

ASHT TIMES

A NEWSLETTER OF THE AMERICAN SOCIETY OF HAND THERAPISTS

PRESIDENT'S MESSAGE

Your Life Vest is Under Your Seat....

The Strategic Plan Journey

By Christine Muhleman, OTR/L, CHT



Christine Muhleman, OTR/L, CHT

On a recent trip flying from my home in Tucson to Charlotte, NC I was struck by the irony of seeing an embroidered sign on the seat cover on the back of the chair in front of me indicating that I was sitting on a life vest. I would consider myself a seasoned traveler and I marveled that I hadn't really paid too much attention to this previously. Mostly I thought of the extremely slim chance of a crash, this trip, into a body of water (maybe the Mississippi River? I think we were flying over St. Louis at the time). It was however nice knowing that the airlines had planned. But a parallel to our own everyday opportunities to use "life vests" also struck me and how they are often just sat on and overlooked.

For the journey with the ASHT Board, our 'life vest' is our Strategic Plan. Fortunately there is nothing mysterious about our strategic plan and when simply stated helps ASHT determine where it is going over the next year or two. Furthermore it helps to decide **how** the Society is going to get there and most importantly to assess if it did indeed arrive at its intended destination.

ASHT actually began strategic planning efforts several years ago and it continues to be an ongoing and

continuously evolving process. How often do we feel that we are "fighting fires" or "juggling bowling balls" in our everyday practices, offices and work settings where we are *reacting* to problems vs. being able to stand back and take a hard look at what we want to accomplish and how we plan to accomplish things. Experience has shown that it is a



much more effective use of time and energy to see the broad perspective and to take a long view at what we would like to see happen in our operations.

Our Board has recognized the benefits of the actual process involved in strategic planning. At our January Board meeting we spent time reassessing the current environment and the needs of hand therapists. We also looked forward at our goals and expectations of where ASHT and the field of hand therapy

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ASHT on the Move!

National Conference of State Legislatures

August 15 - 18, 2006
Nashville, TN

American Society for Surgery of the Hand

September 7 - 9, 2006
Washington, DC

National Ergonomics Conference and Expo

November 28 - December 1, 2006
Las Vegas, NV

Look for a special addendum to the membership directory on page 10.

To view registration information and the most up-to-date program schedule for the American Society of Hand Therapists 29th Annual Meeting, September 14 - 17, 2006 in Atlanta, GA, please visit www.asht.org/.



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EDUCATION

Splinting Challenges

By: MaryLynn Jacobs MS OTR/L CHT*

Every hand therapist comes across splinting challenges. We learn to be quick in integrating injury information and applying that information to what the physician is recommending for splinting. The design of the splint is most often left to our creativity. We must take into consideration a host of factors such as; the extent of injury, patient age, family support, cognitive level of the patient, the materials we have available to work with, and availability of the patient to attend sessions for adjustments. I'd like to share with you a few of my most recent splinting challenges and my rationale for design.

Patient 1: A 22 year old female collegiate volleyball player

DX: Distal radial sensory and median nerve release, thumb MP radial collateral ligament reconstruction

Splint request: Protective 'playing' splint

Rationale: Following extensive rehabilitation, both the patient and physician were concerned about returning to play without some type of protection to the radial distal forearm in order to minimize direct impact to the radial sensory nerve (RSN). This splint was light weight which gave it flexibility, yet the circumferential (figure 1) design gave it stability. The silicone

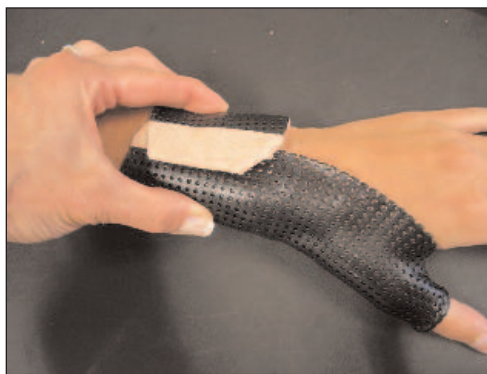


Figure 1: Circumferential distal forearm/thumb immobilization splint made from 1/16th perforated material with integrated silicone and padding.

gel 'lifted' the splint slightly away from the RSN and aided in absorbing shock and vibration to this area. (figure 2) Kinesio® Tex Tape was applied to the overlapping edges to keep the splint from pinching skin. (figure 3)

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Figure 2: Silicone gel 'donut' over radial sensory nerve decompression site and padding over ulna styloid prior to splinting.

