



HEALTH CARE

Hong Kong College of Health Service Executives

Newsletter Issue 2 2016/17

MEDICAL

Council Members

President Dr. LIU Shao Haei
院長 劉少懷

Vice President Ms. CHIANG Sau Chu
副院長 蔣秀珠

Honorary Secretary Mr. YUEN Anders
義務秘書 源志敏

Honorary Treasurer Mr. LUI Leo
義務司庫 呂家豪

Immediate Past President Dr. MA Hok Cheung
上任院長 馬學章

Academic Convenor Dr. NG Fowie
學術召集人 伍時豐

Publication Convenor Dr. CHAN Chi Keung Steve
編務召集人 陳志強

Council Members Ms. CHAN Pearl
委員 陳麗貞

Ms. CHEUNG Liza
張銀弟

Dr. KO Flora
高淑蘭

Dr. KWAN Gladys
關慧敏

Mr. LEUNG Stephen
梁國強

Dr. SHAM Arthur
岑思勁

Ms. TANG Ivy
鄧鳳琪

Dr. YUEN Yin Fun Canissa
阮燕芬

Co-opt Members Ms. AU Joyce
增選委員 區慧蓮

Ms. CHAN Yuk Sim
陳玉嬋

Mr. CHEUNG Leo
張葉聲

Ms. FUNG Peggy
馮碧霞

Ms. LAM Cindy
林愛貞

Mr. LEE Benjamin
李祥美

Mr. LEE Herman
李向榮

Ms. MAN Manbo
文保蓮

Dr. POON Wai Kwong
潘偉剛

Ms. SO Tammy
蘇敏兒

Ms. TUNG Macky
董曼琪

Mr. WU Jimmy
胡仰基

Dr. YUEN Eddie
袁卓斌

Past and Upcoming Events

FEB

Leadership Forum - 「從公共衛生出發……」

Speaker : Dr. Wan Wai Yee
Date : 24 February 2017 (Friday)
Time : 18:30 - 20:30
Venue : Seminar Room 1
M/F, Hospital Authority Building
147 Argyle Street, Kowloon



HKCHSE Members' Night 2017

Date : 17 March 2017 (Friday)
Time : 18:30 - 22:30
Venue : Junior Ballroom I
Level 3
Royal Plaza Hotel

MAR



Leadership in Public Administration - Challenges and Lessons

Speaker : Mr Patrick Nip, JP
Date : 30 March 2017 (Thursday)
Time : 18:30 - 21:30
Venue : Thornton Room, 3/F South Tower
The Salisbury- YMCA of Hong Kong
41 Salisbury Road, Tsim Sha Tsui, Kowloon

JUL

HKCHSE Annual Conference

Theme : Invest in Health, Create Wealth
Date : 22 July 2017 (Saturday)
Time : 14:00 - 22:30
Venue : Cordis, Hong Kong
555 Shanghai Street, Mongkok



Joint ACHSM/ACHS Asia-Pacific
health leadership

#2017Congress

The winds of change -
adjust your sails



27 - 29 Sep 2017
Hilton Sydney

Joint 2017 ACHSM/ACHS Asia-Pacific Congress

Date : 27 - 29 September 2017
Time : 18:30 - 20:30
Venue : Hilton Sydney, Australia

SEP

Disclaimer

This is a publication of the Hong Kong College of Health Service Executives. The articles published are the expressed views of the authors and are not necessarily those of the HKCHSE.

Message from the President

Do something that matters



The College was incorporated on the 12 May, 2004 with a vision of our founding Fellows to improve the health care for people of Hong Kong. One of her key objective is to maintain a professional standard of our members in health service management as well as extending our competence to various areas through academic activities. For the past 12 years, our college has organized a number of educational programs and subsequently established joint Fellowship awarded with our counterpart at Australia, Australasian College of Health Service Management (ACHSM). The College membership now stands at around 200 with half of us qualified with dual fellows. As part of organizational development, the College Council for the Year 16/17 has undertaken to re-vitalize her mission. The strategic planning workshop in November 2016 was attended by the full council. The session was successfully conducted with facilitation by our Advisor, Prof Geoffrey Lieu to collect wisdom among us on who we are and what we stand for. The discussion was in-depth and the core values that were affirmed includes inclusiveness, proactive, social responsibility, drive for changes, collaboration, forward looking and succession. Much more needs to be worked out on consolidation for what shall the College be in 10 years ahead, where are thing going, and how shall we have an impact in the health care. The workshop identified five tracks to address some very important and critical issues.

