Call to order
Deb Schutte called the meeting to order at 1:00 p.m. and presided over the meeting. Introductions were made. Tonya introduced guest Blythe Stanfel to the group. Blythe is a parent concerned with the cost of special formula for infants with metabolic disorders.

MEMBERS PRESENT – IOWA CITY SITE
Paul Romitti, Nancylee Ziese, Celeste Johnson, Roger Williamson, Val Sheffield, Debra Schutte, Jolene Johnson, Christina Trout, Stan Berberich (Representing Mary Gilchrist), Molly Guard.

MEMBERS PRESENT – DES MOINES SITE
Shelley Ackermann, Jerry Wickersham, Linda Brown, Michelle Hall, Senator Amanda Ragan.

MEMBERS ABSENT
James Matsuda, Neil Mandsager, Robert Lee, Gregory Garvin, Jeffrey Lobas, Lisa Heddens, M. Peggy Stokes, Diana Fritz Cates.

OTHER ATTENDEES
Julie McMahon, Pam DeBoer, Judy Miller, Brad McDowell, Karen Brewer, Tonya Diehn, Dawn Mouw, Marcia Valbracht, Don Simmons, Cathy Evers, Kathy Matthews, Sherry Smith

SPECIAL GUEST
Blythe Stanfel, Parent

APPROVAL OF MINUTES
Deb noted that the minutes from the January 16, 2004 meeting had been provided to everyone via email and asked if there were any changes. No changes.

Motion to approve the minutes was made by Nancylee Ziese and seconded by Christina Trout.

Members voted unanimously to approve the 1-16-04 BDAC meeting minutes.

I. METABOLIC GENETICIST RECRUITMENT
Val Sheffield

Val discussed candidates for the metabolic geneticist position to be filled for the Iowa Newborn Metabolic Screening Program and the UI Dept. of Pediatrics. One of the candidates has been offered the position and she has verbally accepted. The program is in the process of officiating her position with a contract agreement.

II. COORDINATOR REPORT
Tonya Diehn

Legislation
There were four items pertinent to the Birth Defects Advisory Committee.
• The Iowa Birth Defects Registry Appropriation Bill has been signed into law and allows a portion of birth certificate fees to be transferred to the Iowa Birth Defects Registry for abstractors’ salaries and other surveillance costs.
• Representative Petersen has introduced a bill that will establish a work group to develop a stillbirth protocol through the health department and require the Iowa Birth Defects Registry to perform stillbirth surveillance as an additional responsibility. Representative Peterson incorporated the Birth Defects Institute code revisions into the stillbirth legislation.
• The new name will be The Center for Inherited Congenital Disorders. This bill will be signed into law today at 1:30.
• Janet Peterson introduced another bill to request insurance coverage of special formula for infants. Special formulas required for infants with metabolic disorders impose a great expense to parents. Blythe Stanfel is one of the parents who had requested insurance or government funding for the formula. This bill did not make it through funnel week.

NBS Retention Policy
Heather Adams, assistant Attorney General to IDPH, is reviewing the NBS retention policy. Tonya will meet with Heather later this month to discuss the policy. The proposal for the retention policy will be ready prior to the next BDAC meeting in July.

Bylaws Subcommittee
When the BDI code revision subcommittee reviewed the code, members mentioned it would be advisable to also review the bylaws. Deb Schutte stated the bylaws and codes were not congruent and need to coincide. Nancy Ziese agreed. It had been over 20 years since the bylaws had been written and are very much out of date. Tonya suggested that it would be advisable for members of the BDAC to also review the bylaws.

Motion was made by Nancylee Ziese to approve a subcommittee to review the bylaws. Seconded by Paul Romitti.
Approved

Tonya asked BDAC members to consider serving on the subcommittee. If there are not enough volunteers, she may contact everyone individually to inquire if they would be interested.

