

Analysis of referrals determined by the screening processes in relation to the access to the clinics in the School of Dentistry at the Federal University of Santa Maria

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Received April 04, 2019. Approved February 12, 2020.

ABSTRACT

The objective of this study was to describe the access to treatment and therapeutic needs of patients who seek care in the clinics of the School of Dentistry at the Federal University of Santa Maria (Brazil) by analyzing the referrals made by the school Screening Service, as well as verify how many of these patients effectively received dental care. It is a quantitative descriptive observational study, based on secondary data from the records of waiting lists of the school Screening Service and the data from the Dental Manager software used to register the procedures. Data from patients who sought dental services between 2015 and 2017 were included. Data were analyzed by using the statistical software STATA 14.0, showing relative and absolute frequencies. The total number of referrals made in the period was 3,945, most of which to female patients at the average age of 51.2 years. From the total of referrals, in 60.2% (2,377) of cases the service was not completed. From the situations which resulted in dental care service, in 77.6% (1,221) of the cases, the service was not provided during the same year. Most referrals were sent to the integrated care clinics, what indicates an assortment of therapeutic needs. This kind of evaluation is fundamental for the strategic planning of a health service, since it provides an analysis and mapping of patient influx in addition to reflecting upon the possibilities of access to people who seek the service.

Descriptors: Academic Institutions. Dental Assistance. Screening. Epidemiology.

1 INTRODUCTION

The life and work conditions of Brazilians are deeply affected by social economic differences and significantly influence the epidemiological patterns of diseases, which are related to social vulnerability issues. Despite the great amount of improvements that have been implemented over the last decades regarding Oral Health, this area may still be considered a Public Health problem. The main Oral Health diseases and injuries, such as caries, tooth loss, problems in the adaptation of dentures, fistulas and abscesses constitute themselves as social and economic issues, once they may interfere the psyche, as well as they may hamper the insertion of individuals into the labor market. It is observed that such situation especially affects people who live under precarious economic conditions.

According to the World Dental Federation (WDF)² oral health is multifaceted and includes, with no limitations, the ability to speak, smile, smell, taste, touch, chew, swallow and transmit a variety of emotions by means of facial expressions, with confidence, painlessly, and with no disease in the craniofacial complex.

Cities that have more difficulties in providing education services, sanitation, dwelling, employment and health to their populations, in an equitable and satisfactory way, are those with the highest rates of caries and tooth loss; therefore, it is evident that social economic conditions represent a vulnerability factor to diseases affecting the oral cavity and in order to promote health it is necessary to understand that individuals are permeated by social, environmental, cultural and psychological factors that interfere in the health-disease-care process. Based on this understanding, strategies should be developed aiming at the maximum chaining of these factors for the establishment of more effective

actions in health, both in assistance and promotion and prevention¹.

Among adult individuals, there is still a low rate of demand for dental services, despite the reduction in the number of new cases of caries verified in the last national survey. Thus, there are some gaps which are thought to be the reason for this situation, such as low social economic conditions, low education levels and autoperception of poor oral health, what results in people not having enough money and sufficient empowerment to seek oral health. Still, in relation to the adult population, it is observed that the demand for dental services are higher among women³.

In order to know the situation of the services offered and the real need of a population and its characterization, descriptive studies are necessary for the elaboration of hypotheses and solutions aiming at the planning in health and education, based on the epidemiological knowledge of the population concerned. This way, the effectiveness of such services offered to the population is evaluated as well as the solubility and quality of structures and processes involved. Thus, knowing the therapeutic needs of people who seek the educational clinics may promote subsidies to qualify the dental care offered by these institutions and the educational and pedagogical processes developed.

The construction of citizenship in the schools of Dentistry, committed to the integration to the social and epidemiological reality is permeated by educational practices in the health area in a human way, forming reality-contextualized professionals and looking for transformations in the places where they are. The service offered to the population must be seen with integrality, distinguishing between their social role and the technique, understanding the whole, from the

organizational, administrative and functional structure of services and institution to the knowledge of community in which patients are inserted and their social needs, in accordance with the National Curricular Guidelines for Undergraduate Studies in Dentistry⁵.