Track 1: Refinement of the College's flagship program to provide development for young generation of aspiring and bright executives. We need a timely review of the fellowship program on how we could enhance members competence in various domains of heath and healthcare management. The structure, content and delivery mode could be further sublimated into excellence in leadership.

Track 2: Engagement of stakeholders. The College has developed network through resources of our members who come from all walks of life. It is obvious that the image and status of an organization is built through our active and proactive involvement of multi-disciplinary sectors in the healthcare environment. The college would strive to add value to connections, to establish collaborative programs, to maintain relationship.

Track 3: Sustainability. Being a nonprofit society for the profession, the financial base is our membership due and their support to College activities. The annual conference and dinner is a popular event among our members and guests. We need to explore more channel for fund raising, increase capacities of our functions, and identify potential contributors.

Track 4: Partnership and building coalition. Healthcare is a rapid developing arena where executive meet challenges of aging and burden of chronic diseases. The application of advances in science and technologies have change the horizon how managers solve problem. To be leading ahead and contributing to our society, the College shall step out of her comfort zone to embrace other groups who are on the direction towards mutually shared destination.

Track 5: Succession planning and further organization development. We shall not be complacent with our predecessor's achievements. We need innovative insights, charming personalities, enriched membership profile to open up a new pages for another decade of the College.



Dr LIU Shao Hai



Geriatric Screening at the Emergency Department Front Door

Background

Elderly patients are frequent attendants of emergency department. During winter in Hong Kong, there is a great challenge to the hospitals due to the increasing numbers of elderly attending Accident & Emergency Department (AED) for accessing urgent care and thus causing access block. Moreover, the increase demand in hospital care has caused the bed occupancy rate to rise to a peak of greater than 120% in medical wards during Winter months⁽¹⁾.

Prince of Wales Hospital is an acute teaching hospital serving 648,200 populations with 13% elderly population in New Territories East⁽⁵⁾, access block issue in the ED has been occurred over past few years, and become a problematic area in this hospital. Therefore, development of effective strategies for managing frail elderly with chronic diseases and complex need is imminent.

Evidence supported the effectiveness of geriatric consultation in the ED to facilitate safe admission prevention⁽²⁾ and reduction of readmission of frail elderly discharged from the ED^(2, 3). Therefore, the provision of geriatric specialist senior decision maker at the 'front door' may be one of the care models to reduce access block. This paper aimed to report and evaluate an initiation of a

"Geriatric Screening at the ED Front Door" project, which was implemented in a local acute teaching hospital during winter. The approach, strategies, difficulties encountered, result and lesson learnt from the project were also be discussed.

Aim

The aim of the project was to reduce medical admissions of elderly patients by introduction of an alternate care pathway at the ED front door.

Objectives

The objectives were:

1. To reduce the number of medical admission of the elderly patients after screened by the Geriatric Screening Team (GST).
2. To decrease their length of stay in the ED
3. To minimize the hospital service utilization after the elderly patients discharged from the ED

Target Group

Patients aged greater than 65 years old, who were pending for medical admission after seen by clinician in the ED and met the referring inclusive and exclusive criteria

Implementation Plan of the Project

The project consists of four phases:

Phase 1: Planning and strategy development

A task force set up with governance structure

A task force was set up with members involving Chief of Service, Consultant clinician and Nurse Manager of the ED; Chief of Service and Associate Consultant of Geriatric Team; Nurse Consultant, manager and Advance Practice Nurse (APN) of community team; and Nurse Manager of convalescent hospital. This set as a governance structure for monitoring the effectiveness of program and care provision.

Phase 2: Project development

Set up a geriatric screening team with manpower deployment

A geriatric screening team (GST) was set up comprising of a geriatrician and a Community APN. The geriatrician had acute and community responsibilities such as providing consultations for elderly patients at the ED front door, Emergency Medical Ward (EMW) the community team.

A community APN was assigned with a key role to work with the geriatrician involving performing early assessment of recruited elderly patients in the ED, initiating discharge planning and social services matching, assigning patients to community team and co-coordination of the patient flow from the ED to convalescent hospital and community.

