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3

Government Relations
Opportunities to Serve our Communities
Confronting an Oral Healthcare Crisis
Oral Health Promotion: An Unexpected Way to Reduce Healthcare Costs
Counties to Benefit from Local Oral Health Projects

11

Lifelong Learning
The Function Junction: Critical Role of Bio-Adaptability in Mouth Breathing, Sleep Apnea and Orofacial Myofunctional Disorders
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2019 is shaping up as a very exciting year for California dental hygienists. The tide of change is sweeping over California and offers fresh hope for the profession of dental hygiene.

First, the California Dental Hygienists’ Association (CDHA) is sponsoring a bill to remove unnecessary restrictions in the Dental Practice Act which limit access to the services provided by dental hygienists. An inadequate supply of healthcare providers has continued to plague California policy makers and health agencies. California has fought a losing battle to provide access to dental care to a population that is growing in both size as well as frailty, thanks to aging baby boomers. California’s 24,000 dental hygienists can be better deployed, in more settings, with fewer restrictions to practice. Over the following pages, you’ll see several articles about different ideas and programs that can improve oral health and provide avenues for RDH’s to be critical members of this health delivery team.

Historically, California’s approach has been to treat disease rather than to promote health, an inefficient and failed use of limited funds. Public agencies are finally recognizing the futility of a “fire-fighting” acute care approach and placing greater value and emphasis on cost-effective prevention – part of CDHA’s core mission statement. This change in public policy outlook means greater opportunities for dental hygienists to play a bigger role in California’s healthcare plan! Now, with an infusion of funding through the Tobacco Tax Act (Prop 56), Rhoda Gonzales relates her experience in increasing the reach of public health dentistry in her county (page 6).

What does this mean for You? Katie Conklin is a fellow hygienist working with the counties in developing their Local Oral Health Program. On page 8 she lays out the goals of the 2018-2028 California Oral Health Plan (in California’s 58 counties) and puts out a passionate “Call to Action” for dental hygienists to be part of this local solution and to participate in this mandated program in your county.

This is only the start! Nationwide, public health advocates and government agencies are calling for increased scope of practice and fewer restrictions to the services of allied health professionals. CDHA’s future plans include exploring more options for California dental hygienists to better serve their communities and help meet the state’s healthcare needs.

And…on March 26, at CDHA 2019 Legislative Day, dental hygienists from across the state will be in Sacramento educating our legislators about the greater role dental hygienists can play in improving healthcare. We will be asking them to support the CDHA sponsored dental hygiene bill and consider the many ways our profession can serve our citizens and save tax payer dollars while improving overall health.

Please ask your local component Legislative Liaison how you can be part of these multiple programs to serve your community and benefit personally through the increased employment opportunities we hope will evolve with them.

About the Author

Lisa Okamoto received her Associate Science Dental Hygiene degree from Foothill College in Los Altos Hills, graduating with high honors in 1980. Her career has included clinical hygiene in both general and periodontal practices, as well as adjunct faculty at Foothill. Lisa believes strongly in professional association membership, and has served as both Treasurer and President of the California Dental Hygienists’ Association. She has co-chaired the CDHA Government Relations Council since 2013.

In her “free” time, Lisa enjoys golf, skiing and travelling with her husband Bob and family, reading sci-fi fantasy novels, and tackling Sudoku and crossword puzzles.
Confronting an Oral Healthcare Crisis

By: Lisa Okamoto, RDH
Government Relations Council, Co-Chair

Voices to Votes... On March 26, CDHA 2019 Legislative Day, California Dental Hygienists’ Association members from throughout the state will be in Sacramento in support of CDHA’s dental hygiene bill. We will ask the Legislature to increase direct access to professional dental hygienists, remove unnecessary restrictions to practice, and better utilize dental hygienists to help address California’s healthcare needs. Hopefully, you are one of those dental hygienists planning to be in Sacramento with us this year.

California faces an ongoing battle with a healthcare system unable to meet the dental needs of a growing population. CDHA proposes California revisit its approach to health care by turning to an available, underutilized, professional workforce to increase the provider pool, improve overall health and decrease total health care costs, with an emphasis on prevention. The dental hygiene bill proposes simple changes to the Dental Practice Act that would significantly improve the public’s access to preventive dental hygiene, in more settings accessible to more Californians.

Prevention is recognized... as a priority in the Dental Transformation Initiative, included in The Tobacco Tax Act (Prop 56) health directives, and is a key component of the 2018-2028 California Oral Health Plan. Research by Kaiser Permanente, Blue Cross and Cigna insurers shows that preventive dental care helps to lower health costs and improves overall health. In 2017, the National Association of Dental Plans (NADP) released an analysis showing that providing a preventive dental service (defined as a prophy, exam, fluoride treatment or sealant) to adult Medicaid recipients was associated with a 36–67% decrease in medical costs for patients with seven chronic conditions, with savings approaching $100 Million. Dental hygienists are the prevention specialists in the oral health field - well-qualified and educated to provide preventive care to fight both tooth decay and gum (periodontal) disease.

The issues:

- An inadequate number of dentists, available and able to provide dental care to all 39.5 million Californians, especially the disadvantaged. This situation is unlikely to change for multiple reasons, including low Medi-Cal Dental (formerly known as Denti-Cal, the state’s insurance for low income people) reimbursement rates and rising dental student debt. In 2009, the American Dental Association projected that between 2010 and 2030, despite an increasing number of dental schools, the ratio of dentists to the population would fall.

- As of January 2019, 23,941 dental hygienists are licensed in California but are not allowed to provide care to the full extent of their education and scope of practice. Included in this provider group are 700 independent Registered Dental Hygienists in Alternative Practice (RDHAPs) who could provide care in schools, residential homes, and dental professional shortage areas. An example of unnecessary restrictions is the fact that dental hygienists are limited in placing fluoride varnish even though individuals with no healthcare background at all are authorized to provide this service.

- An increasing percentage of Californians, in both urban and rural areas, do not have access to dental care. According to the Dept. of Health Care Services (DHCS), only about 20% of California dentists participate in Medi-Cal Dental, while only an average of 22% of Denti-Cal beneficiaries received even one dental service in years 2014–2016. In 2018 the DHCS reported the percentage of Medi-Cal dentists actually shrank by 8 percent during the previous five year period. Conversely, the number of children and adults eligible for Medi-Cal Dental benefits has increased significantly since 2016 due to the Affordable Care Act and reinstatement of adult dental benefits.

