Saturday, November 23, 2019

Dental Hygiene Board of California

Full Board Agenda

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhbc.ca.gov

Notice is hereby given that a public meeting of the
Dental Hygiene Board of California (DHBC) will be held as follows:

DHBC MEETING AGENDA

The DHBC encourages public participation in its meetings. The public may take appropriate opportunities to comment on any issue before the Board during the time the issue is heard.

Saturday, November 23, 2019
Hilton Los Angeles North/Glendale & Executive Meeting Center
100 West Glenoaks Blvd
Glendale, CA 91202

9:00 am until adjournment

AGENDA

1. Roll Call & Establishment of Quorum

2. Discussion and Possible Action on the Education Subcommittee Report:

   The DHBC may take action on any items listed as action items on the Education Subcommittee Agenda and the Recommendations provided by the Subcommittee.

3. Discussion and Possible Action on the Legislative and Regulatory Subcommittee Report:

   The DHBC may take action on any items listed as action items on the Legislative and Regulatory Subcommittee Agenda and the Recommendations provided by the Subcommittee.

4. Discussion and Possible Action on the Licensing and Examination Subcommittee Report:

   The DHBC may take action on any items listed as action items on the Licensing and Examination Subcommittee Agenda and the Recommendations provided by the Subcommittee.

5. Election of New 2020 DHBC Officers

6. Update on 2019-2020 Legislation and Pending Regulatory Packages (Informational Only):

   - Status of 2019 Legislation of Interest to the Board
   - 16 CCR § 1107. RDH Course in Local Anesthesia, Nitrous Oxide-Oxygen Analgesia and Periodontal Soft Tissue Curettage.
   - 16 CCR § 1109. Approval of Curriculum Requirements for Radiographic Decision-Making and Interim Therapeutic Restoration Courses for the Registered Dental Hygienist (RDH), Registered Dental Hygienist in Alternative Practice (RDHAP), and Registered Dental Hygienist in Extended Functions (RDHEF).
   - 16 CCR § 1115. Retired Licensure.
   - 16 CCR § 1116. Mobile Dental Hygiene Clinics; Issuance of Approval.
   - 16 CCR §§ 1135 – 1137. Substantial Relationship and Rehabilitation Criteria (AB 2138).

7. Discussion and Possible Action on Proposal for 2020 Legislative Omnibus Bill

8. Update on the Status of Dental Hygiene Educational Programs (Informational Only)

9. Report on Licensing Statistics (Informational Only)

10. Report on Enforcement Statistics (Informational Only)

11. Discussion and Possible Action on Myofunctional Therapy: Is it Within the Dental Hygiene Scope of Practice [CCR 1088(c)(E)]?

12. Public Comment for Items Not on the Agenda

[The DHBC may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 & 11125.7(a).]

13. Future Agenda Items

14. Adjournment of the November 23, 2019 DHBC Meeting

Public comments will be taken on agenda items at the time the specific item is raised. The DHBC may take action on any item listed on the agenda including informational only items. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. For verification of the meeting, call (916) 263-1978 or access DHBC's Web Site at **www.dhbc.ca.gov**.

The meeting facilities are accessible to individuals with physical disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Elizabeth Elias, Assistant Executive Officer, at 916-263-2010, or email Elizabeth.elias@dca.ca.gov or send a written request to the DHBC at 2005 Evergreen Street, Suite 2050, Sacramento, CA 95815. Providing your request at least five (5) business days prior to the meeting will help to ensure availability of the requested accommodation.

DHBC
Dental Hygiene
Board of California

Roll Call for the Dental Hygiene Board of California

Full Board Meeting

Saturday, November 23, 2019

	Present	Absent
Susan Good, Public Member, President		
Nicolette Moultrie, RDH Member, Vice President		
Edcelyn Pujol, Public Member, Secretary		
Michelle Hurlbutt, RDH Educator Member		
Noel Kelsch, RDHAP Member		
Sandra Klein, Public Member		
Timothy Martinez, Public Health Dentist Member		
Garry Shay, Public Member		
Evangeline Ward, RDH Member		

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 2

Education Subcommittee Report

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 3

Legislative and Regulatory Subcommittee Report

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 4

Licensing and Examination Subcommittee Report

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 5

Election of New 2020 DHBC Officers

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR

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FULL 2-5: Election of 2020 DHBC Officers

2020 Officers			
Office	**Name**	**Nominated**	**Second**
President			
Vice President			
Secretary			

Voting Table for: DHBC Election of Officers			
Motion: *name of member here*	**Second:** *name of member here*		
Member	**Aye**	**Nay**	**Other**
Susan Good			
Michelle Hurlbutt			
Noel Kelsch			
Timothy Martinez			
Sandra Klein			
Nicolette Moultrie			
Edcelyn Pujol			
Garry Shay			
Evangeline Ward			

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 6:

Update on 2019-2020 Legislation and Pending Regulatory Packages (Informational only):

- **Status of 2019 Legislation of Interest to the Board**
- **16 CCR § 1107. RDH Course in Local Anesthesia, Nitrous Oxide-Oxygen Analgesia and Periodontal Soft Tissue Curettage.**
- **16 CCR § 1109. Approval of Curriculum Requirements for Radiographic Decision-Making and Interim Therapeutic Restoration Courses for the Registered Dental Hygienist (RDH), Registered Dental Hygienist in Alternative Practice (RDHAP), and Registered Dental Hygienist in Extended Functions (RDHEF).**
- **16 CCR § 1115. Retired Licensure.**
- **16 CCR § 1116. Mobile Dental Hygiene Clinics; Issuance of Approval.**
- **16 CCR §§ 1135 – 1137. Substantial Relationship and Rehabilitation Criteria (AB 2138)**

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UPDATE ON PREVIOUSLY REPORTED LEGISLATIVE BILLS OF INTEREST TO THE DHBC:
November 22, 2019

Legislation	Topic	Status	DHBC Position
AB 5 (Gonzales)	**Worker Status: Independent Contractors** This bill places into statute the three-part legal test formulated in Dynamex v. Superior Court (2018) 4 Cal.5th 903 ('Dynamex') to determine whether a worker who performs services for a hirer is an employee or an independent contractor in cases related to existing Work Orders enforced through the Department of Industrial Relations and the Employment Development Department. This bill changes the definition of 'employee' under the Labor Code to include the elements of the Dynamex standard and expands the application of Dynamex to all provisions of the Labor and Unemployment Insurance Codes unless otherwise specified. This bill contains numerous exemptions for professions and contract types that are instead governed by preexisting employment law standards, including more than a dozen professions licensed or overseen by programs within the Department. Further, providers of 'professional services' are exempt if they meet further specified workplace and work type standards. A catch-all exemption is also included for third party service contracts and for services rendered through a referral agency.	**Signed by the Governor and Chaptered by the Secretary of State.** Chapter 296, Statutes of 2019	**Watch**
AB 62 (Fong)	**State Government: FI$CAL: Transparency.** This bill would enact the Budget Transparency Act of 2019 and would modify the transparency component of the Fi$Cal system to require it to have information regarding all state expenditures, including the amount, type, and a	**This is a two-year bill and dead for 2019.**	**Watch**

	description of each state expenditure posted on its website. The bill would require the website to be interactive, searchable, regularly updated, and include specified features, including information on each state expenditure.		
AB 71 (Melendez Kiley)	**Employment Standards: Independent Contractors and Employees** This bill would modify existing law on the classification of workers as independent contractors by placing into statute the multifactor test existing prior to the decision in Dynamex v. Superior Court (2018) 4 Cal.5th 903. This bill would preempt the Dynamex decision and codify the multifactor test for claims both related or unrelated to Work Orders.	**This is a two-year bill and dead for 2019.**	**Watch**
AB 193 (Patterson)	**Professions and vocations.** This bill would require the DCA, beginning on January 1, 2021, to conduct a comprehensive review of all licensing requirements for each profession regulated by a board within the department and identify unnecessary licensing requirements, as defined by the bill. Beginning February 1, 2021, and every 2 years thereafter, this bill would require each board within the department to submit to the department an assessment on the board's progress in implementing policies to facilitate licensure portability for active duty service members, veterans, and military spouses that includes specified information. The bill would require the department to report to the Legislature on March 1, 2023, and every 2 years thereafter, on the department's progress in conducting its review, and would require the department to issue a final report to the Legislature no later than March 1, 2033.	**This is a two-year bill and dead for 2019.**	**Watch**
AB 312 (Cooley)	**State government: administrative regulations: review.** This bill would require each state agency to, on or before January 1, 2022, review its regulations, identify any regulations that are duplicative, overlapping, inconsistent, or out of date, revise those identified regulations, as provided, and report its findings and actions taken to the Legislature and Governor, as specified. The bill would repeal these provisions on January 1, 2023.	**This is a two-year bill and dead for 2019.**	**Watch**

AB 316 (Ramos Robert Rivas)	**Medi-Cal: benefits: beneficiaries with special dental care needs** This bill is intended to improve access to care for children and adults with chronic medical, mental, behavioral or developmental conditions and disabilities that complicate their dental care, by increasing compensation for providers who treat them. The 2018-19 budget included supplemental payments of $210 million in Proposition 56 revenues to improve payment rates for dental services provided through the Medi-Cal program. This included a supplemental payment for "Additional time needed for special needs patients," which is also described in the September 2018 Denti-Cal provide bulletin as "Behavior management, by report." Specifically, in 2018-19 the associated procedure code (D9920) is provided through Proposition 56 funding a 40% increase from the Schedule of Maximum Allowance of $100, bringing the total to $140. The governor's 2019-20 budget intends to make most of the provider payment increases—the existing as well as certain new supplemental payment programs—permanent and ongoing. This bill would also make permanent the supplemental dental payments described above specific to beneficiaries with special needs. DHCS is also currently conducting a $750 million, five-year Dental Transformation Initiative, which includes incentives and pilot programs to improve dental care in Medi-Cal.	**This is a two-year bill and dead for 2019.**	**Support as written as of 4-12-19**
AB 476 (Blanca Rubio)	**Department of Consumer Affairs: task force: foreign-trained professionals.** This bill would require the Department to establish a task force to study the workforce integration of foreign-trained professionals. The task force would be required to solicit input from a variety of government agencies, including in-state and out-of-state licensing entities.	**Vetoed.** **Governor's Veto Message:** To the Members of the California State Assembly: I am returning Assembly Bill 476 without my signature. This bill would require the Department of Consumer Affairs to create a task force to study the licensing of	**Watch**

		foreign-trained professionals and create a report for the Legislature. Integrating foreign-trained professionals into California's workforce is an admirable goal. However, creating a new task force and a legislative report to accomplish that goal is unnecessary.	
AB 496 (Low)	**Business and professions.** This is the non-healing arts omnibus bill for the Department of Consumer Affairs that, among other things, provides that a board member's appointing authority has the power to remove that board member from office for specified reasons, and adds household movers to the licensees and registrants the Bureau of Household Goods and Services must disclose information about. This bill also requires the director of the Department to report audit and disciplinary findings annually to the Chairpersons of the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions instead of the Chairpersons of the Senate Committee on Business and Professions and the Assembly Committee on Health.	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 351, Statutes of 2019	**Support as written as of 4-12-19**
AB 544 (Brough)	**Professions and vocations: inactive license fees and accrued and unpaid renewal fees.** This bill would limit the maximum fee for the renewal of a license in an inactive status to no more than 50% of the renewal fee for an active license. The bill would also prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.	**This is a two-year bill and dead for 2019.**	**Oppose as written as of 4-12-19**
AB 613 (Low)	**Professions and vocations: regulatory fees.** This bill would authorize programs within the Department of Consumer Affairs to increase their fees every four years in an amount not to exceed the increase in the Consumer Price Index in the last four years. Fees increased pursuant to this bill would be exempt from the Administrative Procedure Act.	**This is a two-year bill and dead for 2019.**	**Watch**

AB 744 (Aguiar-Curry)	**Healthcare coverage: telehealth.** Existing law requires a Medi-Cal patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward to be notified of the right to receive interactive communication with a distant specialist physician, optometrist, or dentist, and authorizes a patient to request that interactive communication. This bill would delete those interactive communication provisions. This bill would require a contract issued, amended, or renewed on or after January 1, 2020, between a health care service plan and a healthcare provider for the provision of healthcare services to an enrollee or subscriber, or between a health insurer and a healthcare provider for an alternative rate of payment to specify that the health care service plan or health insurer reimburse a healthcare provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder delivered through telehealth services on the same basis and to the same extent that the health care service plan or health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. This bill would authorize a health care service plan or health insurer to offer a contract or policy containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, subject to specified limitations. This bill would prohibit a health care service plan contract or policy or health insurance issued, amended, or renewed on or after January 1, 2020, from imposing an annual or lifetime dollar maximum for telehealth services, and would prohibit those contracts and policies from imposing a deductible, copayment, or coinsurance, or a plan year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed on all terms and services covered under the contract.	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 867, Statutes of 2019.	**Watch**