What is expected is that universities and their educational services in Dentistry work together, sharing their responsibility for the education of future professionals, so that there is a continuous construction of the teaching/learning process, cooperating in their community, aiming at an increase in the social interaction and improvement of services offered. For this reason, it is important to assess educational institutions of future professionals in this area to remove obstacles and qualify education in the context of health needs of the population⁶.

Therefore, the objective of this study was to analyze the referrals made by the screening service of the School of Dentistry at the Federal University of Santa Maria (UFSM), verifying how many screened patients received any care in the school clinics, that is, if they had access to treatment and identify the therapeutic needs of patients, by means of the referrals received in the screening process.

2 METHODOLOGY

Study Design and Participants

This is a quantitative descriptive observational study and its execution was approved by the Ethics Committee of UFSM (CAAE 54136716.0.0000.5346).

Existing secondary data from the waiting lists of the Screening Service of the School of Dentistry and data from the software used for the record of patients and procedures, named Dental Manager were used. Patients from the waiting lists between the years of 2015 and 2017 were included in the study, except those

whose records were incomplete or illegible.

A documental analysis of referrals made by the screening service was carried out. Referrals for adult patients in each semester and not the absolute number of screened patients were considered for the sample composition (considering some patients may have been screened more than once over the analyzed period). The collection of data occurred in the year of 2018.

Scenario

The School of Dentistry at UFSM has currently eighteen clinics, where undergraduate students perform procedures of different specialties and complexity. The referral to each clinic is made by the screening service of the school, but there are other ways of access, such as: i) direct referral made by students/professors in different semesters; ii) direct contact between students/professors from different semesters; iii) referral made by graduate courses in the same institution whose projects carry out epidemiological surveys and aim at a solution for the needs of evaluated people. Adult individuals need to be evaluated by the screening service, where clinical exams shall be carried out with the use of a wooden spatula and, if deemed necessary, radiological exams, and then send them to the most appropriate clinic. Once referred, patients are included in a waiting list and have their appointments scheduled by phone as the availability is opened by the clinics.

Clinics that offer child service have their own way of selecting patients, as well as the extramural clinic of Escola Estadual Irmão José Otão. Another peculiarity is related to the Stomatology Clinic, responsible for the evaluation of injuries and other soft tissue pathologies, which receives patients directly, seeing them on the “first-come, first served”

basis. For this reason, such clinics have not been included in this study, since they do not compose the waiting list of the screening service.

Patients examined at the clinics of the School of Dentistry at UFSM are registered in an internal information system, namely Dental Manager, which is a software that registers personal information of patients and the procedures performed by students in the clinic. This system was initially used by the Operative Dentistry and Integrated Clinics courses (2007). In 2014, the software was changed and expanded to other clinics. In 2016 all clinics had their activities registered in the Dental Manager.

The procedures performed by students in the clinics are registered in individual cards (not standardized and filed in files for each student/pair). Afterwards, employees of UFSM and scholarship students of the Dean's office transfer the information to the Dental Manager. Each procedure has an identifying code, associated with the id number of the student who performed the procedure and the corresponding date. In the patient record, data such as date of birth, sex and address are also included.

Data extraction and sources

The information found in the waiting lists (name, sex, phone number and clinic where the patient was referred to) was collected, tabulated and organized in the Microsoft Excel software (2010) according to the semester and clinics where patients were treated. Data from the Dental Manager were collected by means of the lists created by the software, with the names, sex, date of birth of patients, the clinic where the patient had been treated as well as the date. With such information available, data cross-checking was done in order to identify the patients from the waiting lists who were in the

list of treated patients created by the Dental Manager.