III. IOWA BIRTH DEFECTS REGISTRY NAME CHANGE

Paul Romitti

The Iowa Birth Defects Registry internal advisory committee discussed a name change for the Registry. They looked at the proposed name changes and have decided since the scope of the program has expanded, it would be advisable to change the title of the program. They would like to change the name of the program to Iowa Congenital and Inherited Disorders Registry (ICIDR). Deb asked for a motion to accept the proposed name change.

Motion was made by Val Sheffield to accept the name change from Birth Defects Registry to Iowa Congenital and Inherited Disorders Registry (ICIDR). Seconded by Nancylee Ziese.
Approved.
Discussion
Michelle Hall mentioned the name Iowa Congenital and Inherited Disorders Registry may be offensive to the KIDS Coalition group and the committee should consider the opinions of the group before changing the name. Paul asked Tonya for her opinion on the matter. Tonya suggested running the name past the Kids Coalition group for their opinion to ensure they feel the title is friendly and not offensive. Tonya will discuss name change with Rep. Heddens and the KIDS Coalition.

It was also recommended to change the title of Birth Defects Advisory Committee to Congenital and Inherited Disorder Advisory Committee. This title would coincide with the new title of the Birth Defects Institute, (Center for Inherited and Congenital Disorders).

Motion was made by Val Sheffield to accept the name change of the BDAC to the Congenital and Inherited Disorders Advisory Committee (CIDAC).
Seconded by Linda Brown

Discussion
There was discussion that the bylaws subcommittee should determine the name of the advisory committee as they review and revise the bylaws.

Motion was made by Val Sheffield to amend the previous motion to defer discussion to bylaws committee for official change in bylaws.
Seconded by Linda Brown.
Motion approved by members.

IV. FIRST TRIMESTER SCREENING REPORT
Roger Williamson

Roger stated Screening for Down syndrome is currently available to women in Iowa through the MSAFP Screening Program. The Quad screen is the current standard of care and screens for the following markers; alpha-fetoprotein (AFP), unconjugated estriol (uE3), human chorionic gonadotrophin (hCG) and Inhibin A.

Roger mentioned the false positive rate for AFP screening is of concern to both doctors and practitioners. Some women avoid AFP testing because they perceive the false positive rate is too high. The women who screen positive are offered amniocentesis for a definitive diagnosis. Although the amniocentesis is accurate and considered a low risk procedure, some women do not want to take the small risk.

The concern for the false positive rate has prompted doctors to search for a more accurate, and less invasive screening during the first trimester of gestation (10-14 weeks). Protocols which that have been tested include: biochemical markers, ultrasound findings, and maternal age separately or in combination. The most promising of the tests have been PAPP-A (plasma protein A) and the beta subunit of human chorionic gonadotropin (free β-hCG). PAPP-A is a protein produced by the placenta and can be measured in maternal serum and increases rapidly after the 7th week of pregnancy. This marker is most useful during the first trimester and is found to be lower in fetuses with Down syndrome. Free β-hCG is also made by the placenta and is higher with Down syndrome pregnancies.
Using an ultrasound to measure the fluid collection under the skin behind the fetal neck is another factor that would decrease the false positive rate. This fluid is called nuchal translucency (NT), and may be increased in pregnancies associated with Down syndrome, heart defects and other fetal abnormalities.

Two different trials have been conducted, one in the United Kingdom (SURUSS) and one in the United States (FASTER).

**SURUSS (Serum Urine and Ultrasound Screening Study) Trial** was to identify the most efficacious, safe, cost-effect method of antenatal screening for Down syndrome using nuchal translucency (NT), maternal serum and urine markers in the first and second trimesters of pregnancy and maternal age in various combinations. The results were based on over 47,000 singleton pregnancies and included 25 maternity units.

**FASTER (First and Second Trimester Evaluation of Risk) Trial** was a multi-center prospective study that also compared accuracy between the first and second trimester non-invasive screening methods for Down syndrome and other abnormalities. Each woman received two non-invasive test batteries in both first and second trimesters. The results were based on 33,000 pregnancies from 13 centers in the United States. Urine tests have not been included since they could not be used during the first trimester and had very little effect in the second trimester. Combined serum screening results alone were not reported in either study.

