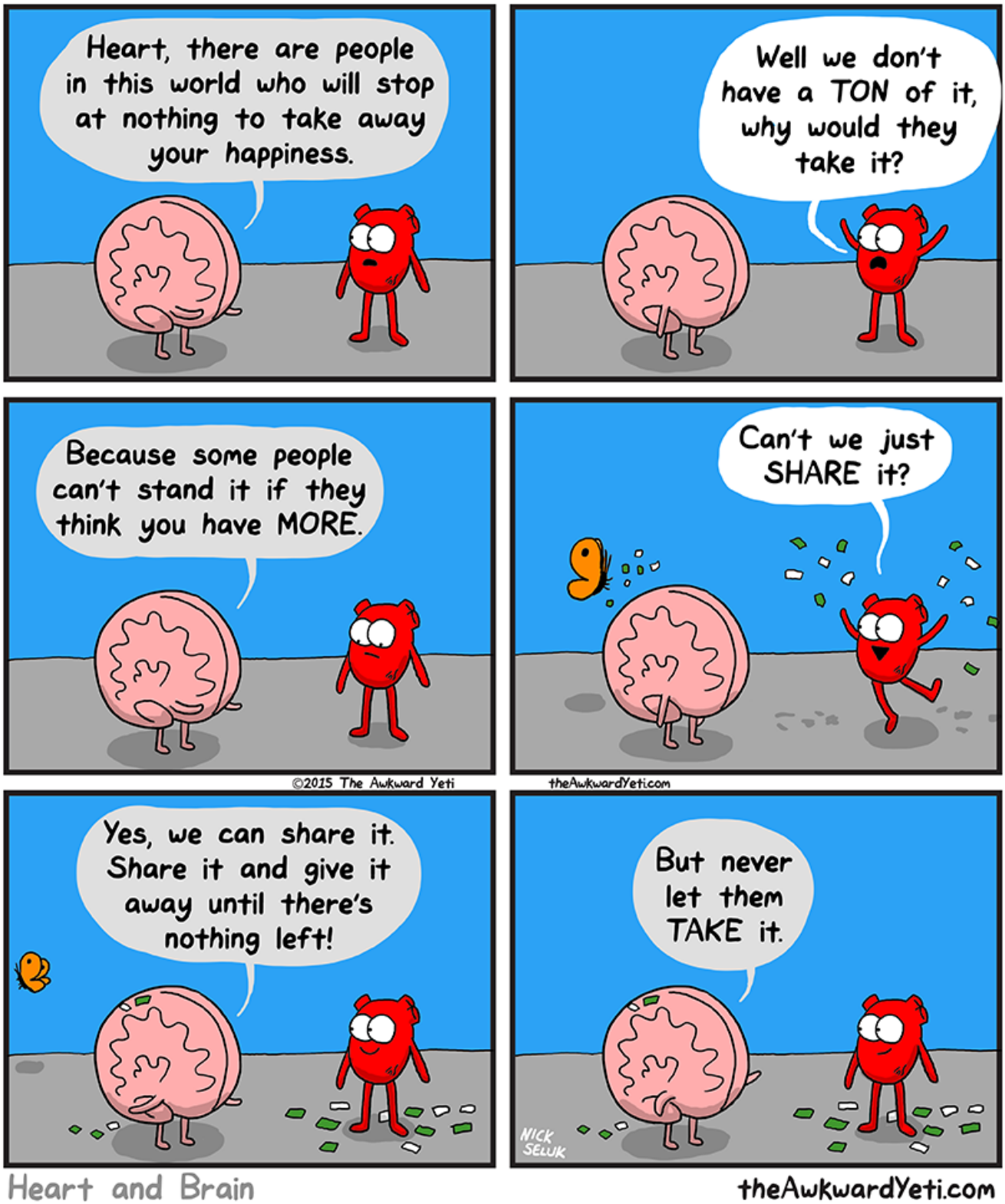



Heart and Brain

theAwkwardYeti.com

Michigan State Council

# MICHIGAN STATE COUNCIL MEETING

**Executive Committee: Rebecca VanStanton President, Josie Kik Immediate Past President, Chelsea Meixner Secretary, Kim Johnson Treasurer, Kelly Ashcraft & Naomi Ishioka Directors**

**ENA'S MISSION** To advance excellence in emergency nursing

**MENA'S FOUR STRATEGIC GOALS** Community, Culture, Practice, Education

## AGENDA

December 3, 2022 0900-1100

A. Call to Order **Rebecca VanStanton**.....5 minutes (0900-0905)
   1. Establish Quorum
   2. Welcome/Introductions
   3. Consent Agenda
      i. Approval of Minutes September 17, 2022

B. President's Report **Rebecca VanStanton**.....30 minutes (0905-0935)
   1. ENA Head Office Update
      i. EN5K had 218 more participants this year and raised $51,000!
      ii. New Triage Curriculum and updated CEN manual with more than 1,100 practice questions, two web-based practice exams and CE.
      iii. Updated intro to Trauma, Pediatrics and Geriatrics courses.
      iv. In 2022, the ENA Foundation approved more than $426,000 in support of conference and academic scholarships.
      v. Emergency Nursing 2023 Conference Scholarships for International Nurses – January 16-February 20
      vi. Emergency Nursing 2023 Conference Scholarships – March 14-April 18
      vii. 2023 Academic Scholarships – March 1-April 18
      viii. A mobile app for ENA Advantage is coming soon! This will give ENA members the chance to access these deals quickly and easily with just a few clicks.
      ix. ENA will work with Nonprofit HR – a DEI consulting firm – to develop a roadmap for ongoing DEI work. The organization will provide guidance in assessing levels of access, equity and inclusion within the staff team, board and member experience. Additionally, they will help design and facilitate training, engage in thought partnership and provide DEI-centered technical assistance to ENA.
      x. For those interested in becoming a Fellow, visit the Academy's webpage at ena.org/about/faen or contact academy@ena.org and staff will connect you with a Fellow.

xi. Lastly, keep listening to the ENA Podcast and reading ENA Connection for great stories, interviews and other features about ENA and its members.

2. Food for Thought
    i. Anyone interested in a 2023 session?
    ii. Different Region Meetings?
3. Succession Plan
    i. Takers?
    ii. Congrats to Lindsey our new Director!
    iii. QSIP Chair
4. 2023 Delegate Tool
5. COMON
    i. https://www.comonmi.com/
    ii. Next meeting via Zoom December 15, 2022 1030-1200
6. 4 meetings in 2023 (cancel March and July meeting?)
    i. Different locations(TN Discussion)
        1. Support for events in other locations
7. 3-tier to 2-tier discussion and vote
8. Bylaws
    i. Regional directors vs increasing # in director role
9. Updating Procedures
    i. Scholarship **Kim Johnson**

C. Immediate Past President **Josie Kik** .....5 minutes (0935-0940)

D. Secretary Report **Chelsea Meixner** .....5 minutes (0940-0945)

E. Treasurer's Report **Kim Johnson** .....15 minutes (0945-1000)

F. Director at Large **Kelly Ashcraft & Naomi Ishioka** .....10 minutes (1000-1010)

G. Chapters Reports/updates ….....20 minutes (1010-1030)
1. East Chapter **Gail VanStanton**
2. West Chapter **Alisha McKay**

H. Committee Reports .....20 minutes (1030-1050)
1. Education **Chelsea Meixner**
    a. Posters
    b. 2025 Location
2. TNCC / ENPC **Marilyn Enriquez**
3. Membership **Gail VanStanton**
4. Foundation/Scholarships **Kim Johnson**

Michigan State Council

5. QSIP **Open**
6. Government Affairs **Naomi Ishioka**
    a. Prosecuting Attorneys Proposal
7. Media **Jac Getzinger**
8. Student Nurse Relations Chair **Christy Rapoza**
    a. MNSA Conference – October 14 – Embassy Suites, Livonia
9. Awards **Aimee Westmore**

I. Open Forum and Action Items for next meeting .....5 minutes (1050-1100)
    1. Dates to Remember
        i. 2023 State Meeting Dates
            1. January 18 - 1p-3p – Hybrid – HFWB
                a. Pediatric Trauma and Implicit Bias CE 3p-5p
            2. March 15 - 1p-3p – zoom only
            3. May 2 - hybrid - TBD
            4. July 19 - 1p-3p – zoom only
            5. September 9 – 9a-3p (with delegate meeting) - hybrid - TBD
            6. December 9 – 9a-3p (with budget meeting) - hybrid - TBD
            7. Board meetings will be called only as needed as many were not needed in 2022
            8. Chairs/Board/Chapter Presidents - as appropriate – please set dates for 2023 to send to membership and to place in agenda
        ii. Triage Notes 2023
            1. Articles Due to Chelsea
                a. February 15, 2023
                    i. Sent to members March 1, 2023
                b. May 15, 2023
                    i. Sent to members June 1, 2023
                c. October 15, 2023
                    i. Sent to members November 1, 2023
        iii. Other Dates/Due Dates
            1. February 23, 2023 Food for Thought - Magnolia Medical - Detroit
            2. April 15, 2023 Delegate Tool Due
            3. April 20, 2023 Food for Thought - Magnolia Medical - Grand Rapids
            4. April 21, 2023 MENA DOTH - Lansing
            5. May 2-3, 2023 MENA Education Conference – Frankenmuth
            6. May - Membership Discount Month
            7. August – Call for volunteers
            8. August 31, 2023 Award Nominations Due
            9. September 15-30, 2023 – Elections
            10. October 9-13, 2023 Award Disbursement
            11. October - Membership Discount Month

