Orofacial Myology News

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Hello to all of you readers throughout the world… Because of many technological improvements and advances, most of us have been able to turn what otherwise could have been a year filled with negatives into something useful and future oriented. We've been able to keep in touch via ZOOM, FaceTime and other means, allowing us to move forward in spite of the limitations of the past year.

And that is almost a template for successful therapy, as well, isn't it? Our clients come to us with challenges and we use whatever is available to move them forward in spite of their initial limitations.

Some of the articles in this edition have that same flavor to them. Our front page article talks about accepting changes in clients' attitudes and schedules and being creative in ways to treat "modern" clients. Other columns deal with ways to reach clients successfully using teletherapy, including articles by Andrea McFarland, as well as useful hints by Zohara Nguyen on how to view oral images more clearly using a mobile phone during ZOOM meetings.

You'll gain more clarity within Hallie Bulkin's column about the differences in working with toddlers to prevent myo issues as opposed to working with older children/adults. RDHs will discover how their myo skills can be useful in a variety of settings as they read Becky Ellsworth's myo journey.

You'll find new convenient types of VIRTUAL class offerings in Orofacial Myology such as the International Course (Early Bird/Night Owl hours!), plus the Supplemental Course for pre-trained therapists. More weekday training courses are being planned to meet the needs of those who cannot attend over a weekend. The short webinar courses are available and being used quite heavily for those in any profession to understand the basics of this specialty area and hopefully be able to more selectively screen patients and send them in the direction of those who are already trained.

While we look forward to some in-person activities in the future and the hugs that go along with them, the overall satisfaction with virtual training has surprised all of us. A once or twice a year reunion and symposium is on our to-do list and we will update you as that becomes a reality.

Wishing all of you good health and the ability to maintain a positive attitude as you continue your very important work of making a difference in the lives of your patients, students and clients.

"Once Upon a Time….."

For those of you who have been practicing for several years, you might have witnessed some of the changes in the behaviors of your pre-adolescent and teen-aged clients that I observed over a period of time.

During initial visits, my procedure has always been to review the historical information and perform the oral exam in order to prepare an individualized program of treatment. Things went smoothly for many years, with my asking the young person to perform (or try to perform) certain movements to which they complied without comment for the most part. They listened patiently as I explained the reasons for the assessment and possible connections to the issue that brought them to me. When they encountered some difficulty making a requested move with their tongues or lips, it ultimately lead to a few giggles and laughs. It was something that helped to create a therapist/client bond on day one. Yes, it was that easy… "once upon a time."

Then, approximately 10-15 years ago, the same-aged clients began to bombard me with questions all along the way as I asked them to perform the lingual or labial movements, to chew or swallow or drink, etc. They pelted me almost nonstop throughout the assessment and seemed fixated on the entire process. If they had any difficulty whatsoever demonstrating what was requested of them, many of these young people asked the same question, "Was that bad?" And it continued with … Did I do it right? Was that OK? Can I keep trying? Why can't I do it? Is there something wrong with me?

It took me awhile to recognize that this was a new "phenomenon" that was occurring. If they could not get it right immediately, they became embarrassed, upset, or even flippant and gave up right at the start. It was, on their part, almost an obsessive striving for perfection along with a lack of patience that I had not seen in my decades of prior experience.

Additionally, they ho-hummed when I tried to provide the reasons behind what was being asked of them. They fidgeted when I attempted to offer any details. The very words I had used previously in therapy to motivate and encourage my clients no longer worked. The approaches I had used so successfully for decades simply fell flat. This left me with no choice: I had to rethink my approaches and how they were presented.

As therapy progressed and as more and more of my clients seemed to demonstrate similar behaviors, I started taking notes of what changes seemed to be occurring year by year. And I wrote down what worked with this "new generation."

- Providing short explanations (VERY short ones!) worked best with these clients.
  - o Saying it briefly; then letting them ask for clarification, thereby "drawing from the client."
- Using technology whenever and wherever possible helped tremendously.
  - o Sending home a video of them or me performing certain exercises.
  - o Using teletherapy on occasion for variety to help maintain interest.
  - o Incorporating helpful apps in various places during treatment.
    - ▪ Examples: for reminders, counter tallies, etc.
- Using wording that distracts them from seeking immediate perfection for every exercise/activity they attempt.