Both first and second trimester screening are very effective when used alone, but, integrating the results of both screenings is most effective to lower the false positive rates. Integration of both the first and second trimester screenings would provide 85% detection rate and false positive rate would decrease to 2.7%.

A woman does have the right to opt for first trimester screening or second trimester screening, but not both if she chooses to have the integrated screening. The integrated screening results cannot be completed or reported out until the results from the first trimester screening are integrated (combined) with the results from the second trimester screening.

Linda mentioned the only place available for complete integrated testing would be in Iowa City and wondered if that wouldn’t add more stress to a mother, she may feel the she is being asked to drive to Iowa City because there is a possibility there is something wrong with the fetus. Roger stated each mother would be given information about the testing and would know that having the ultrasound would be a normal procedure for the screening. The test could also be done in Des Moines, and will grow rapidly after that. Information will be provided to parents through the doctors, practitioners, and brochures.

Tonya asked Roger about the 2 trial tables on page 7 of the proposal. Both tables reflect the first trimester screening with the NT screening (ultrasound measuring the back of the neck); however, neither of the tables indicate what the detection rate and false positive rate would be if the mother opted to have only the PAPP-A and β-hCG screening without the NT ultrasound measurement option. It was mentioned that an ultrasound is needed to do the dating to get the accurate blood tests. The screening wouldn’t be complete without the ultrasound.
Tonya wondered if there was information in the literature that mentions the false positive and detection rate since that is one of the choices being offered to the patient. Roger said one would have to look back retrospectively at some of these studies because this is a trial designed to do the nuchal screening, so each study consists of the ultrasound. If a woman in Iowa wants a good first trimester test, she will have to drive to Iowa City or Des Moines for the ultrasound testing. Roger stated that later more cities will have trained technicians to perform the NT ultrasound.

Tonya asked if Roger had received verification that Dr. Mandsager has technicians in his office trained to do this procedure. Roger said he had received the verification. She also asked him if Dr. Drake and Dr. Mahoney have technicians trained to do the testing. Stanley Grant stated they had sent a sonographer and a physician to a class.

Roger stated the only way a true positive result can be determined is through an amniocentesis. Jerry asked if a positive result has ever been determined after 20 weeks. Roger said that has happened on occasion, the Quad screen can be drawn as late as 20 weeks. Karen Brewer clarified that when the tests are integrated, the first trimester screening result determined until it has been combined with the information from second trimester screening. After the results are integrated, only then can the results be determined. She mentioned that a woman does have the option to receive first trimester screening only, she is not required to receive integrated screening.

Linda asked if the first trimester test could give clear indication that Down syndrome is not present and what percentage of tests that would indicate a definitive negative result. Roger stated the only way to determine that, would be to do an early amniocentesis or an early chorionic sampling. Linda mentioned that many women would be happy with the results from the first trimester screening and wouldn’t want to proceed to the second trimester screening.

Michelle Hall stated she was concerned the test results from the first trimester would be sitting without a diagnosis until the second trimester screening was complete. She felt the parent should have some type of result after the first screening to let them know if they are at high risk or not. Karen mentioned the results are not complete until the results from both tests are integrated. The parent has opted to go with the most accurate detection rate with the lowest false positive rate, the parent chose to wait in order to receive the most accurate test result. The information is not being withheld, they are waiting for the second sample so the best information can be provided after both screenings are complete.

Linda asked if a woman originally opts for first trimester screening, and doesn’t like result, she should have the option to move on to the second trimester screening. Karen stated it is inappropriate to follow screening tests with a second screening test because it would increase the false positive rate if the 2 tests are not integrated at one time. If a mother opts for first trimester screening and chooses to see the results, if she does not like the results she needs to get a diagnostic test (amniocentesis).

Linda asked if it took so much time to explain the integrated testing to her, does the University of Iowa feel confident enough that they would able to take that amount of time to
explain the procedures to parents. Roger agreed the procedure is complicated, but also feels that Iowa is lucky to have a “leg up” because we have a lot of resources. Roger stated that first trimester screening is going to happen in the United States and it will be difficult for the states that do not have a program like we have. Karen Brewer stated that information will be available through doctors, practitioners and if the parents have additional questions they may also refer to websites and brochures.