AB 768 (Brough)	**Professions and vocations.** This bill would authorize the DCA and each board in the department to charge a fee not to exceed $2 for the certification of a copy of any record, document, or paper in its custody. The bill would also require that the delinquency, penalty, or late fee for any licensee within the department to be 50% of the renewal fee for that license, but not to exceed $150.	**This is a two-year bill and dead for 2019.**	**Watch**
AB 931 (Boerner Horvath)	**State and local boards and commissions: representation: appointments**. Prohibit, on or after January 1, 2030, the membership of appointed boards and commissions in cities with a population of 50,000 or more from having more than 60% of the same gender identity, and smaller boards and commissions from being comprised entirely of members having the same gender identity. The Senate Amendments: Restructured the bill to prevent boards and commissions from being comprised exclusively or largely of the same gender identity, instead of requiring a specified number of women members, and make conforming and technical changes.	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 813, Statutes of 2019.	**Watch**
AB 954 (Wood)	**Dental services: third-party network access.** This bill would authorize a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services, including a specialized health care service plan contract or specialized policy of health insurance, or a contracting entity, as defined, to grant third party access to a provider network contract entered into, amended, or renewed on or after January 1, 2020, or access to services or discounts provided pursuant to that provider network contract if certain criteria are met, including if a health care services plan's or health insurer's provider network contract clearly identifies the third-party access provision and the provider network contract allows a provider to opt out of third-party access. The bill would specify that a provider is not bound by or required to perform dental treatment or services under a provider network contract granted to a third party in violation of these provisions. Because a willful violation of the bill's requirements relative to health care service	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 540, Statutes of 2019.	**Watch**

	plans would be a crime, the bill would impose a state-mandated local program.		
AB 1076 (Ting)	**Criminal records: automatic relief.** This bill requires the Department of Justice, as of January 1, 2021, and upon an annual Budget Act appropriation, to review its criminal justice databases on a monthly basis and identify persons who are eligible to have certain arrests and convictions occurring on and after January 1, 2021 sealed, as specified. The bill requires the Department of Justice to grant relief to an eligible person, without requiring the eligible person to file a petition for such relief.	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 578, Statutes of 2019.	**Watch**
AB 1271 (Diep)	**Licensing examinations: report.** This bill would state the intent of the Legislature to reduce barriers to licensure by requiring the Department of Consumer Affairs to prepare and submit a study to the Legislature, by January 1, 2021, which contains information on (1) whether licensure requires completion of a board-approved training program, (2) whether licensure requires passage of a written or clinical licensing exam, (3) the exam fee that is required in addition to other application fees, (4) the average length of time between submitting a licensure application and taking a licensing exam, (5) the average passing rate of the licensing exam, and (6) the percentage of annual applicants due to exam failure.	**This is a two-year bill and dead for 2019.**	**Watch**
AB 1519 (Low)	**Healing arts.** This is the Dental Board of California's (Board's) sunset bill. This bill would, among other things, require the Board to appoint its own attorney by July 1, 2020 and authorize board member's appointing authorities to remove the member of the board they appointed for continued neglect of duty, incompetency, or unprofessional or dishonorable conduct at any time. This bill would also prohibit the Board from approving applications of foreign dental schools beginning January 1, 2020 and would require currently approved foreign schools to complete the international consultative and accreditation process with the Commission on Dental Accreditation of the American Dental Association or a comparable accrediting body by January 1, 2024. This bill would also abolish the State	**Signed by the Governor and Chaptered by the Secretary of State** Chapter 865, Statutes of 2019.	**Support**

	Dental Assistant Fund (Dental Assistant Fund) on July 1, 2022 and transfer any moneys held in that Fund to the State Dentistry Fund (Dentistry Fund). This bill extends the sunset date for the Board until January 1, 2024.		
AB 1529 (Low)	**Cannabis vaporizing cartridges: universal symbol.** This bill was gut-and-amended to address cannabis. Previously, this bill would have specified that a telephone medical advice service is required to ensure that all health care professionals who provide telephone medical advice services from an out-of-state location were operating consistent with the laws governing their respective licenses. Current: Requires a cannabis cartridge or integrated cannabis vaporizer that contains cannabis or a cannabis product to bear the universal cannabis symbol that is at least one-quarter inch by one-quarter inch. Contains an urgency clause to ensure that the provisions of this bill go into immediate effect upon enactment. The Senate Amendments delete the Assembly-approved version of this bill and instead: 1) Reduce the minimum size of the universal cannabis symbol visible on the cannabis cartridge or integrated cannabis vaporizer from a minimum of one-half inch by one-half inch to minimum of at least one-quarter inch wide by one-quarter inch high and requires it to be engraved, affixed with a sticker, or printed in black or white. 2) Define "cannabis cartridge" to mean a cartridge containing cannabis oil that is intended to be affixed to an electronic device that heats the oil and creates an aerosol or vapor. 3) Define "integrated cannabis vaporizer" to mean a singular device that contains both cannabis oil and an integrated electronic device that creates an aerosol or vapor.	**Signed by the Governor and Chaptered by the Secretary of State.** Chapter 830, Statutes of 2019.	**Watch**
AB 1622 (Carillo)	**Family physicians.** This bill would revise the content of the written informed consent statement that must be obtained from a parent or guardian prior to administering general anesthesia or conscious sedation on a minor, to include language encouraging the parent or guardian to consult	**Signed by the Governor. Chaptered by Secretary of State.** Chaptered - 632, Statutes of 2019.	**Watch**

	with the child's dentist, pediatrician or family physician, as needed. This bill would also promote the expertise provided by family physicians by allowing for their input as experts in various specified environments.		
SB 53 (Wilk)	**Open meetings.** This bill would revise the Bagley-Keene Open Meeting Act regarding state body-created advisory committees, by requiring two-member advisory committees to hold open and public meetings if one or more of the advisory committee members is a member of the larger board, committee, or commission, and the advisory committee is supported either wholly or partially by state funds.	**This is a two-year bill and dead for 2019.**	**Watch**
SB 66 (Atkins McGuire)	**Medi-Cal: federally qualified health center and rural health clinic services.** This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.	**Active** 9-11-10: Assembly Appropriations. Ordered to inactive file on request of Assembly Member Calderon.	**Support as written as of 4-12-19**
SB 144 (Mitchell and Hertzberg)	**Criminal fees.** 1) Deletes the provision requiring an ability to pay determination for the use of a public defender and the provision requiring notice that such a determination will be made. 2) Deletes the provision allowing for the recovery of costs associated with arrest. 3) Deletes the $25 administrative processing fee and $10 citation processing fee. 4) Provides that Emergency Medical Air Transportation fees shall cease to be recovered	**Active** 07-09-19: Set for second hearing canceled at the request of author.	**Watch**

	after January 1, 2020 and changes the sunset date to January 1, 2021. 5) Deletes the $50 registration fee for representation by a public defender. 6) Deletes the requirement that a defendant reimburse probation for the cost of reports associated with pretrial diversion. 7) Deletes the fees for laboratory analysis, enrollment and supervision relating to diversion. 8) Deletes the fee to cover the administrative cost of collecting the diversion restitution fee and the county share for collecting restitution. 9) Deletes the ability of a county to collect a fee to cover the administrative costs of collecting restitution. 10) Deletes the ability of an employer to collect up to $5 or $1 for an income deduction for restitution. 11) Deletes the requirement that a probationer reimburse the costs for transfer to another state before being allowed to leave. 12) Deletes the fees relating to home detention. 13) Deletes the provisions allowing fees for pretrial electronic monitoring. 14) Deletes the ability of the entity collecting restitution to add a fee to cover actual administrative costs. 15) Deletes the requirement that a person convicted of a drug offense pay for drug testing. 16) Deletes the fees related to the cost of probation supervision. 17) Deletes the requirement that an offender pay for an ignition interlock and specifically states they are not responsible for the costs. 18) Deletes the ability to recover for incarceration costs. 19) Deletes the ability of a county to seek reimbursement for the reasonable costs of county parole supervision. 20) Deletes the ability to collect state prison costs. 21) Deletes the ability to collect a $150 fee to cover a petition to change a plea or set aside a verdict. 22) Deletes the $60 fee for a petition of the dismissal or an infraction or misdemeanor. 23) Deletes the $150 fee for a petition to change a plea or set aside a verdict for an 1170h offense.		

	24) Deletes the ability to charge a person over 26 years of age the cost of sealing a juvenile record. 25) Deletes the ability to charge a defendant for transferring a case to another county. 26) Deletes the ability to charge a defendant $30 to set up a payment plan. 27) Deletes the ability to charge a fee for work furlough or home detention. 28) Deletes the ability to require a non-violent drug offender to contribute to the cost of treatment. 29) Deletes the ability of probation to charge a person for electronic monitoring. 30) Deletes the $300 civil penalty assessment for a failure to appear. 31) Deletes the ability of the court to order payment of interest on restitution. 32) Deletes the ability of CDCR to collect an administration fee to cover the actual cost of collecting restitution. 33) Deletes the ability of the counties to collect a 10% fee to cover the actual costs of collecting restitution from a person on PRCS/Mandatory Custody. 34) Deletes the ability to charge a responsible party for health care for incarcerated youth. 35) Deletes the ability to charge for expenses relating to a temporary release of an inmate. 36) Deletes the ability to charge for a work-release program. 37) Deletes the ability of CDCR to charge an administrative fee for a work furlough program. 38) Deletes the authorization to charge $15 for a written promise to appear. 39) Deletes the ability to charge a fee for failure to make an installment payment or a fee to setup up the installment plan. 40) Deletes the fee for a "fix it ticket." 41) Provides that as of January 1, 2020, a number of fees that are deleted by this bill are no longer enforceable or collectible and any amounts remaining unpaid shall be vacated. 42) Makes a number of cross-reference and conforming changes.		
SB 154 (Pan)	**Medi-Cal: restorative dental services.** This bill would authorize a provider of services for the treatment of dental caries to provide, and receive reimbursement for, the application of	**Vetoed.** **Reactivated in Senate.**	**Support with Concerns as written as of 4-12-19**

	silver diamine fluoride when used as a caries arresting agent, as specified, if the provider first consults with the beneficiary and obtains written informed consent, and if the treatment is included as part of a comprehensive treatment plan, to the extent that federal financial participation is available and any necessary federal approvals have been obtained. The bill would permit a registered dental hygienist in alternative practice who meets the requirements of the bill to bill for the services described in the bill. The bill would limit availability of the described services to specified Medi-Cal beneficiary populations. The bill would authorize the department to implement its provisions by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.	10/13/19 In Senate. Consideration of Governor's veto pending. **Governor's Veto Message:** To the Members of the California State Senate: I am returning Senate Bill 154 without my signature This bill would allow Medi-Cal dental providers to provide and be reimbursed for the application of silver diamine fluoride when used as an arresting agent for cavities on a per-tooth basis to prevent further decay, and under specified conditions. Expanding the options available for treating dental decay is a worthwhile policy goal, but this bill would require significant General Fund spending not included in the state budget. As such, this change should be considered in the annual budget process.	
SB 601 (Morrell)	**State agencies: licenses: fee waiver.** This bill would authorize any state agency that issues any business license to reduce or waive any required fees for licensure, renewal of licensure, or the replacement of a physical license for display if a person or business establishes to the satisfaction of the state agency that the person or business has been displaced by a declared emergency, as defined.	**Signed by the Governor and Chaptered by Secretary of State.** **Chapter 854, Statutes of 2019.**	**Watch**
SB 653 (Chang)	**Dental hygienists: registered dental hygienist in alternative practice: scope of practice.** This bill would authorize a registered dental hygienist to perform the functions of a registered dental assistant in a dental or medical setting and would authorize a registered dental hygienist to provide, without supervision, fluoride varnish	**Two Year Bill – Dead for 2019**	**Support with Concerns as written as of 4-12-19**

	to a patient. The bill would authorize a registered dental hygienist to provide dental hygiene preventive services and oral screenings in a public health program or in a community-based organization outreach program. This bill would additionally authorize a registered dental hygienist in alternative practice to perform specified functions and duties of a registered dental hygienist in dental or medical settings and would remove the authorization to practice in certified dental health professional shortage areas. The bill would authorize a registered dental hygienist in alternative practice to perform soft-tissue curettage, administration of local anesthesia, and administration of nitrous oxide and oxygen under the direct supervision of a dentist in the above-specified settings and would remove the general supervision requirement for specified duties in those settings. The bill would also authorize a registered dental hygienist in alternative practice to establish a practice in counties with 10 or fewer Denti-Cal providers accepting new Denti-Cal patients, as provided, and to perform specified duties in their practice without supervision of a dentist.		
SB 786 (Senate Committee on Business, Professions and Economic Development)	**Healing arts.** This bill, in the provisions regulating dental hygienists in the Dental Practice Act, would replace all of the references to "hygiene board" with "dental hygiene board."	**Signed by the Governor. Chaptered by the Secretary of State.** Chapter 456, Statutes of 2019.	**Support as written as of 4-12-19**

Current as of October 21, 2019

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
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MEMORANDUM

DATE	November 23, 2019
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer Dental Hygiene Board of California
SUBJECT	**FULL2 - 6 - Status of Dental Hygiene Board of California (DHBC) Regulatory Packages**

Rulemaking File	Board Approved Language	In Progress for Submission	Initial Legal Review Submission Date	Formal DCA Review Submission Date	Agency Submission Date
AB 2138	X	Complete	02-13-19	05-20-19	09-11-19
1115 Retired License	X	Complete	02-13-19	05-20-19	
1109 RDM/ITR	X	Complete	05-13-19	07-30-19	
1107 SLN	X	Complete	07-26-19	09-26-19	
1116 Mobile Dental Hygiene Clinics	X	Complete	08-08-19	10-09-19	
1105.2 RDH Ed Program Requirements	X	X			
1104.3 Inspections, Investigations, Cite, Fine, and Probation for DHEPs					
1105 Requirements for RDH Ed Programs					
1073.2 RDHAP Ed Program Approval	Section 100				
1073.3 RDHAP Ed Program Requirements	Section 100				

#	Rulemaking Title	Location			
	INITIAL PROCESS				
1	**RDH Course in Local Anesthesia, Nitrous Oxide-Oxygen Analgesia and Periodontal Soft tissue Curettage**	**DCA Legal and Budget Office Review**			
2	**Radiographic Decision-Making and Interim Therapeutic Restorations**	**DCA Legal and Budget Office Review**			
3	**Retired Status resubmitted as Retired License**	**Budget Office Review**			
4	**AB 2138 – Substantial Relationship and Rehabilitation Criteria**	**Agency**			
	FINAL PROCESS		**Date of Program Final Submittal to OAL**	**OAL One-Year Filing Deadline**	**OAL Review Deadline**
	N/A	**N/A**	**N/A**	**N/A**	**N/A**

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 7:

Discussion and Possible Action on Proposal for 2020 Legislative Omnibus Bill

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
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MEMORANDUM

DATE	November 22, 2019
TO	Legislative and Regulatory Subcommittee
FROM	Anthony Lum Executive Officer Dental Hygiene Board of California
SUBJECT	**FULL2 - 7 - Discussion and Possible Action, and Recommendation to the Full Board for 2020 Legislative Proposals: Omnibus Bill**

Background

The Senate Business, Professions, and Economic Development (BP & ED) Committee plans to introduce two technical, non-substantive committee bills during the 2020 legislative year that revise provisions in the Business and Professions Code relating to the state's licensure of non-health and health professionals and vocations under the Department of Consumer Affairs (DCA). One bill will be for non-health related fields and the second for health-related professions. The BP & ED Committee states that proposals should include statutory changes that are non-controversial and non-substantive, intended to clarify, update, and strengthen current law.