- Patients resort to costly emergency room visits for dental issues. A 2015 American Dental Association
Health Policy Institute Research Brief notes that Emergency Department visits due to dental conditions continued to increase in 2012, costing the system $1.6 Billion.\(^8\)

- Poor oral health increases overall healthcare costs, adversely affecting systemic conditions including pregnancy, diabetes, respiratory, cardiovascular disease, and autoimmune diseases such as arthritis. Lack of proper dental care has a negative impact on quality of life, lost school days, lower productivity and decreased ability to obtain and retain a job, contributing to a cycle of poverty.\(^9\)

In a report to the 2015-2016 Legislature, the California Health Benefit Review Program found “a preponderance of evidence...that the services potentially provided by RDHAPs are effective in alternative practice settings [and] that it stands to reason that access to effective oral health care would improve health outcomes among these populations.”\(^10\)

In September of 2018 the California’s Legislative Analyst’s Office released a report that stated RDHAPs improve care for disadvantaged populations and recommended expanding scope of practice for RDHAPs.\(^11\) A 2018 U.S. Dept. of Health and Human Services report found that most state practice act restrictions on allied health professionals are not supported by demonstrable evidence or substantial risk to the consumer’s health or safety.\(^12\)

California dental hygienists are available, ready and able to provide more care to more people in more places. Hopefully the Legislature will support the dental hygiene bill. At Legislative Day we will speak with legislators of the importance of passing this bill, and that dental hygienists are available and ready to serve our communities.

“The CDHA Bill has not yet been assigned a number in the legislative process.

### References on Page 26

- **Clarity in Numbers**
  - 32,034 dentists to serve 39.5 million Californians (2018)\(^15\)
  - 20% of dentists (6,400) serving 13.5 million Californian children and adults with Denti-Cal\(^16\)
  - 56% of DentiCal children not receiving any care in 2017\(^17\)
  - 427 CA Dental Health Professional Shortage Areas\(^18\)
  - 23 counties with below standard Denti-Cal provider to beneficiary ratio (2016)\(^19\)
  - 13 counties with no Denti-Cal dentist accepting new patients, 9 with no provider listed at all\(^20\)
  - 23,941 underutilized CA RDH and RDHAPs
Oral Health Promotion: An Unexpected Way to Reduce Healthcare Costs

By: Rhoda Gonzales, RDHAP

One of the biggest problems in health care is we pay for the treatment of illness but we don’t pay for the advancement of health.

~ Diana Dooley, former Secretary of the California State Health & Human Services Agency

National surveys show that dental caries is the most preventable childhood disease. In the past 20 years, some populations have actually seen an increase in caries experience. In a 2011-12 National Survey of Children’s Health, parents ranked California in the bottom 4th of all states on the condition of their child’s teeth. Data from the California Dept. of Public Health (CDPH), based on the last needs assessment in 2004-2005, indicates 53.6% of kindergarten students and 70.6% of 3rd grade students have experienced tooth decay. Even more disturbing, 27.9% of kindergarten students and 28.7% of 3rd graders suffer from untreated decay.

The impact of untreated dental disease on society affects children in lost school days and extends into adulthood, with days of missed work and negative social and health consequences.

- California has the highest rate of emergency department utilization in the nation for preventable dental conditions. In 2012 there were 113,000 visits to California emergency departments with an estimated cost nationally of 1.6 billion dollars.
- In 2009-2012 nearly half of U.S. adults age 30 and older, and 70 percent of adults age 65 and older, had some form of periodontal disease.
- According to a 2014 Journal of American Preventive Medicine Journal, patients with Type 2 diabetes who received periodontal treatment reduced their hospital admissions by 39.4% and total medical costs by 40.2%, from $7,056 to $4,216.
- The same study also states similar savings in healthcare costs to the State for other chronic diseases are realized when periodontal treatment was provided.

Exploring Options in Saving

With hopes of reversing the state’s failing grade in healthcare, California has launched a plan to promote oral health and prevent dental disease. The 2018-2028 California Oral Health Plan (COHP) has the ambitious vision of “Healthy Mouths for all Californians.” The 5 goals outlined in the California Oral Health Plan are to:

1. Improve the oral health of Californians by addressing determinants of health, and promote healthy habits and prevention interventions to attain a healthier status in communities;
2. Align dental health care delivery systems, payment systems and community programs to support and sustain increasing utilization of dental services;
3. Collaborate with payers, public health programs, health care systems, foundations, professional organizations, and educational institutions to expand infrastructure, capacity and payment systems for supporting prevention and treatment services;
4. Develop and implement communication strategies to inform and educate the public, dental teams, and decision makers about oral health information, programs, and policies;
5. To track progress, develop and implement a system to measure key indicators of oral health and identify key performance measures.
One way to track progress is through the Medi-Cal Dental Program (formerly known as Denti-Cal). Using claims submitted by providers, Medi-Cal has established baselines and short term targets. (See Chart)

**Measurable Objectives**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARIES EXPERIENCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>53.6% (2004-05)</td>
<td>42.9%</td>
</tr>
<tr>
<td>Third Grade</td>
<td>70.6% (2004-05)</td>
<td>56.6%</td>
</tr>
<tr>
<td>UNTREATED CARIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>27.9% (2004-05)</td>
<td>22.3%</td>
</tr>
<tr>
<td>Third Grade</td>
<td>28.7% (2004-05)</td>
<td>23.0%</td>
</tr>
<tr>
<td>Preventive dental visit among Medicaid children (0-20 years)</td>
<td>37.8%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Children with dental sealant on a molar (6-9 years)</td>
<td>27.6%</td>
<td>33.1%</td>
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**Oral Health Promotion Programs**

For every dollar spent for dental prevention services, the return is an estimated $8.00. The time has come to focus on and implement oral health promotion programs on a public health level utilizing every dental provider to their full scope of practice. With funding from Prop 56 (the California Healthcare, Research and Prevention Tobacco Tax Act of 2016), county health departments are developing their own local oral health projects (LOHP). These LOHPs help advance the objectives of the COHP.

Registered Dental Hygienists and Registered Dental Hygienists in Alternative Practice have an opportunity to partner with Local Oral Health Jurisdictions (counties).

If you have the desire to impact oral health on a public health level, contact your local public health department to explore these Local Oral Health Programs. Hygienists can play a critical role in oral disease prevention, have a great impact on patient’s overall health and help save their patients and their communities money.

**References on Page 26**

**About the Author:**

Rhoda Gonzales, RDHAP, has had a diverse career as a dental hygiene clinician, instructor, consultant, medical practice office manager and, most recently, a director of quality for a health plan.

Working closely with local and state organizations to improve oral health has given Rhoda a strong appreciation and understanding of collaboration and has fueled her passion for advancing prevention and access to quality care.

**“CDHA is excited about the opportunities Local Oral Health Programs can offer hygienists in every county of California. We are committed to bridging any gap between hygienists and program directors.”**

Susan McLearan, RDHAP, MS
CDHA Liaison

“I am so fortunate to work in the public health sector after working in the private sector for 34 years working as the project manager of the state’s oral health program is an easy jump! I love working on a larger scale with the public and having a dental hygiene background made the transition seem natural. It is so rewarding collaborating with so many fantastic agencies and community partners who are all willing to help with eliminating the oral health burden. I am looking forward to implementing the California States Oral health plan and making a difference here in my community, San Benito County!”

Jennifer Fruetta, RDH
Public Health Services, San Benito County

Quickly Go to: [www.cdha.org](http://www.cdha.org)
Click on the Prop. 56 icon and take a brief survey about Career Opportunities for YOU!
California has 58 counties plus 3 cities (Pasadena, Berkeley, and Long Beach) that make up the 61 local health jurisdictions. Of the 61 local health jurisdictions, 59 have signed a contract with the Office of Oral Health to participate and receive funds to develop and design evidence-based and best practice programs. Suggested programs include School-based Sealant, Community Water Fluoridation, Tobacco Cessation for dental offices and Fluoride varnish at “well child” visits. How can you get involved?

