


Evaluating the organization of dental care demand within the Family Health Strategy in a municipality in Southern Minas Gerais


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Abstract This descriptive, cross-sectional study aimed to analyze how dental demand is organized in the Family Health Strategy (FHS) in a city located in the south of Minas Gerais, using a structured, self-administered, face-to-face questionnaire administered by the dental surgeons who work in the Oral Health teams in this municipality. The questionnaire assessed the demographic data of the participants, as well as how patients are received and referred. Of the eleven dental professionals interviewed, 82% were women with an average age of 33.09 years. It was found that regarding reception, 54.5% of patients were attended jointly by the dental surgeon and the oral health assistant, 27.2% only by the dental surgeon and 18.1% only by the oral health assistant. Concerning action planning, 72.7% was planned jointly with the FHS and 27.3% only by the dental surgeon and oral health assistant. A large proportion (82%) of the units did not classify family and individual risk, nor did they report referrals. Only 45% of the units had time for continuing education and made time available for emergency care, in which an average of 7.09 patients were scheduled. However, all the teams worked according to a pre-defined weekly schedule. It can be concluded that although many of the units have oral health teams working in partnership with the FHS, there is no standardization in dental demand organization among the units evaluated. In addition, dental surgeons actively participate in drawing up strategies to organize demand in this location.

Descriptors: Public Health. Community Dentistry. Primary Health Care. Health Management.

Evaluación de la organización de la demanda odontológica en la estrategia de salud familiar en un municipio del sur de Minas Gerais

Resumen El presente estudio, de carácter descriptivo y transversal, tuvo como objetivo analizar la forma en que se organiza la demanda odontológica en la Estrategia de Salud de la Familia (ESF) en una ciudad ubicada en el sur de Minas Gerais, a través de un sistema estructurado y autoadministrado. cuestionario, de forma presencial, por parte de los cirujanos dentistas que laboran en los equipos de Salud Bucal de este municipio. El cuestionario evaluó los datos demográficos de los participantes además de cómo fueron recibidos los pacientes hasta su derivación. De los once profesionales odontólogos entrevistados, su edad promedio fue de 33,09 años y el 82% eran mujeres. Se observó que, con relación a la recepción, el 54,5% es realizada por el cirujano dentista (CD) y el auxiliar de salud bucal (ASB) juntos, el 27,2% sólo por el CD y el 18,1% sólo por la ASB. En cuanto a la planificación de actuaciones, el 72,7% son planificadas junto con la FSE y el 27,3% únicamente por el dentista y la ASB. La mayoría (82%) de las unidades no realiza clasificación de riesgo familiar e individual y no reportaron derivación. Sólo el 45% de las unidades cuentan con horarios de educación continua y brindan un período del día para casos de atención de emergencia en los que están programados un promedio de 7,09 pacientes. Sin embargo, todos los equipos trabajan con un horario semanal predefinido. Se concluye que, aunque muchas de las unidades cuentan con equipos de salud bucal trabajando en colaboración con la ESF, las unidades evaluadas no siguen una estandarización en la organización de la demanda odontológica. Además, existe una participación del odontólogo en el desarrollo de estrategias para organizar la demanda en esta localidad.

Descriptor: Salud Pública. Odontología Comunitaria. Atención Primaria de Salud. Gestión en Salud.

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Avaliação da organização da demanda odontológica na estratégia saúde da família em um município no sul de Minas Gerais

Resumo O presente estudo, de caráter descritivo e transversal, teve como objetivo analisar a forma de organização da demanda odontológica na Estratégia de Saúde da Família (ESF) em uma cidade localizada no sul de Minas Gerais, por meio de um questionário estruturado, autoaplicável, de forma presencial, pelos cirurgiões-dentistas que atuam nas equipes de Saúde Bucal deste município. O questionário avaliou dados demográficos dos participantes além de como é realizado o acolhimento dos pacientes até o encaminhamento deles. Dos onze profissionais odontólogos entrevistados tinham idade média de 33,09 anos e 82% eram mulheres. Foi visto que, em relação ao acolhimento, 54,5% são realizados pelo cirurgião-dentista (CD) e auxiliar de saúde bucal (ASB) conjuntamente, 27,2% somente pelo CD e 18,1% apenas pela ASB. Em relação ao planejamento das ações, 72,7% são planejadas em conjunto com a ESF e 27,3% somente pelo cirurgião-dentista e ASB. Grande parte (82%) das unidades não realizam a classificação de risco familiar e individual bem como relataram não haver referenciamento. Apenas 45% das unidades apresentam horário para educação permanente e disponibilizam um período do dia para caso apareça casos de atendimento de urgência em que uma média de 7,09 pacientes são agendados. Entretanto, todas as equipes trabalham com agenda semanal pré-definida. Conclui-se que, embora muitas das unidades tem as equipes de saúde bucal trabalhando em parceria com as ESF, as unidades avaliadas não seguem uma padronização na organização da demanda odontológica. Além disso, observa-se uma participação ativa do cirurgião-dentista na elaboração das estratégias para organização da demanda neste local.