Val Sheffield mentioned he felt the proposal was well thought out. When compared to what is currently being done, it is quite an improvement. This would give people an option for a more appropriate diagnostic.

Paul Romitti suggested that adopting the proposed procedure would give patients more options for the best results and feels it should be approved in a somewhat standardized fashion so patients can hear all the options.

Tonya asked if there would be more anxiety increase by women who want the NT measurement but unable to receive it from her provider. Roger stated he felt that people would be willing to travel. At one time, the amniocentesis was only available in Iowa City. Women from all over the state were willing to travel to Iowa City for that testing. In an interim period when there are only 2 sites for a woman to receive a NT measure, he doesn’t think it would be a problem to ask them to travel to Des Moines or Iowa City.

Michelle Hall stated that when a physician tells a patient she needs to go to Iowa City for additional testing, that woman would feel anxiety. She would like to know what kind of efforts are being made to educate the public and not just the physicians and medical personnel. She feels the integrated testing will be a huge shift in standardized care. Roger stated they are thinking about developing a web site that parents could go to for additional information. Stanley Grant and Karen Brewer stated that women already call into their office wanting additional information regarding first trimester screening; therefore, it’s an automatic procedure they’re currently handling.

Linda Brown asked for the cost of the procedures. Karen stated that some of the questions will be questions that will be answered in the development and piloting of the screening. Michelle mentioned she was concerned with the cost of the equipment that would be purchased for the proposed pilot program. She expressed the concern that members will feel obligated to implement the program because the equipment had already been purchased and will not be able to be objective about the issues later.

Stan stated the pilot isn’t really a pilot asking if this would be a useful or beneficial test, that has already been established in the published studies very well. Iowa is fortunate enough to have a state program that addresses this issue. Many states do not. This provides us the opportunity to implement this statewide. This pilot is primarily looking at being as effective as we can in implementing it. This proposal is not an investment to trap the members into not changing their minds, it is upfront data stating it is a legitimate and beneficial task.

Linda Brown asked how many amniocentesis procedures are being performed each year. Roger answered there are approximately 500. Linda asked how many they expect to reduce that amount to. Roger stated they would like to reduce that amount to 250. Stan stated the
screening program cannot actually control the amount of amniocentesis procedures that are performed each year. The screening program identifies a woman at significant risk what would be appropriate to offer them for diagnostic testing. The proposed integrated testing would reduce the amount of women who would be told through the screening that they are at increased risk and need amniocentesis.

Shelley Ackermann asked if they knew if Medicaid and other insurance carriers would cover the cost of these tests in the long run. Roger feels that integrated screening will become standard care. When testing becomes standard of care, that’s when insurance companies will pay for the procedures.

Linda asked if patients will be required to pick up the bills themselves. Roger feels that some insurance companies will pay for it. Shelley mentioned that Medicaid is one of the major providers in the state and asked if they have any plans what to do about Medicaid participants and the fees incurred during the interim, before the procedure is considered standard of care. Roger stated they had not addressed that issue with the agencies yet. Shelley’s concern is that some private insurers will cover the procedure, but public insurers that will not. She also asked for those who do not have insurance or if their insurance will not pay for the procedure, will the test be available for those who cannot afford to pay.

Tonya stated she did check into some insurance companies and codes. Medicaid does cover first trimester ultrasounds. There is no CPT specifically for PAPP-A yet. She was not able to correlate it over to Medicaid, but Medicaid does cover the $hCG.$

Motion was made by Paul Romitti to approve the offering of the proposal to establish statewide integrated screening in Iowa using markers from the first and second trimesters screening.

Linda voiced her concern regarding the current system being used for this conference call is not lending itself for her to clearly understand what’s happening. Linda stated communication is 55% nonverbal and feels much was missed on both ends. She is not comfortable voting on this proposal knowing that she does not have all of the information. She felt the issue was too controversial to be voted on via conference call.