Continue reading this article on page 5

International Course

Orofacial Myology: From Basics to Habituation

July 8-10, 2021 U.S.

(Dates may vary based on your location)

Details

This 3-day course will begin each day at 4 PM US Eastern Time and end at 1:30 AM US Eastern Time. Due to requests from professionals throughout the world, this 28-hour course is brought to you….wherever you are!

Ankyloglossia: Moving from Controversy to Collaboration

Karen Wuertz
DDS, QOM

Considerable controversy remains today around the topic of ankyloglossia or tongue tie. Many ENTs, Pediatricians, SLPs, IBCLCs, Dentists and other interdisciplinary providers have differing opinions regarding the definition, clinical significance, need for surgical intervention and timing of treatment. The diagnosis and treatment of ankyloglossia is not new, reports Anna Messner, MD, a professor at Baylor College of Medicine and Division Chief of Otolaryngology at Texas Children's Hospital in Houston. With increased awareness, facilitation and exacerbation through social media, there has been an exponential rise in the diagnosis and treatment. Combined with an indistinct definition of ankyloglossia and 2 recognized categories (anterior & posterior tongue tie), it can truly be difficult to sort out who needs intervention and/or surgery.

So how common is a tongue tie? Let's look at some statistics:

- Ankyloglossia ranges from 3% to 16% worldwide
- Approximately 8% children <1 year, males > females
- Inheritance rate may be as high as 21% with a family history of ankyloglossia
- X-Chromosome mediated inheritance and a variation in gene expression
- Male vs female ratio 3.79: 1
- 25%-44% of infants with tongue tie have feeding difficulties (both breast and bottle)

What areas can oral restrictions affect & who should be treated?
Oral restrictions can negatively impact oral function, feeding, speech, dentition, gum health, social, personal & recreational functions, and even sleep and breathing.
Recent case studies have demonstrated a strong correlation of tongue tie with multiple issues that may contribute to obstructive sleep apnea, including:

- Habitual mouth breathing – causing micro trauma to the back of the throat contributing to tonsil enlargement and partially blocking the airway during sleep.
- A high or arched palate - during development the tongue should normally rest in an "upper" position, contacting the palate. A tongue tie may affect tongue position causing a lower resting position.
- Interference with palatal development. A tongue tie may interfere with palatal development creating an abnormally high or arched palate, which leaves less room for the nasal passageways. It can also contribute to disproportionate growth of the lower jaw with an increased chance that the airway will be smaller than it should be.

So what can you do?
Under ideal circumstances, a tongue tie should be evaluated, diagnosed and treated early in a child's life. Become a part of or create an interdisciplinary team and standardize your assessment and evaluation tools between providers to ensure that an objective, clear and simple measure of the severity of a tongue-tie is completed with a functional baseline assessment prior to surgical procedure to release.

Grads Corner

Karen Masters
MS, CCC/SLP, COM, QOM

Total Support

Greetings from not-yet-sunny New Jersey. I was thinking about where I was a year ago vs now and can't believe how much has changed! Last April, my office was closed and we were doing teletherapy for most patients. Many families were overwhelmed with the new demands of home school life and opted to put therapy on hold. I worried about my practice staying afloat and the financial implications of that. I spoke to my "myo friends," many of whom are really more like "myo family!" We supported each other with technology, shared ideas and materials, and kept each other company via zoom!

Honestly, though, it didn't take the pandemic for me to be aware of the "support net" I had as a result of my journey into orofacial myology. I have been an SLP for a LOOOONG time but it wasn't until my myo training that I made professional connections like the ones I have now.

The Neo-Health philosophy of providing TOTAL SUPPORT to those who train with us is an opportunity that I hope you all embrace because it really provides you with most of what you need to learn and grow professionally AND it also opens doors for you to make connections you wouldn't otherwise have.