The Committee's deadline to accept proposed language and supporting documentation is normally mid-January of each year but should be submitted prior to this date for review.

Subcommittee Action Requested

Staff requests that the Legislative and Regulatory Subcommittee review the non-substantive and non-controversial grammatical or formatting changes which are identified by underline and highlighted in the attached statutory language and discuss, take possible action, and provide recommendations to the Full Board to provide finalized language to be proposed to the BP & ED Committee for inclusion in the 2020 Omnibus Bill.

Pros: The proposed statutory language changes include non-substantive grammatical or formatting changes which will provide clarity so existing statutory language cannot be misinterpreted as to the intent of the requirement by law.

Cons: If the proposed statutory language changes are not clarified within statute, existing statutory language may be misinterpreted as to the intent of the requirement by law.

Proposed Omnibus Changes

1902.2.

(a) A licensee shall report, upon his or her initial licensure and any subsequent application for renewal or inactive license, the practice or employment status of the licensee, designated as one of the following:
(1) Full-time practice or employment in a dental or dental hygiene practice of 32 hours per week or more in California.
(2) Full-time practice or employment in a dental or dental hygiene practice of 32 hours or more outside of California.
(3) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week in California.
(4) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week outside of California.
(5) Dental hygiene administrative employment that does not include direct patient care, as may be further defined by the dental hygiene board.
(6) Retired.
(7) Other practice or employment status, as may be further defined by the dental hygiene board.
(b) Information collected pursuant to subdivision (a) shall be posted on the Internet Web site of the dental hygiene board.
(c) (1) A licensee may report on his or her application for renewal, and the dental hygiene board, as appropriate, shall collect, information regarding the licensee's cultural background and foreign language proficiency.
(2) Information collected pursuant to this subdivision shall be aggregated on an annual basis, based on categories utilized by the dental hygiene board in the collection of the data, into both statewide totals and ZIP Code of primary practice or employment location totals.
(3) Aggregated information under this subdivision shall be compiled annually~~,~~ and reported on the Internet Web site of the dental hygiene board as appropriate, on or before July 1 of each year.
(d) It is the intent of the Legislature to utilize moneys in the State Dental Hygiene Fund to pay any cost incurred by the dental hygiene board in implementing this section.
(Amended by Stats. 2018, Ch. 858, Sec. 8. (SB 1482) Effective January 1, 2019.)

1910.5.

(a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:
(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:
(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.
(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:
(A) In either of the following settings:
(i) In a dental office setting.
(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.
(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.
(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the dental hygiene board, of having completed a dental hygiene board-approved course in those functions.
(c) No later than January 1, 2018, the dental hygiene board shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05, using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Statewide Health Planning and Development. The dental hygiene board shall use the curriculum submitted by the dental board pursuant to Section 1753.55 to adopt regulatory language for approval of courses of instruction for the Interim Therapeutic Restoration. Any subsequent amendments to the regulations for the Interim Therapeutic Restoration curriculum that are promulgated by the dental hygiene board shall be agreed upon by the dental board and the dental hygiene board.
(d) This section shall become operative on January 1, 2018.
(Amended by Stats. 2018, Ch. 858, Sec. 17. (SB 1482) Effective January 1, 2019.)

1926.2.

(a) Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate one mobile dental hygiene clinic registered as a dental hygiene office or facility. The owner or operator of the mobile dental hygiene clinic or unit shall be registered and operated in accordance with regulations established by the dental hygiene board, which regulations shall not be designed to prevent or lessen competition in service areas, and shall pay the fees described in Section 1944.
(b) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article. Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the dental hygiene board within 60 days of the date on which dental hygiene services are first delivered in the mobile unit, or the date on which the

mobile unit's application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.
(c) A licensee practicing in a mobile unit described in subdivision (b) is not subject to subdivision (a) as to that mobile unit.
(Amended by Stats. 2018, Ch. 858, Sec. 25. (SB 1482) Effective January 1, 2019.)

1949.

A licensee may have his or her license revoked or suspended, or may be reprimanded or placed on probation by the dental hygiene board for unprofessional conduct, incompetence, gross negligence, repeated acts of negligence in his or her profession, receiving a license by mistake, or for any other cause applicable to the licentiate provided in this article. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the dental hygiene board shall have all the powers granted therein.
(Amended by Stats. 2018, Ch. 858, Sec. 42. (SB 1482) Effective January 1, 2019.)

1950.

(a) A licensee may have his or her license revoked or suspended, or may be reprimanded or placed on probation by the dental hygiene board, for conviction of a crime substantially related to the licensee's qualifications, functions, or duties. The record of conviction or a copy certified by the clerk of the court or by the judge in whose court the conviction occurred shall be conclusive evidence of conviction.
(b) The dental hygiene board shall undertake proceedings under this section upon the receipt of a certified copy of the record of conviction. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge of a felony or of any misdemeanor substantially related to the licensee's qualifications, functions, or duties is deemed to be a conviction within the meaning of this section.
(c) The dental hygiene board may reprimand a licensee or order a license suspended or revoked, or placed on probation or may decline to issue a license, when any of the following occur:
(1) The time for appeal has elapsed.
(2) The judgment of conviction has been affirmed on appeal.
(3) An order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under any provision of the Penal Code, including, but not limited to, Section 1203.4 of the Penal Code, allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.
(Amended by Stats. 2018, Ch. 858, Sec. 43. (SB 1482) Effective January 1, 2019.)

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 8:

Dental Hygiene Educational Program Review Update

- **Sacramento City College**
- **Diablo Valley College**
- **Cabrillo College**
- **San Joaquin Valley College – Visalia**

Informational Only

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR
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MEMORANDUM

DATE	November 23, 2019
TO	Educational Subcommittee
FROM	Adina A. Pineschi-Petty DDS Education, Legislative, and Regulatory Specialist Dental Hygiene Board of California
SUBJECT	**FULL2 - 8 - DHBC Site Visit Update**

1. Sacramento City College (SCC)
    a. Site visit generated by a Commission on Dental Accreditation (CODA) Self Study review and as a part of the DHBC oversite goals to review all dental hygiene educational programs in California.
    b. On December 7, 2018 a site visit was conducted at the SCC campus.
    c. Majority of deficiencies were corrected by the original deadline date of February 28, 2019.
    d. SCC requested an extension to the remaining Program Director deficiency.
    e. Current status:
        i. Outstanding Program Director deficiency corrected and now in compliance.
        ii. See SCC Report.

2. Diablo Valley College (DVC)
    a. Site visit generated as a part of the DHBC oversite goals to review all dental hygiene educational programs in California.
    b. On February 26, 2019 a site visit was conducted at the DVC campus.
    c. Deficiencies were required to be corrected by June 1, 2019.
    d. Current status:
        i. Outstanding staff deficiency is required to be corrected by December 1, 2019.
        ii. See DVC report.

3. Cabrillo College
    a. Site visit generated as a part of CODA Self Study review and as a part of the DHBC oversite goals to review all dental hygiene educational programs in California.
    b. On November 7, 2019 a site visit was conducted at the Cabrillo College campus.
    c. Site visit report in progress.

4. San Joaquin Valley College – Visalia (SJVC-Visalia)
    a. Site visit generated as a part of CODA Self Study review and as a part of the DHBC oversite goals to review all dental hygiene educational programs in California.
    b. On November 14, 2019 a site visit was conducted at the SJVC-Visalia campus.
    c. Site visit report in progress.

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May 15, 2019

Dr. Melissa Fellman
Program Director, Department of Dental Hygiene
Sacramento City College
3835 Freeport Blvd.
Sacramento, CA 95822

Dear Dr. Fellman,

The Dental Hygiene Board of California (DHBC) conducted a site visit on December 7, 2018 of the Sacramento City College (SCC) Dental Hygiene Educational Program (DHEP). This site visit was generated due to the review of SCC's Commission on Dental Accreditation (CODA) Self Study, as well as DHBC's oversite goals to review all dental hygiene educational programs in California. Based on the results of the site visit and a review of the documentation provided by SCC, it was noted that evidence of program compliance with the minimum DHEP standards set by the California Code of Regulations (CCR) and CODA was deficient.

On December 14, 2018 SCC was issued a site visit report by the DHBC to correct the deficiencies found in the review of the SCC DHEP CODA Self Study as well as deficiencies discovered during the December 7, 2018 site visit by February 28, 2019 at the SCC DHEP.

Per SCC's request, on February 19, 2019 the DHBC conducted a teleconference with Dean James Collins (SCC), Dr. Albert Garcia, Vice President of Instruction (SCC), DHBC Executive Officer Anthony Lum, and Adina A. Pineschi-Petty DDS regarding clarification on program director requirements. At that time, SCC requested and was granted a three-month extension for SCC to comply with regulations on program director requirements.

On February 26, 2019 SCC provided satisfactory documentation on corrections to outstanding program deficiencies with the exception of program director requirements.

The determination of the remaining deficiency of program director requirements is as follows:

1. Deficiency - Program Director

    a. The SCC DHEP has a "Dental Hygiene Coordinator" for which the job duties are posted as "Dental Hygiene Assistant Professor 60% /Coordinator 40%" and not a "Dental Hygiene Program Director" as prescribed by regulations.

        i. CODA Self Study page 115 states:
            1. "Dental hygiene, dental assisting, occupational therapy assisting, and physical therapist assisting all have 40% release time with the option of 10% release or stipend for chair duties. The dental hygiene program coordinator has 40% release time for administrative responsibilities. Additionally, the dental hygiene program coordinator has a 10% release time option for chair duties."

            2. "A full-time dental health faculty member teaches 30 formula hours each year. A formula hour is described as follows:
            One lecture hour = 1 formula hour One lab/clinic hour = ¾ formula hour. The program coordinator teaches 18 formula hours each year. The program coordinator has the same responsibilities as do other faculty in clinics, laboratories and lectures. 18/30 = Accounts for 60% teaching time."

ii. CODA Self Study p. 116
    1. States: “The most accurate comparison would be to the nursing director. Nursing has a 100% release time position for the nursing program director. Traditionally, statistics alone have justified this difference with dental hygiene: The nursing programs have approximately 210 students while dental health has approximately 70-75 students. Nursing has 18 FTE faculty while dental health has 7 FTE faculty. The student/faculty ratios in their laboratories and clinics are similar to dental hygiene laboratory and clinical ratios. The nursing students are required to spend much of their education at area hospitals, which require additional coordination time. Dental health students have far fewer hours in off-campus facilities. Irrespective of the off-campus coordination time differences, the dental hygiene program coordinator now has strict state mandates related to direct supervision duties and Interim Therapeutic restorations. The Dental Hygiene Board of California requires faculty training, tracking, and law compliance beyond the prior scope of the dental hygiene coordinator. Considering more release time for administration of the program is prudent as the regulatory tracking and calibration has increased over the years.”

iii. CODA Self Study p.123
    1. States: “The program coordinator of dental hygiene has a 40% release-time assignment for all administrative functions. All other functions such as advising and counseling students, supervision of extramural activities and committee assignments are all considered part of the faculty member’s professional responsibility. Therefore the faculty member receives no release time for these activities.”

iv. 40% release time for administrative duties does not provide for sufficient time for the program coordinator to address the primary responsibilities of the operation, supervision, evaluation and revision of the program.

b. Refer to
    i. CCR
        1. § 1105 (j): The educational program director shall have the primary responsibility for developing policies and procedures, planning, organizing, implementing and evaluating all aspects of the program.
        2. § 1105.1 (a): “Program Director” or “Interim Program Director” means a registered dental hygienist or dentist who has the authority and responsibility to administer the educational program in accordance with approved accreditation standards referenced in subsection (c) of section 1103 of this article. The educational program may have an Interim Program Director for a maximum of twelve (12) months. The director shall have a full-time appointment as defined by the institution, whose primary responsibility is for the operation, supervision, evaluation and revision of the program. The program director shall meet the following minimum qualifications: (1) Possess an active, current dental or dental hygiene license issued by the Dental Hygiene Board or the Dental Board of California (DBC), with no disciplinary actions; (2) Possess a master's or higher degree from a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation; (3) Documentation of two (2) years' experience teaching in pre- or post-licensure registered dental hygiene or dental programs. This requirement may be waived for an Interim Program Director; and (4) Documentation of a minimum of 2,000 hours in direct patient care as a registered dental hygienist or working with a registered dental hygienist.

    ii. CODA
        1. 3-2: The dental hygiene program administrator must have a full-time appointment as defined by the institution, whose primary responsibility is for operation, supervision, evaluation and revision of the program.