Variables

This study analyzed the referrals made by the Screening Service, by verifying if the patients had had access to treatment or not. For the evaluation, the variable "treated after screening" was created and those who had at least one record in the Dental Manager, for each all clinic he/she was referred to, were classified in the category 'access'. Any patient referred to more than one clinic and with at least one record, but not to all clinics to which she/he had been referred to was considered as someone with "partial access". Those with no records found in the Dental Manager were considered as someone "without access". Besides, clinics with the highest number of indications were analyzed in order to describe a profile of the dental needs of individuals assessed in the screening process, since each clinic is related to one or more specialties and different levels of complexity. This study did not analyze if the treatment was completed or not.

By means of the record of screening date (waiting lists) and appointment dates (Dental Manager) it was possible to verify the waiting time of patients who had had access or partial access to an appointment in the school clinics and this variable was classified into three groups: (1) those treated in the same year of screening; (2) treated after an one-year wait; and (3) treated after a two-year waiting period. Difference in the demand for dental treatment related to sex was also verified (female/male) and average age of users, concerning only those who sought treatment and had access to it; for those who were classified as without access, it was not possible to survey such data, since date of birth had not been informed in the Dental Manager.

Finally, the variable related to the period in which the patient sought assistance in the screening service was created and categorized according to the school semesters, as follows: 1st semester of 2015; 2nd semester of 2015; 1st semester of 2016; 2nd semester of 2016; 1st semester of 2017; 2nd semester of 2017.

Analysis

Collected data were tabulated in the Microsoft Excel software version 2010 (Office Suite, Microsoft Corporation, USA) and subsequently transferred and analyzed descriptively using the statistical software

STAT 14.0 (Stata Corporation, College Station, TX, USA). Absolute and relative frequencies of variables were generated by the description of the screening profile and treatments carried out in the Dental clinics.

3 RESULTS

The total number of referrals in the years of 2015 to 2017 was 3,945. The number of referrals of female patients (64.8%) was higher if compared to that of males (35.2%) and the average age of patients who had access to the clinics was 51.2 years (standard deviation of 15.2) (table 1).

Table 1. Description of the screening profile and treatments carried out in the dental clinics of UFSM in the years of 2015 to 2017

Variable	n (%)
Sex	
Male	1388 (35.2)
Female	2557 (64.8)
Age	51.2 (15.2)*
When the screening was sought	
1st Semester of 2015	1093 (27.7)
2 nd Semester of 2015	263 (6.7)
1st Semester of 2016	539 (13.6)
2 nd Semester of 2016	572 (14.5)
1st Semester of 2017	769 (19.5)
2 nd Semester of 2017	713 (18.0)
Treatment after screening	
Not treated (Without Access)	2377 (60.2)
Treated at least in one clinic (Partial Access)	590 (14.9)
Treated in all referrals (Access)	982 (24.9)
Time for the first appointment	
Appointment in the same year	1221 (77.6)
Appointment after 1 year of wait	347 (22.1)
Appointment after 2 years of wait	5 (0.3)

* Average and standard deviation of age. Minimum (14.1 years) and maximum (92.6 years). The variable age presents missing data (valid number = 2111).

In relation to the number of referrals over the analyzed period, data showed that the first semester of 2015 had the highest number of referrals (27.7%), followed by the first and

second semesters of 2017 (19.5% and 18%, respectively), The semester with the lowest number of referrals was the second semester of 2015 (6.7%). A total of approximately 49% of

referrals resulted in at least one appointment in the clinics to which patient had been referred to (table 1).

Patients considered “with access” represented 24.9% of the sample. Those with partial access and referrals “without access” represented 14.9% and 60% of the sample, respectively. In relation to the waiting time for the appointment, it was observed that most patients with access had their appointment during the same year of the screening (77.6%) (table 1).

According to table 2, the clinic with the highest number of referrals when compared to the total of referrals was the Periodontics Clinic I (10.8%), followed by: Integrated Clinic I (9.4%), Surgery III (9.4%), Integrated Clinic III

(9.0%), Operative Dentistry II (8.9%) and Periodontics II (8.7%). Clinics with the lowest number of referrals were: Surgery II (1.8%), Surgery IV (2.7%) and Complete Denture (4.4%). Among the clinics which compose the sample and considering the number of appointments in relation to the total number of referrals, it was observed that the clinic of Operative Dentistry was the one with the highest number of access (16.2%), followed by the clinics of Surgery III (11.6%), Periodontics I (9.9%) and Integrated Clinic I (8.2%). Clinics with the lowest number of accesses in relation to the total of referrals were: Surgery IV (1.8%), Complete Denture (1.8%) and Removable Partial Denture (2.5%).