I recently bought a new house and was really overwhelmed with taking care of everything by myself and making it "pretty." Guess who showed up ("virtually," don't worry!) to celebrate my achievement and give me a generous gift: Myo Masters who have become my closest friends! Who helped me pick paint colors? A facetime call with another MyoMaster with a great eye for color! Total support extends beyond the classroom and the clinic. Speaking of the clinic, I recently added a new staff person to my team in my office. I have wanted to work beside an RDH with myo training since I took my class in 2015. I knew they had expertise that I didn't and thought it would complement my practice perfectly. How did I find the perfect RDH to join me? I found her through the same myo network that I am encouraging you all to use!

MyoMasters is a deep, rich, resource filled with people ready to offer their support and opinions and a great place to evolve professionally!

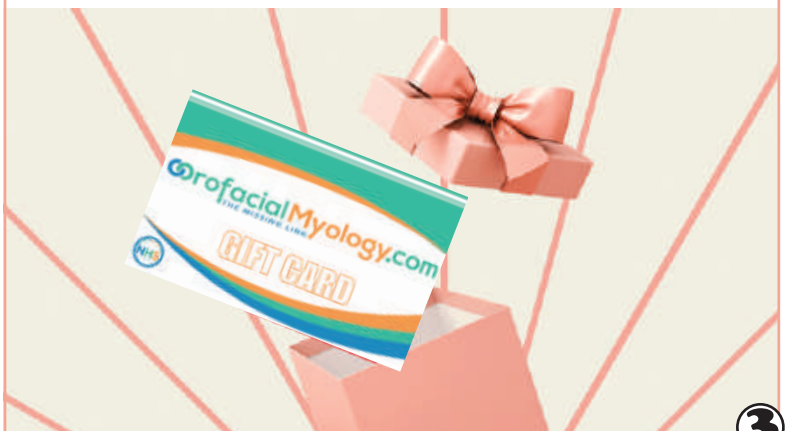
See you on our next monthly virtual gathering!

Sincerely,

Karen

Why don't you surprise your myo friends and colleagues by giving them something that will be most appreciated? Myo Gift Cards are the perfect gifts!
They are valid for all materials, tools and supplies at the Orofacial Myology Store.
To see the variety of choices **click here:**

orofacialmyology.com/shop/myo-gift-card/



Set Up Your Telepractice Like a Pro

Andrea McFarland
MA, CCC-SLP

Are you ready to start offering teletherapy services, but have no idea where to begin? Let's break down the steps to get you started.

First, what is teletherapy and why has it become so popular with therapists and clients?

Teletherapy or telepractice is offering our traditional therapy in a different setting. Rather than being face to face, the therapy is conducted remotely via an online meeting platform.

In recent years, telepractice has been gaining momentum. Since the Covid-19 pandemic, however, the number of therapists using telepractice has skyrocketed. It's convenient, cost-effective and as effective as traditional therapy if you're properly prepared.

Here's how to get started--

Choose your platform. There are many online meeting platforms available, but not just any will do. You must ensure your platform of choice is HIPAA compliant. Full HIPAA compliance includes signing a Business Associate Agreement (BAA). This a document specifying each party's responsibility to patient privacy. Most platforms automatically send a BAA, others you'll need to ask. This agreement must be in place in order to fully satisfy HIPAA regulations.
Once ensuring HIPAA compliance, check out the other features the platforms offer. Other features include: screen sharing, screen recording, allowing multiple users or therapists, the ability to make notes or annotations on the screen for your client and additional bonus features such as waiting rooms or EMR compatibility.

Here's a list of HIPAA compliant platforms:
Google Meet if used with G-Suite and a signed BAA., GoTo Meeting, Zoom if using the Business plan, VSee, WebEx, TheraNest as part of their EMR, Simple Practice as part of their EMR, TheraPlatform is specifically for SLPs, TheraV is specifically for SLPs, Blink Session is specifically for SLPs

If you'd like a copy of our platform pricing and feature comparison chart, send your request to andrea@61marketing.com.