2. 3-3: The program administrator must be a dental hygienist who is a graduate of a program accredited by the Commission on Dental Accreditation and possesses a masters or higher degree or is currently enrolled in a masters or higher degree program or a dentist who has background in education and the professional experience necessary to understand and fulfill the program goals.
3. 3-4: The program administrator must have the authority and responsibility necessary to fulfill program goals including: a) curriculum development, evaluation and revision; b) faculty recruitment, assignments and supervision; c) input into faculty evaluation; d) initiation of program or department in-service and faculty development; e) assessing, planning and operating program facilities; f) input into budget preparation and fiscal administration; g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.

c. Determination
    i. In compliance.

    ii. SCC provided satisfactory evidence of a "Dental Hygiene Program Director" position pursuant to 16 CCR § 1105 (j), 16 CCR § 1105.1 (a), in addition to meeting CODA Standards 3-2, 3-3, and 3-4.

The priority of the DHBC is consumer protection. To ensure consumer protection and the public's right to receive quality dental hygiene care, the DHBC has a responsibility to ensure that all DHEPs meet the same educational standards in preparing their graduates for the profession. If you have any questions regarding this report, please feel free to contact me at adina.petty@dca.ca.gov.

Sincerely,

Adina A. Pineschi-Petty DDS

Education, Legislative, and Regulatory Specialist
Dental Hygiene Board of California

cc: Michael Gutierrez, President, Sacramento City College
Dr. Albert Garcia, Vice President of Instruction, Sacramento City College
James Collins, Dean of Science & Allied Health, Sacramento City College
Anthony Lum, Executive Officer, Dental Hygiene Board of California

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October 22, 2019

Tonette Steeb CDA, RDH, MSEd
Director of Dental Programs
Diablo Valley College
321 Golf Club Road
Pleasant Hill, CA 94523

Dear Ms. Steeb,

The Dental Hygiene Board of California (DHBC) conducted a site visit on February 26, 2019 of the Diablo Valley College Dental Hygiene Education Program (DVC). This site visit was generated due to the review of DVC's Commission on Dental Accreditation (CODA) Self Study, as well as DHBC's oversite goals to review all dental hygiene educational programs (DHEPs) in California. Based on the results of the site visit and a review of the documentation provided by DVC, it was noted that evidence of program compliance with the minimum DHEP standards set by the California Code of Regulations (CCR), CODA, and the Health and Safety Code (HSC) was deficient. During the review of the CODA Self Study and DHBC site visit, deficiencies of minimum DHEP standards were discovered.

On October 21, 2019 DVC sent a response letter to the DHBC addressing the remaining deficiencies. The DHBC determination on deficiencies are as follows:

1. Deficiency: Prerequisites for DHEPs

    a. Prerequisites:
        i. Mathematics prerequisite allows for an Advanced Placement (AP) math exam score.

        ii. Written communication prerequisite allows for an AP English exam score.

    b. Refer to:
        i. CCR
            1. **§1105(f):** Admission.(1) The minimum basis for admission into an educational program shall be the successful completion of all of the following: (A) A high school diploma or the recognized equivalent, which will permit entrance to a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation; and, (B) College-level general education courses in the topic areas of: (i) Oral and Written Communication (ii) Psychology (iii) Sociology (iv) Mathematics (v) Cultural Diversity* (vi) Nutrition* *This course is required prior to graduation, and may be waived as an admission requirement if included within the dental hygiene program curriculum. (C) College-level biomedical science courses, each of which must

include a wet laboratory component, in: (i) Anatomy (ii) Physiology (iii) Chemistry (iv) Biochemistry (v) Microbiology.

ii. CODA

1. **2-8:** The curriculum must include content in the following four areas: general education, biomedical sciences, dental sciences and dental hygiene science. This content must be integrated and of sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies. A curriculum document must be submitted for each course included in the dental hygiene program for all four content areas.

2. **2-8a:** General education content must include oral and written communications, psychology, and sociology.

c. Response:

i. "DVC Dental Hygiene Program has removed the language concerning acceptance of AP courses for English and Math from our catalog and application for the 2020-2021 academic year. We are hopeful the DHBC will reconsider and adjust the policy regarding the acceptance of AP courses for English and Math. I look forward to the discussion on this topic at your November 2019 meeting."

d. Determination:

i. Currently in compliance.

ii. Regulations in 16 CCR §1105 (f)(1) requires that the minimum basis for admission into an educational program shall include the successful completion of college-level general education courses in mathematics and oral and written communication and does not allow for AP English exam scores or AP Math exam scores as an option to satisfy prerequisites.

iii. Per DVC's request, the acceptance of AP English exam scores and AP Math exam scores as an option to satisfy prerequisites for entry into the DVC Program has been placed on the Board's November 22-23, 2019 meeting agenda for consideration.

2. Deficiency: Support Staff

a. Open full-time dental lab coordinator position since July 18, 2018 which equates 50% reduction in staff. DVC did not notify the DHBC within ten (10) days of the reduction in staff.

b. Refer to:

i. CCR

1. **§1105.3 (a)(2)(D):** (a) Each dental hygiene program holding a certificate of approval shall: (2) Notify the Board within ten (10) days of any: (D) Programmatic reduction in program faculty or support staff of more than 10%.

2. **§1105 (i):** The educational program shall have learning resources, including faculty, library, staff and support services, technology and physical space and equipment, including laboratory and clinical facilities, to support the program's

stated mission and goals and in accordance with approved accreditation standards referenced in subsection (c) of section 1103 of this article.

3. **§1105 (k):** The number and distribution of faculty and staff shall be sufficient to meet the educational program's stated mission and goals.

ii. CODA
1. **3-11:** Qualified institutional support personnel must be assigned to the program to support both the instructional program and the clinical facilities providing a safe environment for the provision of instruction and patient care.

c. Response:
i. "DVC acknowledges we are deficient in the area of support staff. We have had difficulty finding a qualified candidate. The position was reposted with the application filing period closing earlier this month. The application screening process provided us with 2 qualified candidates. We will be moving forward with the interview process the week of November 4, 2019. I will notify you when the interview process is complete and a candidate has accepted the position. Thank you for your patients concerning this issue."

d. Determination:
i. Not in compliance.

ii. DVC shall provide adequate support staff pursuant to 16 CCR §1105 (i), §1105 (k), in addition to CODA Standard 3-11.

You will be required to provide evidence of compliance to the above remaining deficiency **no later than December 1, 2019**.

The priority of the DHBC is consumer protection. To ensure consumer protection and the public's right to receive quality dental hygiene care, the DHBC has a responsibility to ensure that all dental hygiene programs meet the same educational standards in preparing their graduates for the profession. If DVC does not correct the above deficiency by **December 1, 2019**, DVC risks the DHBC's approval of the DVC Dental Hygiene Educational Program and for DVC graduates to obtain a California license in dental hygiene. If you have any questions regarding this report, please feel free to contact me at adina.petty@dca.ca.gov.

Sincerely,

Adina A. Pineschi-Petty DDS

Education, Legislative, and Regulatory Specialist
Dental Hygiene Board of California

cc: Anthony Lum, Executive Officer, Dental Hygiene Board of California
Susan Lamb, President, Diablo Valley College
Joseph Gorga, Dean of Physical, Biological, and Health Science, Diablo Valley College

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 9:

Report on Licensing Statistics:

- **Licensure Statistics**
- **Written Exam Statistics**

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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MEMORANDUM

DATE	November 22, 2019
TO	Dental Hygiene Board of California
FROM	Traci Napper, Program Analyst
SUBJECT	**FULL2 - 9 - Licensure Statistics**

DHBC Licensure Statistics (as of November 5, 2019)

LICENSE STATUS	LICENSE TYPE				
	RDH	RDHAP	RDHEF	FNP	TOTAL
ACTIVE	18,049	594	24	123	18,790
INACTIVE	1,900	48	2	0	1,950
DELINQUENT	3,485	97	4	76	3,662
LICENSED SUBTOTAL					
REVOKED	27	1	0	0	28
DENIED	1	0	0	0	1
VOLUNTARY SURRNENDERED	16	2	0	0	18
CANCELLED	8,702	21	2	45	8,770
DECEASED	214	2	0	0	216
RETIRED	34	0	0	0	34
NON-LICENSED SUBTOTAL					
TOTAL POPULATION (Licensed Subtotal plus Non-licensed Subtotal)	32,428	765	32	245	33,469

LICENSE TYPES

Registered Dental Hygienist - **RDH**
Registered Dental Hygienist in Alternative Practice – **RDHAP**
Registered Dental Hygienist in Extended Function - **RDHEF**
Fictitious Name Permit – **FNP**

LICENSE STATUS

Active – A license that has completed all renewal requirements.
Inactive – Renewal fees paid and license placed on Inactive status.
(Reasons include: not practicing, live scan or CE incomplete)
Delinquent – Fees have not been paid for one or more renewal periods.
Revoked – Disciplinary action taken; not licensed to practice in CA.
Denied – License or application denied due to disciplinary action.
Voluntary Surrendered – Surrendered license voluntarily due to disciplinary action.
Cancelled – Result from nonpayment of renewal fees for five years after expiration.

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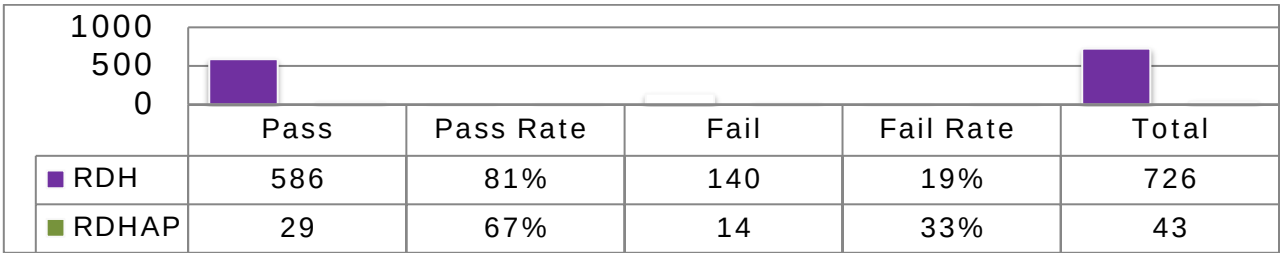
MEMORANDUM

DATE	November 22, 2019
TO	Dental Hygiene Board of California
FROM	Traci Napper, Program Analyst
SUBJECT	**FULL - 9 - Written Examination Statistics**

RDH AND RDHAP WRITTEN LAW AND ETHICS EXAM
(MARCH 12, 2019 – OCTOBER 31, 2019)



RDH WRITTEN LAW & ETHICS EXAMINATION					
Date Range	**RDH** Candidates Tested	**Pass**		**Fail**	
03/12/2019 – 10/03/2019	726	586	**81%**	140	**19%**
10/20/2018 – 03/11/2019	292	242	**82%**	50	**17%**
03/08/2018 – 10/19/2018	736	602	**82%**	134	**18%**

RDHAP WRITTEN LAW & ETHICS EXAMINATION					
Date Range	**RDHAP Tested**	**Pass**		**Fail**	
03/12/2019 – 10/03/2019	43	29	**67%**	14	**33%**
10/20/2018 – 03/11/2019	20	17	**85%**	3	**15%**
03/08/2018 – 10/19/2018	38	33	**87%**	5	**13%**

NUMBER OF ATTEMPTS FOR PASSAGE OF THE RDH OR RDHAP WRITTEN EXAMINATION			
03/12/2019 – 10/31/2019	**1st Attempt**	**Multiple Attempts**	**Total**
• RDH	462	124	586
• RDHAP	20	9	29
Total	482	133	615

NUMBER OF OUT-OF-STATE WRITTEN LAW & ETHICS EXAMINATION PARTICIPANTS					
03/12/2019 -10/07/2019	Pass		Fail		Total
• RDH	10	71%	4	29%	14
• RDHAP	0	0%	0	0%	0

OUT OF STATE ATTEMPTS 03/12/2019 - 10/04/2019	**1st Attempt**	**Multiple Attempts**	Total
RDH	10	0	10
RDHAP	0	0	0

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 10:

Report on Enforcement Statistics

Dental Hygiene Board of California
Enforcement Statistics
FY 19/20 - Data Captured through October 18, 2019

***N/A = Data not available. Data began being captured 9/30/2019.**

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Complaints Received						
Consumer Complaints	16	11	3	2		
Arrests/Convictions	10	15	2	4		
Applicants	13	7	3	8		
Totals	**39**	**33**	**8**	**14**		
Complaint Case Type Received						
Criminal Charges/Convictions	23	22	5	12		
Incompetence/Negligence	0	0	0	0		
Non-Jurisdictional	0	1	0	0		
Sexual Misconduct	1	0	0	0		
Substance Abuse - No criminal charges	0	0	1	0		
Unprofessional Conduct	12	6	2	1		
Unlicensed	2	4	0	1		
Unsafe/Unsanitary Conditions	1	0	0	0		
Other	0	0	0	0		
Complaint Closures w/no additional Disciplinary Action						
Application Approved	9	4	3	7		
Insufficient Evidence	1	6	5	0		
No Violation	5	4	2	0		
No Jurisdiction	6	4	2	0		
Other (includes, but not limited to redundant complaints and those awaiting criminal disposition)	14	3	9	4		
Totals	**35**	**21**	**23**	**11**		

Dental Hygiene Board of California
Enforcement Statistics
FY 19/20 - Data Captured through October 18, 2019

