliation, regulatory pressure, reputational harm, or financial consequences that could restrict their ability to speak freely and contribute honestly to review processes. Meaningful reform cannot occur if subject-matter experts risk adverse consequences for participating in transparent dialogue. Safeguarding independent medical voices strengthens—not weakens—the integrity of institutional review.

This portion of The People's Dossier (Part I) submission represents one analytical layer within a broader, more complex review. We intend to submit additional documented layers sequentially, addressing diagnostic criteria, workforce capacity, laboratory continuity-of-operations safeguards, surveillance sensitivity, and structural intake mechanisms. Following those submissions, we will provide a comprehensive solutions packet consolidating findings and

offering structured policy recommendations. If it would assist the Department, we are prepared to submit proposed solutions concurrently with each analytical layer.

Given the statutory authority of HHS over national public health policy, we respectfully request:

- Formal confirmation of evidence intake and identification of the reviewing office within HHS.
- Department-level evaluation of parasitic diagnostic access criteria and CMS reimbursement alignment.
- Review of CDC parasitology laboratory capacity and continuity-of-operations safeguards.
- Assessment of parasitology workforce capacity and federal training pipelines.
- Clarification of citizen intake and documented review protocols for environmental and parasitic health concerns.

The litigation referenced by affected families exists not to confront the Department, but to preserve life and open lawful pathways to evaluation where procedural barriers persist. It is protective in purpose, not adversarial in intent.

We believe this matter aligns directly with your stated objective of strengthening public health accountability and restoring public trust in federal health institutions. Structured review, transparent evaluation, and measurable alignment between expenditure and infectious disease burden—particularly in light of the positive spending-burden association identified within OECD peers—will reinforce that mission.

We respectfully request leadership grounded in measurable protection of American lives—and the quality thereof.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

Ralph Abraham, M.D.
Principal Deputy Director
Centers for Disease Control and Prevention
Atlanta, Georgia

Re: Diagnostic Access, Surveillance Alignment, and Continuity of Public Health Leadership

Dear Dr. Abraham,

In light of recent leadership transitions at the Centers for Disease Control and Prevention, including the departure of Acting Director Jim O'Neill and the current absence of a confirmed Director, this correspondence is respectfully directed to you as the most senior official presently serving within the agency.

This letter is submitted on behalf of affected American families seeking structured review of parasitic diagnostic access pathways and surveillance alignment within the CDC's jurisdiction.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data indicates that the United States, despite leading globally in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This counterintuitive pattern warrants structured review of allocation alignment and surveillance sensitivity.

The current leadership environment makes continuity of mission especially important. Public health governance must remain stable even amid administrative transition. Surveillance integrity,

diagnostic accessibility, and species-level identification capacity cannot be paused while leadership appointments are resolved.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including restricted access to ova and parasite testing, limited availability of parasitology expertise, fragmented referral pathways, and absence of documented acknowledgment when health concerns are submitted.

These reports raise questions not about individuals, but about system design and continuity safeguards:

- Are diagnostic review pathways sufficiently protected from administrative disruption?
- Is parasitology expertise structurally accessible in clinical contexts?
- Are public reporting mechanisms operational and responsive during leadership transitions?
- Is species-level identification capacity preserved as part of national surveillance readiness?

Parasitology is a specialized discipline. Species identification determines treatment pathway and informs epidemiological tracking. When such expertise exists but is procedurally inaccessible, preventable deterioration may occur and surveillance reliability may be affected.

In periods of institutional transition, safeguarding scientific integrity and diagnostic continuity is essential to maintaining public trust. Transparent review strengthens agency credibility and reinforces the CDC's foundational mission.

This submission represents one analytical layer within a broader structural review currently underway. Additional documented layers addressing diagnostic criteria, workforce capacity,

laboratory continuity safeguards, surveillance sensitivity, and intake mechanisms will follow, along with a comprehensive solutions packet.

We respectfully request:

1. Confirmation of continued operational diagnostic pathways during leadership transition.
2. Identification of interim reviewing authority responsible for parasitic diagnostic oversight.
3. Evaluation of parasitology workforce capacity and species identification accessibility.
4. Clarification of structured intake procedures for citizen-submitted health concerns.

Public confidence depends not on the absence of disagreement within institutions, but on the consistent application of scientific standards and accountability. Diagnostic access and surveillance integrity must remain stable regardless of administrative change.