Do your research. Although it's gaining popularity, telepractice still isn't mainstream. Regulations are likely to continue to change. Be sure to frequently check the requirements in your state. Currently, SLPs providing teletherapy must be licensed in the state where the client they're treating is located. For example, an SLP licensed in Texas can't conduct teletherapy with a client who's located in California.

Also, if you accept insurance, make sure to stay up to date on reimbursement rules and service codes. As of now, in addition to having a consent to treat form, you must also have an informed consent specifically for teletherapy. As a therapist, it's wise practice to do a quarterly check of the regulations and requirements affecting your practice.

Create your space. Whether you plan to conduct your teletherapy from your office or from home, your space should appear professional and organized. Have the background, including walls, free from clutter. Make your space free from distractions, both visual and auditory. Make sure you have adequate lighting. For natural light, it's best to face a window rather than have a window behind you. If natural light isn't available, invest in a ring light. There are many options available on Amazon.

Depending on your specific needs, you can use a stand or select a light that attaches directly to your computer webcam. They're affordable and easy to use. For improved sound quality, use a USB microphone instead of relying on the computer mic. Blue Yeti podcast mics are just one example of a quality microphone and are also available on Amazon. To minimize the risk of technical issues, ensure you have a strong internet connection. Lastly, be prepared and organized. Have your session plan, all of your tools and resources, as well as your client's file, within arms'reach.

Allow time to practice. Enlist friends and family to participate in mock therapy sessions. Use this time to ensure you have adequate lighting, sound and internet connection. Ask for their honest opinion of how you and your space appear on camera. Try out everything your platform has to offer. Practice screen sharing and recording. If available, make notes on the screen. Consider taking your practice clients through your onboarding process. It's useful to create a questionnaire to have your participants fill out after their mock session. Ask questions regarding any areas where you could improve your process. The information compiled can be a great reference in perfecting your client experience.

Provide client instructions. As with any new client, providing a seamless onboarding experience sets the stage for success. This is especially true with telepractice. An efficient way to prepare a client for teletherapy is to create a video. Here you can give instructions, tips and expectations. Do they need to download software or create an account, explain the steps. Does your platform require them to use a computer rather than a phone or tablet, let them know. You can even show examples of poor vs. adequate lighting and why good lighting is essential to therapy. Also let them know that technical issues happen and how to proceed when they do. You could also create a video to send to prior to each session to let them know what you'll be working on and what they'll need to have ready to use for therapy.

If you've been considering opening your own practice, teletherapy is a great way to get started. If you have an established practice, offering teletherapy can be a welcomed addition to your traditional setting. Becoming an expert in telepractice will also set your practice apart from your competitors.

Feel free to contact me for additional ideas and strategies on how to start your telepractice.

A special thank you to our grad, Andrea McFarland, for giving our readers this incredible information in this issue. She has so much more to offer to those of you who want to expand your practice and make your lives easier.

Continue reading from page #1

- Stressing "maximizing." It is helpful to use the word "maximize" wherever possible. You can still tell them the criteria for passing, but avoid the word "perfect" as it seems to be a catalyst to make excuses, complain, or try to over achieve.
- Giving assurance that most other clients have difficulty with X, Y, or Z, just as they are. This helps overcome the strong need for acceptance, fitting in, and being "ok.

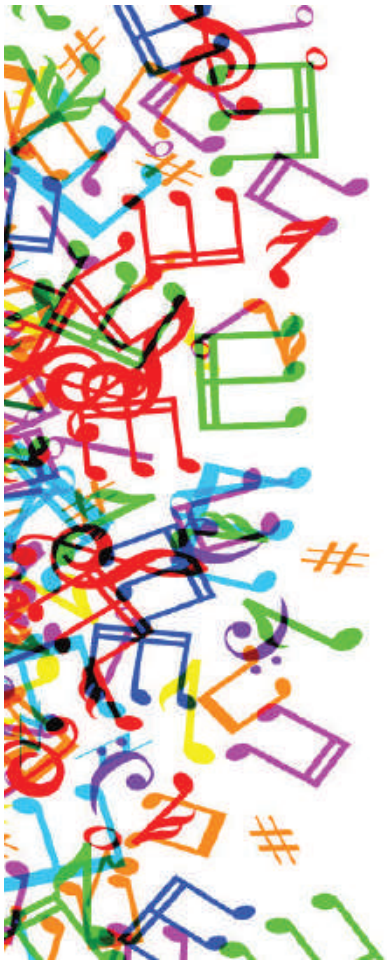
- Considering busy schedules. This is one of the bigger changes over the past several years. Where "once upon a time" a young person had one or maybe two outside activities, many have activities every day of the week or nearly so!
  - In consideration of this, I had to change my way of prescribing exercises/activities to my clients. Where I used to tell them how many times a day to practice, I began to explain that the ideal is to practice X times a time…then asked them what they considered doable within their schedule. What surprised me was that they often came up with something very reasonable once I placed it into their hands.