On January 17th and 18th The California Department of Public Health held the first California Local Oral Health Project Director’s Meeting in Sacramento. The two-day meeting brought public health leaders from across the state under one roof to share, learn, and collaborate. You may ask why they came together and, more importantly, what does this means for you as a hygienist? This means county health departments have made oral health a priority. Through the Tobacco Tax of 2016 (Prop 56), the cost of a pack of cigarettes increased by $2/pack providing $30 million annually to the Office of Oral Health.

“Working with Oral Health Awareness Society and building educational material for the school-based program has been very rewarding personally and professionally. I love using my knowledge as a dental hygienist to make a difference in my community”

Jana Cummings, RDH, BS
Project Coordinator, Oral Health Awareness Society
San Joaquin County

Dental hygienists are positioned to be leaders. In the dental office, many of you are masters at multi-tasking: managing patients, providing treatment, coordinating care with your dentist and front office staff, ordering supplies, and so on. In public health, the big difference is, instead of treating a patient in your dental chair, you are treating the community.

Consider this an opportunity to think beyond the four walls of the dental office and partner with county oral health coalitions. Your contribution could be to attend an oral health coalition meeting, serve on an advisory committee, screen children entering kindergarten for tooth decay, talk about community water fluoridation and tobacco cessation. Who better to serve the community than dental hygienists?

The Department of Public Health’s California Children’s Dental Disease Prevention Program was closed ten years ago. That, and the loss of the adult Medi-Cal Dental program, has left California in the bottom of the nation’s oral health.

Over the past few years, key leaders - including CDHA and CDA - have fought to bring leadership and funding back to California. The state now has a Dental Director, and Prop 56 brought some funding to county departments of health. CDHA, individual RDHs and RDHAPs, the Oral Health Technical Assistance Center and many others are working out the details of making hygienists an integral part of California’s public health system.

The Project Director’s Meeting was the first of many to come. I truly believe we can contribute together to make California healthier for all by stepping out of the dental office part time to build partnerships with our oral health coalitions.

I now work at the UCSF School of Dentistry where my main function is to communicate with the local health jurisdictions under a contract with the California Department of Public Health. I receive questions every day on where to find resources and how to develop programs. The best part of my position is empowering other dental hygienists to choose public service.
“These are exciting, and I’d say unprecedented, times for oral health! Tax revenue generated by Proposition 56: the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 is funding innovative public health projects across the state. Hopefully, this will translate into expanded opportunities for dental hygienists to work to the top of their scope of practice as specialists in the prevention of oral disease. If you’re on the fence, now’s the time to get involved!”

Jan Resler, MPA, RDH
Oral Health Program Coordinator
DHS- Public Health Division, Sacramento County

For more information, contact the
California Oral Health Technical Assistance Center:
Oralhealthsupport@ucsf.edu • Phone: 415-514-3155

About the Author:
Katie Conklin, RDH, MS, is the Project Policy Analyst for the UCSF California Oral Health Technical Assistance Center. A graduate of UCSF’s Master of Science in Dental Hygiene Program, she focused her research project on school-based oral health programs. She has experience collaborating with communities to develop preventive oral health programs and in August of 2018 joined the team at UCSF.

References in online version

March is Gum Disease Awareness Month

The California Dental Hygienists’ Association and the California Society of Periodontists celebrate the 2nd Anniversary of Periodontal Disease Awareness Month.

Seeing the need, both organizations joined together in 2017 to pass the resolution declaring March as Periodontal Disease Awareness Month in the CA Legislature. Authored by State Senator Janet Nguyen, Vice Chair of Senate Health Committee, the resolution was introduced and passed with a majority vote.

“It’s important that the public understand the local and generalized health effects caused by periodontal disease. So many are undiagnosed or under treated, not realizing the importance of diagnosis and treatment of this disease”, states CDHA President Beth Wilson, RDH, BS.

With the Centers for Disease Control (CDC) estimating that about half of U.S. adults over the age of 30 have some form of periodontal disease, it is apparent that the need is great. They further state that 80% of Americans will be afflicted with periodontal disease by age 45. More importantly, 4 out of 5 patients with the disease are unaware they have it.

CDHA is proud to partner with CSP to bring awareness and education to this treatable disease.

Michael Laflamme, RDH, BA
CDHA Vice President of Public Relations & Administration
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The Function Junction: Critical Role of Bio-Adaptability in Mouth Breathing, Sleep Apnea and Orofacial Myofunctional Disorders
By: Kimberly K. Benkert, RDH, BSDH, MPH, COM, FAADH

What is a Function Junction?
A “Function Junction” is the melding of the functional inter-relationships (function) of the airway, orofacial musculature, tongue and mandibular movement patterning, orofacial parafunctional behaviors, resting postures of the tongue, lips, and mandible, the dental freeway space; sleep apnea risk factors; and the impact of nasal or mouth breathing on the hard and soft tissues of the orofacial structures and environment (form).

Orofacial Myology, referred to more often as Orofacial Myofunctional Therapy (OMT), is a therapeutic approach to address breathing, resting postures (of the tongue, lips, mandible, head & neck), chewing patterns, swallowing patterns, and functional speech patterning. OMT is utilized as a therapeutic treatment to:

- harness, reeducate and normalize the relational junction between inadequate or distorted neuromuscular patterning along with facilitating the normalization of a less than ideal structural form.
- reeducate the neuromuscular and behavioral forces on the structural form to enable the bio-adaptability of the soft and hard tissues in the orofacial environment to normalize. (Interventional treatment may also be needed by additional healthcare team members to address additional structural issues.)
- eliminate mouth breathing and establish consistent nasal breathing for a correct breathe-suck-swallow-breathe cycle; establish and habituate correct resting postures of the tongue, lips, mandible, head and neck; develop consistent correct chewing and swallowing patterns; and retrain functional movements for correct speech patterning (movements of the tongue, lips, and mandible during speaking).  

OMT Levels of Function
- Nasal breathing / Airway patency
- Resting postures of tongue, lips, mandible
- Swallowing pattern
- Chewing pattern and bolus formation
- Functional movements during speaking
- Sleeping with nasal breathing, tongue on palate, lips closed, dental freeway space maintained

OMT harnesses the orofacial and oromotor functional forces in a positive manner. This correction of FUNCTION eliminates the harmful impact or significantly reduces the systemic risk factors and allows the structural FORM to reach its full potential.

Addressing the ‘Function Junction’ utilizes oromotor and mechanotherapeutic exercises in both a physical and psycho-physiologic manner. These exercises are the initiating facilitators for creating a positive neuro-muscular impact on the orofacial environment. Retraining and/or eliminating the negative, biologic and physiologic become

Continued on Page 12
neutralized and allow nature’s optimum to emerge as its ‘function’. Normal, physiologic function is further promoted when nasal breathing training, which must be done with lips gently closed, is combined with retraining of the intrinsic and extrinsic muscles of the tongue and swallowing pattern.