We respectfully request leadership grounded in measurable protection of American lives—and the quality thereof—through continuity of scientific mission and transparent review.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

The Honorable Thomas March Bell
Inspector General
U.S. Department of Health and Human Services
Office of Inspector General
Washington, D.C.

Re: Request for Inspector General Review – Diagnostic Access, Allocation Alignment, and Program Integrity

Dear Inspector General Bell,

Congratulations on your recent confirmation and swearing-in as Inspector General of the Department of Health and Human Services. Your extensive background in investigation, federal oversight, law enforcement, and program accountability uniquely positions your office to examine structural vulnerabilities where federal funding, public health performance, and citizen protection intersect.

This correspondence is submitted on behalf of affected American families requesting independent review under the authority of the HHS Office of Inspector General.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data indicates that the United States, despite leading in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This counterintuitive relationship raises a performance-alignment question relevant to the stewardship of approximately $2.8 trillion in federal funding administered by HHS in Fiscal Year 2025.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including:

- Restricted access to ova and parasite testing
- Limited availability of parasitology expertise
- Fragmented referral pathways
- Absence of documented acknowledgment when health threat concerns are submitted to agencies

These patterns raise oversight-relevant questions regarding:

• Whether federal program implementation aligns with appropriated public health objectives
• Whether diagnostic access pathways reflect efficient use of federal funding
• Whether structural limitations in communication channels affect documented disease burden representation
• Whether programmatic criteria inadvertently restrict medically appropriate evaluation
• Whether allocation structures create unintended conflicts of interest in internal review processes

We respectfully request consideration of OIG review in the following areas:

1. Whether federal funding allocations adequately support parasitic diagnostic capacity relative to documented infectious disease burden.
2. Whether documented burden accurately reflects reality in light of reported limitations in structured public communication channels for submission of health threat concerns.
3. Whether program design or reimbursement criteria inadvertently impede medically appropriate parasitic evaluation.
4. Whether laboratory continuity-of-operations safeguards sufficiently protect parasitic diagnostic capacity during resource reallocations.
5. Whether workforce capacity in parasitology aligns proportionately with federal public health mandates and funding levels.

Under the Inspector General Act of 1978, as amended, your office is empowered to detect and deter fraud, waste, abuse, and mismanagement in federally funded programs. This request seeks evaluation of whether structural misalignment constitutes inefficiency or programmatic vulnerability under federal oversight standards.

The litigation referenced by affected families arose following perceived exhaustion of available administrative review pathways. It is not adversarial in intent. It is protective in purpose and reflects procedural escalation when oversight engagement appeared unavailable.

Given your background in complex investigations, congressional reporting, and enforcement of accountability mechanisms, we respectfully submit that structured OIG review could clarify whether allocation, performance, and surveillance sensitivity are properly aligned with statutory obligations.

This submission represents one analytical layer within a broader, ongoing review. Additional documented layers addressing diagnostic criteria, surveillance sensitivity, intake mechanisms, workforce training, and structural allocation modeling will be submitted sequentially. A comprehensive solutions packet will follow.

If helpful to your office, we respectfully request the opportunity for a preliminary briefing so that forthcoming analytical layers may be reviewed in advance. Early awareness may assist your team in determining whether formal audit, evaluation, or investigative pathways are appropriate.

Public confidence in HHS oversight depends on demonstrable accountability and measurable alignment between expenditure and outcome. Transparent review strengthens institutional credibility and affirms that American lives—and the quality thereof—remain the central objective of federal health governance.

Respectfully submitted,

Billie Glazier

Billie Glazier

Levi's Mom

Orice Williams Brown
Acting Comptroller General of the United States
U.S. Government Accountability Office
Washington, D.C.

Re: Formal Request for GAO Performance Audit and High-Risk Review Consideration – Parasitic Diagnostic Access and Federal Allocation Alignment

Dear Acting Comptroller General Williams Brown,

Pursuant to GAO's statutory oversight authority and Congress's constitutional power of the purse, this correspondence formally requests consideration of a GAO performance audit regarding parasitic diagnostic access and allocation alignment within programs administered under the Department of Health and Human Services.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data indicates that the United States, despite leading in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This pattern raises a performance-alignment question squarely within GAO's mandate to evaluate federal program efficiency, effectiveness, and accountability.