- Accepting less formality. The clients of "today" tend to expect a more informal relationship with adults, including therapists. Some still have good manners, of course, but don't be caught off guard when some modern teens seem to lack even the verbiage that was once considered respectful. It works just as well for them to know that you are a friend as well as their therapist, that you can loosen up and enjoy the time together, and that you are not all seriousness and perfection yourself!

While it might be typical to blame the internet, parental over-coddling, schools, or any number of institutions or people for these changes over the past several years, I leave the pursuit of such studies to those with more time than the typical therapist among us has in our schedules. As interesting as it might be to know the "who" and the "why" behind this trend, we have to focus on our tasks as Orofacial Myologists. Our job is to figure out how to deal with and overcome unanticipated changes in a way to keep treatment moving forward, while assuring that our clients maintain a positive attitude. Perhaps some of these clinical findings will put you at ease as you put aside "once upon a time" and settle for "changing with the times"!

Play That Funky Myo Music!

We have found songs that are so very "Myo"….. it is hard to believe, but YES, all of them are real song titles!



Tongue Tied
Lips are Moving
Cut Lip
Tongue Tied
Fat Lip
Sleep Apnea
The frenulum song
Breathe Deeper
Stiff Upper Lip
Tip of My Tongue
The Tonsil Song
Let Me Clear My Throat
Our Lips Are Sealed
Slip of the Lip
Tongue
Love my Lips
How do I breathe?

The Connection Between TOTs, Pediatric Feeding Cases & OMDs

As a pediatric feeding specialist, I have assessed a fair share of infants, toddlers and preschoolers (generally birth to 5 years of age) who have any combination of feeding challenges, tethered oral tissues (TOTs) and/or an orofacial myofunctional disorder (OMD). I have also worked with the more traditional myofunctional therapy (Myo) cases from 4 years of age through adults. Regardless of the age of the patient in front of you, a common theme I have encountered is the lack of awareness that all three of these diagnoses [feeding disorders, TOTs, OMDs] are frequently present at birth.

Hallie Bulkin

MA, CCC-SLP, COM

In infants we may see Ankyloglossia or Tongue Tie lead to a tongue that is tethered to the floor of the mouth, impairing range of motion. We may notice that the tip of the tongue doesn't elevate when the infant cries, the tongue is unable to suction to the palate, cup around a breast/bottle nipple, or lateralize when stimulated (a reflex). This may manifest as a decreased flow of milk from breast/bottle and later a munch chewing pattern that does not develop into a rotary chewing pattern, especially when that tongue cannot lateralize food across molars to prepare a food bolus. As the toddler continues to consume solid foods, we may see single sided chewing, large bites of food or overstuffing, food pocketing, tongue dumping, and of course the ever discussed tongue thrust pushing against or between the teeth when swallowing to create the needed negative pressure to complete a swallow. And these are just a few examples of what may be observed [yes, the list goes on!].

With Aklyolabia or Lip Tie we see a whole different list of symptoms from shallow latch that restricts the flow of milk (from breast/bottle) to aerophagia induced reflux (AIR) misdiagnosed as gastroesophageal reflux (GER), and leakage of liquids/saliva/food bolus. Some infants, toddlers and preschoolers will struggle to drink from an open or straw cup starting at 6 months. They may also have an open mouth posture at rest, struggling to achieve closed mouth posture while awake, asleep and/or when swallowing. These children tend to experience an increase in illness as well due to bacteria entering intra-orally as compared to being filtered through the nose. Again, this is not an exhaustive list; just some of the common symptoms.