***N/A = Data not available. Data began being captured 9/30/2019.**

Investigations

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Open Investigations						
Desk Investigations	*N/A	*N/A	41	40		
Field Investigations	*N/A	*N/A	46	46		
Totals	*N/A	*N/A	**87**	**86**		
Closed Investigations						
Desk Investigations	25	12	14	19		
Field Investigations	4	3	4	2		
Totals	**29**	**15**	**18**	**21**		

Investigation Case Aging (Open Cases)

Desk Investigations						
0-6 months	*N/A	*N/A	25	23		
7-12 months	*N/A	*N/A	11	10		
>1 yr - 1.5 years	*N/A	*N/A	5	3		
>1.5 years - 2 years	*N/A	*N/A	5	4		
>2 years	*N/A	*N/A	1	0		
Field Investigations						
0-6 months	*N/A	*N/A	14	15		
7-12 months	*N/A	*N/A	12	10		
>1 yr - 1.5 years	*N/A	*N/A	7	8		
>1.5 years - 2 years	*N/A	*N/A	8	7		
>2 years	*N/A	*N/A	5	6		

Dental Hygiene Board of California
Enforcement Statistics
FY 19/20 - Data Captured through October 18, 2019

***N/A = Data not available. Data began being captured 9/30/2019.**

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Attorney General's Office (AG)						
Discipline						
Cases Transmitted to AG	0	1	4	7		
Statement of Issues Filed	0	0	0	1		
Accusations Filed	1	0	0	1		
Accusations Withdrawn	0	0	0	1		
Revocation	0	1	1	0		
Surrender	0	1	0	0		
Probation	0	1	0	1		
Probation Subsequent Discipline						
Subsequent Case Transmitted to AG	2	1	2	4		
Petition to Revoke Probation Filed	0	1	2	1		
Accusation/Petition to Revoked Probation Filed	0	0	0	0		
Revoked	0	0	1	0		
Surrendered	0	1	0	0		
Probation Extended	0	1	0	0		
All AG Cases Pending Discipline						
Totals	*N/A	*N/A	17	26		
All AG Pending Case Aging From Time of Transmittal						
0-6 months	*N/A	*N/A	11	21		
7-12 months	*N/A	*N/A	3	3		
>1 yr - 1.5 years	*N/A	*N/A	3	2		
>1.5 years - 2 years	*N/A	*N/A	0	0		
>2 years	*N/A	*N/A	0	0		

Dental Hygiene Board of California
Enforcement Statistics
FY 19/20 - Data Captured through October 18, 2019

***N/A = Data not available. Data began being captured 9/30/2019.**

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Citation/Fine						
Citations Issued	1	3	13	3		
Citations Dismissed	0	0	0	0		
Amount Ordered	$ 3,000.00	$ 1,250.00	$ 12,250.00	$ 3,750.00		
Probation						
Active Probationers	41	39	40	41		
Tolled Probationers	3	3	3	3		
Biological Testing Probationers	26	24	24	24		
Positive Drug Screen for Banned Substances	3	3	3	2		
Violations of Probation Issued	8	4	6	3		

DHBC ENFORCEMENT STATISTICS

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Investigations				
Complaints				
Complaints Received	51	57	31	47
Convictions/Arrests Received	137	127	151	93
Total Intake	**188**	**183**	**182**	**142**
Citations				
Issued	29	35	24	5
Dismissed	-	1	-	0
Enforcement Actions				
Cases Referred to AG	17	16	5	8
Accusations Filed	7	9	8	7
Statement of Issues Filed	2	6	1	1
Petition for Early Termination of Probation	3	1	3	0
Pro/Default Decisions / Stipulations Adopted	8	19	20	8
Allegations				
Criminal Charges	137	127	151	93
Alcohol/Drug Related Offenses	-	2	2	2
Fraud/Misrepresentation	9	2	4	-
Short Continuing Education	-	3	-	-
Non-Jurisdictional	15	11	4	14
Failure to notify of address change	2	7	-	-
Unlicensed or Expired License	14	12	5	7
Excessive/Incompetence/Negligence	8	11	7	8
Patient Abandonment	-	-	1	-
Hippa	1	2	1	-
False Advertising	-	2	-	-
Other	-	-	-	5
Reporting Requirements	-	1	-	-
App Investigation	-	-	-	1
Sexual Misconduct	-	-	-	1
Unprofessional Conduct	-	-	-	11
Working Outside of Scope	2	4	7	-
Probationers				
Active	31	31	42	41
Tolling	4	4	5	3

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 11:

Discussion: Myofunctional Therapy: Is it Within the Dental Hygiene Scope of Practice [CCR 1088(c)(E)]

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhbc.ca.gov

MEMORANDUM

DATE	November 23, 2019
TO	Dental Hygiene Board of California
FROM	Anthony Lum, Executive Officer Dental Hygiene Board of California
SUBJECT	FULL2 - 11 - Discussion and Possible Action on Myofunctional Therapy: Is it within the Dental Hygiene Scope of Practice [CCR 1088(c)(E)]?

Background:

At a prior Board meeting, a member of the public requested to have myofunctional therapy placed on the agenda for the Board to discuss whether this treatment technique is within the scope of practice for dental hygienists. Pursuant to California Code of Regulations (CCR) section 1088(c)(E), only myofunctional evaluation is listed as a service that dental hygienists can provide within their scope. Board staff is aware that there are multiple licensees who have been certified and utilize this technique on their patients to help alleviate problems with chewing, swallowing, temporal mandibular joint (TMJ) function, oral hygiene, or other problems; however, the law states that a myofunctional evaluation is acceptable but does not provide guidelines for ongoing therapeutic treatment. This is a new issue and it has not been determined whether licensees are using this technique independently with their certification or under the supervision of a licensed dentist.

Action Requested:

Staff requests the Board to discuss and make a recommendation as to include or not include ongoing myofunctional therapy treatments within the dental hygiene scope of practice. The section of the law [Business and Professions Code section 1910(a)] which may be utilized to justify the use of this treatment technique is vague and clarity would assist staff in determining whether this is an acceptable technique within a dental hygienist's scope of practice in the interest of consumer protection.

Pros: By clarifying whether myofunctional therapy is considered within the dental hygienist's scope of practice, it will provide staff a solid reference within the law as to whether licensees can perform this technique should there be an instance where action against a licensee occurs.

Cons: In determining that myofunctional therapy is not within the scope of practice for dental hygienists, many licensees currently performing ongoing treatments using these techniques would be banned from providing beneficial help to their patients and may be placing their license in jeopardy.

AOMT
ACADEMY of OROFACIAL MYOFUNCTIONAL THERAPY
(https://aomtinfo.org/)

WHAT IS MYOFUNCTIONAL THERAPY?

Orofacial Myofunctional Disorders (OMDs) are disorders of the muscles and functions of the face and mouth. OMDs may affect, directly and/or indirectly, breastfeeding, facial skeletal growth and development, chewing, swallowing, speech, occlusion, temporomandibular joint movement, oral hygiene, stability of orthodontic treatment, facial esthetics, and more.

Most OMDs originate with insufficient habitual nasal breathing or with oral breathing. The subsequent adaptation of the muscles and the orofacial functions to a disordered breathing pattern creates many OMDs. Orofacial Myofunctional Disorders may impact treatments by orthodontists, dentists, dental hygienists, speech-language pathologists, and other professionals working in the orofacial area.

> *"Correct swallowing depends on a proper relationship between muscles of the face, mouth and throat."*

Correct swallowing depends on a proper relationship between muscles of the face, mouth and throat. The act of swallowing is one function that depends on the body's vital balance. To swallow properly, muscles and nerves in the tongue, cheeks and throat must work together in harmony. When a person swallows normally, the tip of the tongue presses firmly against the roof of the mouth or hard palate, located slightly behind the front teeth. The tongue acts in concert with all the other muscles involved in swallowing. The hard palate, meanwhile, absorbs the force created by the tongue.

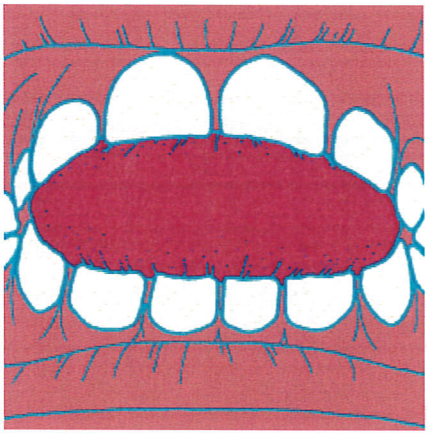
Because a person swallows 500-1000 times a day, improper swallowing can cause a variety of problems.

But it is actually the resting position of the tongue that does the most damage because it is more constant.

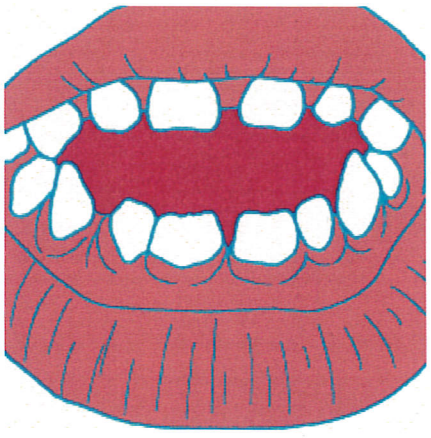
Dental Problems related to an OMD

When a person swallows incorrectly, the tip and/or sides of the tongue press against or spread between the teeth. This is commonly called a tongue thrust. Constant pressure from resting or incorrectly thrusting the tongue away from the hard palate may push teeth out of place. That pressure may later prevent teeth from erupting (breaking through the gum).

An OMD may lead to an abnormal bite – the improper alignment between the upper and lower teeth known as malocclusion. This problem may lead to difficulties in biting, chewing, swallowing, and digesting of food.

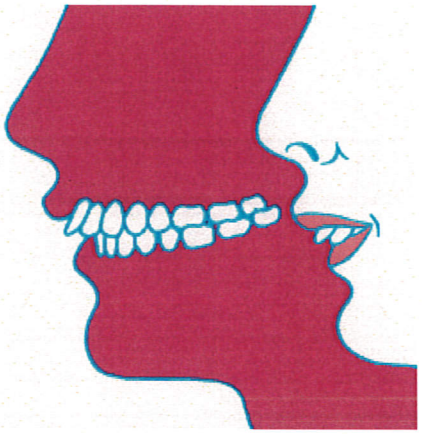


Tongue thrust is the act of pushing the tongue against or between the teeth when swallowing.



(/wp-content/uploads/2015/01/tongue-thrust-211.jpg)

The constant pressure of the tongue against or between the teeth will not allow the teeth to bite together. This is known as an open bite.

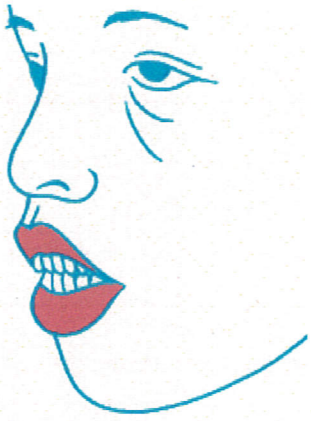


An improper alignment or malocclusion between the upper and lower teeth can lead to difficulties in biting and chewing food.

Cosmetic Problems related to an OMD

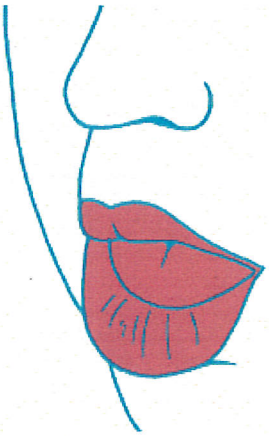
Often the most obvious symptom of incorrect oral posture involves the muscles of the face. A dull, sluggish appearance and full, weak lips develop when muscles aren't operating normally.

Constantly parted lips (with or without mouth breathing) also signal this disorder. A person swallowing incorrectly will often purse and tighten the muscles of the cheeks, chin and lips – a symptom known as a facial grimace. This can give the chin a knobby appearance because these muscles are being overused.



The face can have a dull sluggish appearance when the muscles are not in proper balance.

An incorrect swallow will purse and tighten the muscles of the cheeks, chin, and lips, causing a facial grimace



Mouth breathing or constantly open lips is a cause and/or signal of tongue thrust and low tongue rest posture.

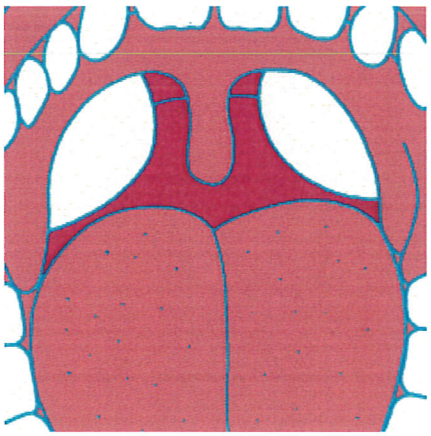
Speech Problems that may develop from an OMD

A person with abnormal oral muscle patterns may suffer a lisp or have difficulty in articulating sounds. If muscles in the tongue and lips are incorrectly postured, this can prevent a person from forming sounds of normal speech.Improper oral muscle function may additionally lead to TMJ dysfunction, headaches, stomach distress (from swallowing air), airway obstruction, and other health challenges.

Sleep Disordered Breathing and Mild to Moderate OSA

Recent research has shown that myofunctional therapy may reduce the symptoms of sleep disordered breathing (such as snoring), and ameliorate mild to moderate OSA (obstructive sleep apnea). When functioning and used properly, the muscles of the tongue, throat, and face, can reduce obstruction to the airway.