**TOTs and Swallowing Patterns**

Tongue ties, or tethered oral tissues (TOTs), must also be released if they are creating a restriction to normal movement. Tethered anterior and mid-tongue tie (posterior tie), labial and buccal frenums must be released. A pre-habilitation program prepares the tethered tissues and a post-operative re-habilitation program reinforces and supports the tongue and retraines the surrounding musculature so it can function correctly. The tongue then has the capacity to act as nature intended as a hydrostatic pump applying appropriate pressures to the hard palate and soft palate. The hydrostatic pressures and retraining of the tongue create a negative air pressure swallow pattern against the hard palate. Saliva, liquids and food bolus are transported into the throat by negative air pressure suction, closing the epiglottis, and allowing the swallow to occur with a smooth, easy elevation of the hyoid with the base and posterior tongue upward lift.

This hydrostatic pump pressure against the hard and soft palate triggers the sinuses and eustachian canals to drain properly. The roof of the mouth is where the negative air pressure function of the anterior, middle, posterior and lateral borders of the tongue occurs and is focused. The roof of the mouth is the floor of the nose.²-⁷,³⁷,⁵²

The orofacial environment, dentition, temporomandibular joint muscular function, and movements of the tongue, lips and mandible also affect functional speaking patterns (movement during speaking). All require normalized function, working in a correct, but neutral manner, for optimal growth and development to take place.

“Function” refers to the impact of the orofacial muscle balances and harmony created between the oromotor behaviors and the habituated oromotor and muscular movements/patterning. The tongue, lips, and jaw, in addition to their resting postures, the dental freeway space, and nasal breathing should be working together in harmony. Eliminating mouth breathing and creating correct functioning of the tongue, lips, and mandible significantly reduces obstructive sleep apnea risks.²,⁵⁹,⁶³ OMT is also used to address parafunctional habits and/or orofacial behaviors impact on the dentition and surrounding environment.¹,²,³¹

**The Epigenetic vs Bio-physiologic Debate**

Some have expressed strong opinions about whether form influences growth and development, requiring the function to become adaptive; or if it is morphological function that influences growth, development, and stabilization of form.⁴-⁸,¹³-¹⁵,²⁵-²⁸ Decades of debate to validate or disprove left the clinician providing orthodontics in the middle, trying to figure out if they must choose a side or ignore the issue. More recently, practitioners in both the oral health and medical communities view *Function and Form as*

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**Bio-Adaptive Theory**

- **Functional Matrix Theory** (Moss, DDS, MS)
- Functional and environmental influences impact the growth and development of the facial arches
- **Malocclusions are influenced** by imbalances of airway flow, resting postures, oromotor imbalances, chewing and swallowing patterns, and incorrect forces of the lips, tongue, and musculature
significantly inter-dependent dynamic processes where both positions must be taken into full consideration when addressing either position. 2-20,23-29,31-35, 52, 53

Regardless of one’s initial stance, the question of how the function impacts the form (and vice versa) must not only be considered, but also incorporated into the critical decision-making process with every airway, sleep related breathing disorder (SRBD), orthodontic, parafunction and TMD case.

The challenge facing otolaryngologists, orthodontic clinicians, orofacial myofunctional therapists, and anyone retraining breathing is the use of evidence-based research along with individualized patient treatment goals. The ultimate goal is the long-term stabilization and habituation to make those benefits last! 2,6,21,22,26-29,31,32

The Role of “freeway space”

Anatomist, Harry Sicher, advocated the importance of “Normalizing the intricate balance between the teeth, skeletal and muscular system”. Sicher describes creating a balance that includes establishing and maintaining a dental (oral) freeway space. 7 A dental (oral) freeway space is the mandibular resting posture maintaining a 2-3 mm minimum posterior (molar) inter-dental (inter-occlusal) space with approximately 4-5 mm maintained in the anterior (incisal) segment. When the mandible sits in its most physiologic resting posture, the tongue is resting on the palate with the dental freeway space maintained, the lips are lightly closed at rest, and relaxed breathing is through the nose. A balanced equilibrium is reached between the external forces of the lips, the facial and masticatory musculature against the dentition, and the internal resting posture of the tongue against the palate while normal nasal respiration takes place in a homeostatic environment. Maintaining the dental freeway space allows the uninterrupted physiologic eruption of the teeth. He conveyed that clinicians need to become biological anatomists and more fully take the biologic-physiologic systems into account during treatment.

Moving Forward Based on Evidence

Most academics support and recognize creating and maintaining normalized function is challenging when orofacial muscular or oromotor dysfunction is present. Orofacial myology should be part of a comprehensive treatment consideration. Orofacial Myofunctional Therapy (OMT) methodologies address the orofacial and oromotor functional issues that can create a negative impact. The literature indicates a clear need to incorporate dealing with these functional issues in the treatment of orofacial myofunctional disorders (OMD) in order to establish an ideal functional occlusion, and maintain its long-term stability within the orofacial and dento-facial environment. The scientific evidence depicting function significantly impacting form is widely present throughout the literature. 2-11,16,25-29,32,53, 56, 59, 60, 61, 63, 64

Current theories indicate that separating the two philosophies of “Function vs Form” and “Form vs Function” is not only impossible, but unwise to ignore in clinical practice. Moss’ Functional Matrix Theory provided the additional academic support to the inter-relational dependence and stressed that these principles be focused in a multi-dimensional and inter-disciplinary manner. Moss stated one cannot separate the environmental (muscular and behavioral) impact on the structural

Orofacial Myology

- The philosophy of “muscle wins” is fundamental to all phases of mechano-therapies
- Bio-adaptive theories along with nasal breathing/respiration and muscle oriented therapeutics influence the long term success and stable outcomes of oral health treatments associated with malocclusions, muscular TMD, periodontics, and cosmetic restorative therapies
- Oromyofunctional/oromotor issues, resting postures of tongue, lips and mandible, creating an appropriate dental freeway space, functional swallowing/chewing patterns, and elimination of parafunctional habit patterns is required for long term stabilization and balanced orofacial/oromotor myofunctional patterns

Continued on Page 14
(epigenetic form), and vice versa.\textsuperscript{25-28} Kondo demonstrated this through case studies, and followed them for 25 years. The cases retained their orthodontic corrective integrity when coupled with orofacial myofunctional therapies.\textsuperscript{6} Benkert, Hanson and Andrianopolous, and Smithpeter and Covell studies also demonstrated stability of the orofacial environment and dentition treated with orthodontics is successfully achieved when utilizing orofacial myofunctional therapy.\textsuperscript{31, 32, 53}

**The Importance of Referral**

Licensed professionals who take the training and specialize in Orofacial Myofunctional Therapy may become a Certified Orofacial Myologists (COM). The Orofacial Myologist provides a comprehensive assessment and jointly determines treatment timing along with the other dental professionals, MD, ENT, or other licensed healthcare professionals. They also plan and implement an orofacial/oromotor treatment and behavioral program and evaluate the progress of the orofacial myofunctional systems. Dentists and dental specialists, Dental Hygienists, MD, ENT, Speech-Language Pathologists, PT, OT, and Lactation consultants refer the greatest number of patients. Patients also find therapists online. Regardless how the patient initially connects with the Orofacial Myologist, an interdisciplinary team approach keeps the patient at the center of all treatment modalities and leads to the most stable outcome.\textsuperscript{1,2,6,9,10,12,18,31,52,53,63}