These lists are not exhaustive but clearly demonstrate the relationship between pediatric feeding disorders, TOTs and OMDs. The way in which we assess for and treat these symptoms differs depending on the age of the child. Neurotypical children who are 36 months of age or under are still developing their oral sensorimotor feeding skills. They are also generally engaged in passive or a combination of passive and active therapeutic interventions to achieve their pediatric feeding goals. The problem: those who are licensed to treat this population, Speech-Language Pathologists (SLPs) and Occupational Therapists (OTs), are not always trained in assessment and treatment of pediatric feeding, TOTs and/or OMDs. We are working to actively change this! When searching for pediatric feeding therapists for our Birth to 4-year-olds it is highly recommended you search for a pediatric feeding therapist who has TOTs and/or myofunctional therapy training as well. I call these cases "feeding with a twist of Myo". ☺

Once a child is at the cognitive level of a 4 year old, they can generally start a traditional myofunctional therapy problem with an SLP, OT, registered dental hygienist (RDH), or dentist (DDS). That said, this is where differential diagnosis is extremely important. It is the job of the receiving provider to ask the right questions and determine if a traditional myofunctional therapy program is the next best and most appropriate approach.

We can all agree that correcting the oral rest posture, oral prep and oral phase swallow plus nasal breathing and habit elimination are all up there on the charts of important skills to teach at a young age. But the success with a Myo program also depends on various factors as described above. When in doubt, contact your colleagues and co-treat across specialties (e.g., an RDH may treat a 4-year-old with an OMD through a traditional Myo approach and then refer to an SLP to take over when it's time to address speech goals or if the feeding goals go beyond prepping a bolus). It is the job of the receiving provider to always put patients first and provide them with the best therapeutic approach for their medical needs. Team approaches are the best approach and get our patients the most effective results in their journey toward optimal health.

All in all, it is important to remember toddlers are still developing their oral sensorimotor feeding skills until at least 36 months of age. It's critical to understand there exists an absolute connection between pediatric feeding, TOTs and Myo, and that these pediatric cases require a pediatric feeding (with a twist of Myo) approach under the care of a pediatric feeding therapist with feeding (and ideally TOTs and Myo) experience.
sensorimotor feeding skills until at least 36 months of age. It's critical to understand there exists an absolute connection between pediatric feeding, TOTs and Myo, and that these pediatric cases require a pediatric feeding (with a twist of Myo) approach under the care of a pediatric feeding therapist with feeding (and ideally TOTs and Myo) experience.

Outside of the "mouthbox"

Different Environments, Evolved Therapy

Becky Ellsworth,
AAS, RDH, BS, QOM

After years of varied experience in orofacial myology, my journey along the way taught me that no matter where I work, I will be successful because of the foundation skills I received. That solid base has been what was needed to work in the different environments and within different therapy regimens. I first heard about Orofacial Myology way back in DHY school when we lived in Texas. It consisted of a 3-hour lecture and I was fascinated by it but as there was never anything further provided, nothing came of it. My first true experience was at Kalamazoo Valley Community College in Michigan, where I became a part-time faculty member. Marge Snow, one of the early pioneers in the field, saw my strong interest in the orofacial myology course she was teaching. Marge was pivotal in setting this course up to become part of the core curriculum for the Dental Hygiene program and it was titled Interceptive Orthodontics. What a bold title for a DHY school started in 1976!!! My part early on was to be an observer during the evaluations, as well as the therapy and habit control sessions. Back then there were approximately 12 sessions for therapy and a huge array of exercises to choose from, depending upon the patients' needs. It wasn't exactly a "cookbook approach" but not far off. The Myo Manual, on the other hand, is completely different. The sequencing of the exercises is very detailed to address the many types of patients that we see today. In the past we trained students to do swallowing exercises on the second visit! Now, it is at the very end of Phase 2! As I look back, I am surprised at the results we got considering we made it much more difficult for a patient to succeed without getting frustrated. That being said, hurrah for Marge and all the other orofacial myologists at that time and earlier, doing whole heartedly what they knew how to do at that time….