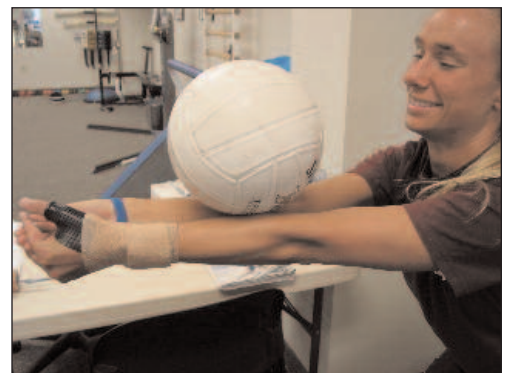


Figure 3: Volleyball hitting the forearm. Splint held in place with elasticized wrap.

Splinting

continued from page 2

Patient 2: 56 year old construction worker

DX: Complex distal radius fracture with volar plating, external fixation, and open reduction internal fixation

Splint request: Wrist extension splint

Rationale: This patient was 8 weeks status post removal of the external fixator. His wrist and digits were very extremely stiff and improvement over these weeks was minimal. A wrist mobilization splint using 'dynamic force' was applied. (figure 4a & 4b) This type of mobilization splint was first

applied to soften end range extension. At the same time we could not ignore the extreme digital stiffness that most likely was a result of combined intrinsic and extrinsic tightness. In order to prevent further digital stiffness (by allowing the digits to rest over the volar distal border of the splint) a simple soft strap flexion system was applied. (figure 5) The patient can now wear the wrist extension mobilization splint and at the same time gently add a composite flexion stretch to the digits.

Once the wrist end range of motion softened (approximately 2 weeks) a static progressive force was substituted for the elastic force. (figure 6)

Outcome after splint use: This gentleman has been wearing the mobilization splint for 6 weeks (2 weeks dynamic force, 4 weeks static progressive force) and has achieved a total wrist AROM of 90 degrees with near normal composite flexion. He continues to wear his splint 3 times a day with a goal set by his MD of 100 degrees of total wrist motion.

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Figure 4a & 4b: Dynamic wrist extension with simultaneous composite flexion of digits. Phoenix wrist hinge was used in combination with an elastic force.



Figure 5: A strap was applied to prevent distal migration of the splint.

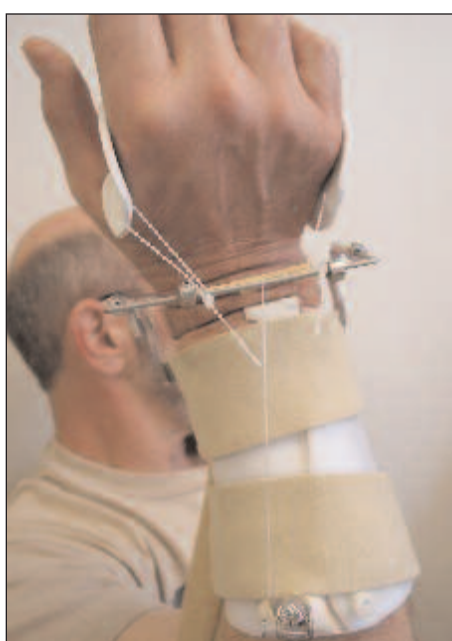


Figure 6: Addition of a MERiT™ Static Progressive Component. Conversion of an dynamic force (elastic) to a static progressive force.