Causes of Tongue Thrust



Enlarged tonsils (shown in white) can block the airway, causing an improper positioning of the tongue.

Thumb or finger sucking habits force the tongue into a low position that pushes it against the teeth.

Orofacial Myofunctional Therapy (OMT) eliminates many of the causes of swallowing abnormalities and improper rest posture of the tongue.

Orofacial myofunctional therapy is painless and the exercises are relatively simple. When certain muscles of the face are activated and functioning properly, other muscles will follow suit until proper coordination of the tongue and facial muscles is attained. For success in this therapy, consistent exercise every day is necessary until the patient has corrected their improper muscle pattern. It also takes commitment by the patient, family – and time. Treatment usually consists of a regular program of exercises over a 6 – 12 month period, although treatment length may vary.

Multi-Disciplinary Approach

A properly trained myofunctional therapist is one member of the team that will successfully treat an OMD. Other allied professionals such as dentists, orthodontists, and osteopaths can ensure that the patient's needs are addressed and handled appropriately. We feel that the patient needs to be looked at from a variety of approaches in order to be successful in treatment.

Positive Impact

With myofunctional therapy, a patient can regain the joy of eating, speaking, breathing, and even sleeping more soundly. Cosmetic improvements can help restore confidence and self-esteem. We believe that everyone deserves to be educated about myofuncitonal disorders and treated if they suffer from OMDs. We endeavor to increase awareness of OMT amongst the medical, dental, and academic communities to support the acceptance and progress of this profession world-wide.

- Home (https://aomtinfo.org/)
- About (https://aomtinfo.org/about/)
- Myofunctional Therapy (https://aomtinfo.org/myofunctional-therapy/)
- Advisory Board (https://aomtinfo.org/advisory-board/)
- News (https://aomtinfo.org/news/)
- Find a Therapist (https://www.myofunctionaltherapists.com/)
- Contact (https://aomtinfo.org/contact/)

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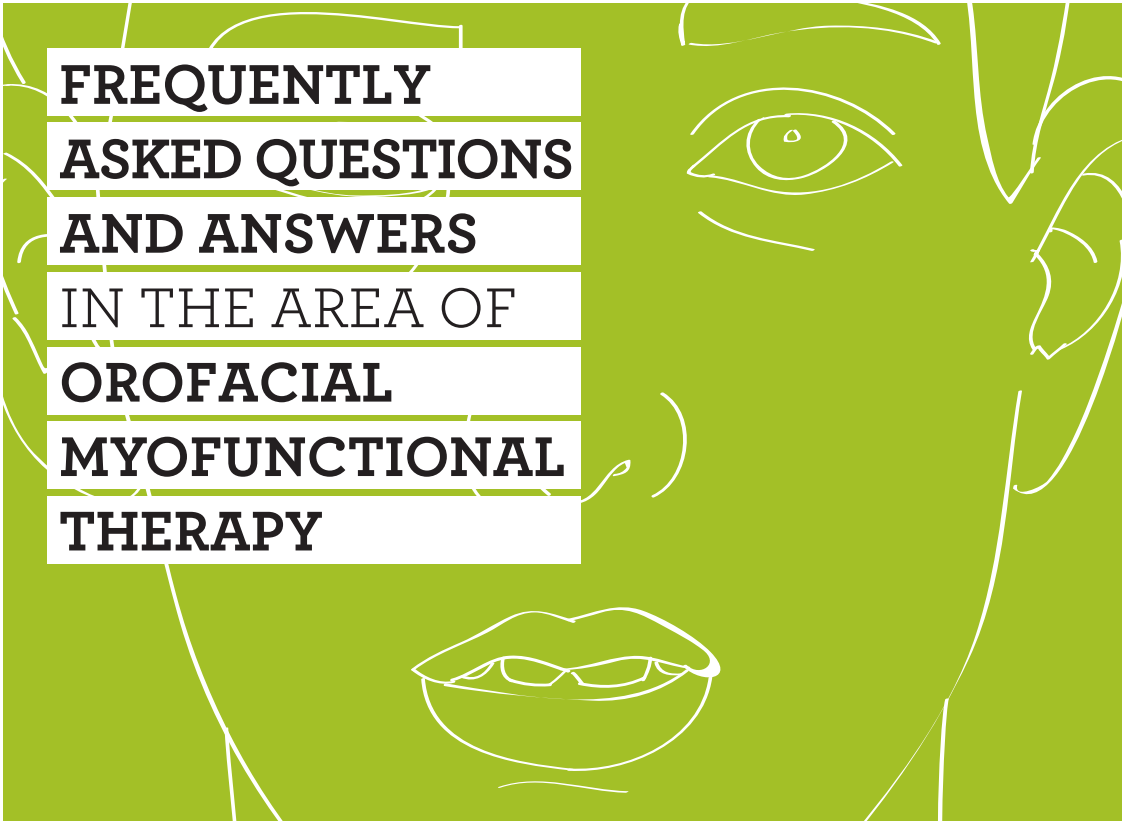
WEBSITE DISCLAIMER (HTTPS://AOMTINFO.ORG/WEBSITE-DISCLAIMER)

LET'S KEEP IN TOUCH!

First Name

FREQUENTLY ASKED QUESTIONS AND ANSWERS IN THE AREA OF OROFACIAL MYOFUNCTIONAL THERAPY



Orofacial Myofunctional Therapy is an interdisciplinary practice that works with the muscles of the lips, tongue, cheeks and face and their related functions (such as breathing, sucking, chewing, swallowing, and some aspects of speech). It acts in the prevention, evaluation, diagnosis and treatment of people who may have these functions compromised or altered. It can also act in improving facial aesthetics. In this area, the Specialist in Orofacial Myofunctional Therapy can work in partnership with other professionals such as dentists, doctors, physical therapists, occupational therapists, nutritionists, nurses and psychologists. As an emerging field, questions are quite common when we talk about Orofacial Myofunctional Therapy. Below are some answers of frequently asked questions.

ON THE FOLLOWING PAGES, WE HAVE COMPILED THE MOST IMPORTANT QUESTIONS AND ANSWERS THAT PEOPLE ASK ABOUT **OROFACIAL MYOFUNCTIONAL THERAPY >**

WHAT IS OROFACIAL MYOFUNCTIONAL THERAPY (OMT)?

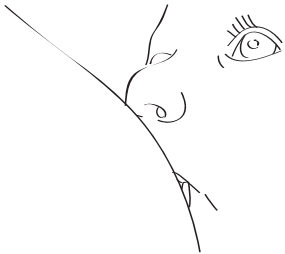
Orofacial Myofunctional Therapy is neurological re-education exercises to assist the normalization of the developing, or developed, craniofacial structures and function. It is related to the study, research, prevention, evaluation, diagnosis and treatment of functional and structural alterations in the region of the mouth (oro), face (facial) and regions of the neck (oropharyngeal area).

WHAT ARE THE MAIN PROBLEMS RELATED TO OROFACIAL MYOFUNCTIONAL DISORDERS (OMDS)?

The main problems related to OMDs are alterations in breathing, sucking, chewing, swallowing and speech, as well the position of the lips, tongue (including what is known as oral rest posture), and cheeks.

WHAT IS THE LINK BETWEEN FEEDING AND SPEECH?

Feeding a child stimulates the orofacial muscles and this promotes the growth of the face. In the same way, proper suction and chewing prevents dental alterations and difficulties when structures such as the lips and tongue are moving. This is fundamental in the production of speech sounds.

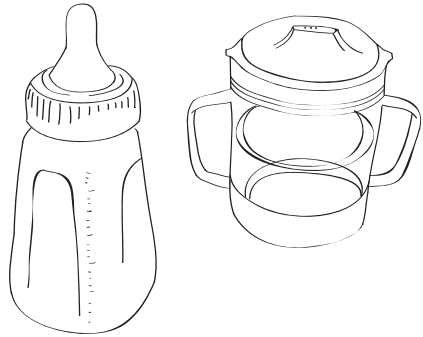


WHAT ARE THE ADVANTAGES OF BREASTFEEDING?

Besides all the nutritional and immunological benefits, the practice of breastfeeding stimulates the proper functioning of the structures of the mouth and face. Breast feeding strengthens the orofacial muscles of the infant, reducing risk of future problems in important functions such as breathing, chewing, swallowing and speaking.

WHY SOME INFANTS HAVE DIFFICULTY SUCKING?

Difficulties of sucking in infants may occur due to: lack of sucking reflexes which decrease the suction force, frenulum restriction, lack of coordination between the actions of sucking, swallowing and breathing; improper positioning of the mother and /or the baby; absence of sealing (closing) of the lips around the breast nipple, and inadequate movement of tongue and jaw during breast feeding.



WHAT TO DO WHEN BREASTFEEDING IS NOT POSSIBLE?

Failing to breastfeed the infant directly at the maternal breast, milk may be collected from the mother's breast, or other milk may be recommended by a pediatrician, which also may be offered by a bottle, a spoon or a small cup. The evaluation of a specialist in Orofacial Myofunctional Therapy, with advanced training in this area, must be individualized in each case, and may assist in indicating the most appropriate way to breastfeed the infant, along with a lactation consultant.

HOW TO FEED A BABY WITH CLEFT LIP AND PALATE?

For breastfeeding infants with a cleft lip, the guidelines are the same as given to infants without clefts. Many babies with a cleft lip may breastfeed with no alterations. However, in cases with a cleft palate, many children may fail to have an adequate milk intake with breastfeeding alone. In these cases, the milk can be offered using special feeding bottles.

HOW CAN FINGER SUCKING AND PACIFIER USE HARM A CHILD?

Depending on the child's facial features, the intensity, frequency and the duration of these oral habits may cause changes in facial growth, alteration of tooth position (anterior open bite), problems in the orofacial muscles, impairment of breathing functions, chewing, swallowing, and may also lead to slurred speech, such as an anterior lisp (placing the tongue between the teeth). The pacifier soothes the baby, because it satisfies the need to suck, but its use can be eliminated as soon as possible.

HOW CAN ONE SUPPRESS HABITS, SUCH AS FINGER SUCKING AND PACIFIER OVERUSE?

The first step is to understand how these habits began and why are they still occurring. The child must be understood and not ridiculed. Awareness is crucial to gain the cooperation of the child. Depending on the case, the Orofacial Myofunctional Therapy Specialist may indicate exercises for strengthening the orofacial muscles (especially the lips and tongue), and the balance of the stomatognathic functions (breathing, chewing and swallowing). An occupational therapist may also be indicated for consultation.

WHY DO SOME YOUNG CHILDREN LOVE TO EAT VERY SOFT FOOD?

The preference for soft foods may be related to the reduction of the strength of the muscles of mastication (chewing) and also because of enlarged tonsils. Some children prefer foods with such consistency, as they would not need to chew much or at all. Feeding early on with different consistencies may stimulate the strength of the orofacial muscles and enhance harmonious development of the face.

WHAT IS A LISP?

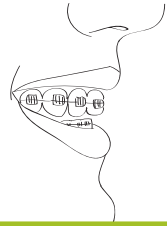
A lisp is a distortion of speech, characterized by placing the tongue between the front teeth during the production of the sounds /s/ and /z/.

CAN CHEWING ON ONE SIDE ONLY BE HARMFUL?

Yes it is. By chewing only on one side, only the muscles of one side of the face are emphasized. This can cause a facial asymmetry over time. In addition, the bite can be altered and the temporomandibular joint (TMJ, the joint that connects the jaw to the skull and allows the mouth to open and close) on the opposite side of mastication, may suffer an overload.

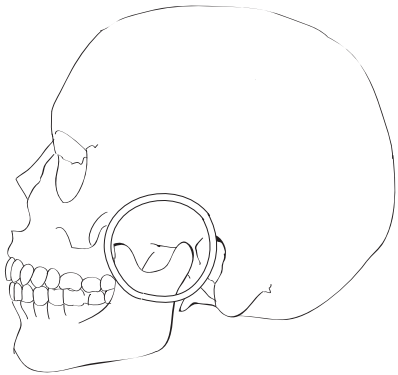
WHAT CAN CAUSE AN OPEN BITE?

An open bite corresponds to a problem of occlusion caused by multiple factors. Harmful habits (such as finger sucking or pacifier use) as well as the presence of functional disorders (such as mouth breathing and inadequate pressure for an optimal position of the tongue during swallowing and /or speech).



SHOULD OROFACIAL MYOFUNCTIONAL THERAPY OCCUR BEFORE OR AFTER ORTHODONTIC TREATMENT?

Orthodontic and Orofacial Myofunctional Therapy can be closely related with each directly impacting the other. Each case must be analyzed and discussed by the professionals involved. Treatment may be indicated before, during, and or after orthodontics. Orofacial Myofunctional Therapy specialists promote a balance of the muscle and orofacial functions, improving the oral rest posture of the tongue and thus the stability of these cases treated by orthodontists by helping diminish orthodontic relapse after the removal of braces.



WHAT IS TEMPOROMANDIBULAR JOINT DYSFUNCTION?

The term temporomandibular dysfunction (TMD) is used to define some problems that can affect the temporomandibular joint (TMJ), as well as muscles and structures involved in chewing.

WHAT CAUSES TMD?

TMD may be related to various factors such as dental changes (loss or wear of the teeth, poorly fitting dentures), unilateral chewing, mouth breathing, lesions due to trauma or degeneration of the TMJ, muscle strains caused by psychological factors (stress and anxiety) and poor habits (nail biting, biting objects or food too hard, resting a hand on the chin, grinding or clenching teeth during sleep).

WHAT ARE THE MAIN SIGNS AND SYMPTOMS OF TMD?