Descritores: Saúde Pública. Odontologia Comunitária. Atenção Primária à Saúde. Gestão em Saúde.

INTRODUCTION

For many years in Brazil, oral health and dental practices in the Unified Health System (SUS in Portuguese) were developed in parallel but remained separate from the organization of other healthcare services. This trend is currently being reversed, with efforts underway to better integrate oral health into general healthcare services by combining knowledge and practices aimed at health promotion and surveillance. Moreover, the importance of respecting the principles of universality, equity, and comprehensiveness is highlighted, advocating for a review of care practices that incorporate a family-centered approach and life protection¹.

Oral health within the Family Health Strategy (FHS) is an opportunity to create a space for practices and relationships that contribute to reshaping the work process. Oral healthcare now requires a team structure that engages with users and participates in service management². In other words, teams should organize the process and the quality of oral health services³.

In January 2004, the Ministry of Health developed "Guidelines for the National Oral Health Policy," which calls for reorganizing oral health care at all levels and developing intersectoral actions. This document aims to establish the concept of care as the central axis for reshaping the model, responding to a health conception that is not solely focused on assisting patients, but primarily on promoting a good quality of life and intervening in the factors that put it at risk, incorporating programmatic actions more comprehensively⁴.

For these changes to effectively replace traditional practices in Basic Health Units, the Ministry of Health has outlined the characteristics it expects to see established after implementing the Oral Health Team within the FHS, including: population assignment; comprehensive care; coordinating referrals and counter-referrals to more complex services; defining the family as the central focus of the approach; humanized care; a multi-professional approach; encouraging health promotion actions, intersectoral coordination, social participation, and control; ongoing professional education; as well as continuous monitoring and evaluation of actions carried out⁵.

Despite significant efforts to implement this new model of care, oral health teams still face challenges, especially in organizing demand, especially in care-related activities, where attention is linked to spontaneous demand⁵. Spontaneous demand occurs when a patient visits the health unit unexpectedly, whether due to an acute issue requiring immediate or priority care or because the patient sees the need to do so, even in cases where the intervention could be scheduled⁶. In contrast, scheduled demand consists of appointments arranged in advance, focusing on preventive actions⁷.

In this context, using tools to reorganize the work process is essential to ensure equity and comprehensiveness in actions. One such tool is the schedule, a key resource for optimizing time, prioritizing, and planning care based on analyzing the population's oral health needs. This approach can promote the organization of work routines, facilitate shared responsibility for outcomes, and enable equitable access to health services⁸.

Both spontaneous and scheduled dental demand have posed challenges due to a lack of clear technical criteria to guide them. Consequently, this research aimed to analyze and describe the organization of spontaneous and scheduled dental demands within the FHS in a medium-sized city in southern Minas Gerais.

METHODS

The research is a descriptive, cross-sectional study that used a quantitative approach, approved by the Research Ethics Committee (opinion no. 2.892.823). It adhered to the principles of Resolution No. 466/12 of the National Health Council and was authorized by the Municipal Health Secretariat.

The FHS was implemented in the municipality in 1996 and currently comprises 17 Family Health teams and two Family Health Support Centers, which include nutritionists, social workers, and psychologists, covering 61% of the population.

The Oral Health Team is part of 17 FHS, modality I (including a dentist and a dental health assistant). It operates a Municipal Dental Center, which serves as a Basic Health Unit focused solely on dental care, designated to serve regional areas without FHS coverage. This center is also responsible for distributing materials to all FHS and houses the municipality's Oral Health Coordination.

The study population consisted of dentists working within the Oral Health teams of the Family Health Unit in this medium-sized municipality in southern Minas Gerais. Founded in 1805, the municipality had an estimated population of 78,970 in 2022, according to the Brazilian Institute of Geography and Statistics (IBGE in Portuguese), with 93.8% residing in urban areas and 6.2% in rural areas.

This study used a structured, self-administered questionnaire as a data collection instrument, which included questions regarding the organization of demand within the Oral Health teams, as well as participants' sociodemographic data, such as sex, age, postgraduate education, and questions related to patient reception and professional roles. After the researcher in charge explained the risks and benefits of the study, participants who agreed to take part read and signed the Informed Consent Form (ICF). The questionnaire was administered in person and included demographic questions about the participants, with inquiries about the patient reception process in the FHS. This process involved listening to users' complaints, recognizing their agency in the health and illness process, and referring them as necessary.

The collected data were tabulated and presented using descriptive statistics.