Individuals have been addressing orofacial/oromotor dysfunction with orofacial muscle exercise since the early 1900’s. Providing a program of therapeutics became better known in the 1950’s through Walter Straub’s efforts, and became an organized specialty focus in the 1970’s through the organizational formation of the International Association of Orofacial Myology (IAOM).\textsuperscript{1,2,4,6,7,9,12,16,19-20,35-40} However, a disparity still exists in the number of Certified Orofacial Myologists in comparison to the numbers of individuals who would benefit from their potential treatment. This can pose a dilemma for dentists, orthodontists, MDs, ENTs, and other health care professionals not located in close proximity to an orofacial myologist. Leaving orofacial myofunctional disorders untreated due to lack of access to care increases the risk factors for SRBD, obstructive sleep apnea, speech disturbances and orthodontic relapse.\textsuperscript{49, 51, 53, 63, 64} A bigger dilemma exists when the orofacial myofunctional disorders remain unnoticed and referral doesn’t occur. Sadly, many practitioners observe and recognize that the dysfunction is present, but take no action. This leaves the patient at increased risk for problems and places the non-referring practitioner in both an ethical and potentially legal dilemma.\textsuperscript{48-51} The American Dental Association adopted a policy statement at their 2017 House of Delegates validating issues related to sleep related breathing disorders (SRBD), obstructive sleep apnea (OSA), and upper airway resistance syndrome (UARS) and stated it requires working collaboratively with colleagues in medicine and dentistry utilizing various methods to mitigate these issues.\textsuperscript{51} The practitioner becomes even more vulnerable to clinical liability regarding the
patient who continues to endure risks added onto the clinician’s lack of awareness of the patient’s increased relapse potential.6,7,25-28,31,51,53,63

Dental, medical, and speech practitioners can no longer claim a lack of therapists in their area for non-referral. Some experienced orofacial myologists are capable of tele-therapy. It’s a viable therapeutic option for patients without an orofacial myologist in their area or when a more advanced expertise is required.

The Orofacial Myologist or Orofacial Myofunctional Therapist, is also considered a Mechanotherapist, defined under the National Uniform Claim Committee Code as a practitioner who examines patients by verbal inquiry, examination of the musculoskeletal system by hand, and visual inspection and observation. In the treatment of patients, mechanotherapists employ the techniques of advising or supervising exercises; neuromuscular stimulation; massage or manipulation; or using air, water, heat, cold, sound, or infrared therapy.

**Shifting Paradigms**

Many practitioners must go through a personal paradigm shift to begin including orofacial myofunctional therapeutics into their routine patient assessments and treatment planning. They may have to learn how and when to work with an orofacial myologist. This shift occurs especially if their past referral and/or treatment patterns relied only on the most traditional dental, orthodontic, otolaryngologic, speech or medical modalities. Many practitioners are transitioning by incorporating orofacial myofunctional therapy (OMT) concepts more frequently. Those having the easier time transitioning are those medical and oral health practitioners who embraced concepts of ‘muscles always win’ and/or functional behavioral therapy during their formative development or during their own self-discovery as a professional. Sadly, some professionals only arrive at this realization after noting relapses or failures of medical, dental, or speech ‘finished’ cases and where delayed patient growth or the original form can no longer be blamed. Long face vertical growth syndrome is an example of years of the patient’s life passing with failure to improve the airway and address orofacial myofunctional imbalances present.

**Acceptance Increases Success Factors**

Conceding that ‘function’ can positively impact ‘form’ allows medical, oral health, and speech practitioners to take advantage of increased orofacial myofunctional capacity. Normalizing the increased capacity occurs when OMT concepts are included. One cannot ignore the systemic impact of proper orofacial and oromotor functional processes when coupled with proper nasal respiration and the elimination of mouth breathing. These are dynamic processes. These biophysiologic processes impact the on-going oxygenation of the brain, and the evolving dento-cranio-facial functional environment over a lifetime and, they begin in utero. The importance of ‘function’ and how to apply its concepts clinically is occurring more often in the literature and is being transferred for practitioner’s use.6,41-47,53,63 Medical and oral health practitioners are improving their own assessment abilities in and recognition of the many orofacial myofunctional disorders as the scientific evidence increases in support.

**It is Finally Happening!**

Clinicians from many disciplines are increasing their awareness of the overall impact of the risk factors related to sleep and systemic health from birth throughout the lifetime. Identifying sleep disordered breathing at any age has become crucial.

Practitioners are asking how/when to incorporate orofacial myofunctional therapies to help their patients and make their cases more predictable. This increases the orthodontic, dental, medical, and speech therapy practitioner’s ability to monitor, successfully treat and complete cases, and maintain their outcomes with less relapse. Early recognition of orofacial myofunctional issues along with appropriate therapeutics is fundamental to achieving long-term stability goals.

*Continued on Page 16*
Defining Moments and Creating Parameters

Understanding a definition of Orofacial Myology (OM) is essential when conducting a comprehensive orofacial myofunctional and temporomandibular muscular assessment and examination. This understanding is essential when introducing these concepts to the patient. Defining OM/OMT allows one to label the dysfunction for placement into the international coding and nomenclature systems.

Benkert defines orofacial myology as: Orofacial Myology/Myofunctional Therapy is the treatment of the orofacial musculature to establish nasal breathing, increase muscle balance and tonicity while establishing correct activities of the tongue, lips, and mandible so that normal growth and development may take place in a homeostatic environment. This includes treatment of tethered oral tissues (TOTs), elimination of parafunctional habits and noxious oral habit behaviors, reducing or eliminating temporomandibular muscular dysfunction, bruxism, clenching, muscle bracing, and retraining range of motion (ROM) activities of the mandible, and postural habits.1,2,5,6,29,31,41-47,52

The initial core of this definition was adopted by the IAOM Board of Directors and Membership in 1992.48 The American Dental Hygienists’ Association (ADHA) adopted a policy statement in 1992 under the area of Practice, Patient Care Services 9-92: The ADHA acknowledges that the scope of dental hygiene practice includes the assessment and evaluation of orofacial myofunctional disorders; and further advocates that dental hygienists complete advanced clinical and didactic continuing education prior to providing treatment.49

The parameter of treatment provided by an orofacial myologist depends on their formative core professional accredited education and licensure, and the extent of their post-licensure didactic and clinical training. It is important for the orofacial myologist to understand airway assessment, TOT assessment and treatment, infant to adult eating - feeding - chewing - swallowing, understand the mechanics of movement of the TMJ and screen the occlusion, recognize periodontal disease issues, understand sleep related breathing disorders (SRBD), obstructive sleep apnea (OSA), functional speech patterning, speech development and posture, especially of the head, neck and upper body. In general, orofacial myofunctional therapy treatment should include:

- Establishing nasal breathing and normalized respiration using the diaphragm;
- Referring for release of tethered oral tissues (TOTs) of lingual anterior and mid-tongue (posterior) tongue ties, along with labial and/or buccal ties;
- Establishing a correct breathe-suck-swallow-breathe cycle in infants to adults;
- Correction of resting postures of the tongue, lips, and mandible;
- Establishing a consistent oral (dental) freeway space;
- Balancing and equalizing the muscle function and tonicity of the tongue, lips, muscles of mastication and deglutition, including muscles of the face, head and neck;
- Eliminating oral habits/behaviors of oromotor and orofacial functional behaviors negatively affecting muscle tone and/or impacting the growth and development of the face and dentition;

Establish a tongue on the palate resting posture: “The Spot”
Correcting abnormal chewing and deviated swallowing patterns; correcting muscular deficiencies of resting postures of the tongue, lips, mandible, head and neck; correcting ‘tongue thrusting’ swallowing (preparatory, oral, and oropharyngeal phases); eliminating parafunctional habit patterns that may cause destruction of the dentition (especially bruxism, muscle bracing, and/or clenching); providing neuromuscular reeducation and retraining to eliminate impairment in muscle tone and function; eliminating deviated range of motion muscular and functional deviations of the mandible especially those related to resting postures, chewing, open/closure patterns, speech functional movements/patterning of the tongue, lips and mandible, and orofacial/oromotor functions of related activities of daily living.

Orofacial Myology concepts and principles are rooted between professional domains in physical medicine, dentistry, dental hygiene, and speech pathology. Although many professionals still refer to orofacial myology as only being ‘tongue thrust therapy’, references to orofacial myofunctional disorders (OMD) have appeared in the literature under many names and for many years. The correct name determined by the International Association of Orofacial Myology in 1978 is: orofacial myofunctional therapy or orofacial myology. Nomenclature consistency will facilitate communication and research across professional domains. It also allows consistency with respect to taxonomy, international coding and insurance submissions.

**Best Practice - Incorporating a Process of Care**

Behavioral studies add to the evidence that function can impact form across categories of age, race, culture, and pre-/post-orthodontics in a similar manner. The challenge of discovery for each clinician/practitioner begins in a similar manner, through their experience gained by treating cases in a collaborative manner with an orofacial myofunctional therapist. Learning about airway, orofacial function and how to refer is best accomplished while still a pre-licensed professional student. Sadly, this training is still sorely missing in most professional education programs. The post-licensed clinician is left to figure it out through clinical trial and error or professional continuing education as a life-long learner. Best practice, regardless of when or where one begins this journey, requires each case to be considered utilizing a similar process of care.

Best practice process of care includes:

- Completing a comprehensive orofacial myofunctional assessment and examination
- Developing a differential diagnosis
- Incorporating airway, function and form into the treatment planning process
- Integrating an inter-disciplinary therapeutic team approach
- Continuing an on-going evaluation process throughout the rehabilitation and habitation phases

Maintaining the long-term stability of airway patency, orthodontics, orofacial orthopedics, and functional speech patterning is achieved by combining these treatment processes with OMT. The collaborative treatment of airway issues, releasing tethered frenums and restricted oral tissues, addressing sleep disordered breathing, snoring and sleep apnea symptoms, and orthodontic/orthotropic processes with orofacial myofunctional therapy fully incorporates treating function and form in the most comprehensive manner. Mechanotherapy, orofacial myofunctional therapy, should be incorporated by facilitating the individual’s neuromuscular and bio-physiologic capacity while reducing, redirecting, and reeducating the negative orofacial/oromotor myofunctional and neuromuscular imbalances, and eliminating noxious

*Continued on Page 18*
parafunctional behaviors/patterns. Establishing nasal breathing and evaluating airway considerations always takes first priority with swallowing, nutritional intake and speaking function coming close behind. And, in the end, to achieve the stability… muscles and their function always win! So, it is better to work with and reeducate the muscles than be surprised by their ability to unravel the good work of professionals later! 2,6,7,29,31,32,42,53,63

Incorporating OMT as a fundamental element in treatment planning when orofacial myofunctional imbalances or parafunctional behaviors are identified assists in successfully completing and producing more desirable outcomes. Addressing long-term stability should actually begin during every assessment and examination process by recognizing all factors that can present issues down the road. Cases with functional disorders detected at any stage of the pre- or post-treatment process will benefit from incorporating orofacial myofunctional therapy. Incorporating OMT as early as possible is advised as a best practice policy in order to reduce/eliminate the risk of orofacial functional imbalances/interferences impeding or slowing the growth and developmental processes, or orthodontic relapse. Occasionally, OMT should be completed in stages (phases) based on the patient’s age, their structural form, or the other types of dental or medical treatment collaboratively taking place.

### Raising the Bar on the Standard of Care

Dental and medical treatment processes, including a comprehensive orofacial myofunctional assessment and examination, raise the bar on the standard of care delivered to the patient. A comprehensive assessment and examination for all orofacial myology patients includes:

- Take a detailed medical and dental history;
- Assess the dental occlusion with measurements of the open bite, overjet, crossbite, diastemas and Angle classification;
- Determine the severity of the orofacial myofunctional disorders (OMD);
- Assess the breathing patterns;
- Assess the oral and nasal airways with a visual inspection;
- Analyze the breathe-suck-swallow-breathe pattern, analyze the chewing pattern utilizing a food item and the degree of functional dysphagia (difficulty swallowing and ‘tongue thrust’ swallowing pattern);
- Assess resting postures of the tongue, lips, and mandible;
- Measure philtrum, lip, lingual frenum stretch (LFS), and inter-labial gap (ILG);
- Identify and measure the dental freeway space;
- Analyze noxious oral behaviors;
- Assess the impact of temporomandibular muscle dysfunction (TMD) including palpation of the head, neck, facial and TMJ musculature;
- Review airway/imaging reports; review self-reported pain scale;

### Assessment & Examination

#### Structural
- Anatomical: airway, head, neck & face, dentition
- Muscular: capacity/tonicity
- Neurological: responses motor/sensory

#### Functional
- Breathing: nasal/oral mouth breathing
- Resting postures of tongue, lips, mandible, head/neck
- Mastication patterns
- Deglutition: infant/toddler to adult
- Range of Motion (ROM) of mandible and TM joints
- Functional speech patterning

#### Behavioral
- Habit patterns – present or past
- Parafunctional habits/patterns

Assess and measure the range of motion (ROM) of the TMJ and mandible and neuro-muscular patterning;

Assess postural/functional relationships;

Assess functional deviations in the mechano-physiologic movements of the tongue, lips and mandible during speaking patterns (as related to dental interferences, occlusal and incisal attrition patterns, and/or anterior/posterior/lateral functional patterns);

Review behavioral and sleep questionnaire responses;

Assess attrition of the dentition and abfractions as related to parafunctional patterns of bruxism, muscle bracing and clenching;

Assess the impact on the periodontium and oral hygiene.\(^1, 2, 31, 33, 42-47\)

**What are the Goals? Relationship to Orthodontics**

It is most ideal to begin OMT prior to the onset of orthodontics/orthotropics especially in cases where the dysfunction is more severe as this will usually make early phases of orthodontics/orthotropics progress at a more predictable speed. Oral habits, especially digit or lip sucking/propping, should be eliminated prior to beginning ortho to eliminate potential interferences that would slow the dental process.