Motion to call the question to end the discussion was made by Nancylee Ziese. Motion is non-debatable. Motion passed.

Motion was made by Paul Romitti to approve the offering of the proposal to establish statewide integrated screening in Iowa using markers from the first and second trimesters screening.
Seconded by Val Sheffield

Members voted per role call vote:
Members Opposed: Shelley, Jerry, Amanda, Linda, Michelle
Members Approved: Paul, Nancy, Celeste, Roger, Val, Deb, Jolene, Christina, Stan (on behalf of Mary Gilchrist) and Molly Guard
Motion approved.
Stan mentioned there was clearly a split between the two sides, which reiterates what, has happened in the past, when the members are not in the room same together for discuss items. He felt that those who had attended the meeting from both the Iowa City and Des Moines sites were very bright and thoughtful people and he feels the outcome of the meeting was disappointing because it was held from different sites.

V. Department Update

Julie McMahon

Julie discussed the IDPH Iowa Excellence Process. The department will go through a very comprehensive self-assessment. Each department needs to do that every 3 years. The Iowa Department of Public Health assessment will be done this year and will begin this spring. The assessment is referred to in the business sector as the Baldridge Model. The department will be moving through the process in late April. Following the self-assessment, which will include our external partners as well as employees, Public Health will move into a strategic planning session looking ahead for the next 2-3 years. While working on the strategic plan five years ago, biohazard emergency was not in the vocabulary of the Department of Public Health; however, it certainly is now. She wanted the members to be aware because they will be receiving messages from Tonya asking for input to the department’s self-assessment and strategic plan. The strategic plan needs to be completed by December 2004.

Dr. Ed Shor was the medical director for the Division of Community Health within the department. That position was paid for by the Title V block funds. Since his departure, Public Health has not had a medical director; however, there is certainly a need for one. We are moving forward, not with an employee, but with a contract with Dr. Jeff Lobas. He will be the medical director for the Division of Community Health. Jeff has already began meeting with the division management team and Julie. Julie believes we will see much more integration of our programs, not just within the division, but throughout the department and beyond.

Budget

The budget seems to change on the hour. When Public Health first received the budget for FY 2005 from the health and human services appropriation subcommittee, the budget reduction, which had been anticipated, was decreased by $350,000. The difficult part of that, while any budget decrease is difficult, is that it was entirely out of the 1 K number (budget categories) for Resource Management. Resource Management has four staff people for four personnel (FTEs) within Resource Management paid for by general funds. Those positions are the cashier for the department of public health, deputy director for public health, the executive assistant to the director, and Mary Hansen as the director for public health. Those are the only four positions. The other expenses supported by general funds are expenses in areas we do not have much flexibility: contributing to the Attorney General so that we have Attorney General representation, worker’s compensation, and health insurance issues.

Julie stated that Director Hansen has spent a fair amount of time with legislators as far as education on the impact of these reductions. Local public health is very concerned about the reductions. Julie mentioned that public health representatives did contact legislators. She is happy to report at this time that amendments were made, and $274,000 of that $355,000 has been restored and was passed by the senate and is now under discussion at the house level. It is not a “done deal” by any means, but, it is very fortunate when we look at what may have
happened. With that particular K number, there would have been a 61% reduction in just the past two years. That is where we do all of our fiscal piece, information management, and many other administrative functions that support all of our programs.

The additional piece to the budget is that this year IDPH will not receive any salary adjustment budget. In the past years, the department received a salary adjustment budget that was usually less than 100% of the funds needed but there was some funding. It is estimated that the DPH needs $307,000 to meet the negotiated contract amounts. The management team has put together a plan which is 100% supported by the executive team, that no funds that are necessary to support that salary adjustment will come from any contracts or services to the people of Iowa, as far as through contracts with local providers. The $307,000 will come from personnel within the department. When the decrease was initially going to be the $307,000 plus $355,000 that would have been very devastating in a couple of areas. Public Health is moving forward and looking at what we can do with these reductions and what will have the least impact on Iowans and the department as well. Julie thinks it is good news, it is far better than what we might have anticipated, given our budget situation. It is still a difficult situation, as we look forward to the next year, we continue to look forward and find every single place where we can be more efficient and continue to work toward collaborations and securing additional federal funds or grant funds to be able to continue to do our work in Iowa.