Pain may be present around the TMJ (it may radiate to the head and neck), along with earache, tinnitus, ear fullness, sounds when opening or closing the mouth (popping or other noises in the TMJ), pain or difficulties when opening the mouth, and pain when moving the jaw and the muscles involved in chewing.

HOW IS OROFACIAL MYOFUNCTIONAL THERAPY CARRIED OUT FOR PATIENTS WITH TMD?

Most cases of TMD should be treated by a team of allied health professionals such as an Orofacial Myofunctional Therapy Specialist, dentist, psychologist, physical therapist, neurologist and otolaryngologist. The Orofacial Myofunctional Therapy Specialist, after conducting a thorough assessment, working in an allied approach, may apply techniques to rebalance the muscles of the mouth, face and neck, and restore the functions of breathing, chewing, and swallowing. With this, there may be attenuation and/or elimination of the signs and symptoms of TMD. The patient should be made aware about any harmful oral habits and oriented to contribute to the evolution of its clinical case.

WHO CAN PROVIDE OROFACIAL MYOFUNCTIONAL THERAPY?

The stomatognathic system is supported by an interdisciplinary team including speech language pathologists, otolaryngologists, orthodontists, dentists, dental hygienists, physical therapists, occupational therapists, kinesiotherapists and others. Each country's healthcare system is different, with one specialty having differing degrees of leadership roles. In some countries speech pathologists may take a leading role where in others another profession such as physical therapy or dental hygiene may have a more prominent role. It's a truly interdisciplinary therapy, with several professions contributing, each according to their own scope of practice. It is incumbent upon the professional to complete additional training in orofacial myofunctional therapy and to abide to local laws in the country in which they reside.

WHAT CAUSES FACIAL PARALYSIS?

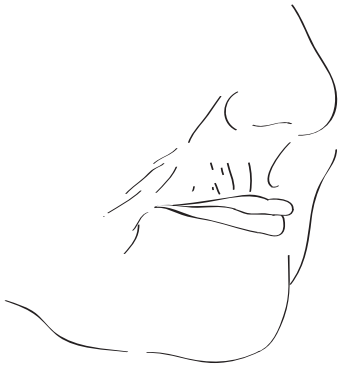
There are two types of facial paralysis: Peripheral Facial Paralysis, that affects the facial nerve (lesion outside the brain) and can be caused by trauma, tumors, infections or unknown factors, and Central (brain injury) caused by cerebral vascular accident (stroke), head injuries and brain tumors.

HOW ARE THE TWO KINDS OF FACIAL PARALYSIS DIFFERENTIATED?

In Peripheral Facial Paralysis, only one side of the face or the whole face is affected. In Central Facial Paralysis, only the lower region of the face (around the mouth and nose) is paralyzed. In the presence of a facial palsy or any facial paralysis, it is critical to seek medical advice, seeking a diagnosis and appropriate treatment.

HOW MAY AN OROFACIAL MYOFUNCTIONAL SPECIALIST WORK WITH PATIENTS WHO HAVE FACIAL PARALYSIS?

A specialist in Orofacial Myofunctional Therapy may work, with advanced training and according to their particular specialty's scope of practice, on the underlying muscles that may be involved. This work should be performed in conjunction with otolaryngologists and neurosurgeons. The main objective of the Orofacial Myofunctional Therapist is to rehabilitate the functions of chewing, swallowing, sucking and facial expression (essential to human communication). The muscles of the face are manipulated so that they can "relearn" the functions performed by them before the injury. The Orofacial Myofunctional intervention should be initiated as early as possible, in order to prevent muscle atrophy.



WHAT IS THE RELATIONSHIP BETWEEN OROFACIAL MYOFUNCTIONAL THERAPY AND FACIAL AESTHETICS?

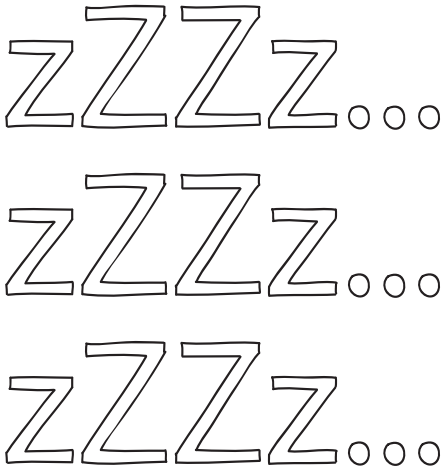
Wrinkles and marks caused by facial expressions and habits that are directly linked to the function of the muscles of the face, which should be quite familiar to the specialist who works in Orofacial Myofunctional Therapy.

HOW ARE WRINKLES PRODUCED?

Wrinkles may be the result of inadequate postures, habits and repetitive movements, when chewing, swallowing, breathing and in speech. Furthermore, the wrinkles may be influenced by the exaggerated strain of the facial muscles.

HOW MAY THE OROFACIAL MYOFUNCTIONAL SPECIALIST WORK WITH FACIAL AESTHETICS?

The Specialist in Orofacial Myofunctional Therapy works with the functions of chewing, swallowing, and breathing. When these functions are working adequately and habits are eliminated, with the manipulation of the facial muscles, one may achieve a significant improvement in facial aesthetics with facial rejuvenation and smoothing of wrinkles.



WHAT IS SNORING?

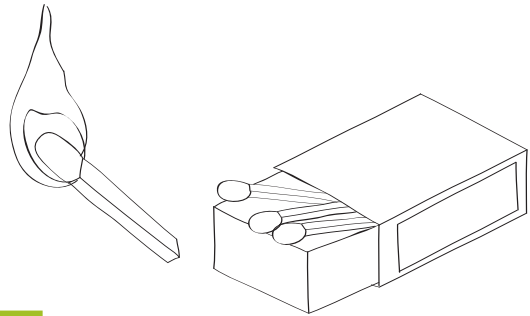
Snoring is defined as partial obstruction of the upper airways causing noise and vibration produced by some muscles of the mouth and throat during sleep.

DOES SNORING CONTRIBUTE TO THE EMERGENCE OF OBSTRUCTIVE SLEEP APNEA?

Yes, due to constant vibration, the muscles of the mouth and throat become larger, and may bring about changes in size, width and thickness. This may contribute to the appearance of total or partial obstruction of breathing during sleep.

WHAT IS OBSTRUCTIVE SLEEP APNEA?

Obstructive Sleep Apnea Syndrome is defined as an obstruction of the airflow channel during sleep.



HOW COULD OROFACIAL MYOFUNCTIONAL THERAPY BE RELATED TO CASES OF SNORING?

Whoever snores and presents Obstructive Sleep Apnea should be treated by a multidisciplinary team including a sleep specialist. In this team, the Orofacial Myofunctional Specialist may help by directing and performing specific exercises to strengthen the muscles of the mouth and throat and exercises that may help, if indicated, in improving oral rest posture.

WHAT ARE POSSIBLE ISSUES AFFECTING PEOPLE WHO'VE SUFFERED BURNS ON THE FACE AND NECK?

Burns that affect the face and neck can trouble breathing, the act of opening and closing the mouth, chewing and swallowing. The aesthetics of the face is also affected.

HOW MAY OROFACIAL MYOFUNCTIONAL THERAPY HELP PATIENTS WHO HAVE SUFFERED BURNS IN THE FACE AND NECK?

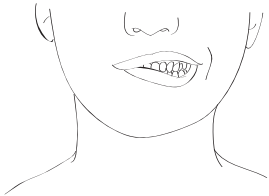
A burned patient must be treated by a multidisciplinary team. Within this team, advanced specialists in Orofacial Myofunctional Therapy may help patients with third degree burns. In an initial period, the therapy aims to prevent scarring sequelae. In later periods, it seeks to improve the functions of breathing, chewing, speech, voice and swallowing, as well as reducing tissue retraction affected by burning (to promote balanced muscles of the face and neck and improve the aesthetics of the face).

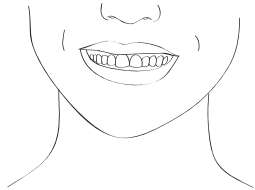
AFTER BURNING THE FACE, WHEN SHOULD A PERSON SEEK OROFACIAL MYOFUNCTIONAL THERAPY?

After being evaluated and treated by a medical team and finding that the patient is clinically stable, they may now be evaluated by an Orofacial Myofunctional Therapy Specialist, with advanced training in this area, in order to help prevent the emergence of sequelae.

WHAT IS A FACIAL TRAUMA? WHAT ARE THEIR CAUSES?

The traumas and fractures caused on the face are called facial trauma. Traffic accidents, falls, assaults, accidents with firearms, among others, could cause trauma and fractures in various parts of the body, including the face.





WHAT ARE THE POSSIBLE DIFFICULTIES PRESENTED BY PEOPLE WHO HAVE SUFFERED FACIAL TRAUMA?

Chewing and swallowing are the functions more impaired, because facial trauma is mainly comprised of damage to the facial muscles, teeth and bones of the maxilla and mandible. Thus, a change occurs in speech articulation and also in the opening and closing of the mouth during speech and chewing. The TMJ and the aesthetics of the face may also be impaired. Speech is in the domain of a Speech-Language Pathologist.

HOW MAY OROFACIAL MYOFUNCTIONAL THERAPY HELP PATIENTS WHO HAVE SUFFERED FACIAL TRAUMA?

Treatment of a patient who has suffered a facial trauma is multidisciplinary and specialized. The goal of the specialist in Orofacial Myofunctional Therapy is to promote the balance of the muscles of the face which may help to relieve pain, decrease swelling, improve chewing, speech, and the appearance of scars and facial aesthetics. Patients may also benefit from re-education of chewing, swallowing, and breathing patterns.

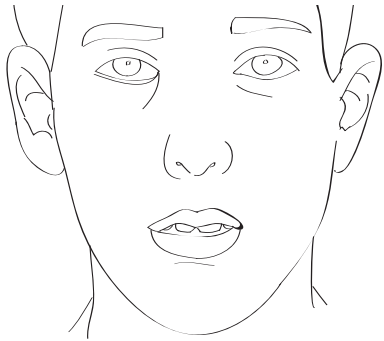
MOUTH BREATHING >

WHAT IS MOUTH BREATHING?

Mouth breathing refers to breathing performed predominantly by the mouth. In this way of breathing, the individual does not use, or uses very little, the nose to inhale and exhale the air.

CAN MOUTH BREATHING CAUSE DAMAGE?

Yes in several aspects, such as the mouth's and face's structures and their function, including sleep, feeding, learning, hearing and speech.



HOW CAN ONE IDENTIFY A PERSON WHO BREATHES THROUGH THE MOUTH?

The person may have one or more of the following characteristics: nasal congestion, open mouth at rest; parched lips, lip color change, appearance of a large tongue that may be recessed and projected forward; long face syndrome; forward head posture; dark circles under the eyes, sagging cheeks, wheezing, and snoring. In such cases it is recommended that an otolaryngologist (ENT) and/or allergist be consulted.

IS THERE A DIFFERENCE BETWEEN NASAL AND ORAL/MOUTH BREATHING?

Yes, when breathing is done through the nose, the air is filtered (cleaned), warmed and humidified, and thus it reaches the lungs with less impurities that are in the air. When you breathe through your mouth the air does not go through this process and reaches the lungs full of impurities. The oral rest posture of the tongue and the mandible when mouth breathing may also alter mandibular posture, palate width, and other craniofacial growth patterns as well as posture of the head, neck, and upper body.

WHAT CAN CAUSE MOUTH BREATHING?

The most common causes of mouth breathing are: allergic rhinitis, sinusitis, bronchitis, enlarged adenoids; enlarged tonsils; weakness or low tone of facial muscles that may lead to open mouth rest posture, habits such as thumb sucking, tumors in the region of the nose, enlarged turbinates, and nose fractures, amongst others.

HOW CAN MOUTH BREATHING CAUSE CHANGES TO THE STRUCTURE OF THE MOUTH AND THE FACE?

Keeping an open mouth posture can cause: dry and chapped lips, short and fast breathing; diminished strength of the muscles of the lips, cheeks, jaw and tongue; a lowered and more anterior oral rest posture of the tongue, leading to changes in aesthetics and position of teeth/occlusion (improper fit of the teeth); elongated face, retruded mandible, and palate ("roof of the mouth") becoming more narrow and /or deep.

HOW CAN MOUTH BREATHING AFFECT FUNCTIONS RELATED TO THE MOUTH AND FACE?

Mouth breathing leads to chewing food with lips apart, which becomes faster, noisier and less efficient than with lips closed. This can lead to greater digestive problems and potential for choking due to the poor coordination between breathing, chewing, and an increase in the swallowing of air. It's hard to breathe through the mouth when the mouth is full, thus an individual will need to choose whether to chew or to breathe. In the process of swallowing, one may also notice changes such as: anterior projection of the tongue, noise, contraction of muscles that wrap around the mouth and movements of the head. There may also be excessive production of saliva and an anterior lisp: which is a distortion of speech characterized by placing the tongue between the front teeth during sound production of /s/ and /z/.

WHAT ARE KEY ISSUES THAT MAY BE CAUSED BY MOUTH BREATHING DURING SLEEP?

When sleeping with the mouth open, a person may have some of these characteristics: restless sleep, snoring, headaches, drooling on the pillow, thirst when waking up, morning sleepiness, sleep apnea (breathing interruptions during sleep), and decreased oxygen saturation in the blood.

WHAT ARE DISADVANTAGES THAT MOUTH BREATHING MAY CONTRIBUTE WITH REGARDS TO FEEDING AND BODY WEIGHT?

Mouth breathers may have poor appetite, lower strength for chewing and swallowing difficulties. Thus they may prefer softer foods and the use of liquid to assist feeding. The feeding of mouth breathers may also be impaired because of decreased olfaction (smell) and taste (taste). As a result of changes in chewing, smell, and taste, the individual may have decreased appetite, gastric changes, constant thirst, gagging, pallor, anorexia, and weight loss with less physical improving or, conversely, obesity.

