Tutorial

Communication the easy way

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Suggested Citation

Snyder, G. (1991). Communication the easy way. *International Journal of Orofacial Myology*, 17(3), 19-20.

DOI: <https://doi.org/10.52010/ijom.1991.17.3.7>

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collection of observations that might constitute a valid basis for "saying no" to therapy.

PHYSICAL LIABILITIES

Deep palatal vault on adults with no correction available

Patient has severe allergies — how and if they are being treated?

Severely enlarged tonsils and no treatment scheduled (age is a factor)

Patient in need of a lingual frenectomy and it will not be done. Tongue of older patient may never have the mobility that is necessary for success.

Severe open bite. You would be working against a tremendous force. Could it be closed down somewhat before you begin?

A class II, so severe that patient cannot close lips. You would be asking too much from the patient without intervening orthodontics.

Neurological dysfunction. Sometimes very difficult to detect, but it can certainly cause difficulties.

Pain sensitivity, when orthodontics causes considerable discomfort. The patient will be much more cooperative if treatment is delayed.

Mental retardation, or severe motor disorders in

patients. Success will be limited. Set realistic goals for improvement.

EMOTIONAL LIABILITIES

Social Interferences

Numerous outside activities

Poor relationship with parents or other family members

Poor motivation

Unrealistic goals by the patient. Adults have a tendency to want a "quick fix."

SUGGESTIONS

Determine your initial perceptions of the patient. Learn to trust your instincts.

Perhaps a "delay" can be a key tactic, rather than saying "no." However, your candid and honest reasons for saying "no" should bring respect for your professionalism. The field of orofacial myology has had its credibility damaged because of failure rate. The taking on of "impossible" cases does us all great harm. Your referral source wants you to succeed, so you really do have the opportunity to be more selective and realistic. We *all* want to win, and it is possible if you can choose the therapy patient that has the very best chance to succeed.

Communication the Easy Way

Gayle Snyder, M.A.

One of the many things we do as orofacial myologists is to communicate in writing with patients and related health professionals. Documentation of patient progress is included in this category as we are often required to submit copies of patient files for insurance purposes. Additionally, concise record keeping is beneficial in these days of medical litigation. Without a system, written communication can become time consuming and often ineffectual. With a system, even one simplistic in nature, this task becomes an important but less time consuming part of an orofacial myology practice.

This article is divided into three sections: (1) how to communicate with referral sources and related health professionals, (2) how to communicate with patients/parents, and (3) how to communicate with yourself (record keeping).

I. Communicating With Health Professionals

Forms used in this category:

- a. 3-part NCR Referral form
- b. Thank you for referring card
- c. Assessment report
- d. Patient progress reports — 4 during active treatment
- e. Final report

All referral sources should be provided with forms to refer patients. A 3-part form, one copy to the patient, one for the referring office and one for the therapist, makes it easier for you and the referral source to keep track of

patients. A thank you note to your referral source shows appreciation for the referral, and keeps your name in his/her mind.

The Assessment Report should be brief but concise, describing what was observed, providing a diagnosis and a prognosis for success. Most referral sources appreciate a simplified report due to the volume of material they receive. Copies of the assessment report are sent to all related health professionals who are involved with this patient.

It is essential that progress reports be sent during the patient's active treatment. A short progress note sent after each phase of treatment is recommended. Copies of all progress reports are sent to each member of the team. It is also beneficial to give a copy of the progress report to the patient. Of course, a final report is sent when the patient is dismissed from treatment.

II. Communicating With Patients/Parents

Forms used in this category:

- a. Letter confirming first appointment
- b. Consent for exchange of information
- c. Office Policies form
- d. Patient/Parent observation form
- e. General guidelines to prepare for therapy
- f. General guidelines during the therapy program
- g. Patient questionnaire
- h. Patient mail-in evaluation

The first written communication with the patient is an

appointment letter. This letter, confirming the date and time of the initial evaluation, should include a brochure giving information about orofacial myofunctional disorders. This gives the patient background information that will promote discussion at the first appointment.