If the patient is referred while the orthodontics are in progress, it is best to do so with enough time remaining in their treatment to reduce risks prior to debanding. New patterns should be well established prior to debanding.

If referral occurs after relapse is noticed, it is wise to make a strong referral as quickly as relapse appears. When OMD is noted early in a relapse situation, often correcting the function will allow the dentition to return to its pre-debanded orthodontic form. If retreatment is planned, OMT should be initiated prior to retreatment. However, parafunctional habit patterns may be successfully corrected at any point along the lifetime continuum of pre- to post-orthodontics. As establishing new orofacial myofunctional patterns is similar to a rehabilitative process, habituation levels increase in depth the longer and more often the new patterns/functions are correctly repeated.\(^1, 2, 6, 30, 31, 41-47, 52\)

**How to find OMT Treatment?**

Orofacial Myologists are the licensed professionals whose focus on treatment issues are related to the orofacial/oromotor functional, dento-facial functional aspects, and oral-related parafunctional and behavioral issues. Referral for orofacial myofunctional therapy is primarily to a Registered Dental Hygienist (RDH), Dentist (DDS), Speech Pathologist (SLP), Physician (MD) or other licensed healthcare professional specifically trained in Orofacial Myology.

The International Association of Orofacial Myology (IAOM) recognizes the education and licensure of the RDH, DDS, MD, and SLP as having the pre-requisite education in the areas of orofacial/dental anatomic, biologic and physical/medical sciences to train in Orofacial Myology and becoming Certified (COM). Other licensed professionals may train and apply to take the Certification examination on a case-by-case basis determined by their education, licensure and experience. Very few pre-licensure educational programs provide OMT training or integrate this area of study across their professional curricula.

The IAOM is currently the only not-for-profit international, inter-disciplinary accrediting body administering a blinded written and on-site clinical Certification examination culminating with a COM. The IAOM membership consists of practitioners or supporting member professionals from around the globe. The IAOM is the current respected certifying body since Orofacial Myology specialty licensure is non-existent in any USA state/territory or Canadian territory or province.

The RDH in Japan is the preferred OMT practitioner. The SLP in Brazil completes OMT training in their formative professional post-graduate educational programs.

Continued on Page 20
In the USA and Canada licensed professionals are trained through post-graduate continuing education programs. Courses are available in seminar format, internship style, and web-based.1,2,48,52 Other countries may have fewer practitioners, but are discovering the OMT concepts and recognizing these therapeutics are desirable.

**How Long Is Therapy and What Happens?**

Depending on the degree of orofacial/oromotor dysfunction, an average orofacial myology program usually consists of weekly appointments, approximately 30-60 minutes in length (depending on appointment goals) and ranging from 3-7 sessions (visits) to approximately 24-36 sessions (visits) usually over a 12-24 month period.

Patients begin with closed mouth nasal breathing training and orofacial neuro-muscular retraining with muscle toning and development, and conditioning phases. Dysfunctional processes are broken down into all of the bio-physiologic movements and activities of daily living (ADLs). Each muscle group activity, functional movement, and muscle functional pattern is retrained using correct bio-physiologic movements, patterning, and actions in a manner to normalize them or achieve breathing patterns and muscles performing in a neutral environment.

Orofacial Myologists must incorporate diaphragmatic breathing with the tongue correctly postured on the palate with the lips closed and a dental freeway space present. The tongue creates a seal within the oral environment and...
facilitates nasal breathing. Therapists must incorporate orofacial concepts of breathe-suck-swallow-breathe with a negative air pressure swallow, centric occlusion (CO), centric rest (CR), and balancing functional use of anterior/posterior/lateral group actions along with speech movement concepts of correct tongue positioning for the on/off glide of the tongue on the palate and the functional mandibular range of motion (ROM) movements during speaking. Lingual, labial and buccal frenums must be stretched through exercise and referred when needed for surgical release procedures (frenectomy) of the tethered oral tissues (TOTs).

Those referred for frenectomy releases should have stretching, toning and functional conditioning exercises in a pre-habilitation and post-surgical rehabilitation process. ROM patterning of the mandible must incorporate normalized jaw and tongue mechanics with patient-specific dental freeway space emphasizing nasal breathing, increasing the end tidal CO2, and training respiration. The intrinsic and extrinsic muscles of the tongue, soft palate, lips, facial muscles, muscles of mastication, and neck muscles with hyoid elevation are exercised as needed to achieve treatment goals. As needed, chewing and swallowing exercises are incorporated and noxious oral habits and parafunctional habits must be addressed.

Many articulation errors/lisping patterns improve significantly once the tongue, lips, and mandibular patterns function correctly. Infant patient therapy focuses treatment on breathing through the nose and suck-swallow-breathe with the tongue on the palate and lips closed. Infants are treated very briefly prior to surgical release of TOTs and post-surgically to address the latch onto the breast or bottle and habituate their therapy goals.

As treatment progresses and patients habituate, the orofacial myofunctional environment and SRBD with OSA risk factors reduce, the OMT activities and exercises wean away. The goal is maintaining corrected function. An annual re-assessment is ideal for 1-5 years post completion of a comprehensive OMT program to monitor long-term stability.

Digit sucking habits can be eliminated completely or significantly reduced on their way to extinction within the first 24-72 hours of therapy. The OMT digit program is literally a ‘Quit in A Day’ behavior modification program that works effectively for 90% of the individuals. Continued monitoring for 30-60-90 days insures full extinction of the behavioral habit. A TMD patient with pain symptoms or a patient with special needs treatment program may take less/more time than other OMT patients to successfully complete. Their patient-centered program must be individualized and based on complexity.

Most parafunctional patterns are addressed during the course of the OMT orofacial program. The background and training of the orofacial myologist will determine the extent and ability to address the orofacial myofunctional disorders and parafunctional habits present. Not all orofacial myologists are trained to address muscular TMD and parafunctional habits/patterns.

As with any case assessment, the time and intensity of treatment is determined by the severity and complexity of the orofacial myofunctional disorders. As a best practice, orthodontists should also include the orofacial myologist in the re-evaluation of the patient for 1-5 years following the completion of an orofacial myofunctional therapy program. MD primary care providers, general dentists and dental hygienists are able to continue monitoring their patients’ long-term stabilization once orofacial myofunctional therapeutic services conclude.