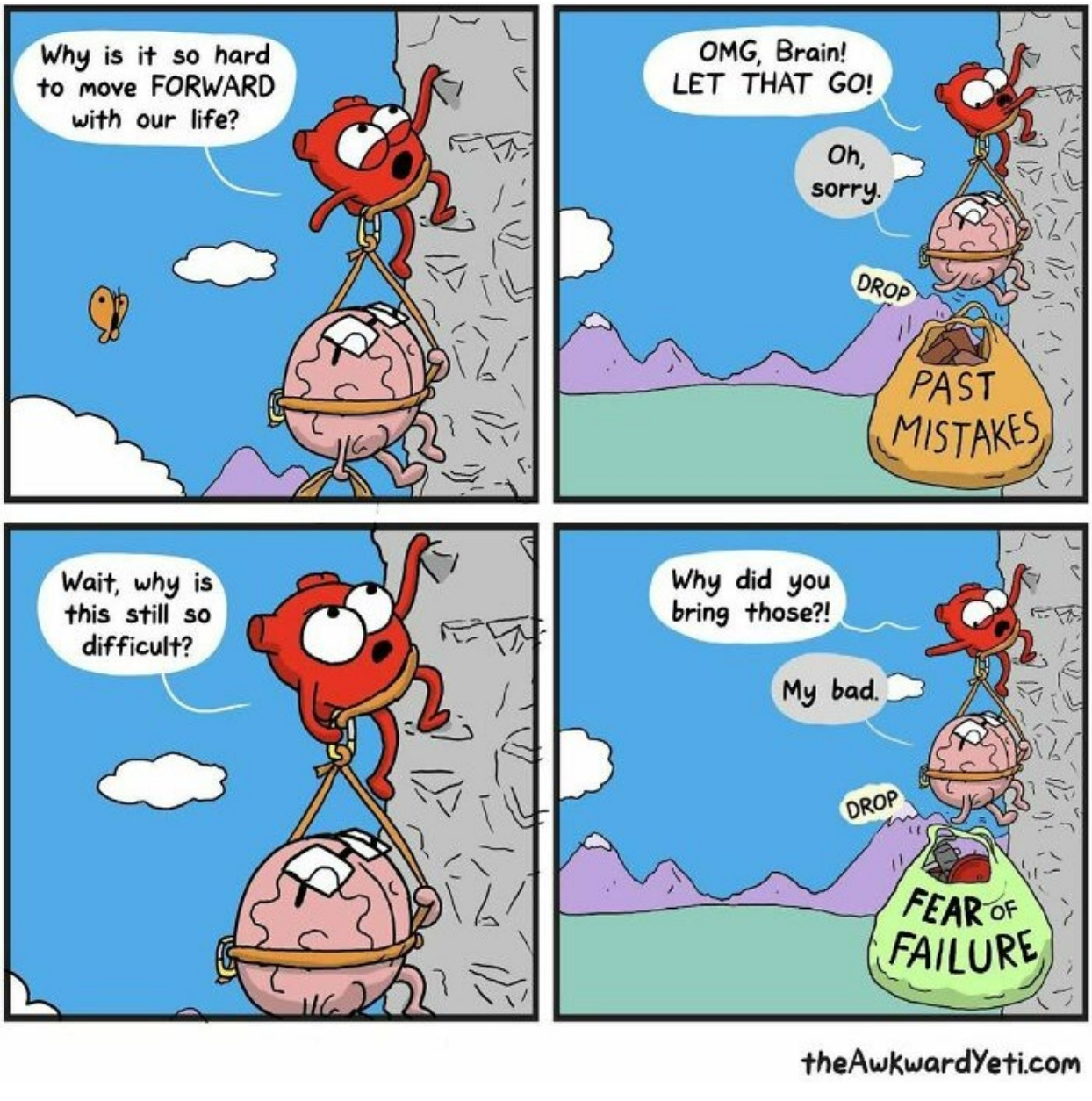
iv. HQ

1. 2023 Leadership – January 26-29 – Scottsdale
2. TBD – DOTH – Washington DC
3. General Assembly – September 20-21 – San Diego
4. EN23 - September 21-24 – San Diego
5. ENWeek 2023 – October 9-13, 2023

J. Adjourn ..... (1100)

Attachments: Agenda, Minutes

Budget Meeting ..... (1100-1500)



### FRIDAY, JANUARY 27

| | |
|---|---|
| 1:00 p.m. | Opening General Session |
| 2:15 - 5:15 p.m. | Concurrent Education Sessions |
| 5:30 p.m. | Welcome Reception |

### SATURDAY, JANUARY 28

| | |
|---|---|
| 6:00 a.m. | Health and Wellness Activity |
| 7:30 a.m. | Breakfast |
| 8:00 a.m. | ENA Update |
| 8:45 a.m. | General Session |
| 9:45 a.m. | Concurrent Education Sessions |
| 10:45 a.m. | Board Liaison Networking |
| 11:45 a.m. | Lunch |
| 1:00 - 4:15 p.m. | Concurrent Education Sessions |
| 4:30 p.m. | General Session |
| 5:30 p.m. | Dine around Scottsdale |
| 8:30 p.m. | ENA After Dark |

### SUNDAY JANUARY 29

| | |
|---|---|
| 8:00 a.m. | Breakfast |
| 9:00 a.m. | General Session |
| 9:45 a.m. | Strategic Planning and Goal Setting |
| 10:30 a.m. | Closing General Session Keynote |
| 11:45 a.m. | Wrap Up |

(schedule subject to change)

## FAQS

### WHO CAN REGISTER?

The 2023 ENA Leaders (President, President-elect, Secretary, Treasurer, Secretary/Treasurer), Membership Chairs, TNCC and ENPC Chairs listed in the State Council/Chapter Management area are eligible for complimentary registration.

### WHAT IS THE COST?

This event is free for those that are eligible for complimentary registration (listed above). If you are a 2023 leader whose role is not listed as complimentary, pricing for registration is as follows (please note: space is limited for non-complimentary registrations):

- Dec. 1-Jan. 20 - $225 registration rate
- After Jan. 20 - $275 on-site registration rate

### WILL CNE BE AVAILABLE?

CNE will not be offered for this event.

Michigan State Council

# dare to lead™

Brené Brown

**I've dedicated my entire career to studying human behavior, emotion, and thought. I've spent the last ten years specifically looking at leadership. Here's what I know for sure:**

We can't understand leadership if we don't talk about power. We have a strange relationship with the word, "power." We often think of it as a negative, strong-arm experience, yet – at the exact same time – one of the single worst human experiences is powerlessness. No one wants to feel powerlessness. It's a desperate and isolating experience.

In a 1968 speech given to striking sanitation workers in Memphis, Reverend Martin Luther King, Jr. defined power as **the ability to achieve purpose and effect change.**

This is the most accurate and important definition of power that I've ever seen. The definition does not make the nature of power inherently good or bad, which aligns with what I've learned in my work.

**What makes power dangerous is how it's used. Power over is driven by fear.**

**Daring and transformative leaders share power with, empower people to, and inspire people to develop power within.**

| *Leaders who work from a position of* **Power Over:** | | *Leaders who work from a position of* **Power With/To/Within:** | |
|---|---|---|---|
| 01. | BELIEVE THAT POWER IS FINITE AND USE FEAR TO PROTECT AND HOARD POWER. | BELIEVE THAT POWER BECOMES INFINITE AND EXPANDS WHEN SHARED WITH OTHERS. | 01. |
| 02. | LEVERAGE FEAR TO DIVIDE, DESTABILIZE, AND DEVALUE DECENCY – DECENCY ACTUALLY FRAMED AS A SIGN OF WEAKNESS AND "FOR SUCKERS." | LEVERAGE CONNECTION AND EMPATHY TO UNITE AND STABILIZE. VALUE DECENCY AS A FUNCTION OF SELF-RESPECT AND RESPECT FOR OTHERS. | 02. |
| 03. | GIVE PEOPLE EXPERIENCING FEAR AND UNCERTAINTY A SENSE OF FALSE CERTITUDE AND SAFETY BASED ON IDEOLOGY AND NOSTALGIA OVER FACTS. *Being right is more important than getting it right.* | OFFER PEOPLE EXPERIENCING FEAR AND UNCERTAINTY TRANSPARENCY AND CREATE LEARNING CULTURES BASED ON CRITICAL THINKING AND EVIDENCE-BASED DATA FROM MULTIPLE PERSPECTIVES. *Getting it right is more important than being right.* | 03. |
| 04. | GIVE PEOPLE SOMEONE TO BLAME FOR THEIR DISCOMFORT – PREFERABLY SOMEONE WHO LOOKS/ACTS/SOUNDS DIFFERENT THAN THEY DO. | NORMALIZE DISCOMFORT AND MOVE AWAY FROM SHAME AND BLAME AND TOWARD ACCOUNTABILITY AND MEANINGFUL CHANGE. | 04. |
| 05. | MAINTAIN POWER OVER BY DEMONSTRATING AN EVER-INCREASING CAPACITY FOR CRUELTY, INCLUDING SHAMING AND BULLYING – ESPECIALLY TOWARD VULNERABLE POPULATIONS. | FRAME LEADERSHIP AS A RESPONSIBILITY TO BE *IN SERVICE OF* OTHERS RATHER THAN *SERVED BY* OTHERS. | 05. |
| 06. | FRAME CONSTRUCTS LIKE PERSONAL RIGHTS AND FREEDOM TO POLARIZE AND BEING *IN SERVICE* OF OTHERS IS SEEN AS WEAK. | FRAME RIGHTS AND FREEDOMS AS PRIVILEGES THAT ARE CONNECTED TO RESPONSIBILITY TO THE LARGER COMMUNITY OR ORGANIZATIONAL CULTURE. | 06. |
| 07. | INCITE HATRED AND VIOLENCE WITH PERSISTENT DEHUMANIZING LANGUAGE AND POLICIES. | CENTER CONNECTION AND HUMANITY WITH EMPATHY-DRIVEN AGENDAS, POLICIES AND VALUES. | 07. |

***For more information on the four types of power:***

*Making Change Happen:* Just Associates, *Making Change Happen: Power; Concepts for Revisioning Power for Justice, Equality and Peace.* Just Associates, 2006, justassociates.org

# ENA, AONL Continue Commitment to Preventing Workplace Violence

*Organizations launch updated workplace violence guidelines and toolkit to support health care workers*

**SCHAUMBURG, Ill. (Oct. 25, 2022)** – Faced with the unfortunate reality that health care workers are five times more likely to experience nonfatal violence-related injuries on the job compared to those who work in private industries, the Emergency Nurses Association and the American Organization for Nursing Leadership have updated the Guiding Principles on Mitigating Violence in the Workplace and related toolkit that were originally penned in 2015.

A recent survey of nurses showed that 44 percent reported experiencing physical violence and 68 percent reported experiencing verbal abuse from February to June 2020. These statistics, along with the frequency of violent incidents in hospitals over the last few years, prompted the organizations to review and update the guidelines.

"Workplace violence in health care remains a pervasive problem that touches all areas of a hospital, sometimes in unbelievably tragic ways," said ENA President Jenn Schmitz, MSN, EMT-P, CEN, CPEN, CNML, FNP-C, NE-BC. "The toolkit and these guiding principles show how important teamwork is to developing and implementing solutions that create a path to safer work environments with improved protective measures for emergency nurses, their health care colleagues and patients."

This week, ENA CEO Nancy MacRae and AONL CEO Robyn Begley, who is also the American Hospital Association's chief nursing officer, shared their thoughts on the urgent need to drive a culture change that views any violence towards health care workers as unacceptable.

MacRae and Begley also highlight what's available in the updated guidelines and toolkit that help build an environment of safety.

You can find the updated guidelines and toolkit here.

###

**About the Emergency Nurses Association**

The Emergency Nurses Association is the premier professional nursing association dedicated to defining the future of emergency nursing through advocacy, education, research, innovation, and leadership. Founded in 1970, ENA has proven to be an indispensable resource to the global emergency nursing community. With 50,000 members worldwide, ENA advocates for patient safety, develops industry-leading practice standards and guidelines and guides emergency health care public policy. ENA members

have expertise in triage, patient care, disaster preparedness, and all aspects of emergency care. Additional information is available at www.ena.org.

ENA Media Contact:
Morgan Wietecha
Media Relations Strategist
847-460-4038
morgan.wietecha@ena.org

# ASK: Higher penalties for assaults to ED personnel

EMERGENCY NURSES ASSOCIATION

Every year **1 in 5 healthcare workers** will be assaulted while on the job. Each week **1 in 10 Emergency Department** staff members will be assaulted, while simply taking care of patients.[1] Assaults against nurses and other frontline healthcare workers is appallingly common. That's why ***31 states*** have acted to provide additional protection to these professionals who have dedicated their lives to patient care.