After Marge retired in the 90's, I was privileged to take over the clinical portion of the course and a couple of years later, I was also the didactic instructor, teaching the way I had been taught. Then, when I joined Neo-Health Services in 2014, my Myo life changed. Learning the way that Sandra approached therapy was totally eye-opening for me. I had to relearn therapy via the Myo Manual and expand my thinking about orofacial myology as so many new discoveries concerning its influence were being uncovered, as they continue to be. I love working at Neo-Health Services as well as loving the incredible team that has been built over the last few years.

My other Myo hat involved working as an Independent Contractor for two wonderful SLP's in their private Speech and Myo practice, Kalamazoo Speech Associates. I was privileged to be part of their amazing team also. They receive many referrals from area dentists and orthodontists and if the client was a Myo client, I was the one who took them on. My clients ranged from age 5 to 66 and I loved it all! Once Covid hit, though, and my client load was low, I chose to step away from it for now. It was the first time that I was the actual therapist and I can tell you that all those years of observing and commenting really honed my Myo eyes! I was easily able to implement the Myo Manual into my practice there and had very successful results.

The take away is that there are many ways to find a place where you can grow and thrive doing Orofacial Myology! I have been involved in three different arenas and have gained and grown tremendously in each one! Whether you find yourself in a school setting, teaching courses for a organization, working as an independent contractor, becoming a presenter at seminars or opening your own private practice, your solid training provides you with the skill set to succeed in any place you choose to go! We are always here to encourage you to move forward.☺

Till next time,
Becky

Featured Graduates

We want to recognize the more than 100 professionals from around the world who have achieved the Qualification in Orofacial Myology and have earned the credentials of QOM or QOM-D.

CONGRATULATIONS 100+ QOMs and QOM-Ds!

Neo-Health Services, Inc. Home of the QOMs

Seeing the Bigger Picture: Intraoral images with a mobile phone.

Zohara Nguyen
CCC-SLP, MSPA CPSP, QOM

Enhancing intraoral images for virtual evaluations and teletherapy.

In the past year we have become intimately close to our computer screens, trying to decode what we can see in our clients' mouths as they also lean closer for better viewing. Since it can be difficult to view intraoral structures and oral movements over virtual evaluations and in teletherapy, a mobile phone can be used as a second camera to enhance the therapist's view of the client. The following steps detail how to do this over Zoom, but you can probably apply most steps to the whatever video platform you use with your clients:

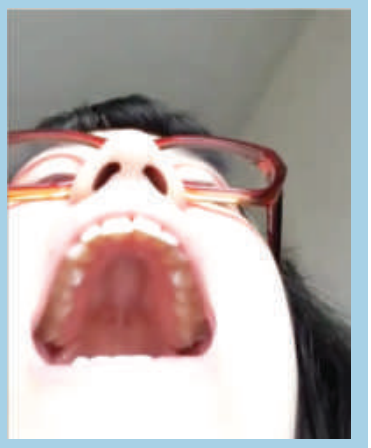
The client needs to:

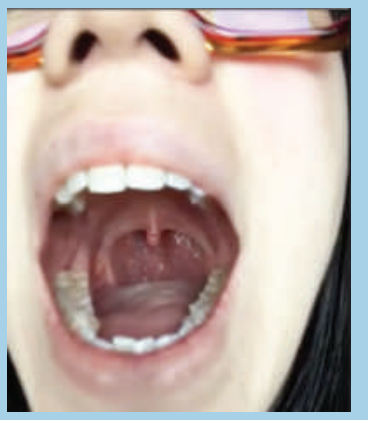
1. Sit facing a window or clear light source.
2. Sign in to the session over their usual computer or tablet.
3. Also sign in using a mobile phone (they might need to download the app for the video platform you use). A mobile phone will be easier to move around than a tablet/iPad.
4. Mute the mobile phone on the platform AND completely turn down/turn off the volume on the phone that comes out of the speaker. Both of these steps must be taken to prevent an echoing of voices and noisy feedback.
5. Turn on the front-camera of the mobile phone (the client will be able to see what is on the screen this way).
6. Bring the phone closer to the mouth when a clear intraoral image is needed.