Splinting

continued from page 3

Patient 3: 26 year old salesman

DX: History of crush injury to left hand with traumatic amputation of the thumb. Thumb replantation was unsuccessful. He has had multiple surgeries and reconstructive procedures to increase function and decrease pain. This case is his most recent surgery which was to release contractures of his middle and ring fingers and realign flexor tendons.

Rationale: These are only a few of the numerous splints and adjustments we made to this patients splinting regime. As his



Preoperative hand, maximum extension of digits. Note: Index finger MP Joint has been fused and the SF MP joint is fixed in extension.



Preoperative hand, maximum flexion of digits. Ring finger is subluxed and radially deviated 40 degrees.



Postoperative hand, volar view. Wound left to heal by secondary intent. Radial proximal incision was due to the removal of exostosis base of thumb.



Postoperative hand, dorsal view. Pin is stabilizing 3rd MP joint. This joint was unstable and will warrant further intervention in the future. The pin allows the flexor tendons to glide without applying further stress to the fragile MP joint.

tissues healed and matured, so did the need for us to continue to be creative in designing his splints. One of our greatest achievements for him was to create this very simple flexion glove that allowed him to use his kayaking paddle and enjoy the ocean where he grew up.

Outcome after splint use: After kayaking season he will undergo implant arthroplasties of his MF and RF, along with pulley reconstruction of the RF. ■

* *MaryLynn Jacobs MS OTR/L CHT, is affiliated with Performance Rehabilitation with offices in East Longmeadow Mass. and in Springfield, Mass.*



Wrist/hand immobilization splint (perforated TailorSpint 3/32nds material). Material choice was to allow good aeration and adequate coverage secondary for the need to apply gentle stress to the volar tissues while healing (the longer the proximal base of the splint the more stable and comfortable the splint is on the extremity)



Longitudinal view of the immobilization splint. The straps are applied to provide proper alignment and gentle extension forces.



A MF PIP and RF MP extension mobilization splint using elastic force was used after wound closure and pin removal (at approximately 4 weeks). This allowed the patient to exercise the involved tendons in flexion while maintaining alignment. The SF MP joint was left free to encourage MP flexion.



Volar wrist/hand immobilization splint. This splint was designed for night use once the volar wound was healed. Note the small finger MP was again left free to encourage flexion. A PIP extension cast (QuickCast) lined with paraffin was used to attempt to reduce a long standing PIP flexion contracture.



At approximately 6.5 weeks, a MP immobilization splint for day use was fabricated to support the MP joints of MF/RF in extension while allowing unimpeded wrist and digital flexion.



The physician and therapist suspected RF MP joint collapse or A1 pulley damage because of the RF bowstringing during unsupported digital flexion. An additional small thermoplastic insert was added to the RF MP joint area to further support the MP joint into extension and apply pressure over the A1 pulley region. This made a significant difference when attempting flexion.



Digital flexion with pulley pressure.



Flexion glove modified for one of his life passions, kayaking.

EDUCATION

Casting Motion to Mobilize Stiffness: Is It a New Treatment Approach?

By Judy C. Colditz, OTR/L, CHT, FAOTA

What is the Casting Motion to Mobilize Stiffness (CMMS) technique?

Many therapists think the CMMS technique is drastically different from typical patient treatment. In reality, it uses basic principles of positioning and blocking joints to illicit active movement at selected joints, isolating muscle activity. If muscle activity is isolated the power is directed to mobilize stiff joints rather than wasted on moving loose joints. Thus active motion can mobilize even a rock-hard joint. With acute hand patients the intermittent use of a splint can accomplish this goal, but with more protracted stiffness a cast establishes the prolonged input required to affect change.

How can immobilizing a stiff hand make it more mobile?

One example is interosseous muscle tightness which is a common reason for limited finger flexion. By blocking the metacarpophalangeal (MP) joints in extension and allowing only interphalangeal (IP) joint flexion the muscle energy is directed to mobilize the primary limiting factor. See Figure 1. Each patient is examined to determine the specific primary reason for the limitation of motion and this determines the casted position. Unlike conventional therapy where we often address several areas at once, CMMS focuses on reaching one goal at a time, in a sequential manner.