Affected families across multiple states report recurring barriers to parasitic diagnostic evaluation, including restricted access to ova and parasite testing, limited availability of parasitology expertise, fragmented referral pathways, and absence of documented acknowledgment when evidence is submitted to federal authorities.

Accordingly, we respectfully request GAO review of:

1. Whether federal appropriations adequately support parasitic diagnostic capacity relative to documented infectious disease burden.
2. Whether documented burden metrics accurately reflect reality in light of reported limitations in structured communication channels for members of the general public to submit health threat concerns for formal review.
3. Whether reimbursement structures and program criteria inadvertently restrict medically appropriate parasitic evaluation.
4. Whether continuity-of-operations safeguards sufficiently protect parasitic diagnostic infrastructure.
5. Whether parasitology workforce capacity aligns proportionately with federal health expenditure and surveillance responsibilities.
6. Whether program oversight mechanisms sufficiently mitigate structural conflicts of interest in allocation review.

Under the Inspector General Act of 1978, as amended, oversight bodies are empowered to detect fraud, waste, abuse, and mismanagement in federally funded programs. This request seeks evaluation of whether structural allocation misalignment constitutes inefficiency or programmatic vulnerability under federal oversight standards.

Additionally, GAO's responsibility to report to Congress on high-risk areas of federal operations provides a relevant framework. If diagnostic access misalignment, surveillance sensitivity gaps, or allocation inefficiencies materially affect national health preparedness and expenditure integrity, consideration for inclusion in GAO's High-Risk List review framework may be appropriate.

The litigation referenced by affected families arose after perceived exhaustion of available administrative review pathways. It reflects procedural escalation where structured oversight mechanisms appeared unavailable or inaccessible. It is protective in nature, not adversarial in intent.

We recognize GAO's obligation to report objectively to Congress. Failure to examine allocation-performance alignment in a system of unprecedented healthcare expenditure may itself raise oversight concerns.

This submission represents one analytical layer within a broader and more complex review currently in development. Additional documented layers addressing diagnostic criteria, surveillance sensitivity, workforce capacity, structural intake limitations, and allocation modeling will be submitted sequentially. A comprehensive solutions packet will follow.

If helpful to your office, we respectfully suggest a preliminary briefing meeting to provide advance review of forthcoming analytical layers. Such engagement would allow GAO to assess scope, determine relevance to existing oversight initiatives, and prepare for potential congressional reporting implications.

We submit this request in good faith and with respect for GAO's independent oversight authority. Transparent evaluation strengthens institutional credibility and affirms that federal health governance remains accountable to measurable outcomes.

We respectfully request serious consideration of a formal performance audit or equivalent review under GAO authority.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

The Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce
U.S. House of Representatives

Re: Formal Oversight Request – Diagnostic Access and Allocation Alignment

Dear Chairman Guthrie,

As Chairman of the House Committee on Energy and Commerce, you possess direct oversight authority over HHS, CDC, CMS, and the federal public health infrastructure. You also exercise legislative and appropriations influence over the structure and performance of these programs.

I write on behalf of affected American families — including constituents across Kentucky's 2nd Congressional District — requesting formal oversight review of parasitic diagnostic access and allocation alignment within federally funded health programs.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data demonstrates that the United States, despite leading globally in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This raises a performance-alignment question squarely within your committee's jurisdiction.

Families report consistent barriers to parasitic diagnostic evaluation, including restricted access to parasite testing, limited availability of parasitology expertise, fragmented referral pathways, and lack of documented acknowledgment when health threat concerns are submitted to agencies.

Given the committee's oversight and investigative authority, we respectfully request consideration of:

1. Formal oversight inquiry into parasitic diagnostic access pathways.
2. Request for documentation from HHS and CDC regarding species identification procedures and diagnostic criteria.
3. Review of CMS reimbursement alignment relative to infectious disease evaluation.
4. Examination of laboratory continuity-of-operations safeguards.
5. Coordination with GAO regarding potential performance audit evaluation.

This matter involves not only national expenditure alignment, but the lived reality of constituents within Kentucky who are seeking access to timely evaluation.

Oversight exists precisely to examine alignment between appropriated funding and measurable outcome. When data and recurring access concerns converge, review becomes not optional, but responsible.