Developing a new alternate care pathway

A new alternate care pathway was developed. Admission avoidance may be considered by diversion of the elderly patients either to:

- 1) Discharge back home/aged home with community team support next day or early medical follow up soon; and fast track clinic will be arranged subsequently if indicated; or
- 2) Transfer patient to a convalescent hospital for further care; or
- 3) Arrange in EMW for short stay observation.

Nasopharyngeal Swab (NPS) screening

NPS screening would be provided for recruited elderly patients with symptoms of influenza like illness in the ED starting at 9am before geriatric screening. The result should be available at 11am before patients transfer to convalescent hospital.

Phase 3: Project implementation

The pilot project was implemented from 5 January 2014 to 31 March 2015 during winter months.

The workflow of the project was as follows (Figure 1):

Phase 4: Project evaluation

The project effectiveness would be evaluated. A data base was designed to evaluate the service outcome including length of stay in the ED, hospital readmission. Preliminary result would be reported to the taskforce meeting.

Overcome Barriers

Several barriers were identified with correction actions made during the project implementation.

(i) Delay of Nasopharyngeal Swab (NPS) result

Delay laboratory result of NPS for one recruited patients were reported. Test result was not available even patients been transferred to convalescent hospital. Corrective measure was made that a supporting staff was then assigned to assist the nurse who performed NPS specimen collection procedures in the ED. There was no more delay result reported afterwards.

(ii) Resistance of the ED nursing staff

During the early implementation, the ED frontline expressed their workload were increased. The issue was solved after discussion with the ED in-charge. The ED frontline staffs were briefed with the new workflow every shift. The Community APN also offered help to mobilize respite care for difficult discharged patients. The geriatrician and community APN went to EMW daily for clinical round with supportive attitude until recruited patients be discharged. Eventually, the cooperation and teamwork were built among the ED staff and GST.

(iii) Potential patients and caregivers resistance

Task group identified a potential challenge that patients or caregivers might refuse the alternate care offered in the ED. A proactive approach was used by the GST to initiate a clear explanation of new pathway to patients and caregivers. Continuity of care was emphasized if alternate care was provided. Patient had the right to refuse the arrangement. Surprisingly, 97% patients and caregivers accepted the new pathway without much resistance.