**Michigan has not yet enacted such legislation.**

Michigan is one of the few states without criminal statues specifically addressing assaults on healthcare providers. Over the past 2 years, nurses in Michigan emergency departments have sustained numerous assaults, including assaults that resulted in significant injuries. We continue to see these violent patients and visitors be let go with little or no consequences. Many of these people end up becoming repeat offenders, returning again and again. In one hospital in the state, for instance, the same patient with history of drug seeking behavior assaulted emergency department staff 12 times in the space of one month, including causing a nurse such significant injuries that he was off work over 3 months. Federal EMTALA rules require that Emergency departments assess and treat all who present to our doors. We have a legal and moral responsibility to provide care to all, but with this responsibility comes the inability to protect ourselves from people who have been violent in the past, Michigan ENA would like to see that similar protections are extended to healthcare workers and medical volunteers against physical assault that are currently in place for assaults against other emergency care providers. The Michigan Penal code specifically extends protection to police, fire, EMS, and others that legally cannot turn away those who may become violent yet leaves hospital Emergency Department staff out. Such legislation would help augment the measures currently in place to keep nurses and other essential emergency providers safe on the job.

**Current bill:** HB 5082 passed by the house, referred to the senate. Michigan ENA is concerned with the language that states “the enhanced fine under this subsection does not apply if the defendant is a patient who is receiving treatment from the victim”

***We request substituting language that allows for prosecutorial discretion to ensure patient’s rights are respected while providing for increased consequences for intentional assaults directed towards nurses and other staff in our workplaces.***

1. Occupational Safety Health Administration (OSHA). 2015. Workplace violence in healthcare, Understanding the challenge, p. 1-4.

EMERGENCY NURSES ASSOCIATION

# ENA, NonprofitHR Team Up to Assess DEI Progress, Plan Future Initiatives

*Association seeks to measure growth in areas of diversity, equity and inclusivity*

**SCHAUMBURG, Ill. (Nov. 7, 2022)** – As part of ENA's ongoing commitment to embracing the diversity of its membership, staff and the communities emergency nurses serve, while also seeking to address the need for equity and inclusivity in health care, the association this week announced a partnership with NonprofitHR to assess current progress and future growth of its DEI initiatives.

Based in Washington, D.C., NonprofitHR is a leading human resources firm that specializes in work with nonprofits and provides a specific focus on creating inclusive and equitable organizations. Since 2020, ENA has sought to advance the conversation around DEI issues and developing resources to help ED nurses better care for all patient populations.

"Whether through continued development of clinical and practical education or by increasing member engagement on these important topics, ENA continues to be thoughtful in its work to be a DEI leader in health care," said ENA President Jennifer Schmitz, MSN, EMT-P, CEN, CPEN, CNML, FNP-C, NE-BC. "ENA has taken many positive steps forward, but there's still plenty more to do. NonprofitHR will help ENA build on the momentum created in recent years to outline a strong roadmap for the future."

In the coming weeks, NonprofitHR plans to survey ENA members and ENA staff, respectively, to develop baseline information that will help develop a greater understanding of the association's DEI environment and the impact of the work to support it.

"Our EDIJ team is excited to partner with ENA as they further embed diversity, equity and inclusivity into their organizational environment. ENA's investment to greater understand their environment for staff and members, coupled with this inaugural benchmark data, will serve as a foundation for future success," said Nonprofit HR Senior Consultant Steven Krzanowski. "We have seen tremendous impact within the medical professional community as nonprofit organizations have utilized their data to create intentional strategies – strategies that create meaningful and systemic change within their internal and external stakeholder communities."

###

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ENA Media Contact:
Dan Campana
Director of Communications
847.460.4017
dan.campana@ena.org

**About NonprofitHR**

Nonprofit HR is the country's leading and oldest firm focused exclusively on the talent management needs of social impact organizations. We focus our efforts on HR Outsourcing and project-based human resources and talent management consulting, Strategy & Advisory; Total Rewards; Equity, Diversity, Inclusion and Justice (EDIJ) and Search. Nonprofit HR also offers customized trainings, research, and events to strengthen the social impact sector's workforce's people management capacity. Since 2000, our staff of credentialed experts has advanced the impact of some of the world's most influential brands in the sector. Learn more at www.nonprofithr.com.

NonprofitHR Media Contact:
Atokatha Ashmond Brew
Managing Director for Marketing & Strategic Communication
abrew@nonprofithr.com

October 28, 2022

President Joseph R. Biden
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Mr. President:

There is no question that Americans have suffered great loss of life and endured financial hardships, across all sectors, over the past 32 months due to the COVID-19 pandemic. Frontline healthcare workers risked their lives, provided care during physically and emotionally demanding situations, and bore witness to their patients' goodbyes to loved ones from afar.

Yet, in recent months, hospital emergency departments (EDs) have been brought to a breaking point. Not from a novel problem – rather, from a decades-long,[1] unresolved problem known as "patient boarding." While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses and other health care professionals.

**Boarding has become its own public health emergency.** Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission to an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing or other specialized facilities, or waiting simply to return to their nursing home. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Boarding doesn't just impact those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician. The story recently reported[2] about a nurse in Washington who called 911 as her ED became completely overwhelmed with waiting patients and boarders is not unique – it is happening right now in EDs across the country, every day.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have included last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of covid as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."* --anonymous emergency physician

To illustrate the stark reality of this crisis, the American College of Emergency Physicians (ACEP) recently asked its members to share examples of the life-threatening impact the recent uptick in boarding has brought to their emergency departments. Excerpts of the responses received, as well as key findings from a qualitative analysis of the submissions, are included in this letter to summarize aspects of the problem. The full compilation of anonymized stories, attached as an appendix, paint a picture of an emergency care system already near collapse. As we face this winter's "triple threat" of flu, COVID-19 surges, and pediatric respiratory illnesses that are on a sudden rise, **ACEP and the undersigned organizations hereby urge the Administration to convene a summit of stakeholders from across the health care system to identify immediate and long-term solutions to this urgent problem.** If the system is already this strained during our "new normal," how will emergency departments be able to cope with a sudden surge of patients from a natural disaster, school shooting, mass casualty traffic event, or disease outbreak?

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[1] Andrulis DP, Kellermann A, Hintz EA, Hackman BB, Weslowski VB. Emergency departments and crowding in United States teaching hospitals. Ann Emerg Med. 1991 Sep;20(9):980-6. doi: 10.1016/s0196-0644(05)82976-2. PMID: 1877784.

[2] "Silverdale hospital short on staff calls 911 for help after being overwhelmed with patients"

## Background

Imagine a short-staffed restaurant with seating for 40, with a long line of starving customers that cannot be turned away. The chef and line cooks are desperately trying to keep up to provide safely prepared and high-quality meals. They create space for an extra 15 diners in a back hallway and assign one server to attend to them all. But there are 50 more customers waiting to come into the dining room to eat. They serve as many as possible in chairs in the lobby with a much more limited menu. Now imagine that those who are fed never leave and stay there until they need food again. Meanwhile, Uber Eats and other delivery service orders are also coming in, and the delivery drivers crowd the room further, waiting to pick up orders.

In this simplified analogy, the restaurant is the emergency department, the chef, line cooks, hosts, and waitstaff all comprise the emergency care team, the meals are the emergency care itself, and the Uber Eats drivers are EMS crews bringing in more patients. Customarily, patients who arrive to the ED via walk-in are checked in and either directed to a treatment area or the waiting room to wait until space is available, depending on the severity of illness. Once space becomes available, they are taken back into the treatment area for a completion of the clinical assessment and any needed treatment. A decision is then made that the patient is either well enough to go home or requires admission to the hospital for continued treatment. Inpatient beds traditionally require both a physical bed space (patient room) and nurses to care for that patient. Unlike in the ED, most hospitals have ratios of nurses to patients for inpatient beds to promote quality of care and patient safety that are set by state laws, regulatory agencies, and accrediting bodies. So if there are no available (staffed) beds within the specific unit to which the patient needs transferring, the patient must wait, or be "boarded" in the ED, often for hours, sometimes days or even weeks. The same issue of required staffing ratios holds true for transfer outside the facility, such as to an inpatient psychiatric facility or a skilled nursing facility. As well, patients that arrive in an ambulance via emergency medical services (EMS) must be appropriately screened by ED staff before the EMS crew can release the patient and return their ambulance to service. So once the hospital's available inpatient beds are full, more ED patients are boarded and must be accommodated in the ED, filling up valuable ED beds and even hallways. Unless the ED can go on diversion status (which is becoming increasingly difficult), more patients continue to show up via EMS. Needed ambulances must be taken out of service as the EMS crews must often wait hours with their patient in the ED before they can safely hand them over to ED staff. And through this all, walk-in patients continue to arrive to the ED and cannot be turned away under the federal Emergency Medical Treatment and Labor Act, or EMTALA, requirements.

Boarding and ED crowding are not caused by ED operational issues or inefficiency; rather, they stem from misaligned economic drivers and broader health system dysfunction.[3] Boarding and ED crowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED and higher overall health care costs. Much has been written on causes of and potential solutions to boarding, but the issue persists, due in part to its many derivative factors, the disparate stakeholders involved, and misaligned economic incentives.

## Preventable Patient Harm

There is ample evidence that boarding harms patients and leads to worse outcomes, compromises to patient privacy, increases in medical errors, detrimental delays in care, and increased mortality.[4] The Joint Commission identifies boarding as a patient safety risk that should not exceed 4 hours[5], yet many of the responses to the ACEP's call for stories cite boarding times much longer than that as an almost routine occurrence; 97 percent of stories with times provided cited boarding times of more than 24 hours, 33 percent over one week, and 28 percent over 2 weeks. Descriptions of the negative impact on patient outcomes, including potentially avoidable deaths, follow:

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[3] Kelen GD, Wolfe R, D'Onofrio G, et al. Emergency Department Crowding: The Canary in the Health Care System. NEJM Catalyst. Epub 2021 Sep 28.

[4] Boudi Z, Lauque D, Alsabri M, et al. Association between boarding in the emergency department and in-hospital mortality: a systematic review. PLoS One. 2020;15(4):e0231253. doi:10.1371/journal.pone.0231253

[5] The Joint Commission. R3 report: requirement, rationale, reference. Accessed March 13, 2022.