Table 2. Description of referrals and appointments in relation to the total number of patients and percentage of patients with appointments in each dental clinic at UFSM in the years from 2015 to 2017

Clinic	Screening referrals n (%)	Patients with access/partial access n (%)	Percentage of patients referred who had an appointment
Periodontics I	661 (10.8)	242 (9.9)	36.6
Integrated Clinic I	579 (9.4)	201 (8.2)	34.7
Surgery III	570 (9.4)	284 (11.6)	49.8
Integrated Clinic III	553 (9.0)	119 (4.8)	21.5
Operative Dentistry	542 (8.9)	398 (16.2)	73.4
Periodontics II	532 (8.7)	200 (8.1)	37.6
Removable Partial Denture	481 (7.8)	62 (2.5)	12.9
Integrated Clinics IV	436 (7.1)	142 (5.8)	32.6
Integrated Clinics II	351 (5.7)	179 (7.3)	51.0
Integrated Clinics V	319 (5.2)	147 (6.0)	46.1
Endodontics II	300 (4.9)	139 (5.7)	46.3
Endodontics I	270 (4.4)	145 (5.9)	53.7
Complete Denture	259 (4.2)	44 (1.8)	17.0
Surgery IV	164 (2.7)	43 (1.8)	26.2
Surgery II	111 (1.8)	109 (4.4)	98.2

When compared to the number of referrals for each clinic and the number of accesses the mentioned clinic received (table 2), it was

verified that the clinics of Surgery II and Operative Dentistry offered at least one appointment for 98.2% and 73.4%, respectively,

of the total referrals they received. As for the clinics of Periodontics I, Periodontics II, Integrated I and Integrated IV, they had an access lower than 40% of the referrals they received. Around 50% of patients referred to the clinics of Integrated II, Integrated IV, Endodontics I and II and Surgery III received at least one appointment. The clinics of Removable Partial Denture and Complete Denture received 12.9% and 17%, respectively, of the total referrals received.

4 DISCUSSION

This study analyzed the referrals made by the screening service in the School of Dentistry at UFSM, identifying patients' therapeutic needs and verifying how many screened patients received care in the clinics (access to treatment). The total number of referrals from 2015 to 2017 was 3,945, out of which 60.2% did not have access to treatment in the clinics. Most referrals which had access to treatment were related to female individuals, at the average age of 51.2 years. Clinics that received the highest number of referrals were those offering integrated service, indicating that individuals who seek the service had an assortment of therapeutic needs.

The access to the services occurs through spontaneous demand, that is, people interested in a treatment make an appointment for an evaluation in the Screening Service in the beginning of each semester. During this evaluation, patients are examined and referred to the appropriate clinic(s) according to their treatment needs. This evaluation is carried out by supervising Doctors of Dental Surgery and undergraduate students who diagnose the needs identified in the clinical and radiological examination (if necessary), take notes of the patients' personal information and the clinic(s) they are being referred to. The population access occurs in a similar way to that at the Higher

Education Federal Institutions (IFES), which offer the graduation course in Dentistry in Southern Brazil⁷. This information composes the waiting list for the UFSM clinics and the data of this study.

People who seek treatment in the dental clinics of UFSM may live in any district of the city and in other towns, since there is no defined territory for the service. Besides, the service offered does not integrate the Unified Health System and therefore fees are charged for the appointments, procedures and/or external services (such as, for instance, the services offered by the dental prosthesis laboratories or histopathological exams); it is believed that such charge may limit the access to many patients who seek the service.

The Screening Service is destined to adults, what explains the high average age found in this study and most users are female. Junior and Souza (2011) also observed the prevalence of females is higher in the search for dental services, maybe due to the autoperception of the health-disease process, as well as to the higher availability of time related to the informal insertion of women in the labor market⁸.