We submit this request in good faith and with respect for the committee's authority. Transparent examination strengthens institutional credibility and reinforces the principle that American lives — and the quality thereof — remain central to federal health governance.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

The Honorable Robert Aderholt
Chair
House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

The Honorable Rosa DeLauro
Ranking Member
House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

1036 Longworth House Office Building
Washington, D.C. 20515

Re: Bipartisan Appropriations Oversight Request – Diagnostic Access and Allocation Alignment

Dear Chair Aderholt,
Ranking Member DeLauro, and Members of the Subcommittee,

This correspondence is submitted on behalf of affected American families requesting structured appropriations oversight review of parasitic diagnostic access and allocation alignment within programs funded under this Subcommittee's jurisdiction.

The matters raised in this layer of *The People's Dossier* are neither partisan nor ideological. They are human. The expanding population of affected Americans includes individuals from across the political spectrum — rural and urban communities, conservative and liberal households, veterans and civilians alike. Disease burden does not recognize party affiliation.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data demonstrates that the United States, despite leading globally in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This raises an

appropriations-performance alignment question squarely within this Subcommittee's responsibility.

Families across multiple states report recurring barriers to parasitic diagnostic evaluation, including:

- Restricted access to ova and parasite testing
- Limited availability of parasitology expertise
- Fragmented referral pathways
- Absence of documented acknowledgment when health concerns are submitted to agencies

These concerns intersect directly with funding oversight for CDC programs, CMS reimbursement frameworks, laboratory infrastructure, and workforce training initiatives supported through annual appropriations.

When federal funds are allocated at historic levels, but measurable infectious disease detection does not align proportionately with expenditure, review is not political — it is procedural.

We respectfully request that the Subcommittee consider:

1. Whether appropriated funds sufficiently support parasitic diagnostic capacity relative to documented infectious disease burden.
2. Whether documented burden accurately reflects reporting realities where structured public communication channels may be limited.
3. Whether reimbursement and programmatic criteria inadvertently restrict medically appropriate parasitic evaluation.
4. Whether laboratory continuity-of-operations safeguards are adequately funded and protected.
5. Whether parasitology workforce capacity reflects proportional investment under current appropriations.

This submission represents one analytical layer within a broader, ongoing structural review. Additional documented layers will follow, along with a consolidated solutions packet. The objective is alignment — not confrontation.

Oversight responsibility exists independent of individual disputes or procedural matters. Appropriations review should proceed based on measurable alignment between federal expenditure and public health outcome.

We respectfully request bipartisan leadership grounded in measurable protection of American lives — and the quality thereof.

Respectfully submitted,
Billie Glazier
Billie Glazier
Levi's Mom

The Honorable Andrew R. Garbarino
Chairman
House Committee on Homeland Security
U.S. House of Representatives
Washington, D.C.

Re: Homeland Security Implications of Diagnostic Access, Surveillance Alignment, and National Preparedness

Dear Chairman Garbarino,

As Chairman of the House Committee on Homeland Security, your leadership centers on preparedness, resilience, and the responsibility to identify threats before they escalate. Your commitment to safeguarding the homeland—shaped by the enduring lessons of September 11th—underscores the importance of early detection, transparent reporting, and structural readiness.

This correspondence is submitted on behalf of affected American families requesting review of parasitic diagnostic access and federal surveillance alignment from a homeland security perspective.

Comparative analysis using Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2023 age-standardized Disability-Adjusted Life Year (DALY) data and World Bank 2022 health expenditure per capita (PPP) data indicates that the United States, despite leading globally in per-capita healthcare spending, does not demonstrate proportionately lower parasitic disease burden relative to peer high-income nations. Within the OECD high-income comparison group, the regression model demonstrates a positive association between per-capita spending and parasitic DALY burden in this sample ($R^2 = 0.5481$; $p = 0.0571$). This counterintuitive pattern raises a preparedness and surveillance-alignment question.

When families across multiple states report consistent barriers to parasitic diagnostic evaluation—including restricted testing pathways, limited access to specialized expertise, and lack of documented acknowledgment when health threat concerns are submitted—it raises structural questions directly relevant to homeland security:

- Are public health surveillance channels sufficiently sensitive?
- Are communication pathways accessible for early threat detection?
- Does diagnostic infrastructure reflect appropriate readiness standards?
- Are workforce pipelines aligned with emerging biological realities?