*"We are a very rural hospital with only family practice and emergency physicians - there are no specialists within 90 miles…Recently I had a woman with abdominal pain in the ER. When she arrived she had normal vital signs and was not really very sick. Testing showed that she had an infected gallbladder - a simple problem for any surgeon to treat. We called 27 hospitals before one in a different state called us back when a bed finally opened up. She spent thirty six hours in our ER, and was in shock being treated with maximum doses of drugs to keep her alive when she was transferred. She didn't survive."*

*"…The physician finally was able to see her in a side waiting room, he stepped out of the room for several minutes and on return she was face down and blue. They immediately began trying to resuscitate her, brought her back to our trauma bay in which they were unable to intubate her and then performed an emergent cricothyrotomy on her. She had anoxic brain injury and died. While this sounds like a random occurrence, I am frequently asked to come to the waiting rooms to help carry people out of their cars or off the floor because they have passed out or gone into cardiac arrest in the waiting rooms on multiple occasions. I have since reached out to nearly all my close friends and family and have begged them under no circumstances to go to the ED without reaching out to me first. I have begun doing house calls in my neighborhood as well as Zoom calls with family to keep them out of the ED's because they are so dangerous. In fact, I've gone as far as begun sending people home from the ED whom I would normally admit because the hospitals have become that dangerous. It's safer for many of these people to be discharged home and taken care of by family than run the risk of the multitude of mistakes that are taking place in the hospitals because there is no staff."*

*"In the past six months, 3 people have died in our er waiting room. One only noticed when he had been sitting for > 6 hours and slumped to the floor. When he was found had been dead "awhile". The patient had been triaged by a nurse, but in a very busy urban where the waiting room is always packed and people regularly wait > 8 hours to be seen regularly the er physicians were never aware of this patient. We can only see new patients all day rotating through 3- chairs as all other beds are full. We physicians want desperately to see patients but there is a huge stop gap as we cannot pull back patients efficiently because there are no nurses for new patients. All ER nurses are now functioning floor nurses for all the boarding patients."*

**Waiting Room Care**

Many emergency physicians who submitted stories reported daily numbers of boarders close to or even exceeding 100 percent of the total number of beds in their EDs, while the number of patients in the waiting room comprised up to 20 times the number of free treatment beds in which they could even be seen. In the past, that often left only hallway stretchers within the ED to care for incoming patients. But now, those too are increasingly over-capacity, and so the emergency department waiting room has become the latest ad-hoc location for receiving patient care.

*"We've had lobby nurses responsible for 15-20 patients each. We've pushed diltiazem, hung amiodarone, cared for septic shock, and are now admitting patients regularly directly from the lobby. Care is being provided in chairs with little privacy and the hope of a portable monitor. Meanwhile 40 boarders are being cared for in an ED with overhead pages, lights on all the time and a total of 5 bathrooms and no showers. One night we had a septic patient waiting two hours for triage code and die in our triage room."*

*"My shop is 34 bed rural tertiary care center that serves an area greater than 20,000 square miles. Month after month our boarding issues continue to exacerbate and have surpassed critical levels many months ago. We are frequently the largest in-patient ward in the hospital. Currently we average 28 boarding patients in our department and this has been as high as 41 boarded inpatients and 31 patients in the waiting room less than a week ago…Due to these challenges we have fully implemented "waiting room medicine", closed down our Provider in Triage, instead all providers pickup patients in the waiting room. Nearly 50% of our patient encounters now result in discharge from the waiting room. Finally, it is not at all uncommon to have patients in the waiting room with SarsCoV-2, pending orders for heparin, diltazem, or other vasoactive medications. In the past month we have had SAH [subarachnoid hemorrhage, or brain bleed], Fournier gangrene, hip fractures, Septic shock all being treated in the waiting room with no available beds to move them into."*

*"...our 40 bed ED was boarding a large number of patients up to several days awaiting an inpatient hospital bed with a waiting room of >30 people. We had someone in the lobby who was not being appropriately monitored and began having large bloody vomiting. Vitals were only available from when he initially presented to triage almost 8 hrs ago. He lost pulses in the waiting room in front of others including children. As the resuscitation began in the lobby, this posted high risk for other patients in the*

*lobby as we began CPR while blood ejected from his mouth with every compression. It wasn't until he was in a proper room that we were able to obtain IV access and suction the blood. This was not only scarring for the others and hospital workers, but may have been avoided if our emergency department was decompressed and an appropriate history/exam/workup had been done by me or another physician much earlier in order to initiate treatments that have been shown to improve outcomes related to his presenting complaint and known risk factors."*

Patients don't just arrive in the ED through the waiting room—they are also brought in by EMS via ambulance. Many hospitals are unable to go on diversion status, even when the emergency department is completely backed up with patients, which means EMS crews must wait with the patient until they can be seen. This means the ambulances are stuck at hospitals and unable to respond to new emergencies:

*"We have 26 beds in the emergency department but often over 50 total patients. We are not allowed to go on divert as [County] does not allow us to. It is often very unsafe in the emergency department when there are too many patients without any physical space or enough nurses to care for them. It puts physicians in a bad place as we have to continue to accept ambulance traffic without being able to care for them or the 20+ patients in the lobby."*

*"Our County's Emergency Medical Services reduced our ability to go on diversion down to 200 hours max for the month of October. Diversion is when paramedics bypass our hospital to take patients with heart attacks and strokes to other hospitals and is the only mechanism we have to offset ED overcrowding due to inpatient boarding. Removing this ability means patients will continue to arrive despite all beds being occupied with admitted patients thereby forcing us to care for these patients in areas such as ambulance ramps and public hallway spaces. Therefore we are essentially disrobing patients in public spaces in order to care for them. All this because of inpatients boarding in the ED. Basically the ED is the largest inpatient unit in the hospital. Patients are receiving bills for 2 or 3 days of inpatient care but never actually arrive upstairs to an inpatient space.*

**Pediatric Care**

Unfortunately, the pediatric population is not immune to the serious ED boarding issue we are facing—particularly those with mental health conditions. During the last decade, pediatric ED visits for mental health conditions have risen dramatically.[6] The COVID-19 pandemic led to a greater acceleration of these visits, causing several pediatric health organizations to issue a national emergency for children's mental health in 2021 and the U.S. Surgeon General to release an advisory on mental health among youth. According to the Centers for Disease Control and Prevention (CDC), during March–October 2020, among all ED visits, the proportion of mental health-related visits increased by 24 percent among U.S. children aged 5–11 years and 31 percent among adolescents aged 12–17 years, compared with 2019. Further, a metanalysis conducted in 2020 illustrates the detrimental effects of boarding among the pediatric population. Multiple studies show that pediatric patients with mental health conditions who are boarded are more likely to leave without being treated, and less likely to receive counseling or psychiatric medications. Beyond mental health, children with other health care conditions are experiencing similar ED wait times as adults; even children's hospitals that only serve the pediatric population are already overcapacity[7] as cold and flu season is only getting started. The stories below illustrate how boarding is particularly impacting those children in the greatest need of immediate medical attention:

*"We are a 28 bed pediatric ED, with a catchment area of 2.5 million children. I came onto shift yesterday morning. We had 15 children on psych holds, many of them waiting in the lobby for their 24-72 hours stays so we could use our beds to see medical patients. One of those patients had been in the ED for >150 hours, as their parents had relinquished their rights and DFS was refusing to take the patient back, even though our psychiatry team had cleared them as no longer a danger to self or others. We had 10 admissions boarding, 7 on high-flow oxygen, 4 of which were Peds ICU level. There are no open Peds ICU beds in our 4 closest counties, including our own. We had 35 patients in the waiting room in addition to the 20 medical patients being managed by the ED. We had 7 transfers pending from outside facilities to the ED, plus more awaiting direct admissions from*

[6] Cutler GJ, Rodean J, Zima BT, et al. Trends in Pediatric Emergency Department visits for mental health conditions and disposition by presence of a psychiatric unit. Acad Pediatr. 2019;19:948–955.

[7] https://www.cnn.com/2022/10/25/health/childrens-hospital-beds-delayed-care-long-waits/index.html

*an outside ED to an inpatient bed whenever a bed became available. One that left another hospital's ED against medical advice and came to our ED had been waiting 3 days for transfer. They had an AVM in their brain that needed urgent surgery."*

*"We had a 12 month old patient who presented in respiratory distress and low oxygenation who was found to have pneumonia and required a high amount of oxygen (Opitflo) to maintain his oxygen saturations. After stabilizing him for the interim, we attempted to transfer to a Pediatric ICU (PICU). We were met with not a single open PICU bed in the state, as well as no hospitals with capability to accept transfer in every major city in the surrounding states. The critically ill child stayed in our emergency department for over 24 hours awaiting acceptance at one of our state's Children's Hospitals and still had an over 8 hour wait for EMS once a bed was available. Luckily, this child started to improve with antibiotics and treatment over those 24 hours though if they had progressed, we may have had to be boarding a child on life support (ventilator) without access to a Pediatric ICU."*

*"My wife is a Pediatric Emergency Physician. She works at the [redacted] Children's Hospital in the world, with all available services at the hospital and patients from all over the world who come for care. She walked into her shift the other day with over 50 patients in the waiting room of a 60+ bed ER, with all hospital and ER beds already full with sick patients and others holding to be admitted. 27 ER beds were being held up with actively psychotic or suicidal children with nowhere else to go. A young child had to sit in the waiting room for 8+ hours with their lower lip lacerated and nearly completely hanging off of their face, because there weren't any beds available to properly evaluate and treat the patient."*

**Psychiatric**

Boarding of psychiatric patients in EDs is particularly prevalent, disproportionately affecting patients with behavioral health needs who wait on average three times longer than medical patients because of significant gaps in our health care system. While the ED is the critical frontline safety net and the most appropriate setting for acute unscheduled care for individuals suffering from a mental health crisis, it is not ideal for long-term treatment of mental and behavioral health needs. Research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours. However, far too many Americans have limited options for accessing outpatient mental health care. This can exacerbate ED boarding from two directions: on one end, as patients who can't access outpatient treatment may then enter into a crisis that requires an ED visit, and from the other end, a lack of available outpatient follow-up care prevents patients from being discharged from inpatient psychiatric care and freeing up a bed for the next admission waiting in the ED.

*"We have ~ 70 beds, this AM we had 42 admitted patients (admitted up to 38 hours earlier), 10 boarding Behavioral Health Patients, and 5 social boarders/group home patients. Our group home patients all have chronic, lifelong behavioral issues, and were inappropriately 'dumped' in ED by the group home and guardian (whether LME or DSS, after not following state guidelines related to appropriate group home discharge). Our group home patients have been here from 1200 - 3520 hours. Considering average ED visit being 3-4 hours, those 6 group home patients boarding hours = loss of ability to see upwards of 2500 other ED patients."*

*"Our system has failed our most vulnerable patients. We held a 14 yr old girl in a tiny ED room for 42 days (!!!) awaiting transfer/placement for inpatient psychiatric care. In our ED we routinely board patients due to the hospital at capacity, but it's particularly bad with mental health patients who need inpatient psychiatric treatment. Our hospital is not a licensed psychiatric facility, and by law we may only hold for 72 hours under a 5150 application. That said, just because there are no facilities able and/or willing to take the patients doesn't mean their psychiatric emergencies have resolved. Can you imagine being confined to a small room, without actually getting psychiatric care, for 42 days??? This could have been the subject of a Stephen King novel. Horrific."*

*"I'm working in a 9-bed ED with an additional 3-beds dedicated to psychiatric patients. We now have a patient who has been boarding with us for over 5 MONTHS with no end in sight. She is unfortunately a disruptive person as well, interrupting patient care elsewhere in the ED as she wanders the hallways (we do have to allow her out of her 10x10 room on occasion and tying up our security resources. She has injured herself on occasion, and has refused medications until she is so psychotic that she can't refuse them any longer."*

**Burnout**

Overcrowding and boarding in the emergency department is a significant and ever-growing contributor to physician and nurse burnout, as they must watch patients unnecessarily decompensate or die despite their best efforts to keep up with the growing flood of sicker and sicker patients coming in. Health care professionals experiencing burnout have a much higher tendency to retire early or stop practicing all together. This increases the loss of skilled health care professionals in the workforce and adds more strain to those still practicing, which continues the cycle of burnout within the profession.