Workflow of Geriatric Screening at ED Front Door during Winter Surge

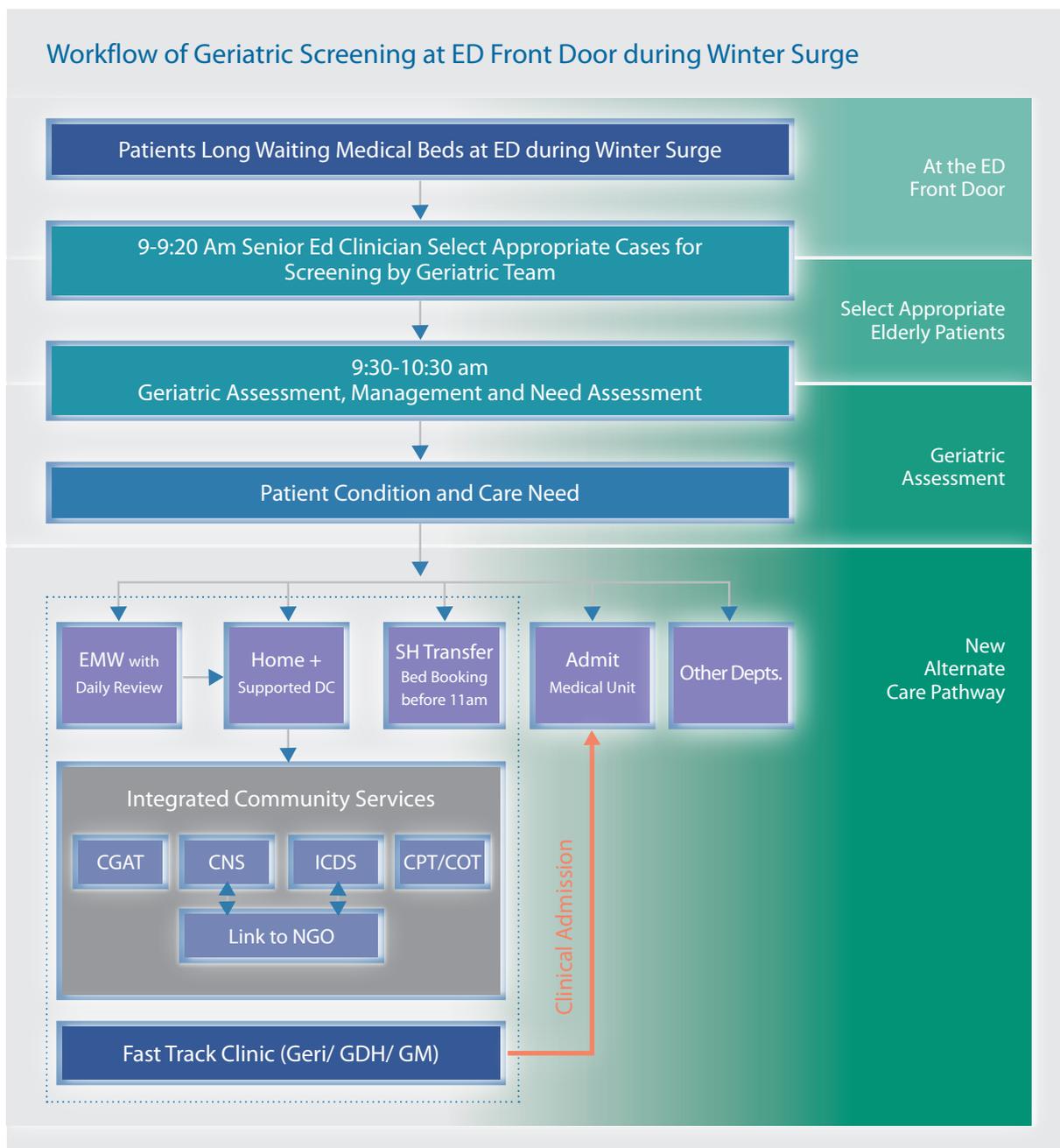


Figure 1: Workflow of geriatric screening at ED front door during winter surge

Result and Outcome

(i) General information of the recruited elderly patients (Table 6)

From 5 January 2015 to 31 March 2015, a total of 148 elderly patients were screened by the GST. 73.6% (N=109) were home-dwelling while 26.4% (N=39) were old aged home residents. The median age was 83.7 (range 58 to 105) with 52% male (n=77) and 48% female (n=71).

(ii) Common health problem of the recruited elderly patients

Chief complaints of the screened elderly patients were identified. The most common were heart failure (18.2%), dizziness/syncope/LOC (14.5%), COPD (10.9%), CVA (5.5%) and GI problem (5.5%). When grouping the complaints, chronic diseases occupied 43.5% while geriatric problems were 25.3% respectively.

(iii) Hospital service outcome

a. Medical admission prevention

During the three months in winter, GST were able to facilitate the discharge of 55.4% (82/148) of elderly patients after screening (Table 8). Among them, 36.6% were discharged home with the support by the community team or early clinic follow up, 31.7% of them were transferred to convalescent hospital for further care directly; and 31.7% of them were arranged in EMW for short stay then might be discharged with community team support or transfer to convalescent hospital afterward.

b. Length of stay in EMW

For elderly patients who was arranged in EMW for short stay, their average length of stay in EMW was only 2 days. 96.2 % (25/28) were discharged from EMW with community team support or early follow up; 3.8% (1/28) patient were transferred to convalescent hospital and 7.7% (2/28) were admitted in medical unit.

c. Post discharge support

For elderly patients who were discharged from the ED or EMW, a total of 81 home visits were provided by the community team; and a total of 12 early medical consultation (in fast track clinic or geriatric day hospital) were arranged during the post discharge supported period.

d. Unplanned hospital admission

Comparison of the statistics of the same season in preceding year (i.e. January to March of 2014), the screened elderly patients with direct discharge from the ED/EMW revealed higher hospital readmission rate within 7 days (7.3% in 2015 vs 5.1 % in 2014) but lower hospital readmission rate within 28 days in 2015(i.e. 10.9% in 2015 vs 14.6% in 2014).