Why does CMMS work in the chronically stiff hand?

As hand therapists we are well schooled in applying graded stress as part of early motion protocols. These and other intermittent treatments we apply during the inflammatory and fibroplastic stages allow us to regain glide of repaired structures while maintaining protection. When stiffness continues and a hard end-feel develops, intermittent techniques are no longer effective. This is because the chronically stiff hand has developed three coexisting problems: 1) tissue adherence/stiffness, 2) chronic edema, and 3) abnormal motor patterning.

Traditional treatment methods address one

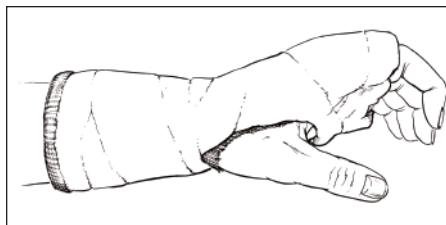


Figure 1. When the primary limitation of finger flexion is caused by tight interosseous muscles, this cast prevents the dominate MP flexion from occurring and demands that extrinsic flexor power mobilize the interphalangeal joints. This mobilizes both the stiff IP joints and elongates the interosseous muscles.

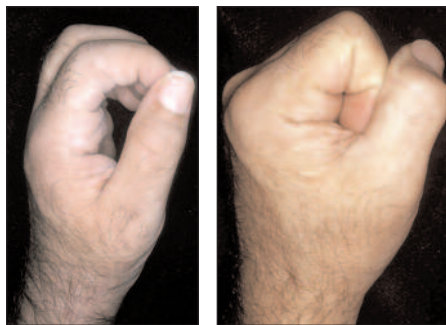


Figure 2. Active finger flexion before and after the use of CMMS. This patient started CMMS three months after a distal radius and scaphoid fracture which required open reduction and internal fixation.

of these problems at a time but often the treatment that positively affects one problem negatively influences another. An example is splinting to increase joint motion; the splint constricts which increases edema and since the patient does not move in the splint there is no influence on active motor pattern.

With the CMMS technique the snugly fitted cast provides warmth and gentle sustained pressure while active motion is

initiated across stiff joints, thus reducing chronic edema. Since in the cast the patient can only move the desired joints within the desired range, cyclical movement transforms the stiff joints into mobile joints.

Movement of the previously stiff joints is imprinted on the motor cortex and the patient relearns how to incorporate this joint motion into normal finger movement. See Figure 2. I know of no other treatment approach that can change these three key problems simultaneously.

Why are more therapists not using CMMS?

In the last ten years, I have taught this technique to almost 600 therapists here in the US and about 300 therapists in six foreign countries. I think there are perceived barriers for therapists to integrate these treatment principles in their practice.

- 1) This technique requires a dramatic change of clinical thinking.
- 2) Cast application/removal skills are a new skill for most U.S. therapists.
- 3) There is fear of immobilizing joints in a cast, especially the MP joints which we have been taught should never be immobilized in extension.
- 4) We have previously never thought that a chronically stiff hand should be approached with different treatment techniques. The dramatic positive response to this technique in stiff hands that have not been responsive to traditional treatment methods has been my motivator to continue teaching this technique. It is my hope to plant the seed of this technique with a number of therapists and in the coming years find it a widespread part of usual and customary clinical practice. ■

NOTE: Therapists seeking additional information about the CMMS technique can download PDF files of articles and chapters written by Ms. Colditz at www.HandLab.com (under Publications).

Upcoming Redesign for www.asht.org!

Be on the lookout for the debut of our new Web site! We've been hard at work improving the functionality, look and feel of www.asht.org. Please pardon our electronic construction as we continue to make improvements. ■

ANNUAL MEETING

ASHT's 29th Annual Meeting: Advancing the Art and Science of Hand Therapy

Register today! Visit www.asht.org/06AnnualMeeting/annual_mtg.html for complete details. The August 23rd Registration Deadline is fast approaching.