A certain amount of paperwork is necessary during the initial assessment appointment. A signed consent form for the mutual exchange of information, an information sheet regarding office policies, a patient/parent observation sheet, (suggestions for home observation of the patient), and written guidelines to assist the patient to prepare for therapy are examples of written communication used during the initial evaluation appointment.

When treatment begins, it is beneficial to provide the patient with general guidelines for the therapy program. Outlining goals and objectives at this time will increase the overall success of the program. In addition, having the patient fill out a questionnaire during the active therapy phase provides a tool whereby the therapist can assess the patient's ongoing progress. During the habituation phase of the program when the patient is not seeing the therapist on a weekly basis, a mail-in form allows the patient to monitor his/her own progress and report this to the therapist. Using a mail-in evaluation allows for quicker identification of relapse in learned behaviors.

III. Communicating With Yourself — Record Keeping

Forms used in this category:

- a. Initial patient intake information
- b. Patient progress sheet

It is important that accurate records are kept for each patient. Using a system that is easy to duplicate makes this daily task a simple one. Each patient should have a manilla file folder. Keeping all the initial intake information, evaluation report, progress reports, and insurance information on the right side of the folder makes it easily accessible. On the left side of the folder is the patient progress sheet. This form provides space for written notes from each therapy session, a record of telephone messages and any other information pertinent to the therapy session. Color coding these notes: black for daily notes, red for a cancellation of appointment and green for observed airway problems, makes it easier to recall information. These notes, legibly printed in ink, and kept up-to-date allow for duplication for insurance purposes. Also, if litigation should occur, daily notes are essential in recalling past performance.

The overall goal of orofacial myology is to assist the patient in the successful change of a behavior. Creating an organized treatment plan is one way of achieving that goal. An organized system of written communication assists the therapist in the administration aspect of the treatment program.

Food in the Therapy Program

Anita Weinfield, M.A., C.O.M.

My personal philosophy encompasses the belief that not only is the tongue resting posture, saliva swallows, and lip posture important; but how the patient manipulates and swallows food is also important. I feel correct insertion of the food, chewing, gathering and swallowing of food is an integral part of the overall picture. This conclusion is not based on scientific data but on my own clinical data. I further feel if a patient performs the functions of mastication incorrectly it is our job as orofacial myologists to help these patients attain satisfactory oro myofunctional results in all areas that will insure a lifetime of correct function. (Pam Marshalla gave an excellent description of the normal mature swallow at the Convention in Minneapolis. I recommend you look at her literature.)

Like most therapists my treatment plan included an eating exercise. Basically this involved having the patient understand a correct swallow and then I incorporated a small cookie or cracker as part of the swallow. Most patients had no difficulty with this exercise and they were then instructed to use the "cookie swallow" with all foods. It wasn't until I took Donna to dinner (she was an adult patient and my last patient for the day) that I discovered that a perfect cookie swallow in my office didn't carry over to correct food swallows eaten at meals. Donna was an excellent patient with excellent cookie swallows and yet when we were eating in a restaurant the correct cookie

swallows didn't carry over to meals. All the work we had done on food swallowing was non-existent. Shortly after my dinner with Donna I gave a picnic for my patients and again I discovered all the good "cookie swallows" disappeared in the social situation of a meal outside my office. These two experiences led to a re-evaluation of the food portion of my therapy program.

I've discovered that many patients don't know how to gather a bolus of food correctly. To help develop an awareness of how a suck feels I have the patient suck a finger and feel the sides of the tongue and the cheeks meet. I then have the patient remove their finger and place the tongue tip on the spot, explaining that when sucking saliva or a bolus of food the tongue tip is on the spot and the sides of the tongue contact the cheeks just as they did when they sucked on their finger. If they are still having difficulty sucking in their cheeks I use one or both of the following exercises. Be sure your patient understands that the suck they are working toward has the tongue tip on the "spot." 1. Kiss — purse lips and make kissing noises. The tongue tip is not on the spot in this exercise. 2. Suck noodle — Use well cooked (soft not al dente) noodles again. I only use this exercise if the patient is having difficulty sucking in the cheeks, because the tongue tip is not on the spot when you suck the noodle.

Initially I have the patient use a mirror for all food