Though stress is a given in emergency medicine, the rate of burnout is of tremendous concern and causing additional strain to an already crippled healthcare system. Shift work, scheduling, risk of exposure to infectious disease, and violence in the emergency department, can all affect the mental health and wellbeing of the physicians and nurses. Coupled with overcrowding and boarding in the ED, health care professionals are now facing stresses and moral injury that go well beyond everyday practice. The danger of the cycle of burnout is further demonstrated with the American Medical Association (AMA)'s recently released study that shows that **62.8 percent of physicians felt burned out in 2021.** Additionally, according to another recent study[8] in Mayo Clinic Proceedings, the burnout rate among physicians in the United States spiked dramatically during the first two years of the COVID-19 pandemic. As the winter's "triple threat" of flu, COVID-19 surges, and pediatric respiratory illnesses approaches, it is critical that we end the burnout cycle in EDs to ensure our nation's health care workforce can meet the needs of its patient population.

*"We are a large-volume ED, seeing 350-400 patients per day. When we have over 50% of our ED beds full of admitted patients (which happens frequently) we have a plan in place to move our physicians out to see patients in the waiting room. We also, at the same time, fill the hallways with stretchers, where patients are interviewed, examined and often given discharge instructions after their workup is complete. As you can imagine, this is not ideal as it is hard to ensure privacy, and patient comfort in either of these settings. Patient experience is impossible to improve for these patients (would you be happy if this was you or your family member???). Physicians are unhappy as it feels like we can't provide the care we want to, the care we went into medicine for... we are drowning, stressed and we need help - desperately."*

*"Evening shift with 55 boarding admitted patients, waiting room backs up to 45-50 patients. A 70 year old woman presents with abdominal and back pain but relatively normal vital signs. She is in a chair in the waiting room. Due to the # of people in the waiting room her husband is sent up to another waiting area. She waits for over 3 hours. Her husband tries communicating with his wife via text messages, but no response. He comes down to ED to find his wife slumped over in the chair and yells to the triage nurses. The patient is in cardiac arrest. She is brought back to the resuscitation bay but is not able to be resuscitated and dies. The ED team, attending physicians, residents, nurses, techs, when finding out that she had been in the waiting room that long, are devastated, many in tears, highly frustrated by the failure of our institution and US healthcare in general to be able to provide adequate access for patients, adequate staffing for our hospitals and ED's, enough options for longer term care, and a safe environment for patients and providers. Our level of burnout in physicians and nurses is at an all time high. A tragic case like this, a consequence of boarding, is another wound in this long battle which shows no signs of letting up. It even seems to be worsening."*

*"By the time I saw her she had been there for 6 hours, stuck on a stretcher inches from an intoxicated man who was vomiting on himself and another patient screaming obscenities. She had not gotten any pain medication and was having severe right hip pain. She also had to urinate badly but had been unable to get anyone to help her. There are 2 triage nurses who are there to watch the 15+people who were in ambulance triage that night while also receiving the new EMS patients. Orthopedic surgery saw my patient and admitted her from ambulance triage. For the rest of my 8 hour shift she remained in ambulance triage waiting for a bed upstairs or to go to the or, whichever happened first. She is only 1 of many patients with broken bones that I have seen wait for hours before being seen because of how boarded our ED is…It is demoralizing to start every patient encounter with profuse apologies for the wait and difficulty they have had to endure just being in our emergency department. It is heartbreaking to find*

[8] Tait D. Shanafelt, Colin P. West, Lotte N. Dyrbye, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Christine Sinsky, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic, Mayo Clinic Proceedings, 2022, https://doi.org/10.1016/j.mayocp.2022.09.002.

*someone who could be my grandmother languishing in pain for hours before we are finally able to see and evaluate her. We are in a crisis and although we do everything we can to MacGyver solutions to the problem while we are on shift, there is only so much we can do from the ground. We cannot fix this problem in the ED, we need help."*

**Staffing Shortages**

Nursing shortages have exacerbated the deficiency of the health care workforce and stretched care teams to take on extra hours, care for more patients, and shoulder additional clinical and nonclinical duties. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. Prior to the pandemic, the American Association of Colleges of Nursing already projected a nursing shortage. That trend has accelerated due to COVID-19, confirmed by a recent American Nurses Foundation survey[9] which found that 21 percent of nurses surveyed intended to leave their position, with another 29 percent considering leaving. Almost half of all respondents cited insufficient staffing as a factor in their resignation, and their departures will only increase the insufficiency, forcing their fellow nurses to an even more severe condition and impeding the ability to provide high-quality patient care.

*"I work in a 34 bed ED in southwestern PA. At night we normally staff enough nurses a PA or NP and myself for 20 patients. We calculate one RN to 4 patients. Unfortunately over the past year or more we have nights we hold 20 or more patients in the ED waiting for beds. Some are ICU patients. In the unit they would have one nurse to 1-2 patients. Ours nurses will have one or more sick patient that takes lots of work and at least 3 other patients. Some nights 7 patients to one nurse. This is not safe. We cannot turn people away when over whelmed. That means many people sit in the waiting room uncared for 8-9 or up to 12 hours waiting to be seen."*

*"While previously we were able to adapt, utilizing float pool to care for these patients and creating "care spaces" in every nook and cranny, the current boarding and staffing crisis leaves us at the breaking point. ED nurses, with less than 50% staffing sometimes at night, are left to care for boarders in the ED as well as acute patients. Inpatients rooms are closed due to staffing with ratios upstairs barely budging from 1:4."*

*"We are a 70 bed tertiary emergency department as part of a health system and we continually have holding of 10-30 patients in our emergency department for 7-72 hours. This holding may be a result due to volume, a lack of movement upstairs on the inpatient floors (having 'clean' beds available so the nurse doesn't get another patient), holding 'dead beds' for theoretical postoperative patients and trauma victims, nursing ratios of how many patients an inpatient nurse can see (1:4,6 vs and emergency nurse 1:6,8,10,12,18). I've seen elderly patients that cannot fend for themselves in the hallway under cared for and dwindling for hours. I've seen pediatric psychiatric patients held with no free bed to transfer to for two to three days. I've see adult psychiatric patients locked away on a constant observation order in a 4x6' room for 48-80 hours with only the freedom to walk to the bathroom and back (no sunlight, no exercise)."*

**Misaligned Incentives**

Despite years of advocacy and research to draw attention to the harmful impacts of boarding, it continues, largely due to misaligned incentives in how health care is financed. As hospitals continue to bring in and dedicate beds to elective admissions while boarding the backlog of non-elective patients in the ED, the financial benefits of ED boarding exceed the cost[10]. This was reflected in numerous anecdotes collected in the ACEP poll:

*"We are a top nationally ranked hospital that, due to budget issues, has now prioritized transfers and surgery admissions over ED admissions. We typically board 120-200 hrs/day and LBTC rates have climbed from 3-4% to 15-20%."*

*"Since July boarding has become the new norm. In our 15 bed ER we are utilizing space in an adjacent unit to house holds. We have had a steady uptick from 5 in July to 5-10 in august, to now consistently 8-15 boarders/holds per day. Last week the*

[9] Mental Health and Wellness Survey Report. American Nurses Foundation 2021.

[10] "Despite CMS Reporting Policies, Emergency Department Boarding Is Still A Big Problem—The Right Quality Measures Can Help Fix It", Health Affairs Forefront, March 29, 2022. DOI: 10.1377/forefront.20220325.151088

*AM doc came in to 15 holds and 2 spaces available to see patients. A nursing leader came down and he told them he was tired of this and admin answer was "we will get through it like we have the last few weeks". We didn't get through it, our patients suffered extensive delays and suboptimal care boarding. Admin doesn't want to pay agency rates, so the ER is bearing the brunt of shortages…We are treating things like acute appendicitis out of the waiting room with IV fluids and antibiotics, fluids while awaiting OR. We have not cancelled any elective surgeries and until last week they were getting inpatient beds before people holding in ED >24 hours right after PACU."*

*"We are a 38 bed ED, usually with 30-40 pts in the waiting room and many EMS patients waiting for rooms in the hallway. Patients come in agitated, acutely psychotic occasionally violent. We cannot provide these patients with high-quality medical care when they are waiting for a bed for hours/sometimes days. We also have critically ill patients requiring higher level of care who have to wait in hallways. It's not unheard of for these patients to decompensate before we are able to get them into a ED room. This is not sustainable. Saving beds for elective surgical patients while truly ill, critically ill patients waiting hallways in the emergency department is disheartening. It's unsustainable, morally, wrong, and dangerous for staff and for patients. How did we go from being healthcare heroes to an afterthought of the medical system?"*

All these stories paint a stark picture of boarding's impacts on every aspect of the health care system. Yet it is clear a disproportionate share of that burden is being carried by two key stakeholders – the emergency care team, and their patients. At any time, any of our loved ones are just a moment away from becoming one of these patients, and their health and safety will depend on your immediate action to address a system that is heading towards collapse.

We greatly appreciate the commitment and attention your Administration has given to the health and safety of those in our nation over the last two years, and we implore you to now make the growing crisis of boarding a major priority. We stand ready to collaborate with you and other impacted stakeholders to identify near- and long-term solutions. If you have any questions, please contact Laura Wooster, MPH, ACEP's Senior Vice President of Advocacy & Practice Affairs, at lwooster@acep.org.

Sincerely,

American College of Emergency Physicians
[Other signatories]


Michigan State Council

# MICHIGAN STATE COUNCIL MEETING

**Executive Committee: Rebecca VanStanton President, Josie Kik Immediate Past President, Chelsea Meixner Secretary, Kim Johnson Treasurer, Kelly Ashcraft & Naomi Ishioka Directors**

**ENA'S MISSION** To advance excellence in emergency nursing

**MENA'S FOUR STRATEGIC GOALS** Community, Culture, Practice, Education

## AGENDA/ Minutes

### September 17, 2022 0900-1100

A. Call to Order **Rebecca VanStanton**.....

1. Establish Quorum Jac, Alisha, Dianne, Gordon, Jennifer, Chris, Rebecca, Kim, Lindsey, Kelly, Gail, Christina, Eleanor, Aimee, Chelsea, Sheila, Marilyn, Josie, Tori
2. Welcome/Introductions
3. Leadership Reflection – Armored Leadership (pg 94)
4. Consent Agenda
    i. Approval of Minutes July 20, 2022- Gail 1st, Aimee 2nd

B. President's Report **Rebecca VanStanton**.....

1. ENA Head Office Update- email sent to all members
    i. See July HQ Board Meeting Updates
        1. Membership looking at fee schedule and transition from student to full membership – still developing
        2. Board of Directors elections are upcoming. Elections committee is working with people that are interested and helping them to find experiences to strengthen their CV for preparation for leadership
        3. 7 resolutions for GA
        4. Looking at how to make a statement for safe care in light of Dobbs decision and assessing member receipt of assault rifle statement from ENA
2. Succession Plan
    i. Last Call for Officer Candidates for Election
    -President Elect, Director open- Lindsey applied for Director
3. 3-tier to 2-tier discussion – possible vote

3 tier to 2 tier- removing local level (East, West)- additional work for treasurer, ideas to build more committees, various meetings throughout the state, most on the same page to go to 2 tier- need to rewrite

bylaws, and transition, add additional plans and committees to State Level- include in October meeting to send to membership, request for work group, 3-4 directors (regional), potential for elect- Rebecca to send out information

4. Call for Volunteers
    i. HQ- until Oct 7th
    ii. State- closed
5. Updating Procedures- date added under for review

Michigan Emergency Nurses Association - Council Procedures and Forms

Michigan ENA is comprised of the members of the Emergency Nurses Association who live in the state of Michigan. Each member has an opportunity to become involved at their local chapter and at the state level.