At this time, it is not Julie’s belief that there will be any reductions to our genetics programs for FY 2005.

VI. CF and MSAFP Programs
Roger Williamson/ Stan Berberich
Roger stated it is appropriate to discuss the CF and MSAFP budgets together because they are intertwined in terms of personnel. They had anticipated they would receive more specimens than what they have seen. There has been a budgetary shortfall in their CF Program. They feel the best way to resolve the situation is to leave the cost for CF testing at a $197.00, as it has been, and bring some of the personnel that were transferred from the MSAFP budget onto the CF budget and fold it back into the MSAFP budget (current Quad screen). He thinks it was appropriate for these individuals to be transferred from MSAFP to CF the program was being initiated, but now it’s sort of self running and all the counseling and other aspects of follow/ up are really almost part in parcel with MSAFP screening in terms of the way it’s handled. The CF budget would remain the same. They think if they can get more education out and receive more specimens in the laboratory, this will cover their reagent supply costs. They feel that the $197.00 fee is still reasonable compared to some of the commercial laboratories.

When they look at their Quad Screening Budget (MSAFP), when they had the triple marker screen in 2003, the cost was $77.00. Then, in 2004, they added birth marker Inhibin A and that marker was added at a modest cost of $8.00. The total cost of the Quad screen was $85.00. They have had a year to look at the $85.00 to decide if it was a sufficient amount of money. If the personnel from the CF budget are placed back onto the MSAFP budget, as was the case prior to the initiation of CF, and when looking at the reagent costs, they are requesting that they increase that fee by $6.00. The total fee would be $91.00.
Tonya asked Roger if he would share who would be moved over from CF to MSAFP. Roger explained that Karen Brewer was on the CF budget for 50% of her income, she had a big role in helping to initiating the CF screening program. He would like to move her back to the MSAFP budget. He would also like to move himself to the MSAFP budget. That would save an additional 5%. Stan mentioned that 5% of his salary has been placed on the CF budget, and would also be moved back to the MSAFP budget.

Jerry asked who pays the cost, Medicaid, private insurance, or consumer. Roger stated it comes from 3rd party payers, whoever pays for most of the care. It comes from insurance, Medicaid, Medicare.

Linda asked when they were charging $85.00, what percent of reimbursement were they receiving. Roger answered the collection loss is approximately 10%. Linda asked if they expect to receive more money after increasing the fee. Stan said that the current CPT codes applicable for the four biochemical markers they are testing for, covers more than $85.00. Stan stated the collection loss would be 10% of $91.00 instead of 10% of $85.

Stan stated that if the fee were not increased, they would not be able to cover the program. Linda mentioned her concern was they would not benefit from the increase because the collection loss could increase if the 3rd payer parties would not cover the $91.00. Now, she understands they would benefit from the increase and feels they should receive the dollars needed to cover the cost of the program.

Tonya mentioned if the budget is approved, we would like to do what John Deere had suggested. Their suggestion was to send a letter to all insurance companies, indicating the costs and CPT codes. A representative from John Deere told Tonya they had not been aware of the current fee for the costs. If they are aware ahead of time, they can assist the providers in receiving more reimbursement. If the fee increase is approved, we would make sure letters are sent to insurance companies. Stan mentioned if the fee increase were approved, he would like the letters to be sent as soon as possible.

Motion was made by Linda Brown to approve the 2004-2005 CF and MSAFP Budget as presented.
Motion was seconded by Jerry Wickersham. Approved by all.