Advancing the Discipline and Cross -Training

Orofacial myology/myofunctional therapy (OM/OMT) continues to evolve and grow in a patient-centered, interdisciplinary, specialty-focused manner. Cross training of professionals provides an overall knowledge base, with needed concepts and theories integrated from dentistry, dental hygiene; speech pathology, otolaryngology and areas of physical medicine. Therapeutic principles are rooted with a foot in dentistry/speech and a foot in medicine. Many

Continued on Page 22
individuals possess knowledge and clinical skills gleaned through cross training. These well-trained interdisciplinary therapists are capable of providing treatment, thereby interfacing and collaborating with practitioners across professional disciplines. Collaborative practice with disciplines outside of their original licensed profession benefits their shared patients by widening the boundaries of their therapeutic team.\(^1,2,6,9,10,12,16,18,29,34,47,52,53,62,64\)

Research points to the significant impact of sleep related breathing disorders (SRBD), and tethered oral tissues (TOTs) on the normal growth and development of the face in infants to adults. These issues place them at risk for feeding/eating and food aversion issues, cardiovascular risk, impaired human growth hormone release as well as learning and behavioral issues. These issues can continue as toddlers grow into teens and adults. In addition to the medical/dental/speech issues it also disrupts their quality of life.

More collaborative medical and dental related research incorporating OMT is needed. The nomenclature utilized by dental and medical professions needs greater consistency when describing orofacial myofunctional disorders/dysfunctions. Consistent identification of orofacial myofunctional concepts will encourage more practitioners to identify similar issues for their patients and within the literature. Practitioners must become more aware of dysfunctional interferences, SRDB, OSA, functional damage to the dentition, unwanted changes in growth and development, TMJ muscular dysfunction, functional speech disturbances and parafunctional habit patterns.

**Conclusion**

A variety of orofacial myofunctional issues can be present for the clinical practitioner to observe and assess. The issues are usually multi-factorial and the patient must be assessed from the structural, functional and behavioral aspects to determine which levels of function are affected.

So, it is no wonder many practitioners become confused about the topic of treating orofacial function and orofacial parafunctional behaviors. Embarking on this journey begins with identifying the licensed OMT professional to work with them in a collaborative manner. OMT services coordinate well with other dental and medical services in a preventive, interceptive and/or restorative manner. The OMT treatment planning may include referral to determine airway obstructions or eliminate impairments with an ENT, allergist, or MD.

OMT treatment programs require on-going re-evaluation throughout treatment and during the habituation/follow-up phases. Re-evaluation or follow-up may take place in a phased manner depending the age at which a patient is referred and if orthodontics/orthotropics/orthognathic surgery take place. Long term stability of a patent airway, the primary to adult dentition, and management of the orofacial and head/neck environment should be a team effort among practitioners utilizing best practice methods.

Orofacial Myofunctional Therapists can be a key member of the dental/medical team and their services are critical.
to the long-term stability of the orofacial environment structural, functional and behavioral health. Orofacial myofunctional therapy plays a critical role in reduction of pediatric sleep disordered breathing and reducing OSA, plus reducing risk factors in both children and adults. Continued on-going research across disciplines is needed to further document and validate the vital role of the therapist. The rest of this story ends with providing collaborative care for patients, reducing health risk factors, improving orofacial-system health, and enjoying the results!

Contact Kimberly Benkert
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for information regarding patient services, consulting, and OMT training/lecturing.
Go to the IAOM website: www.iaom.com for a directory of orofacial myologists.

References on Page 27

About the Author

Kimberly K. Benkert, RDH, BSDH, MPH, COM, FAADH is owner of Midwest Orofacial Myology and MYO USA, Inc. She lives and practices in the western suburban area of Chicago, IL. A graduate of Loyola University, College of Dentistry, with a BS in Dental Hygiene, she holds a Masters of Public Health in Health Policy and Administration majoring in Dental Public Health. She is Certified in Orofacial Myology through the International Association of Orofacial Myology and holds Fellowship status in Orofacial Myology, and in Temporomandibular Dysfunction with the American Academy of Dental Hygiene.

She is a former faculty member at the University of Illinois-College of Dentistry and the Kennedy-King Dental Hygiene program. Kimberly is a past president of the American Dental Hygienists’ Association, the Illinois Dental Hygienists’ Association and the West Suburban Dental Hygienists’ Society. She served on the Board of Directors of the IAOM, ADHA, IDHA, and Scientific Core Committee of the International Federation of Dental Hygiene. Currently, she is a member of the IAOM Education Committee, American Academy of Dental Hygiene Bylaws Committee, and the IDHA Governmental Affairs and Ethics Committees.

She is the recipient of the ADHA/J&J Award of Excellence, ADHA/Discus Dental Distinguished Service Award, ADHA Outstanding Service Award as President, ADHA Irene Newman Award, IAOM Connie Painter Award, IAOM President’s Award for Outstanding Commitment and Service, and the IDHA Hygienist of the Year Award of Merit. Kimberly lectures and provides training courses for dental hygienists, dentists, physicians, speech-language pathologists and other healthcare professionals in Orofacial Myology on a national and international basis.

Her office locations are in Glen Ellyn, Aurora/Naperville, and Oak Park, IL. Courses are offered seminar style, as in-services and internships and web-based. Kimberly may be contacted at kbenkert@gmail.com or 708-309-3844.
1. Orofacial Myofunctional Therapy (OMT) is provided mainly by dental hygienists, dentists, and speech-language pathologists?
   a. True
   b. False

2. The “Function Junction” is a melding of professionals providing orthodontics, periodontal therapy, dental hygiene services?
   a. True
   b. False

3. Tongue, lip, and buccal tethered oral tissue restrictions are referred to as:
   a. Tongue thrust
   b. Tethered olfactory ties
   c. Developmental attachments
   d. TOTs

4. Pre-habilitation and post-surgical rehabilitation orofacial myofunctional therapy is strongly recommended for tethered oral tissues requiring surgery?
   a. True
   b. False

5. What has the ‘Function Junction’ orofacial epi-genetic vs bio-physiologic debate been over?
   a. Growth and Development
   b. Form and Function
   c. Dental Anatomy and Dental Physiology
   d. Histology and Physiology

6. An ideal (total between the anterior to posterior) dental freeway space between should be:
   a. 2-5 mm
   b. 4-8 mm
   c. 1-2 mm
   d. 3-4 mm

7. Individuals have been addressing orofacial/oromotor dysfunction since:
   a. late 1970’s
   b. early 1950’s
   c. early 1900’s
   d. middle 2000’s

8. The American Dental Hygienists’ Association adopted a policy statement on Orofacial Myofunctional Therapy?
   a. True
   b. False

9. The ADA policy statement on SRBD passed in 2017 refers to:
   a. Sleep Related Breathing Disorders
   b. Snoring, Respiration, Breathing Disorders
   c. Sleep, Respiration, Breathing, Dentition
   d. Snoring Related Biologic Disturbances

10. Retraining breathing, resting postures, chewing, swallowing and functional speech movement patterning are the key levels of function addressed in orofacial myofunctional therapy therapeutics.
    a. True
    b. False
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Spring Scientific Session

Friday, May 17th, 2019
8:30 a.m. – 4:00 p.m.

Anaheim Marriott
700 West Convention Way
Anaheim, CA 92802

Martinis & Menopause: Exploring Oral and Systemic Implications in Women’s Health (3 CEUs)
Speaker: Kelli Jaecks

Hurts So Good!: Managing Acute Dental Pain, Opioid Analgesics and their Impact on the Dental Community (2 CEUs)
Speaker: Tom Viola, R.Ph.

Student Table Clinics and Marketplace (1 CE)

To register or for information, visit www.cdha.org or email info@cdha.org