(VI) Cost Effectiveness of the “Geriatric Screening at the ED Front Door” Project

A. Effectiveness:

It is observed that the new pathway was more effective than conventional pathway for medical admission prevention. There is no death reported from the recruited patients who were discharged from the ED.

a. Acute bed days saved

308 acute bed days in medical unit were saved in the new pathway as total number of 55 elderly patients had been successful be discharged from the ED after screened by GST. In conventional pathway, the 55 elderly patients would ultimately be admitted to medical unit.

b. Lower unplanned hospital readmission rate

The unplanned hospital readmission within 28 days in the new pathway was 10.9% which was lower than preceding year in conventional pathway (i.e. 10.9% in 2015 vs 14.6% in 2014)

c. Quality and safety

Quality of care was provided to the recruited elderly patients as they were diverted to either under the care of EMW, or community team support / early follow up; or the care in convalescent hospital. Geriatrician also provided daily review to patients in EMW and medical back up to community team. There was no adverse event reported in the new pathway.

B. Cost

The total cost of conventional pathway was HK\$1,243,500 if 55 elderly patients be admitted to the medical unit. The cost of patients being discharged in the new pathway with community team or early follow up in medical clinic was HK\$ 49,418. The cost is much higher in conventional pathway than the new pathway with patients be treated and cared in community.

When evaluating the aspect of cost effectiveness, the project was achieved in medical admissions prevention. The cost in new alternate care pathway is cheaper than the conventional on focusing hospital admissions. The potential cost saving for the 55 patients in this small pilot project was HK\$1,194,132.



Lesson Learnt

There were a lot of learning points from the project, these included:

Success Factor:

- The success of the project depended on the strong leadership with clear vision. The geriatrician provided screening at the ED front door, and medical back up for the community team. The community APN made a great contribution to the project. She was familiar with the community resources thus mobilized them to support the discharged elderly patients with special needs.
- Importance to explore barriers relevant to people. The ED nursing staff did not familiar of the workflow that might affected the outcome of the project. Repeated explanation and onsite support to the staff should be given to ensure everything was running smooth in the project.
- Importance to explore barriers relevant to process and timely corrective measures should be made. Early NPS screening could facilitate early transfer of patients to convalescent hospital; arranging supporting staff to assist nurse performing the procedure could save time and ensure timely arrival of NPS to laboratory. This showed the process flow need fast and efficiency co-ordination with involvement of different partner's cooperation and collaboration.



Limitations

The pilot project could only benefit for a limited number of patients due to the limitation resources as geriatric screening service be only available from 9am to 11 am during weekdays. If more patients could be benefited and access block in ED could be relieved, additional resource have to be invested for expansion of the service.

Besides, the NPS screening in the ED was workable during the small scale project in winter. However, it may prolong the elderly patients waiting in the ED for the result if full-scale project would be implemented. The logistic in NPS screening have to be improved and capacity of laboratory support for the NPS test needed to be deliberated if project would be expanded.

Conclusion

In sum, the “Geriatric screening at the ED front door project” created a new pathway for admission avoidance in the ED with effective outcome. Half of the screened elderly patients could be managed in alternate care setting during winter surge period. The project has been able to provide the right care to the patients at the right place in a timely manner without jeopardizing their clinical outcomes. Although there is no additional resources added for the pilot, it established a better liaison between acute, extended care and community services as a team working together to achieve a common goal of the admission avoidance in the ED. Health resource is scare, the project utilities the existing health resource efficiently to maximize benefits from activities.

CHIM Chun-king 

References:

- 1 Research Office Secretariat, Information Note: *Population profile of Hong Kong*. 1N07/1415, Hong Kong. Available from: <http://www.legco.gov.hk/research-publications/english/1415in07-population-profile-of-hong-kong-20150416-e.pdf>
- 2 Jones S and Wallis P. 2013. Effectiveness of a geriatrician in the emergency department in facilitating safe admission prevention of older patients. *Clinical Medicine*, 13(6): 561–564.
- 3 Conroy SP, Ansari K, Williams M, Laithwaite E, Teasdale B, Dawson J, et al. A controlled evaluation of comprehensive geriatric assessment in the emergency department: the Emergency Frailty Unit. *Age Aging*. 2013 Jul 23. Epub ahead of print.



Powder free now!! But Amber or Blue??

The US Food and Drug Administration (FDA) recently published a final rule banning the use of powdered gloves.* As stated in the citation summary, "The Food and Drug Administration (FDA or Agency) has determined that Powdered Surgeon's Gloves, Powdered Patient Examination Gloves, and Absorbable Powder for Lubricating a Surgeon's Glove present an unreasonable and substantial risk of illness or injury and that the risk cannot be corrected or eliminated by labeling or a change in labeling. Consequently, FDA is banning these devices. This rule is effective on January 18, 2017." Further clarification in the final rule indicates that "the ban applies to all powdered surgeon's gloves and powdered patient examination gloves without reference to the type of material from which they are made. Additionally, the identification of non-powdered surgeon's gloves and non-powdered patient examination gloves is also being revised to remove reference to material."