In addition to diagnostic access concerns, families across multiple states have reported recurring observations within virtual support communities of suspected parasitic organisms or unexplained moving substances associated with consumer products on retail shelves. In some instances, these reports reference imported goods, including products labeled as manufactured in China. While these observations remain unverified due to the absence of reporting mechanisms, the consistency of such reports across geographically dispersed communities warrants structured surveillance review.

The concern is not speculative attribution. It is surveillance sensitivity. If public reporting channels are unclear, underutilized, non-existent, or procedurally inaccessible, potential biological anomalies—whether naturally occurring, environmental, or supply-chain related—may not be formally documented or evaluated. In such circumstances, perceived inaction can erode public trust while legitimate review opportunities are missed.

When citizens report recurring biological concerns and receive no structured acknowledgment or investigative pathway, the appearance of a surveillance blind spot emerges. Even if no confirmed contamination exists, the absence of transparent evaluation creates national resilience

vulnerability. For example, I called the CDC, EPA, HHS, state health departments, elected officials, and other agencies with a direct interest in public health. I reported that I am extensively trained in hazmat, emergency response, environmental threats, and infectious diseases—and experienced in teaching courses on these topics. I shared that there is an aggressive parasitic contamination on my Alabama farm that affects my home, grounds, vehicles, trees, child, husband, me, and most of my animals, and that the pathogen does not respect property lines. I offered video, images, and specimens. Those offers were not accepted. Aside from the state veterinarian, I did not receive a response. When he arrived, he had been stripped of authority to scoop dirt, swab surfaces, or sample the animals described in the report. He was permitted only to take a minimal sample from a pig that was not in the implicated area. This experience illustrates an operational surveillance gap. It is a homeland security issue all day long.

We respectfully submit that any credible homeland security posture must include accessible, documented mechanisms for reviewing public reports of potential biological anomalies in consumer and community environments. Surveillance integrity depends not only on laboratory capacity, but on functional intake systems that allow early pattern recognition.

Homeland security does not begin at the border. It begins with detection. The ability to identify, classify, and respond to biological threats—whether naturally occurring, accidental, or deliberate—depends upon functional diagnostic systems and transparent reporting mechanisms. The homeland security implications of these concerns are addressed extensively in a separate layer of The People's Dossier, which examines biological surveillance resilience, reporting infrastructure vulnerabilities, and detection sensitivity gaps in greater detail. These issues are

also referenced in ongoing litigation, not to escalate conflict, but to signal the seriousness of the structural exposure we believe the nation is facing.

Preparedness requires confronting structural exposure before crisis reveals it. Surveillance gaps—whether caused by allocation misalignment, workforce limitations, or reporting barriers—constitute readiness vulnerabilities.

We respectfully invite direct communication with your office regarding specific threat patterns and structural vulnerabilities we have identified that have not, to date, successfully moved through existing administrative gatekeeping channels. Our objective is not public alarm, but responsible escalation to appropriate oversight authorities when ordinary pathways appear insufficient. We believe certain documented concerns warrant direct Homeland Security-level awareness and evaluation. It should not be as complicated as it is to report threats with appropriate response to follow.

Parasitology is a specialized scientific discipline. Species-level identification informs not only treatment but epidemiological tracking. When specialized expertise exists but remains procedurally inaccessible within clinical pathways, early detection and broader surveillance integrity may be compromised.

We respectfully request that the Committee consider reviewing:

- Whether public health reporting channels allow adequate submission and formal review of potential parasitic health threats.
- Whether federal diagnostic infrastructure aligns with homeland preparedness standards.
- Whether parasitology workforce capacity reflects appropriate national resilience benchmarks.

- Whether interagency coordination between HHS and homeland security entities sufficiently accounts for biological surveillance integrity.

This is a national resilience matter. Preparedness is strongest when vulnerabilities are examined before they are exploited or magnified. Transparent evaluation strengthens—not weakens—homeland security posture.

We respectfully request leadership grounded in measurable protection of American lives—and the quality thereof—through surveillance integrity, diagnostic readiness, and elimination of preventable blind spots in the homeland security enterprise.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

Administrator Lee Zeldin
U.S. Environmental Protection Agency
Washington, D.C.