Standards and Procedures
Updated July 2022 - Due July 2026

Conflict of Interest
MENA Conflict of Interest Procedure

Conflict of Disclosure
MENA Conflict of Interest Disclosure

Records Retention Policy
Updated July 2022 - Due July 2026

State & Chapters Election Process
Updated July 2022 - Due July 2026

Travel Policy
Updated November 2021 - Due November 2025

Social Media Policy
Updated July 2022 - Due July 2026

Reimbursement Form
Reviewed July 2022 - Due July 2026 (or with new treasurer)

Credit Card Usage Policy
Updated July 2022 - Due July 2026

Whistleblower Policy
Updated July 2022 - Due July 2026

Reserves Policy
Updated July 2022 - Due July 2026

    i. Conflict of Interest/Disclosure- only for chair and board members to be signed annually
        1. https://umichumhs.qualtrics.com/jfe/form/SV_2bBJ4mOXieEs498
        2. Statement with link on website:
            a. Michigan ENA aligns itself with ENA HQ and follows the conflict of interest and disclosure statement and policy as set forth. Please follow the link to submit. This is required annually for board members, committee chairs, and education committee members. (date).
    ii. Scholarships..... Kim Johnson
    Form updated and will be revised for December meeting and brought to membership

6. COMON- updates from the board of nursing, many parties involved
    i. Oct 6-7 Michigan Center for Nursing 2022 Michigan Nursing Summit Park Place Hotel, Traverse City
7. General Assembly
    i. Delegate Number: 15 and 1 Alternate
    ii. Confirmed Attendees
        1. Rebecca, Gail, Chelsea, Kim, Josie, Kelly, Alisha, Chris, Jac, Tori, Lindsay, Eleanor, Marilyn, Aimee, and Sheila and Jennifer as Alternate
    iii. T-Shirts..... Lindsey Sams

C. Immediate Past President **Josie Kik** .....
No report

D. Secretary Report **Chelsea Meixner** .....
October 10th Triage Notes

E. Treasurer's Report **Kim Johnson** .....

Working with Alisha to get treasurer reports, working with Chelsea for conference, most of money made from TNCC/ ENPC, delegate conference to reduce the amount from the accounts, hotel and air fare to be paid afterwards

F. Director at Large **Kelly Ashcraft & Naomi Ishioka**.....
No report

G. Awards **Aimee Westmore**.....
5 awards to be given out this year- no winners in some categories, doubled in some areas

H. Chapters Reports/updates …. .....
1. East Chapter **Gail VanStanton** next meeting Oct 27th, 2022
2. West Chapter **Alisha McKay** next meeting Oct 19th, 2022

I. Committee Reports .....
1. Education **Chelsea Meixner**
    a. 2024 Traverse, 2025 Detroit- plan to move forward for Traverse
    b. Budget- increase vendors fees
    c. Conference Cost- lower cost for members
2. TNCC / ENPC **Marilyn Enriquez**
    5 candidates in the state who need to be checked off before, TNCC update online, learning management system updates, TNCC/ENPC updates for instructors, all candidates have a place to teach, meeting rescheduled to Tuesday, state TNCC/ENPC is

aligned to National guidelines per Marilynn. Marilyn and Rebecca to discuss offline per Marilyn.

3. Membership **Gail VanStanton**
   1060 members currently, membership drive to be offered in October
4. Foundation/Scholarships **Kim Johnson**
   Starting to purchase for 2023 conference

5. QSIP **Chapter Presidents**
   a. East Chapter- no report
   b. West Chapter- no report
6. Government Affairs **Naomi Ishioka**
   a. Handout on Workplace Violence- no report
7. Media **Jac Getzinger**
   No report
8. Student Nurse Relations Chair **Christy Rapoza**
   a. MNSA Conference – October 14 – Embassy Suites, Livonia- Rebecca will be in attendance
9. Awards **Aimee Westmore**
   a. Information distribution
   b. Nominator drawing
   c. Award distribution planning- will be done during ER Nurses Week

J. Open Forum and Action Items for next meeting .....5 minutes (1050-1055)
   1. Dates to Remember
      i. 2023 State Meeting Dates
         1. January 18 - 1p-3p – zoom only (Education and Early Bird Special dinner afterwards)
         2. March 15 - 1p-3p – zoom only
         3. May 2 - hybrid - TBD
         4. July 19 - 1p-3p – zoom only
         5. September 9 – 9a-3p (with delegate meeting) - hybrid - TBD
         6. December 2 – 9a-3p (with budget meeting) - hybrid - TBD
         7. Board meetings will be called only as needed as many were not needed in 2022
         8. Chairs/Board/Chapter Presidents - as appropriate – please set dates for 2023 to send to membership
      **ii. Next Meeting/ Budget Meeting: December 3, 2022 HFWB/Hybrid**

Michigan State Council

iii. General Assembly September 29-30 – Denver
iv. EN22 September 30-October 3 – Denver
v. October is Discount Membership Month
vi. Triage Note Articles Due to Chelsea: October 10, 2022
vii. Awards and EN Week 2022 October 10-14, 2022
viii. HQ
    1. 2023 Leadership – January 26-29 – Scottsdale, Arizona
    2. EN23 - September 21-24 – San Diego

K. Meeting Minutes/Key Learnings

L. Adjourn ..... 1107

# BYLAWS OF
# ENA MICHIGAN STATE COUNCIL

## ARTICLE I
## NAME, PURPOSES AND TERRITORY

**Section 1. Name.** The name of this corporation shall be the Emergency Nurses Association - Michigan Council (State Council), a Michigan not-for-profit corporation, doing business as Michigan ENA State Council.

**Section 2. Purposes.** In addition to the purposes set forth in the State Council's Articles of Incorporation, the purposes for which the State Council is organized Internal Revenue Code (IRC) are educational, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, including but not limited to the advancement of emergency nursing through education and public awareness; and (ii) advancing and promoting the interests of the Emergency Nurses Association, an Illinois not-for-profit corporation ("National ENA") within the geographic area covered by the State Council ("Territory") and other appropriate purposes.

**Section 3. Offices.** The State Council shall have and continuously maintain in Michigan a registered office and a registered agent whose office is identical with that registered office and may have such other offices, within or without the Michigan, as the State Council Board of Directors may determine.

**Section 4. Rules.** The following rules shall conclusively bind the State Council and all persons acting for or on behalf of it:

(a) No part of the earnings of the State Council shall inure to the benefit of, or be distributed to, its directors, officers, committee members or other private persons, except that the State Council shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth above.

(b) No substantial part of the activities of the State Council shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the State Council shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf or in opposition to any candidate for public office.

Notwithstanding any provision of these Bylaws, the State Council shall not carry on any activity not permitted to be carried on by:

(i) a corporation exempt from federal income tax under Section 501(c)(3) of the IRC (or the corresponding provision of any future United States Internal Revenue Law); or

(ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the IRC (or the corresponding provision of any future United States Internal Revenue Law).

## ARTICLE II
## MEMBERSHIP

**Section 1. National ENA/State Council Dual Membership**. Each member of the National ENA in good standing who is licensed or resides within the Territory automatically shall be assigned membership in the State Council in accordance with National ENA procedures.

In addition, any National ENA member in good standing outside of the Territory may elect to become a member of the State Council upon written request to the National ENA in accordance with its procedures. However, members may only belong to one State Council. National ENA members shall be placed in the State Council membership category that corresponds with their National ENA membership category. State Council members must be National ENA members in good standing.

**Section 2. Membership Categories.** The membership of the State Council is composed of the following categories and such additional categories as may be established by National ENA from time to time: Voting Members (which includes National, International, Senior and Military members) and Nonvoting Members (which includes Affiliate, Student and Honorary members). The criteria for membership are the same as those established by the National ENA for each such membership category in its bylaws and policies.

**Section 3. Member Rights & Obligations.**

(a) Each member has the responsibility to support the purpose, mission, vision, values and objectives of National ENA and the State Council.

(b) Voting Members shall be entitled to hold elected office in the State Council; serve and participate in committees and task forces; vote in the State Council's elections and on all matters presented to the State Council's Voting Members; and attend the member meetings and social functions of the State Council. Each eligible Voting Member in good standing shall have one (1) vote in the State Council's elections and on all other matters presented to the Voting Members. All State Council members must abide by these bylaws, the National ENA Bylaws, and such other rules, policies, procedures and regulations as the National ENA or the State Council may from time to time adopt.

(c) Nonvoting Members shall be entitled to serve and participate in the State Council's committees and task forces; and attend the member meetings and social functions of the State Council. Nonvoting Members do not have the right to vote on any matter.

**Section 4. Member Resignation.** Any member may resign by submitting notice to the National ENA administrative office in writing. Resignation will be effective upon receipt. Resignation will not relieve the member of the obligation to pay dues and other assessments accrued before the effective date of the resignation. No portion of any dues paid shall be refunded to the resigned member.

**Section 5. Member Suspension/Expulsion.** A State Council member may be censured, suspended, and/or expelled for cause or otherwise disciplined by ENA National provided that a statement of the charges shall have been sent by certified mail to the last recorded address of the member at least fifteen (15) days before final action is to be taken. This statement shall be accompanied by a notice of the time and place of the meeting at which the charges shall be considered, and the member shall have the opportunity to appear in person and/or to be represented by counsel and to present any defense to such charges before action is taken by ENA National. Such disciplinary actions shall be conducted in accordance with such additional procedures as may be established by the ENA National Board of Directors.

**Section 6. Automatic Termination.** Membership in the State Council automatically shall be terminated whenever a State Council member's membership in the National ENA is terminated. In addition, the membership of any State Council member who is in default of payment of National ENA dues or any other charges for a period of three (3) months from the date on which such dues or charges become payable, or otherwise becomes ineligible for

membership in the State Council or the National ENA, shall be terminated automatically, unless such termination is delayed by the National ENA Board of Directors.
**Section 7. Member Reinstatement.** State Council members may request reinstatement in accordance with National ENA's bylaws, policies and procedures.
**Section 8. No Property Rights.** State Council membership is a privilege and not a property right. No member has an ownership or property right or interest in the State Council's funds, property or other assets.

## ARTICLE III
## DUES, FEES AND ASSESSMENTS

**Section 1.** The initial and annual dues for State Council members, if any, and the time for paying such dues and other assessments or fees, if any, shall be established by the National ENA Board of Directors, and such dues shall be submitted to National ENA in accordance with National ENA's policies and procedures.
**Section 2.** State Council shall be held harmless from any discrepancies or errors in computation and collection of dues, fines, and/or assessments made by the National ENA.