ASHT demonstrates *Advancing the Art & Science of Hand Therapy* through a unique educational line-up that provides attendees an opportunity to earn up to **31 Continuing Education hours or 3.10 CEUs**. Discover the art and science of hand therapy by participating in one of five Pre-Conference Institutes, listening to expert lecturers, learning the latest applications in Instructional Courses, Paper and Poster Presentations, hearing first-hand knowledge in Educational Vendor Showcases and experiencing 60 Pearls in 60 Minutes. This new addition to the ASHT Annual Meeting allows you to learn a variety of tips and tricks in 60-minute sessions.

ASHT's 29th Annual Meeting offers additional benefits of attending an in-person meeting. You'll have numerous opportunities to meet face-to-face with your peers during networking breaks and at the Opening Reception hosted by HTCC. You'll also have plenty of time to visit more than 70

vendors in a packed Exhibit Hall featuring the latest hand therapy products and services. These are invaluable benefits you can't experience through online seminars.

View detailed program information, download the Advance Program, and register online at www.asht.org/06AnnualMeeting/annual_mtg.html.

Optional Pre-Conference Institutes

These workshops are designed to expand your knowledge base in the areas most conducive to your practice.

Pre-Conference Institute 1: The Art and Science of Splinting

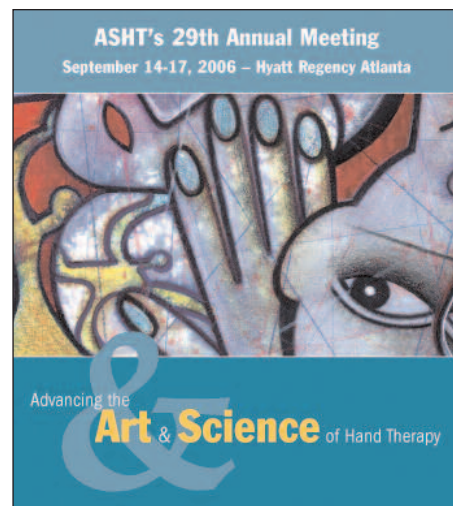
Pre-Conference Institute 2: Therapeutic Ultrasound in the Upper Extremity (Lab)

Pre-Conference Institute 3: The Science of Function: Evaluation and Treatment of Hand Pitfalls

Pre-Conference Institute 4: AOTA

Reimbursement/Payment: Coding and Documentation for Maximum Reimbursement Update on L-codes for Upper Extremity Orthotics

Pre-Conference Institute 5: TWU Program: Qualitative Research Exchange: Integrating Quantitative and Qualitative Approaches



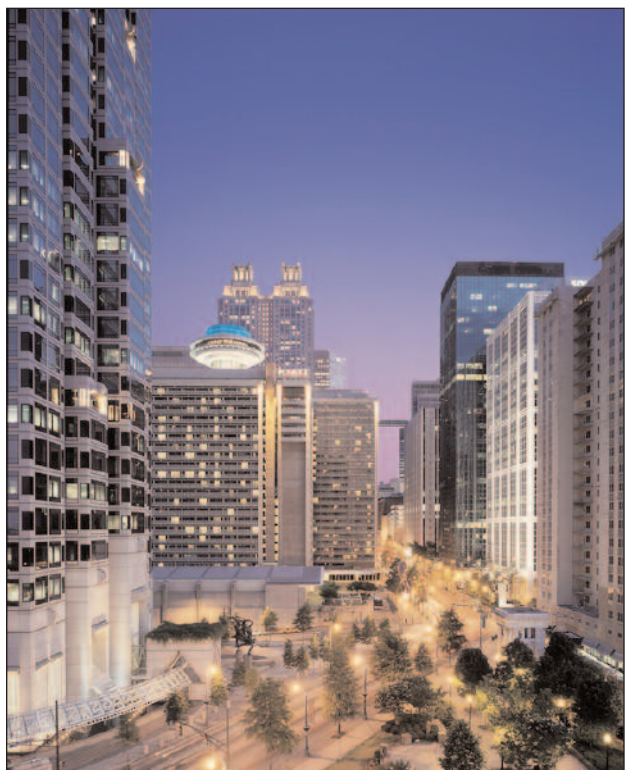
Networking Highlights

Opening Reception — Friday, September 15:

Share your meeting experiences at the annual Opening Reception, hosted by the Hand Therapy Certification Commission (HTCC). All attendees are invited to enjoy beverages, hors d'oeuvres, an evening of entertainment and plenty of networking opportunities.