Re: Environmental Vectors, Reporting Authority, and Homeland Security Vulnerabilities

Dear Administrator Zeldin,

You were sworn in as the 17th Administrator of the United States Environmental Protection Agency on January 29, 2025, after more than two decades of service in the United States Army, including deployment to Iraq with the 82nd Airborne Division, and years of legislative experience in the New York State Senate and the U.S. House of Representatives. That record of military and public service reflects a career grounded in national defense, duty to country, and protection of the communities you represent.

I write on behalf of affected American families to request documented EPA review of environmental vectors, contaminated environments, and reporting gaps that are contributing to preventable health decline and creating avoidable vulnerabilities in our national resilience and homeland security posture.

On my Alabama property, we are experiencing an aggressive, persistent contamination that presents with clear environmental and parasitic characteristics. It affects the home, grounds, vehicles, trees, animals, my child, my husband, and me. It does not respect property lines. I have repeatedly sought assistance and formal evaluation from entities tasked with protecting public health and environmental safety, including your agency, state and local health departments, the Centers for Disease Control and Prevention, and the Department of Justice. In each case, the consistent message has been that there is either no authority or no jurisdiction to respond in a substantive, investigative way.

When residents report an apparent environmental contamination with potential parasitic or biological characteristics and are told “we have no authority to respond,” the result is not simply bureaucratic frustration. It is the creation of an unmonitored hazard zone where potential threats are neither characterized nor contained. If no agency claims jurisdiction to test, sample, or investigate, the contamination is effectively invisible to the very systems that are supposed to detect and mitigate environmental risks.

The EPA’s mission includes protecting human health and the environment. That mission is not limited to chemical releases or easily categorized pollutants. Environmental vectors capable of carrying or sustaining parasitic or biological threats fall squarely within the concern set that links environmental health to public health and, by extension, to homeland security. A pathogen or contaminant that can spread across properties, affect multiple species, and resist basic mitigation efforts is not just a local nuisance; it is a potential vector for broader environmental and public health impact.

From a homeland security perspective, the refusal or inability of multiple agencies to assert investigatory authority over a reported environmental contamination creates a systemic blind spot. If no one is formally responsible for receiving, evaluating, and acting on such reports, then emerging threats, whether naturally occurring or otherwise, can advance unchecked. That is an unacceptable condition in a nation that claims to prioritize preparedness, resilience, and early detection. If EPA does not hold clear authority here, the obvious question is: **who** does? If statutory or practical authority over potential environmental biohazards has been fragmented, diluted, or effectively hijacked by process or policy, the American public deserves to know where that authority now resides and how it can be accessed in an emergency.

In my own case, I offered to provide images, videos, and physical specimens. I explicitly identified my training in hazardous materials, emergency response, environmental threats, and infectious disease instruction. Despite that background and the seriousness of the reported conditions, the consistent response was that no one had the authority or mandate to come, test, or even formally log and investigate the concern. That is not a technicality. It is a structural failure that leaves Americans unprotected and leaves the homeland vulnerable.

Respectfully, when an environmental contamination with clear potential health implications is reported, “we have no authority” should never be the end of the conversation. It should be the beginning of an escalated, interagency response that clarifies which entity does have authority and ensures that the site is evaluated, documented, and addressed.

Accordingly, we respectfully request that the Environmental Protection Agency:

1. Formally acknowledge receipt of this concern and identify the EPA office responsible for evaluating potential biological or parasitic contaminants in residential and agricultural environments.

2. Clarify EPA’s authority and responsibilities when citizens report suspected environmental vectors or contaminations that may involve biological or parasitic agents, including how those reports are coordinated with public health and homeland security partners.

3. Establish or publicly document a clear pathway for citizen-submitted environmental health concerns, including procedures for intake, triage, and investigative referral when potential biological or parasitic vectors are involved.

4. Evaluate whether current regulations, guidance, and interagency agreements leave gaps in authority or jurisdiction that allow environmental health threats to go uninvestigated when multiple agencies decline responsibility, and specify where operational authority currently resides.

5. Coordinate with health and homeland security agencies to ensure that environmental surveillance, reporting mechanisms, and response authorities are aligned so that environmental contaminants with health and security implications are not left in a jurisdictional void.

The pattern that affected families are experiencing—every agency disclaiming authority while obvious environmental and health threats remain unassessed—is a clear signal that something is structurally wrong. It undermines public trust, exposes communities to ongoing harm, and leaves the nation with blind spots that can be exploited by time, nature, or adversaries.