VII. Newborn Screening Budget
Stan Berberich
Stan mentioned a summary of the budget was included in the packet of information. He noted there is no increase in the fees for the budget. North Dakota continues to rely on the University of Iowa Laboratory in Des Moines to do all of their newborn screening. North Dakota has included among the mandated disorders hemoglobinopathy screening as well as the other disorders. This has had an affect on the lab’s budget. Within the last couple of years, he has tried to reflect how doing the newborn screening for North Dakota and how it actually helps to support our program in Iowa. The costs are fixed, and whether we were to do North Dakota’s screening or not, those costs would primarily remain about the same. In the past, the North Dakota program had supported 20% of the salary of the staff in the laboratory. However, because they weren’t doing hemoglobinopathy screening, the staff person for this disorder was paid 100% by Iowa. This year, they were able to shift 20% of that salary over to the North Dakota program. The actual increase in the salaries, created a
3% raise. By removing that portion from the Iowa budget, it led to only a 0.7% increase in salaries. Also, at the U of I, there was a decrease in the fringe benefits. The total personnel for the hygienic laboratory had reduced 1.5% from last year’s budget. That’s good news. There have been increases in each of the other areas. The equipment costs have had a significant increase primarily as a result of the 2nd MS/MS instrument purchased as part of their program. The one-year warranty has expired; therefore, there is an increase in the maintenance contract as well as the cost recovery. There was an 8.7% increase in equipment costs.

In other expenses for the laboratory, there were two very significant increases in the lab supplies and utilities. One of the things they have done in the laboratory this year has been to change some of the testing methodology they are using to create a more automated system. The manufacturer also restructured some of its kits. The result of that is that some of the components that were part of the kits are no longer part of the kits. The lab will not have to purchase these components separately, causing yet another increase to the costs of laboratory supplies.

The other increase they’ve seen has been the utilities for the Des Moines laboratory on 2nd Avenue. The increase is associated with the other instrument used for air handling needs, as well as the increase in the power and utilities that are required for its usage. The overall cost to operate the program has increased another $1.33 per specimen, which is equivalent to a 3.9% increase.

Linda asked Stan if he had mentioned during the beginning of his statement that there would be no increase, and if indeed there actually is an increase. Stan stated that if you compare this year’s budget with last year’s, there were different costs associated between the budgets. The overall fee is unchanged. There would be no change in the budget, other than the shift in the expenses. He mentioned he had provided a summary of what affect costs have had on the laboratory operations.

Stan also added that under last year’s budget, there was a fund that was established so they would have a mechanism for recruiting and paying a metabolic specialist. It has been incorporated into the budget and is not a separate fund in the budget this year.

Motion was made by Roger Williamson to approve the 2004-2005 Newborn Screening Program budget by Roger Williamson.
Seconded by Michelle Hall.

Paul asked about the motions made at the January meeting. He wanted to verify that the members had approved the retention of newborn screening specimens and the associated cost increase pertaining to the newborn screening from $.50 to $1.00 per test to cover storage costs. He mentioned at the outset of today’s meeting, it was mentioned that changes are being made to the documents and being reviewed by Heather. He wondered if he had misinterpreted the vote for the January meeting or was it approved and if it should it be added to this budget. Tonya stated any time there is an approval for a proposal or approval of a budget, those recommendations are reviewed and then a final decision is made by the health department. Heather Adams is still reviewing the newborn retention policy; therefore, the
health department has not made a final approval on the four recommendations that were motioned at the January meeting.

Paul asked if it was possible that the recommendations will be overturned. Tonya said it is potential. Paul said he thought they had discussed implementing the project and had assumed it went to approvals by July 1st of this year. Tonya mentioned there was a motion to have a proposal for use of developmental funds to begin retaining the specimens at room temperature; however, she has not received that proposal yet.

Paul inquired if Tonya had an idea of the timeline for the approval of the retention of dried blood spots. Tonya told Paul she will be meeting with Heather Adams on April 13th. If Heather has the decision that day, Tonya will be able to move on to the next step. Paul asked if there would be an opportunity to amend the budget if indeed it moves forward into the next fiscal year. Tonya answered there would be an opportunity.

ADJOURNMENT
Meeting was adjourned at 4:00

Minutes respectively submitted by Sherry Smith.