ASHT Research Breakfast — Sunday, September 17:

Attendees may purchase a ticket for \$30. Interested attendees will network and learn from facilitators and each other about conducting research and getting research articles published. The breakfast will allow you to share tips and tools of the trade. ■



HOUSING

Be sure to book your hotel room at the Hyatt Regency Atlanta to receive the conference rate of \$149 single/double per night (excluding taxes). You may reserve your hotel room online at <http://atlantaregency.hyatt.com/groupbooking/atlrasht>.

ASHT Chapter Contacts



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NORA

The National Occupational Research Agenda (NORA)

What is NORA?

The National Occupational Research Agenda (NORA) is a collaborative program under NIOSH (National Institute of Occupational Safety and Health) to stimulate and fund innovative research in workplace safety and health. NORA's vision is to cultivate partnerships among a wide variety of people who are interested in injury prevention.

Each area of the country has been assigned to a sector that will be represented by a Research Council composed of 16 local individuals and one NORA administrator. Their first task will be to review input on the major issues in occupational safety and health that affect their region. This input is derived from local town hall meetings that were held throughout 2006 and from the online feedback form. Their second task will be to determine the highest priorities that would benefit from robust research strategies.

Who can apply for research funds?

NORA seeks to develop partnerships among a wide array of diverse people and groups (business, health professionals, academics, policy makers, federal and state programs) who are interested in injury prevention specific to their sector. Grants will be offered to collaborative studies that address populations at-risk for high frequency or high severity work related illness or injury such as:

- Epidemiology studies
- Evaluation techniques
- Intervention strategies
- "R2P" Research to Practice: how to disseminate research results to practitioners
- Education/Outreach studies
- Outcomes that measure intervention impact

NORA

What can you do?

- Go to the NORA web site at www.cdc.gov/niosh/nora and view comments from your sector
- Post your comments about areas where new research will make the greatest contribution to work-related injury and illness
- Volunteer to serve on a regional Research Council
- Volunteer to participate in the research project chosen for your sector
- Partner with others to develop a grant proposal ■

Mark Your Calendars for These Upcoming Events!

SEPTEMBER

September 14 - 17, 2006

ASHT's 29th Annual Meeting: Advancing the Art & Science of Hand Therapy
Atlanta, GA

OCTOBER

October 13 - 14, 2006

Allegheny General Hospital Eighth Annual Disorders of the Hand and Upper Extremity
Pittsburgh, PA

NEW MEMBERS

Welcome New Members

ASHT welcomes these new members who joined between April 9th and June 13th, 2006.