## ARTICLE IV
## MEMBERSHIP MEETINGS

**Section 1. Annual Meeting.** An annual business meeting of the Voting Members of the State Council (see Article II, Section 2) shall be held at such time and place as shall be determined by the State Council Board of Directors (see Article V).
**Section 2. Special Meetings.** Special meetings of the Voting Members of the State Council may be called at the request of the President, a majority of the State Council Board of Directors, or at the written request of **[10%]** of the Voting Members of the State Council's ~~voting members~~. The time and place for holding special meetings shall be determined by the State Council Board of Directors.
**Section 3. Education, Social and other Meetings and Functions.** The State Council shall hold or combine the annual meeting with educational, social and other meetings and functions as may be determined by the State Council Board of Directors.
**Section 4. Notice.** Notice stating the place, day, and hour of the meeting and, in the case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not more than sixty (60) and not less than five (5) days prior to the date of such meeting, unless otherwise required by applicable law.
~~**Section 5. Quorum.** The lesser of 10 percent (10%) eligible Voting Members of the State Council present shall constitute a quorum for the transaction of business at any duly called meeting of the voting members, provided that if less than a quorum is present, a majority of the voting members present may adjourn the meeting to another time without further notice.~~
**Section 5: Quorum.** The Voting Members of the State Council present at any duly called meeting shall constitute a quorum for the transaction of business at any duly called meeting.
**Section 6. Manner of Acting.** The act of a majority or more of the voting members present at a duly called meeting ~~at which a quorum is present~~ shall be the act of the members, unless the act of a greater number is required by law, the Articles of Incorporation, or these bylaws.

**Section 7. Rules of Order.** Generally accepted parliamentary authorities (such as Robert's Rules of Order) may instruct the State Council in all applicable situations insofar as they are not inconsistent with these bylaws, applicable law, or any rule or regulation of National ENA or the State Council.

**Section 8. Electronic Communications.** Member meetings may be held via telephone conference call, similar form of telecommunications, or any technology available which would permit all participants to effectively participate by way of two-way (hear and be heard) communication.

**Section 9. Voting.** Voting by ballot, proxy, mail, e-mail or other electronic means on any matter before the voting members shall be permitted to the full extent allowed by law (e.g., the not-for-profit corporation act or similar law governing the operation of not-for-profit corporations in the State Council's state of incorporation) ("Law"). A ballot, mail, e-mail or electronic vote may only be called by the State Council Board of Directors. In order for a mail, e-mail or electronic vote to be valid (i) the action must be approved by a majority of voting members casting votes; ~~(ii) the number of voting members casting votes must be sufficient to constitute a quorum had such action been taken at a meeting~~; and/or (iv) such other requirements as may be required by Law must be satisfied.

**Section 10. Minutes.** The Secretary of the State Council Board of Directors will maintain minutes of all meetings of the Voting Members on the Michigan ENA website and provide copies of those minutes to National ENA upon request.

## ARTICLE V
## STATE COUNCIL BOARD OF DIRECTORS

**Section 8. Section 1. Authority and Responsibility.** The affairs of the State Council shall be managed by the State Council Board of Directors, which shall have supervision, control, and direction of the affairs of the State Council; shall determine the policies or changes therein within the limits of these bylaws; and shall actively promote its purposes and have discretion in the disbursement of its funds. The State Council Board of Directors may adopt such rules and regulations for the conduct of its business as shall be deemed advisable and may, in the execution of the powers granted, appoint such agents as it may consider necessary.

**Section 2. Composition.** The State Council Board of Directors shall be comprised of the President, President-Elect, Secretary, Secretary-elect, Treasurer, Treasurer-elect, Immediate Past President and ~~2~~ 4 Directors. For the purposes of this Article, the term "Director" shall refer to any member of the State Council Board of Directors, regardless of the specific office held.

**Section 3. Qualifications.** Directors must be Voting Members in good standing in both the National ENA and the State Council.

**Section 4. Term. Directors** shall serve ~~a one (2) year term in office~~, for a period of 2 years or until such time as their successors are duly elected, qualified and take office. The term of office for each Director shall begin on January 1 following his or her election. Directors may serve no more than 2 consecutive terms in office (4 consecutive years).

**Section 5. Elections.** The Voting Members shall elect the Officers and Directors at or before the Annual Meeting of members in accordance with such procedures as shall be established by the State Council Board of Directors and National ENA.

(a) The nomination slate will be presented at the Spring State Council meeting.

(b) Voting is to be complete by October 1st. ~~This is for both State Council Offices and Directors and the State Chapters Officers.~~

**Section 6. Regular Meetings.** The State Council Board of Directors may take action to set the time, date, and place for the holding of a regular annual meeting of the State Council Board of Directors and such additional regular meetings of the State Council Board of Directors as the State Council Board of Directors may determine without other notice than such action.

**Section 7. Special Meetings.** Special meetings of the State Council Board of Directors may be called by, or at the request of, the President or upon a written request to the Secretary of three (3) members of the State Council Board of Directors. Notice of any special meeting of the State Council Board of Directors shall state the time, date, and place of the meeting and shall be delivered at least five to ten (5-10) days prior to the date of such meeting.

**Section 8. Meeting by Conference Call**. Any action to be taken at a meeting of the State Council Board of Directors or any committee thereof may be taken through the use of a conference telephone or other communications equipment by means of which all persons participating in the meeting can communicate with each other. Participation in such a meeting shall constitute presence in person at the meeting of the persons so participating. Notwithstanding anything set forth to the contrary in these bylaws, notice of any meeting to be held by conference call (whether regular or special) may be delivered a minimum of twenty-four (24) hours prior to the meeting.

**Section 9. Waiver of Notice.** Notice of a regular or special State Council Board of Directors meeting need not be given to a Director who signs a waiver of notice either before or after the meeting. Meeting attendance by a Director will constitute a waiver of notice and a waiver of objections to the meeting time and place and the manner in which it was called or convened, except when a Director states, at the beginning of the meeting or promptly upon arrival at the meeting, an objection to transacting business because the meeting is not lawfully called or convened.

**Section 10. Quorum.** A majority of the State Council Board of Directors shall constitute a quorum for the transaction of business at any duly called meeting of the State Council Board of Directors; ~~provided that when less than a quorum is present at said meeting, a majority of the State Council Board of Directors members present may adjourn the meeting to another time without further notice.~~

**Section 11. Manner of Acting.** The act of a majority of Directors present at a duly called meeting at which a quorum is present shall be the act of the State Council Board of Directors, unless the act of a greater number is required by law, the Articles of Incorporation, or these bylaws.

**Section 12. Informal Action.** Any action requiring a vote of the State Council Board of Directors may be taken without a meeting if a consent, setting forth the action taken, is approved by all of the members of the State Council Board of Directors entitled to vote with respect to the subject matter thereof.

**Section 13. Minutes.** The Secretary of the State Council Board of Directors shall maintain minutes of meetings of the State Council Board of Directors on the Michigan ENA website and provide copies of those minutes to National ENA upon request.

**Section 14. Resignation and Removal.** A Director may resign in writing submitted to the State Council's President. In the case of the resignation of the President, the resignation will be submitted to the Secretary who will refer such resignation to the State Council Board of

Directors. A resignation will be effective on the acceptance date of the resignation as determined by the State Council Board of Directors. A Director who no longer meets the qualifications for office shall be automatically removed and such vacancy shall be filled by the State Council Board of Directors. Any Director may be removed at any time with or without cause by a majority vote of the voting members present and voting, in person or by proxy, at any regular or special meeting at which a quorum of the voting members is present, when in their judgment the best interest of the State Council or the National ENA would be served by such removal.

**Section 15. Vacancies.** The State Council Board of Directors shall take action to fill any vacancy on the State Council Board of Directors. A Director appointed pursuant to this Section shall hold their position for the remainder of the original term.

**Section 16. Compensation and Loans.** Neither Directors nor Officers of the State Council shall receive salaries or other compensation for their services as Directors, but the State Council Board of Directors may, by resolution, authorize the reimbursement of expenses of attendance of Directors for each regular and special meeting of the State Council Board of Directors; provided that nothing herein contained shall be construed to preclude any Director or Officer from serving the State Council in any other capacity and receiving reasonable compensation therefor. The State Council may not make any type of loans to Directors.

## ARTICLE VI
## OFFICERS

**Section 1. Officers.** The Officers of the State Council shall be a President, President-Elect, Secretary, Treasurer, Immediate Past President and such other officers as may be determined by the State Council Board of Directors (collectively, the "Officers").

**Section 2. Qualifications.** Officers must be Voting Members in good standing in both National ENA and the State Council.

**Section 3. Elections & Term.**

(a) The Voting Members of the State Council shall elect the Officers at or before the Annual Meeting of Voting Members in accordance with such procedures as shall be established by the State Council Board of Directors. At the end of the President's term, the President-Elect automatically will succeed to the office of President. At the end of the President's term, the President automatically will succeed to the office of Immediate Past President.

(b) ~~The Officers shall serve:~~ The term of office of President shall be ~~one (2) year term in office~~, a maximum of two 2-year terms (4 consecutive years in total) or until such time as their successors have been duly elected and installed . The term of office of President-Elect is a (1) one year term. The Secretary and Treasurer shall each serve a (2) year term or until such time as their successors have been duly elected and installed. The Past-President is a (1) one-year term. The term of office for each Officer shall begin on the January 1 following his or her election.

**Section 4. Vacancies.** If the office of President becomes vacant, the President-Elect automatically will succeed to the office of President. Vacancies in any other office shall be filled by the State Council Board of Directors**.**

**Section 5. Resignation and Removal.** An Officer may resign in writing submitted to the President. In the case of the resignation of the President, the resignation will be submitted to the Secretary who will refer such resignation to the State Council Board of Directors. A resignation will be effective on the acceptance date of the resignation as determined by the State Council Board of Directors. An Officer who no longer meets the qualifications for office shall

automatically be removed and such vacancy shall be filled by the State Council Board of Directors. Any Officer may be removed at any time with or without cause by a majority vote of the voting members present and voting, in person or by telecommunication, at any regular or special meeting at which a quorum of the voting members is present, when in their judgment the best interest of the State Council or National ENA would be served by such removal.

**Section 6. Duties of Officers.**

(a) **President.** The President shall be the chief executive officer, and shall supervise and control the affairs, of the State Council. Except as otherwise provide by the State Council Board of Directors or the President, only the President may take official action, make public statements, or otherwise hold himself or herself out to the public as authorized to act on behalf of the State Council and all such actions must be approved, in advance, by the State Council Board of Directors. The President may sign, with the Secretary or any other proper officer of the State Council authorized by the State Council Board of Directors, any contracts, or other instruments which the State Council Board of Directors has authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the State Council Board of Directors or by these bylaws or by the statute to some other officer or agent of the State Council. The President shall set the agenda and preside at all meetings of the State Council's members and Board of Directors; except as otherwise provided in these bylaws, shall appoint the chair of all committees and, in consultation with the chairperson, make all committee appointments; and in general shall perform all duties incident to the office of President and such other duties as may be prescribed by the State Council Board of Directors. The President shall automatically succeed to the office of Immediate Past President at the end of his or her term in office as President.

(b) **President-Elect**. The President-Elect shall, in the absence of the or at the direction of President, preside at all meetings of the State Council's members and Board of Directors; and shall perform all duties incident to the office of President-Elect and such other duties as may be prescribed by the President or by the State Council Board of Directors.

(c) **Secretary.** The Secretary shall keep or cause to be kept the minutes of the meetings of the State Council Board of Directors and voting members; shall see that all notices are duly given in accordance with the provisions of these bylaws or as required by law; shall be custodian of the corporate records; and shall in general perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the President or by the State Council Board of Directors.