Latex and nitrile are polymeric dispersions that have a wide range of applications. The term 'latex' is used to define a broad range of latices, which includes both natural and synthetic latices whereas the term 'nitrile' is used for acrylonitrile butadiene rubber, NBR. This is the key difference between nitrile and latex. Usually, both forms exist as a liquid in nature and can be processed to obtain polymeric solid materials.

Nitrile gloves are a type of disposable glove made of synthetic rubber, NBR which made up of copolymers of acrylonitrile and butadiene. Nitrile is produced by a process called emulsion polymerization. The production is either a batch or continuous process. This form of nitrile is actually a

terpolymer of acrylonitrile, butadiene, and methacrylic acid and often referred to as carboxylated NBR lattices. Nitrile has a high butadiene content which represents 55-70%, while the acrylonitrile and methacrylic contents are 25-50% and 3-6% respectively.

Nitrile rubber shows excellent resistant to solvents, oils, greases, and fuels. Moreover, it possesses good abrasion resistant, a high degree of toughness and bonds to various types of substrates. Nitrile rubber is mainly used as a main raw material for disposable latex gloves and a textile and non-woven reinforcement. It is also used to produce synthetic leather, adhesives (by blending with phenolic and epoxy resin emulsions), coatings, sealants, and as an additive for coal tar and asphalt. Because of its wide application range, nitrile rubber has become one of the main competitors of natural rubber latex.

Latex is a colloidal dispersion, which mainly contains polymeric particles with a few hundred nanometers in diameter and water. Water is the dispersion medium of polymeric substances. Colloid fraction usually comprises about 50% by weight of the dispersion. There are two types of latex, namely; natural and synthetic latex. The most common natural latex is the natural rubber latex, which is collected from a tree called *Hevea brasiliensis*. Most of the main ingredients of synthetic latices are obtained as byproducts of petroleum products. Some examples for synthetic latices include nitrile latex, polychloroprene latex, styrene-butadiene rubber latex, acrylic latex, butyl latex, chlorosulfonated polyethylene latex, etc.

Owing to unique properties of these latices, they are used for many applications. Typical applications for latex include paints and coatings, adhesives, sealants, asphalt modifications, packaging items (manufacture of bags, envelopes, tubes, etc.), textile and nonwovens, furniture (manufacture of foam pillows, foam mattresses, etc.), consumer products, paper and miscellaneous applications (gloves, vehicle inks, etc.).

Most important of all the differences, Nitrile has significant advantages over common latex rubber when used for gloves; it is non-allergenic and contains no latex proteins, often causing irritation and rashes on the skin. They are often considered to be one of the strongest types of disposable glove and are generally safe for people who are allergic to latex. It does avoid the worry that comes from discovering patient is allergic to latex by choosing a pair of latex-free exam gloves.

Unlike other disposable gloves, nitrile gloves have low resistance to friction and are very easy to slide on. As with some other types of disposable gloves. Nitrile gloves come in a variety of sizes and can be made in a variety of textures, cuff lengths and thickness. It offers excellent resistance to wear and tears. Nitrile is about three times more resistant to punctures, and much more resistant to a wider range of chemicals than latex rubber. This additional strength makes Nitrile gloves last longer when being removed and put on repeatedly, or washed and reused.

These gloves are popular for their high degree of flexibility and superior solvent resistance. They are resistant to many oils and some acids, making nitrile gloves a good choice for many manufacturing environments. Nitrile gloves should not be stored under excessive light or heat, however, as that can make the rubber disintegrate more rapidly.

Nitrile does not have the "memory" of latex. That is, after wearing for about 30 minutes the material adopts the shape of your hand. This is why Nitrile Gloves are much more comfortable to wear. Latex gloves on the other hand continue to want to return to their original shape. Powder free gloves go through an extra process of chlorinating the gloves to ease donning.

Nitrile gloves are the perfect compromise between latex and vinyl if considering for changes; however, powdered free is a must first now!!