Kamna Agarwal	Cheryl Harrison, OTR	Anita Putman, OTR/L
Sarah Anderson, OTR/L	Christine Hobbs, OTR/L	Jennifer Reitz, OTR/L
Jennifer Ball, CHT	Carol Hohowski, OTR/L	Matthew Ricketson, BS/MS,
Karen Barrett, OTR, CHT	CHT	OTR/L
Tammy Bohuslaw	Amy Howard, OTR	Marlene Riley, OTR/L,
Paul Brach, MS, PT, CHT	Kerry Jenkins, OTR/L	CHT
Julie Bright, OTR/L	Laura Jones, OTR/L, CHT	Catherine Ringer, MHS,
Lori Buckley, OTR	Mary Kennedy, OTR/L	OTR/L, CHT
Shelly Chamberlin, OTR/L	Kimberly Lovelace, OTR/L,	David Riniker, MS, OTR
George Chen, PT, CHT, LAC	CHT	Mary Roche, PT, CHT
Annette Chop, RN OTR/L,	Krista Marquardt, MPT, CHT	Matthew Rose, OTR/L,
MOT	Lori McGonagle, OTR/L,	CHT
Renee Cohen, OTR/L,	CHT	Erin Rubano, MS OTR/L,
CHT	Gregory Molatch, MA,	CHT
Anita Dantzig, PT(BS), CHT	OTR/L, CHT	Sara Sipple, OTR/L, CHT
Christopher Dunbar, MS,	Rosanna Musto, MOTR/L,	Ruthie Spencer, OTR/L,
OTR/L	CHT	CHT
Barbara Engel, OTR	Julie Oyanguren, OTR/L,	Bharat Vallurupalli, MS,
Shelley Estrels	CHT	OTR/L
Kimberly Fritz, MS OTR/L,	Andrea Paz, MOT, OTR/L	Najwa Wallschlaeger,
ATC	Mary Picard, OTR/L	MS/OTR/L
Mark Hardisky, MPT	Audra Ponci, MPT, OCS	Kim Walters, OTR

Allegheny General Hospital, Pittsburgh, PA, Presents: Eighth Annual Disorders of the Hand and Upper Extremity

Friday and Saturday,
October 13-14, 2006

Friday's conference is a CHT Review Course and is intended for physical and occupational therapists who are preparing for their certification boards.

Saturday's conference focuses on the most recent developments in sports-related injuries to the hand and upper extremity and is intended for therapists, orthopedic surgeons, emergency room physicians, athletic trainers and other health care professionals.

For more information, please e-mail Cheri Jackel at CJACKEL@wpahs.org.



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Strategic Plan

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might be going over the next several years. This afforded us the opportunity to look at the big picture now and where we want to be in the future. We started with a focus on our mission statement and then established the Divisions' objectives to help work to meet the mission goals. We also set forth actions plans of the "who, what and when" of the Plan. It forced us to take a look at our environment with a much wider view. We have quickly learned that there is no perfect plan and thus a continuous evolution. There is an ongoing analysis of our strengths, weaknesses while we look at both threats or perceived threats and opportunities. The outcome of the Strategic Planning process also helps:

- as a method to clearly communicate the Society's goals and objectives to our members.
- to develop an ownership of the plan by those involved.
- to focus ASHT's resources on key priorities
- provide a platform from which we can measure our success and establish a mechanism to recognize when change is needed.

- build consensus about our direction as an organization to help produce more efficiency and effectiveness.
- communicate clear direction and expectations **from** the Board to our headquarters staff to help direct the Society's goals and priorities. Our headquarters staff works diligently to help us meet the directives set forth by the Board through the strategic plan.

Our 2006 Strategic Initiatives are:

1. to move to a more proactive organization with a focus on our governance structure to make this happen.
2. redefine our Mission and Vision in the future by investigating using the term "upper quarter."
3. redefine the purpose of each Division (Professional Relations, Advocacy, Education, Research, Membership, and the Board of Directors).

As a result of our Strategic Initiatives our goals are to:

1. increase membership and maintain our retention rate.

2. provide cutting edge educational products to our membership and hand therapy professionals.
3. promote the profession of hand therapy.
4. advocate on behalf of hand therapists.
5. improve our overall governance structure and financial stability.
6. promote research and use of critical inquiry that leads to evidence-based practice.

I am very pleased to report that ASHT has made great headway with our 2006 strategic initiatives but I also know that our work is far from done. We continue to rely on our membership to help devote time, energy, expertise, talents and hard work to help us meet our goals and objectives. If you would like to become more involved with ASHT please contact info@asht.org and let us know of your interest. Stay tuned for more updates as we make progress with our strategic initiatives. Thank you to all of you that give of yourself to join us on this journey and make ASHT the leader in Hand Therapy organizations that it is. ■

Save \$25 on Cadaver III CD-ROM

This special offer is for members only!