RESULTS

Although the municipality had 17 Family Health Units, six did not have a dentist because the city had not yet called all the candidates who had passed the public examination. Therefore, at the time of the research, the municipality had 11 Family Health Units with Oral Health Teams, and all 11 dentists participated in the study. The average age of the participants was 33.09 years, and most of them were women (82%).

When asked about postgraduate education, 73% of the respondents indicated they had further qualifications, including

in endodontics, public management and health organization, orthodontics, and a master's degree in dental sciences. Half of these respondents had specialized in family health and public health. Regarding the physical infrastructure of the FHS, it was found that most have their own facilities (73%), while the others are located in rented establishments.

Regarding the question about the number of users scheduled daily for each professional, an average of 7.09 people were observed. All units that participated in the study allocate time for emergency care every day.

Table 1 presents the descriptive statistics of the other collected data concerning reception practices, planning, meetings, home visits, collective health activities, and referrals to secondary care.

Table 1. Absolute and relative frequencies of the surveyed variables.

Variable	n	%
<i>Reception</i>		
Dental Surgeon and Oral Health Assistant	6	54.5
Dental Surgeon	3	27.2
Oral Health Assistant	2	18.1
<i>Planning oral health activities in the unit</i>		
Only by Dental Surgeon and Oral Health Assistant	3	27.3
Together with FHS	8	72.7
<i>Characteristics of the meetings</i>		
During a reserved time/period	7	63.6
Monthly	6	54.5
Fortnightly	3	27.3
Weekly	2	18.2
<i>Home visits</i>		
Yes	8	72.7
By the Dental Surgeon	5	62.5
By the Oral Health Assistant	3	37.5
<i>Activities</i>		
Supervised brushing	3	27.3
Activities in daycare centers and schools	3	27.3
Participation in operational groups	2	18.2
Distribution of toothbrushes and toothpaste	2	18.2
Talks held in the waiting room	1	9.0
<i>Referrals</i>		
To undergraduate courses	5	45.5
To specialization courses	5	45.5
To private establishments	1	9.0

It was noted that 82% of the units do not perform risk classification for families and individuals to organize demand. Among the teams that do conduct such classifications, the criteria used include systemic conditions (e.g., pregnant women, hypertensive patients, diabetics, and individuals with special needs).

Regarding the referral of users who require secondary care, it is worth mentioning that the municipality has two universities—one federal and one private—that provide services through the Unified Health System (SUS), together with institutions offering specialization courses in dentistry that serve the population. This helps meet the demand, as there is no Dental Specialty Center in the city.

In terms of information on referral back to primary care after secondary care appointments, 82% reported that there is no referral process in place, while 18% indicated that there is a referral for secondary care services.

DISCUSSION

Although the municipality where the study was conducted consists of 17 Family Health Units, only 11 of them had a dentist, which is a detrimental situation. Studies indicate that the (dis)organization of the number of professionals has a negative impact, both on users—who do not receive effective care—and on workers, such as exhaustion, fatigue, and the inability to meet all demands with the same quality criteria leading to dissatisfaction among both parties involved in the reception process. The individuals engaged in the practice need support to perform effectively⁹. Qualified professionals are also needed in sufficient numbers, highlighting the need to recruit new professionals to fill the vacancies in the FHS that lack coverage due to the shortage of staff¹⁰.

Triage or risk classification is a clinical risk management tool used in emergency services worldwide to establish patient flows when clinical demand exceeds supply¹¹. According to the Ministry of Health¹², it is a tool that not only organizes the waiting list but also proposes a different order of service that is not based on the order of arrival. Risk classification enables the organization of user flow seeking emergency services and can ensure effective and humane care for those who have acute or exacerbated chronic conditions of any nature¹³.

According to Santos and Hugo (2018)¹⁴, in the most recent results of the second cycle of the Improvement of Access and Quality in Primary Care Program (PMAQ in Portuguese), it was observed that among the 12,581 responding dentists, 69.5% have some type of specialization, and 34% of them specialized in Family Health (either specialization or residency). A study conducted in over five thousand Brazilian municipalities highlights that out of the 19,898 Family Health Teams that participated in the second cycle of PMAQ, 14,178 (78.3%) of the responding ESBs reported conducting home visits.

Lima *et al.* (2018)¹⁵ found that the average duration of employment in Family Health Teams for the interviewed dentists was 7.83 years. In comparison, the municipality studied has a much lower average tenure in the Family Health Team, at just 19 months, due to the recent public competition and the recent assumption of roles by the professionals.

Unlike the findings by Souza (2011)¹⁶ in the Basic Health Units of Três Rios (RJ), where most are located in rented premises or properties provided by non-governmental entities or public organizations, only 30% of the units operate in buildings owned by the Municipal Public Authority. Considering the sociodemographic and infrastructure characteristics, it is essential for the municipality to be able to organize its health services, ensuring that they have adequate facilities, which, when necessary, should be adapted for better public access.