POON Wai-kwong 



* US Food and Drug Administration (FDA). *Banned Devices; Powdered Surgeon's Gloves, Powdered Patient Examination Gloves, and Absorbable Powder for Lubricating a Surgeon's Glove*. Accessed Feb 9, 2017. <https://www.federalregister.gov/documents/2016/12/19/2016-30382/banned-devices-powdered-surgeons-gloves-powdered-patient-examination-gloves-and-absorbable-powder>

Leadership Forum 「從公共衛生出發.....」

Speaker : Dr WAN Wai Yee
Director,
Public Health Consultancy Network, Hong Kong
Chairman,
Community Health Organization for Intervention
Care and Empowerment

Date : 24 February 2017 (Friday)

Dr WAN shared her working experience in the WHO and the Community Health Organization for Intervention, Care and Empowerment (C.H.O.I.C.E). The latter is a charitable non-governmental, volunteer based organization to help vulnerable communities to reduce at-risk sexual behavior and its harm on individuals. Dr WAN led us to link her expertise in public health and HIV/AIDS control with the community by opening the 'window and door', and finally building the 'bridge' between the healthcare experts and volunteers, and those disadvantaged and neglected groups in our society. Very touching and inspiring!

Leo CHEUNG 



Benefits and Roles for being a College Member



Benefits

WHAT are the BENEFITS of being a College Member?

- Name of members will be updated in the membership register and published in the webpage of the College. The membership list will be updated in the College webpage twice a year.
- Access to all seminars, workshops and activities of the College
- Attend the Annual Congress of Australasian College of Health Service Management (ACHSM) at discounted fee
- Receive latest news and updates of the College and its affiliates by email and/or postage



Roles

WHY is it important to renew your membership ?

By renewing on time, you will ensure that there is no lapse of your membership/ status. Failure to complete the renewal procedures will result in removal of your name from the membership register, if applicable. For members who have not renewed their membership, no fellowship postnominal, for FCHSM and/or FHKCHSE, should be claimed until the membership is renewed

WHEN will the annual renewal process begin?

Renewal notice will be sent by email and by post in month of January. Members should contact the College Secretariat if no renewal notice is received by the month of February.

In general, members are requested to pay the specified annual fee(s) and submit the Annual Return on or before 31 March to complete the annual renewal process. New members admitted after the month of November are required to pay the next year member annual fee for annual renewal purpose.

HOW does a member know if his/her membership has been renewed?

Email confirmation will be sent after members have completed all renewal procedures. Membership fee payment receipt will also be sent to respective members in due course.

The updated member list will be published in the College Webpage on a regular basis.

WHAT does a member do if his/her name is removed from the membership register?

For members who have failed to renew their HKCHSE membership on time, they have to reactive the membership by paying the annual subscription fees since his last membership. For those members have not renewed the HKCHSE membership for over 3 years, its membership status will be removed from the College Membership Register permanently.

Application Form



Hong Kong College of Health Service Executives 香港醫務行政學院 Year 2017-2018 New Membership Application / Renewal Form

Title : Prof / Dr / Mr / Ms / Mrs

Name:

(Surname)

(Other name)

❖ please ✓ in the appropriate box

Please RENEW my membership (please fill up area of any changes that apply ONLY)

Please consider my NEW membership application (please fill up all the below items)

HKID No.: - X X X (X) Sex: M / F

Professional Qualification : _____

Qualification in Health Care Management : _____

Work Position Held : _____

Place of Work : _____

(Department / Division)

(Organization / Institution)

Nature of Organization : HA Government Department Private Hospital

Academic Institute Other Public Organization

Commercial Organization

Correspondence Address : _____

Contact No. : (Off) _____ (Mobile) _____

Email : _____

Membership Type	Annual Membership Fee			
	HK Membership (HKCHSE)		Dual Membership (HKCHSE and ACHSM)	
Fellow *	HK\$500	<input type="checkbox"/>	HK\$2,200	<input type="checkbox"/>
Associate Fellow **	HK\$300	<input type="checkbox"/>	HK\$2,000	<input type="checkbox"/>
Associate	HK\$200	<input type="checkbox"/>	N/A	<input type="checkbox"/>

* Fellow membership only applied to those who have been conferred Fellowship by HKCHSE.

** Qualification for Associate Fellowship: holding a degree in management or a full time managerial position.

Please send this application with cheque payable to "Hong Kong College of Health Service Executives Ltd." to P.O. Box No. 70875, Kowloon Central Post Office, Hong Kong