Therapist:

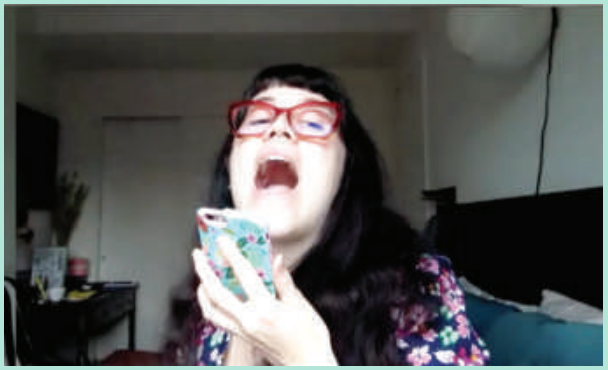
1. Over Zoom you can "pin" the client's mobile phone screen so you can see their video full-screen. Unpin the mobile when you don't need to see the client that close up. (You don't want the client to have to hold up the phone the entire session.)
2. Instruct the client to "look up at the ceiling" and tilt their head back to view the palate. They might need to angle the phone from under their chin.

Mobile Phone Camera

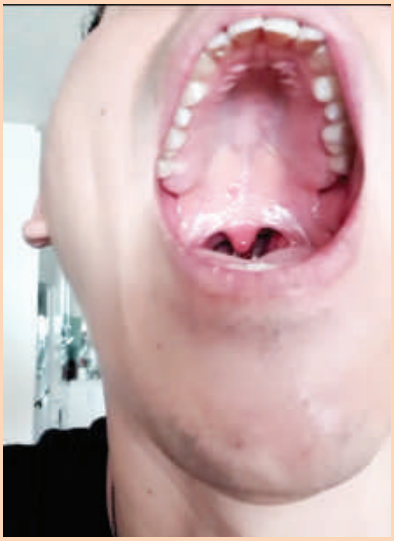


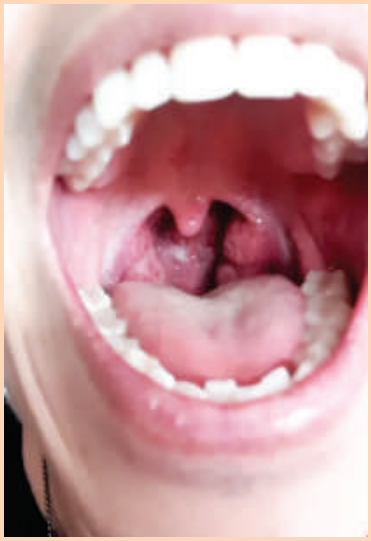


Laptop Camera



More intraoral video stills using a mobile phone as an additional camera:





This course is presented by real-time virtual instruction and provides an online learning enviroment that offers LIVE INTERACTION between the instructors and you. By participating in group discussions, individual/partnered opportunities during evaluation and treatment training, and lively Q&A sessions, you will feel as though you are in a live classroom setting!

Orofacial Myology: From Basics to Habituation

Sandra R. Holtzman MS, CCC-SLP, COM, QOM

Becky Ellsworth RDH, BS, COM, QOM

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28 Hour Course	SUPPLEMENTAL Course	28 Hour Course	INTERNATIONAL Course	28 Hour Course
Online CLOSED	Online	Online	Online	Online
MAY 2021	JUNE 2021	JUNE 2021	JULY 2021	AUGUST 2021
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Strictly for those who have received instruction in a 28-hour or longer introductory course in Orofacial Myology from an organization other than Neo-Health Services, Inc. This 16-hour **Supplemental Course** was created to enhance prior learning skills and the opportunity to be part of the Total Support System of the Neo-Health community. You must be licensed as a DDS, SLP, RDH or other approved medical/dental professional. Proof of prior course completion will be required.

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