Sobrinho *et al.* (2015)¹⁷ found in their study of the state of Pernambuco that among the Family Health Teams participating in the second cycle of PMAQ, dentists were identified as professionals involved in patient reception in 369 teams (46.06%). Furthermore, 643 teams (80.27%) reported that patient reception and spontaneous demand were specifically addressed for dental health. However, a study conducted in the Federal District in 2018 highlighted the poorly structured and fragmented nature of Family Health Teams, indicating obstacles to both scheduling dental appointments and conducting patient reception effectively¹⁸.

Amaral Júnior *et al.* (2020)⁸ observed that regarding the construction of the schedule, 88% of respondents participate monthly in management and planning activities related to agenda setting. In their research on the ideal number of patients for optimal care, Santos *et al.* (2007)¹⁹ found that 54% of dentists indicated that the ideal number would be eight patients, 41% stated it would be ten patients, and 5% said it would be 15 patients.

The guidelines produced by the Secretary of State for Health of Minas Gerais emphasize that urgent and emergency care should be prioritized in primary health care for all users, regardless of whether they fall within the coverage area. A time slot should be reserved daily for this type of care. Moreover, these time slots should be made by the team based on local demand²⁰.

Continuing education allows professionals to be trained to meet the ongoing needs of care and service organization, which are dynamic in nature. Managers should always recognize the importance of continuing education at the service level to ensure that professionals are qualified to carry out their responsibilities in alignment with the population's health needs²¹. Permanent education enables the establishment of new agreements and collective pacts, strengthening team actions and leading to institutional change and the transformation of technical and social practices²².

In the study conducted by Reis *et al.* (2015)¹, most dentists reported feeling integrated with the team; however, few participated in meetings or used unified patient records. The work of dentists rarely involved shared practices with professionals from other areas, as their actions were predominantly carried out autonomously, independently, and individualized.

Regarding the weekly scheduled first dental consultations, all teams conduct these appointments with an average of 9 users. Melo *et al.* (2016)⁹ conducted a study in a municipality in São Paulo, finding that one dental health team performed 33 scheduled first consultations in a month. Roncalli *et al.* (2016)¹³ reported that 11,485 first consultations were conducted in a year in Araçatuba.

Silva *et al.* (2016)²³ highlighted that the indicator for scheduled first dental consultations reflects the population's access to dental services for individual care within the Unified Health System (SUS). They emphasize the importance of actions that enhance this indicator, such as planning the workflow of the dental health team to ensure broad access to scheduled demand. This approach aims to reduce oral health problems by proposing to implement a preventive-therapeutic plan, which is established based on a clinical dental examination during the first consultation, ensuring a comprehensive resolution within primary care.

When proposed by the Ministry of Health, the coverage indicator for the first scheduled dental consultation should reflect the percentage of individuals who received an initial consultation focused on diagnosis, which must also include the development of a preventive-therapeutic plan tailored to address the identified needs²⁴.

It was found that regarding clinical care organization, 91% of professionals rely on spontaneous demand, while only 9% are scheduled based on life cycle, systemic condition, or social risk. Supporting this, studies from 2018 indicated that most dental health teams organize their schedules to accommodate both spontaneous and scheduled demands (91.4%) and provide users with opportunities for scheduling follow-up dental treatments (92.3%)²⁵.

Scherer *et al.* (2018)¹⁸ noted that organizing user referrals to specialties also posed challenges. The authors highlighted that bureaucratic processes and limitations in providing care to users referred to by the FHS create obstacles to coordination and comprehensive care.

Schunemann and Leite (2017)²⁶ also identified difficulties in tracking referred patients, as many often did not return to their local unit for follow-up or completing treatment. To effectively integrate Dentistry into the FHS, it is essential to understand its core principles to consolidate the Unified Health System (SUS) while respecting its foundational principles of public participation, comprehensiveness, equity, universality, hierarchization, and regionalization²⁷.

It is important to emphasize that although the study population consists of 11 professionals, this includes all dental professionals working in the FHS as 6 of the 17 FHS did not have hired professionals. Therefore, the results of this study have internal validity and can encompass the region of this municipality. In addition, although the research was conducted in a single municipality in southern Minas Gerais, the proposed objective was to demonstrate how demand organization is carried out in this area. It is also worth noting that, although the municipality studied does not have a Dental Specialty Center to receive referrals requiring secondary care, referrals can be made to the universities, both of which provide dental care through the Unified Health System (SUS). Thus, the population of this municipality and surrounding cities continues to receive care.

CONCLUSION

The units assessed in this study do not exhibit a standardized approach to organizing dental demand, even though dental health teams collaborate with the FHS in many of these units. Furthermore, dentists actively participate in developing strategies to organize demand in this area, and all dental health teams reported conducting patient reception.

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