We are not seeking conflict. We are seeking a functioning system in which environmental and health protections are real, where no family is told that no one has the authority to respond when their home and land are clearly compromised, and where environmental health threats are understood and treated as part of the nation's broader homeland security landscape.

We respectfully request leadership grounded in measurable protection of American lives, their environments, and the homeland they depend on.

Respectfully submitted,

Billie Glazier

Billie Glazier
Levi's Mom

X. The Road Forward: *In Lieu of aConclusion*

Federal agencies and elected leaders are now confronted with a reality that millions of Americans have been forced to live inside for years: people cannot even find doctors willing—or able—to help them stay alive. Families report being turned away from basic parasitic evaluation, denied referrals, and left to navigate complex, deteriorating illnesses with no meaningful clinical partnership, even as their ability to work, parent, and remain financially stable collapses around them. These are not isolated anecdotes; they form a national pattern of abandonment described consistently by patients across states, ages, and political lines.

When one of our nation's lead public health institutions states on a recorded call that there is no channel for Americans to report these issues, the problem is no longer confined to bedside decision making; it becomes a structural indictment of our reporting and accountability architecture. In operational terms, the radar for parasitic infections has effectively been switched off: signals from affected Americans are not being received, logged, or acted upon. When the CDC, EPA, HHS, EMA, FBI, the federal judiciary, and even elected officials respond—if they respond at all—by saying they "have no authority to respond," the message to affected families is devastatingly clear: there is no recognized doorway into the very systems funded and mandated to protect their lives. A system that cannot even hear the people it is failing cannot credibly claim to be safeguarding the public.

This silence has consequences measured in more than statistics. Parents are watching their children deteriorate. Adults of working age are losing jobs, homes, and futures because untreated illness has stripped them of the capacity to work. Grandparents are forced to become full time caregivers instead of enjoying their final years. The costs are borne first by families, then by communities, and finally by taxpayers who are funding a system that appears structurally unable —or unwilling—to respond when lives are truly at stake. In this context, unaddressed

parasitic disease is not only a public health failure; **it is a homeland security vulnerability**, leaving gaping, exploitable weaknesses in the nation's biological defenses.

The data presented in this Part I demonstrate a measurable misalignment between spending and parasitic disease burden. The voices of families describe a parallel misalignment between need and access. Together, they suggest that current structures may be incentivizing inaction, allowing preventable harm to continue while resources flow without outcome-based accountability, and permitting critical vulnerabilities in parasitic disease detection and response to widen unchecked. That is not merely a health systems problem; it is a public trust, governance, and national security problem.

This dossier does not end with critique. Each category of procedural barrier that Americans are now encountering—

—the inability to secure lifesaving evaluation and treatment,

—the absence of safe, functional reporting channels,

—the fragmentation between agencies who each claim "no authority,"

—the financial collapse that follows when sick Americans cannot work,

—and the suffering and deaths of children trapped inside these gaps—

—will be addressed in subsequent parts of this dossier with specificity, documentation, and proposed remedies. Those future submissions will map these failures step by step: from the bedside, to the clinic, to the laboratory, to the agency intake desks that currently stand silent, and finally to the legislative and judicial structures that must be engaged to correct them.

This Part I therefore closes with a clear and simple assertion: when millions of Americans are reporting that they cannot access lifesaving care, when core agencies acknowledge that no channel exists to hear them, and when leaders repeatedly disclaim authority to act, the system is not merely strained—it is structurally out of alignment with its most basic purpose. The question before our federal leadership is whether that misalignment will be formally reviewed and

corrected, and the nation's parasitic disease radar turned back on, or whether American families will be left to navigate this abandonment—and these widening vulnerabilities—alone.

In Memory of Suzie Hitch, who died at the hands of this corrupt system,

Billie Glazier,
Levi's Mom

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STATISTICAL APPENDIX

Regression Equation: DALY = 0.003572 × Spending -11.6112

R^2 = 0.5481

Standardized Beta = 0.7403

p-value (slope) = 0.057055

F-statistic = 6.063794

F p-value = 0.057055

SS Regression = 397.867843

SS Residual = 328.068378

SS Total = 725.936221

df Regression = 1

df Residual = 5

Mean Square Regression = 397.867843

Mean Square Residual = 65.613676

Z-score (United States) = 1.9398