Don't miss your chance to save on the third CD-ROM in the ASHT Surgical Demonstration Series!

The Plexopathy Patient: Brachial Plexus Dissection, Evaluation, And Treatment Strategy

Features **unique treatment approaches** that can be used by CHTs, general OT/PTs, nurses, and Physician assistants

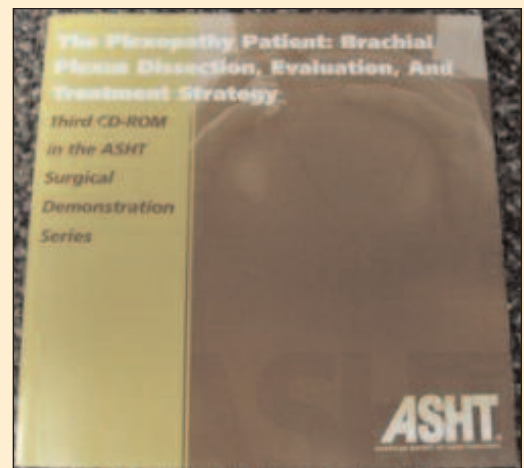
Includes an **in-depth review** of nerves and nerve function as well as a review of detailed and specific anatomy

Provides functional situations to teach you how to educate your patient about the various activities of daily living

Great review for the advanced therapist but is a **"must see"** for the new therapist.

Order Cadaver CD-ROM III for only \$100! Hurry, this chance to save ends August 31, 2006.

To order, visit the marketplace at www.asht.org.



Membership Directory Addendum

The following information is an addendum to the 2006 Membership Directory. The addendum contains a listing of members of the American Society of Hand Therapists as well as clinic listings inadvertently omitted from the printed directory. Increase patient referrals by placing this information with your 2006 directory!

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Schwartz, Lynne, OTR/L (AS)

Kessler Institute for Rehab., Kessler Hand Center
Saddle Brook, NJ
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CLINIC LISTINGS:

Arizona

Dynamic Rehab and Hand Therapy
3303 E. Baseline Rd.
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(480) 813-7900
(480) 813-7901 Fax

1972 E. Baseline Rd.
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(480) 730-0502 Fax

3303 S. Lindsay Rd.
Suite 116
Gilbert, AZ 85296
(480) 813-7900
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dynamicrehab@msn.com

Dynamic Rehab has operated in the South East Valley since 2001 specializing in hand therapy, while offering a full range of rehabilitation services including, physical therapy, sports rehab and vocational programs. With full time Certified Hand Therapists at all three convenient locations, Dynamic Rehab offers a personal approach to your rehab needs. Find out more at www.dynamicrehabaz.com.

Florida

Fort Lauderdale Hand Clinic
2000 West Commercial Boulevard
Suite 101
Fort Lauderdale, FL 33309
(954) 351-0511
(954) 351-0411 Fax
robinmiller@handclinic.com
www.handclinic.com

Our staff includes:

Robin E. Miller, OTR/L, CHT
Chris W. Smethie, OTR/L, CHT
Tami R. Seltman, OTR/L, CHT
Martha Handler, OTD, OTR/L, CHT

The Fort Lauderdale Hand Clinic, established in 1981, is a therapist-owned private practice, staffed entirely by certified hand therapists. The practice is devoted to rehabilitation of the upper extremity with the highest quality of care.

Texas

Lubbock Hand Therapy, PLLC
6913 Indiana Avenue
Lubbock, TX 79413
(806) 687-2788
(806) 687-2791 Fax

Our staff includes:

June Reedy-Hurst, OTR, CHT
Laura Alexander, OTR

Lubbock Hand Therapy specializes in injuries and conditions of the upper extremity. Services also include custom splinting and fittings for Lymphedema custom garments. The therapists at Lubbock Hand Therapy have combined work experience in upper extremity rehab for 22 years and work closely with local orthopedic surgeons and physicians. ■

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September 14-17, 2006 | Atlanta, Georgia



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