(d) **Treasurer.** The Treasurer shall be responsible for all funds and securities of the State Council; shall receive and give receipts for monies due and payable to the State Council from any sources whatsoever, and shall deposit all such monies in the name of the State Council in such banks, trust companies, or other depositories as shall be selected in accordance with the provisions of these bylaws; shall submit financial reports to the National ENA, to the State Council Board of Directors at its regular meetings, and to the State Council membership at its Annual Meeting; and shall in general perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned by the President or by the State Council Board of Directors.

(e) **Immediate Past President.** The Immediate Past President shall perform all duties incident to the office of Immediate Past President to include the coordination of the elections for State Council offices and such other duties as may be specified by the President or by the State Council Board of Directors.

**(f)Director (2) (4 positions).** Directors shall perform all duties assigned by the President, including special projects and regional representation. The Directors serve as liaison between the Voting- and non-Voting members of the State Council and the State Council Board of Directors.
~~**(g)Regional Directors (3)**~~

## ARTICLE VII
## COMMITTEES

**Section 1. Committees.**
(a) **Committees with Authority of the State Council Board of Directors.**
The State Council Board of Directors, by resolution adopted by a majority of the Directors in office, may designate one or more standing committees, each of which shall consist of a majority of Directors and no fewer than two Directors, which to the extent provided in said resolution shall have and exercise the authority of the State Council Board of Directors in the management of the State Council; but the designation of such committee(s) and the delegation thereto of authority shall not operate to relieve the State Council Board of Directors or any individual Director of any responsibility imposed upon them by Law. In accordance with ENA Procedures, the State Council must maintain the following core committees: (i) Membership; (ii) Government Affairs; (iii) Quality, Safety, and Injury Prevention (QSIP); (iv) Pediatric; (v) Trauma; ~~and~~ (vi) Fundraising ~~and~~ (vii) Awards; (viii) Nominations; and (ix) Finance.
(b) **Other Committees.** The State Council Board of Directors may establish such other committees not having the authority of the State Council Board of Directors as it deems necessary or prudent in the exercise of its authority and responsibility as set forth in these bylaws.
**Section 2. Authority.** The action establishing a committee shall set forth the committee's purpose, authority, and composition, and the qualifications required for membership on the committee. All committees shall report to and be subject to the ultimate authority of the State Council Board of Directors, unless otherwise set forth in the resolution establishing such committee. Committees may be terminated or repurposed by a majority vote of the State Council Board of Directors.
**Section 3. Composition**. In the absence of any direction to the contrary in the authorizing action, the President shall appoint the Chairperson and members of all committees, subject to the approval of the State Council Board of Directors. The President may also appoint Vice-Chairpersons to committees as deemed necessary.
**Section 4. Quorum and Manner of Acting.** At all meetings of any committee, a majority of the members shall constitute a quorum for the transaction of business unless otherwise set forth in these bylaws or the resolution establishing such committee. A majority vote by committee members present and voting at a meeting at which a quorum is present shall be required for any action.
Section 5. Terms of Office. The termof office for Chairperson (and Vice Chair-person, if present) shall be for a maximum of two 2-year terms (4 consecutive years in total) or until such time as their successors have been duly elected and installed
**Section 5. Vacancies & Removal.** Unless otherwise provided in the resolution establishing a committee, vacancies in the membership of a committee shall be filled by appointments made in

the same manner as the original appointments to that standing committee. Unless otherwise provided in the resolution establishing a committee, any member of a committee may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the State Council or the National ENA would be served thereby.
**Section 6. Policies and Procedures.** The State Council Board of Directors (or its designee(s)) shall develop and approve policies and procedures for the operation of all committees.

## ~~ARTICLE VIII~~
## ~~LOCAL CHAPTERS~~

~~**Section 8. Local Chapters.** State Council Voting Members that are licensed or reside within the same local geographical territory may be organized as a local chapter of the State Council and each such local chapter will be an integral part of the State Council (each of which is referred to as a "Local Chapter"). The State Council Board of Directors may authorize the establishment of Local Chapters and shall determine the name, geographical boundaries, eligibility requirements and policies and procedures governing their operations (subject to the prior written approval of the National ENA Board of Directors and such rules and policies as may be adopted by the National ENA Board of Directors from time to time including, without limitation, the ENA Procedures). The State Council Board of Directors is responsible for overseeing and managing the activities of its Local Chapters and has the right to disband or dissolve any Local Chapter it creates as set forth below.~~
~~**Section 9. Application for Recognition as a Local Chapter.** The State Council Board of Directors, or its designee(s), shall adopt an application form and procedures to facilitate the consideration of applicants seeking to be organized as a Local Chapter. All applicants must complete the application form and submit the application to the State Council President. The State Council Board of Directors (or its designee(s)) shall review the application of all applicants and determine, based on the criteria set forth in these bylaws, the ENA Procedures and such other policies or guidelines as the State Council Board of Directors may prescribe, if applicants meet the qualifications necessary for recognition as a Local Chapter.~~
~~**Section 10. Operation.**~~
~~(a) Local Chapters may not incorporate (except as otherwise provided in the ENA Procedures) and shall operate and function as committees or special interest groups of the State Council.~~
~~(b) All Local Chapters report to and are subject to the ultimate authority of the State Council Board of Directors.~~
~~(c) The State Council Board of Directors (or its designee(s)) shall develop and approve policies and procedures for the operation of all Local Chapters.~~
~~(d) The State Council Board of Directors has the right to disband or dissolve Local Chapters according to due process procedures established by the State Council Board of Directors. Upon dissolution of a Local Chapter, the Local Chapter immediately shall remit any funds in its control or possession to the State Council and any funds held by the State Council for the benefit of the Local Chapter shall be forfeited and used by the State Council for its general purposes.~~

## ARTICLE IX
## RELATIONSHIP WITH NATIONAL ENA

The State Council shall abide by the terms of its National ENA's bylaws, rules, regulations, and policies as may be adopted by the ENA National Board of Directors from time to time, which, among other things, set forth the relationship between ENA National and the State Council, the rights, responsibilities and obligations of the State Council and ENA National with respect to one another, the limitations and requirements governing the State Council's use of ENA National's name, trademarks, service marks, logos and other intellectual property, and the grounds upon which the State Council's affiliation with National ENA may be terminated and its charter revoked.

## ARTICLE X
## CONTRACTS, CHECKS, DEPOSITS AND BONDING

**Section 8. Contracts.** The State Council Board of Directors may authorize any Officer or Officers, agent or agents of the State Council, in addition to the Officers so authorized by these bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the State Council and such authority may be general or confined to specific instances.

**Section 9. Checks, Drafts, Etc.** All checks, drafts, or other orders for the payment of money, notes, or other evidence of indebtedness issued in the name of the State Council shall be signed by such Officer or Officers, agent or agents of the State Council and in such manner as shall from time to time be determined by resolution of the State Council Board of Directors. In the absence of such determination by the State Council Board of Directors, such instruments shall be signed by the President and countersigned by the Treasurer.

**Section 10. Deposits.** All funds of the State Council shall be deposited from time to time to the credit of the State Council in such banks, trust companies, or other depositories as the State Council Board of Directors may select.

**Section 11. Bonding.** The State Council Board of Directors may provide for the bonding of such Officers and employees of the State Council as it may from time to time determine.

## ARTICLE XI
## FINANCIAL MATTERS

**Section 8. Books and Records.** The State Council shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Voting Members, the State Council Board of Directors and any committees having the authority of the State Council Board of Directors. The State Council shall provide National ENA with copies of such books and records upon request.

**Section 9. Fiscal Year.** The State Council's fiscal year shall be determined by the National ENA Board of Directors.

**Section 10. Annual Budget.** A budget shall be prepared by the Treasurer showing anticipated revenue and expenses will be adopted annually by the State Council Board of

Directors and presented to members at the first meeting of fiscal year start.

**Section 11. Financial Review.** The State Council Board of Directors may, in its discretion, provide for an annual review or audit of the State Council's books and records by an independent accountant. Results of such review or audit, if any, will be reported by such accountant to the State Council Board of Directors, with copies provided to National ENA.

## ARTICLE XII
## WAIVER OF NOTICE

Whenever any notice whatsoever is required to be given under the provisions of the applicable Law, or under the provisions of the Articles of Incorporation or bylaws of the State Council, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated herein, shall be deemed equivalent to the giving of such notice.

## ARTICLE XIII
## BYLAW AMENDMENTS

**Section 1. Amendment by Voting Members.** These bylaws may be altered, amended or repealed and new bylaws may be adopted by a majority vote of the voting members voting in person. Notwithstanding the foregoing, all proposed bylaw amendments shall be first submitted to National ENA and are subject to the prior written approval of ENA. Amendments not receiving the approval of National ENA shall be of no force or effect.

**Section 2. Amendment by National ENA's Board of Directors.** National ENA's Board of Directors (or its designee(s)) also shall have the authority to amend these bylaws from time to time in order to bring them into compliance with National ENA's policies and procedures without the approval of the State Council's voting members; provided, however, National ENA's Board of Directors (or its designee(s)) shall provide the State Council's voting members notice of any such amendments at least thirty (30) days prior to the effective date of such amendments.

## ARTICLE XIV
## INDEMNIFICATION

The State Council shall indemnify all past and present officers, directors, committee members, and other authorized State Council representatives to the full extent permitted by applicable Law, and shall be entitled to purchase insurance for such indemnification of officers and directors to the full extent as determined by the State Council Board of Directors. Notwithstanding the foregoing, such indemnification shall be limited to the extent of the insurance (i.e., Directors and Officers insurance and other further coverages as may be applicable) maintained by National ENA on behalf of the State Council.

## ARTICLE XV
## ELECTRONIC COMMUNICATIONS

Unless otherwise prohibited by Law, (i) any action to be taken or notice delivered under these bylaws may be taken or transmitted by electronic mail or other electronic means; and (ii) any action or approval required to be written or in writing may be transmitted or received by

electronic mail or other electronic means.

## ARTICLE XVI
## DISSOLUTION

In the event of the dissolution of the State Council, the State Council Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the State Council, transfer all remaining assets of the State Council to National ENA (except any assets held by the State Council upon condition requiring return, transfer or other conveyance in the event of dissolution, which assets shall be returned, transferred, or conveyed in accordance with such requirements) or, in the event National ENA previously has been dissolved, the State Council shall dispose of all of the remaining assets of the State Council (except any assets held by the State Council upon condition requiring return, transfer or other conveyance in the event of dissolution, which assets shall be returned, transferred, or conveyed in accordance with such requirements) exclusively for the purposes of the State Council in such manner, or to such organization or organizations as shall at the time qualify as a tax-exempt organization or organizations recognized under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended or the corresponding provision of any future United States Internal Revenue statute, as the State Council Board of Directors shall determine. Any such assets not so disposed of shall be disposed of by the court of general jurisdiction of the county in which the principal office of the State Council is then located, exclusively for such purposes in such manner, or to such organization or organizations that are organized and operated exclusively for such purposes, as said court shall determine.

Revised, 2019
Revised, 2015
Revised, 2013
Revised, 2010
Revised, 2006
Revised, 2004