WHAT ARE THE MAIN DISADVANTAGES TO LEARNING CAUSED BY MOUTH BREATHING?

Sleep disturbances that have been previously explained can generate agitation, anxiety, impatience, decreased levels of alertness, impulsiveness and discouragement. All of these changes can cause difficulties with attention, concentration, memory problems, and subsequent learning difficulties in children. During the critical periods of a child's development, mouth breathing can be more detrimental to learning.

WHAT ARE THE MAIN DISADVANTAGES TO HEARING AND SPEECH CAUSED BY MOUTH BREATHING?

It is common in mouth breathing children to have more colds, infections in the nose, throat and chronic ear infections. Ear infection may lead to hearing loss, speech problems, language delays and vestibular issues. It is important to pay close attention to children in such cases: listen well to determine if they have difficulty hearing in the presence of noise; if they are unable to answer questions or follow direction, or could be considered inattentive. Most common changes are hoarseness in voice. This is because of the constantly open mouth leading to a drying out of all the structures that produce the voice and because the muscles are contracted for a long time, they may also appear to frequently have a cold and a runny nose.

WHAT ARE THE MAIN DISADVANTAGES OF MOUTH BREATHING REGARDING BODY POSTURE?

One major alteration is a change in the head's postural position. The head will go forward seeking a larger space to breathe better, as often the tongue is resting in the floor of the mouth. We can also find other changes in the body caused by mouth breathing, as the abdominal muscles are weakened and stretched; dark circles with asymmetric positioning of the eyes, tired eyes, and shoulders that may come forward and compresses the abdomen.

WHICH KIND OF SPECIALIST IN OROFACIAL MYOFUNCTIONAL THERAPY SHOULD A MOUTH BREATHER SEEK?

An individual who breathes through the mouth can seek an Orofacial Myofunctional Therapy Specialist to assist in the treatment of mouth breathing, as any general Myofunctional Therapist is trained to deal with these cases, but some seek additional training in respiratory education techniques that may be helpful in treatment. Orofacial Myofunctional Therapy is commenced only after evaluation of the cause. It is advisable to also work within an allied team, with an otholaryngologyst/ ENT, a breathing specialist and /or an allergist as well.

LINGUAL FRENULUM >

WHAT IS TONGUE-TIE?

Tongue-tie is a popular term used to characterize a common condition that often goes undetected. It occurs during pregnancy when a small portion of tissue that should disappear during the infant's development remains at the bottom of the tongue, restricting its movement. When an infant is born with tongue-tie, it is important to research other family members, since this change has a genetic influence.

WHO CAN DETECT THE PRESENCE OF TONGUE-TIE?

A specialist in Orofacial Myofunciotnal Therapy should be well suited to detect a tongue-tie since they should know about the lingual frenulum and also the normal way the newborn sucks. In the case of infants, a pediatrician and a lactation consultant may also be involved.

MAY THE TONGUE AND FRENULUM BE INSPECTED AS SOON AS THE BABY IS BORN?

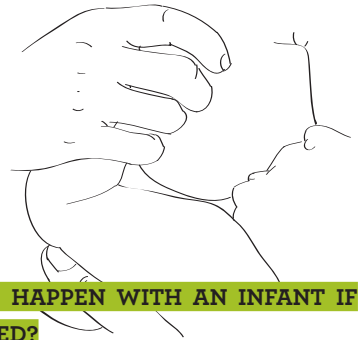
Yes, but there are varying degrees of tongue-tie, so the importance of having a test or validated protocol that evaluates the tongue and the "trickle" under the tongue (lingual frenulum) is crucial, as well as the way the infant sucks. This will ensure an accurate diagnosis, and indicate whether or not the need to do a frenotomy (or small "cut" under the tongue) is recommended.

HOW AND WHEN SHOULD TONGUE-TIE BE TREATED?

When the tongue cannot perform all the necessary movements and thus jeopardizes the way of sucking, swallowing, chewing or talking, a small surgery or frenotomy in the tongue is indicated. The "cut" of the frenum in infants is a simple procedure done with scissors, scalpel, or laser and anesthetic gel, which lasts about five minutes. In older children and adults the most common procedure is the frenectomy (partial removal of the lingual frenulum).

WHEN IS A SURGICAL PROCEDURE INDICATED TO RELEASE THE LINGUAL FRENULUM?

In infants, surgery is usually indicated when the lingual frenulum restricts the tongue's movement and compromises breastfeeding. In older children and adults, the indication is made when the tongue is visibly restricted, is unable to adequately reach the palate, or when possible distortions in speech are caused by limitation of the elevation of the tongue tip (especially in producing the sound of the "L" and "R") that could not be corrected in speech therapy. A lactation consultant may also be indicated for consultation.



WHAT CAN HAPPEN WITH AN INFANT IF NOT TREATED?

Many people with tongue-tie suffer the consequences without knowing the cause. There are infants who have changes in the feeding cycle, causing stress for the infant and for the mother; there are also children with difficulties in chewing, children and adults with speech problems affecting communication, social relationships and professional development. With the chronic oral rest posture of the tongue in the floor of the mouth, many of the Orofacial Myofunctional Disorders (OMDs) enumerated above may result.

This project, **FREQUENTLY ASKED QUESTIONS AND ANSWERS IN THE AREA OF OROFACIAL MYOFUNCTIONAL THERAPY**, is coordinated by the Academy of Orofacial Myofunctional Therapy (AOMT), a USA based post graduate training institution that specialises in training allied health professionals in Orofacial Myofunctional Therapy. This pamphlet has been created with the support of the Brazilian Speech Pathology Society (Sociedade Brasileira de Fonaudiologia/SBFa) and their Orofacial Myofunctional Therapy Committee, upon whose original work, *"Repostas Para Perguntas Frequentes Na Area De Motricidade Orofacial,"* originally published in 2011, with a second edition in 2012. Brazil is the world's leader in research, protocols, and standards in Orofacial Myofunctional Therapy and the SBFa has consistently been at the forefront. This project is also supported by the Academy of Applied Myofunctional Sciences (AAMS), an international, non-profit NGO and membership association engaged in advancing research, standards, education, and public health initiatives in the area of Orofacial Myofunctional Therapy worldwide.

ACADEMY OF OROFACIAL MYOFUNCTIONAL THERAPY

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Beverly Hills Myofunctional Therapy

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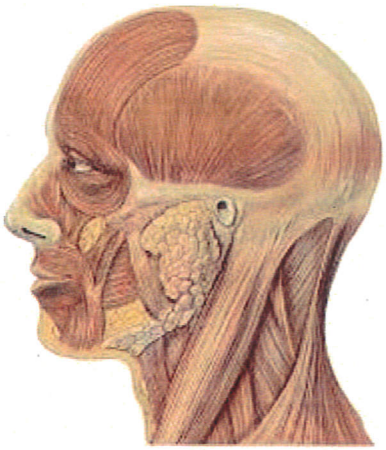
MyO2I-OH

Beverly Hills Mobile Myofunctional Therapy

What is Myofunctional Therapy?

MYO= muscle



Oral Myology is the study of the muscles of the face, jaws, and pharynx (throat) at rest and during **functions** such as breathing, speaking, chewing, and swallowing.

Myofunctional therapy is the evaluation of orofacial myofunctional disorders (OMD's) and the application of therapeutic techniques to eliminate parafunctional habits, normalize nasal-breathing patterns, establish a tongue-palate resting position, and promote typical chewing and swallowing habits.

Orofacial myofunctional disorders (OMD's) inhibit the oral and facial muscles from performing optimally during functions such as breathing, speaking, chewing, and swallowing. OMD's have been known to cause craniofacial abnormalities (small growth of the jaws) and occlusal dysfunctions (misaligned tooth position, open-bites, and cross-bites). Research also associates untreated OMD's with breastfeeding difficulties, speech disorders, temporomandibular joint dysfunction, orofacial pain, and sleep-disordered breathing conditions. Myofunctional therapists are trained to identify and manage the following OMD's:

- Parafunctional habits (Bottle, Pacifier use/ Nail, Object, Pencil biting/ Thumb, Finger and Non-nutritive sucking habits)
- Open-mouth posture/ lack of lip seal (Mouth breathing)
- Low-tongue resting posture
- Oral, facial, pharyngeal hyper/hypo-tonia
- Atypical chewing habits
- Atypical swallowing habits (Tongue-thrust)
- Tethered oral tissues TOT's (Lip-tie/ Buccal-tie/ Tongue-tie)

Myofunctional therapists are trained health care professionals. Typically they have specialized degrees and hold licenses in dental hygiene, nursing, physical therapy, speech pathology, massage therapy, and more!

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Beverly Hills Mobile Myofunctional Therapy

Myofunctional Therapy Treatment

Myofunctional therapy works through behavioral and neurological modification of oral, facial, and pharyngeal muscle habits. It takes time for the body and brain to relearn functions properly and treatment is generally 6 months to 1 year long.

Goals of myofunctional therapy include nasal-diaphragmatic breathing patterns, establishing tongue to palate contact, and developing proper chewing and swallowing habits.

Myofunctional therapy programs are tailored to each individuals needs. Programs require daily participation of exercises and a conscious effort by the patient to reestablish habits. Goals are set at the commencement of treatment and must be achieved in order to complete therapy.

Typically children progress quicker through the recommended therapy and their treatment length may be shorter.

Myofunctional therapy treatment may also be available via Skype.

Call today to find out more about myofunctional therapy treatment!

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Meet the Therapist

Kaitlyn Tarbert is a registered dental hygienist by trade and has become an advocate, entrepreneur, lecturer, researcher, and published author in the field of myofunctional therapy since beginning her career in 2012.

She started in pediatric dentistry, integrating myofunctional therapy into her routine process of care, and now works part-time in a General-Periodontal practice offering the same standard of care to patients of all ages.

Kaitlyn is a clinical instructor at the TMJ/Orofacial Pain Clinic associated with White Memorial Medical Center, in Los Angeles, and has been participating in Grand Rounds since 2012. She is dedicated to continuing education and providing the highest standard of quality care to her patients.

Kaitlyn has developed a working-network with a variety of health care professionals including

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Beverly Hills Mobile Myofunctional Therapy

If you have any question about myofunctional therapy or would like to speak with Kaitlyn, call the office or send us a message today!

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Frequently Asked Questions

What is myofunctional therapy?

Myofunctional therapy is the evaluation of orofacial myofunctional disorders (OMD's) and the application of therapeutic techniques to eliminate parafunctional habits, normalize nasal-breathing patterns, establish a tongue-palate resting position, and promote typical chewing and swallowing habits.

What are Orofacial Myofunctional Disorders (OMD's)?

OMD's inhibit the oral and facial muscles from performing optimally during functions such as breathing, speaking, chewing, and swallowing. OMD's have been known to cause craniofacial abnormalities (small growth of the jaws) and occlusal dysfunctions (misaligned tooth position, open-bites, and cross-bites), OMD's are:

- Parafunctional habits (Bottle, Pacifier use/ Nail, Object, Pencil biting/ Thumb, Finger and Non-nutritive sucking habits)
- Open-mouth posture/ lack of lip seal (Mouth breathing)
- Low-tongue resting posture
- Oral, facial, pharyngeal hyper/hypo-tonia
- Atypical chewing habits
- Atypical swallowing habits (Tongue-thrust)
- Tethered oral tissues TOT's (Lip-tie/ Buccal-tie/ Tongue-tie)

Why should I be concerned?

Untreated OMD's may lead to breastfeeding difficulties, craniofacial growth and development dysfunction, speech disorders, occlusal dysfunction, orthodontic relapse, orofacial pain and headaches, temporomandibular joint dysfunction, and obstructive sleep apnea.

How come I haven't heard of myofunctional therapy before?

Myofunctional therapy has been around for hundreds of years. It was popularized in the United States in the early 1900's by Orthodontists and has been gaining popularity, research, and support all over the world. There are currently dozens of universities around the world conducting leading new research everyday!

Is myofunctional therapy right for me?

If you are experiencing any of the signs and symptoms of myofunctional disorders, please call today to find out more!

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-At what age can they start treatment?

Children can start myo at any age! Parents and caregivers can be taught myofunctional exercises and techniques to do with their newborns at home who have difficulty feeding and latching.

How does myofunctional therapy work?

Myofunctional therapy works through behavioral and neurological modification of oral, facial, and pharyngeal muscle habits.

How long is myofunctional therapy treatment?

Generally treatment is 1 year long. Each program is tailored to specific needs, and treatment length varies per individual.

How does myofunctional therapy relate to OSA?

Oral-facial structural changes caused by myofunctional disorders can increase the risk of obstructions of the airway at night, and research now links untreated myofunctional disorders such as mouth breathing, oral muscle hypotonia, and tongue-tie to obstructive sleep apnea in both children and adults.

Does insurance cover treatment?

Currently myofunctional therapy is billed under medical coding. Not all insurance companies will cover recommended myofunctional therapy treatment. Call your medical insurance provider to inquire about coverage. A letter of medical necessity from your primary physician is usually required by insurance companies. **Please note our office policy:** We are not contracted with any insurance provider and we do not accept insurance in lieu of payment. As a courtesy, a superbill will be provided to you.

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 12

Public Comment for Items Not on the Agenda

[The DHBC may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 & 11125.7(a)]

DHBC
Dental Hygiene
Board of California

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 13

Future Agenda Items

Saturday, November 23, 2019

Dental Hygiene Board of California

Agenda Item 14

Adjournment of the November 23, 2019 DHBC Meeting