In the screening phase, people are warned about the possibility of not getting an appointment in the clinics they were referred to. Currently, after all available vacancies are filled, those people who were scheduled are kept in the waiting list during a year; after this period, they must seek the screening service again. This time limitation was defined in 2017, considering many patients were kept in the waiting lists for long periods and, not rarely, when were appointed, their treatments needs had already changed and did not correspond to the initial clinic they had been referred to.

The variation observed in the number of referrals from one semester to the next in 2015

is due to the closing of the waiting list for the integrated clinics in the second semester, considering the excess of referrals/screenings in the first semester that year. Guimarães and Mello (2017) also described as a problem in the IFES analyzed, issues concerning the redirection of patients to screening services, in addition to the extended periods of wait to have an appointment⁷. The reduction in the number of referrals in the years after 2015 occurred due to a limitation in the number of patients for screening, in order to reduce the waiting line.

This waiting list is not organized according to risk or emergency, but to the chronological order of patients screened, differently from what is ideally prescribed, which should be risk classification. Risk classification is an excellent tool to serve the population with higher equity and better service organization⁹. When stratifying risk, biological, dental, behavioral and socio-economic factors must be considered in order to plan the patient's treatment, as well as consider the stratification of this population and identify their risks and vulnerabilities.

As identified by Guimarães and Mello (2017), several situations may result in the non-appointment of patients in the waiting list, such as; changes and errors when registering the information in the waiting lists, phone problems, service times not compatible with the routine of patients, treatment already done somewhere else or when the clinic considers the patient does not have the profile of therapeutic needs compatible to those proposed by the discipline⁷. At the Federal University of Goiás (UFG), a study carried out by Ferreira and collaborators (2012) in order to evaluate the teaching-learning process and the functioning of the clinics, students in the School of Dentistry reported that one of their biggest difficulties were problems concerning the organization of

the Higher Education Institutions, such as schedules, bureaucracies, insufficient number of professors by clinic, lack of computer resources, lack of patients and lack of material in the final education period¹¹.

More than 60% of referrals determined by the screening process, along the analyzed period, were not assimilated by the clinics in the School of Dentistry at UFSM, what means people did not have any of their oral health needs fulfilled by the institution. Even if the objective of the service offered by the clinics is the professional education and, in that aspect, there may be some requirements that must be met in relation to the clinic activity, it is important to notice that people who seek the service have health needs and must be treated with dignity and respect and not as a means for the acquisition of a technical ability. Besides, when the service is organized based on the type of procedure/need, the idea of integrality and health promotion is lost – we treat the mouth, not the individual. The appreciation of the technique rather than human aspects leads to the training of less thoughtful professionals, inattentive to the needs of the community that seeks their services and not completely committed to the social aspects concerning the prevention of diseases and promotion of health¹².

The National Curricular Guidelines for Undergraduate Studies in Dentistry courses define that graduate professional should be guided not only by technical and scientific standards, but also ability to work with the oral health of populations, taking into consideration socio-economic and cultural aspects, acting in a critical and thoughtful way and objecting to transform the local health reality. The education of a dental surgeon should have as objective, in addition to prevention, protection and rehabilitation of health, integral and continuous

practice of assistance, considering that “health care is not over after the technical act, but with the solution of a health problem, both individually and collectively”⁵.

Something to be highlighted as a positive aspect is that service was offered in the same year of screening for most patients who received treatment, considering a longer wait could worsen oral problems and demands for these individuals.

Most referrals were to clinics of integrated care, periodontal disease, surgical procedures (especially exodontics) and prosthesis needs, indicating that individuals who seek the course have a variety of therapeutic needs, a great number of tooth loss and need curative and rehabilitation treatments, in order to reduce damages, that is, they are unattended in relation to health promotion and prevention. Clinics such as the Operative Dentistry and Surgery absorb referrals more rapidly, since they provide the procedures that demand less time of service. It is also verified that the population who seeks service at UFSM is basically composed by adults and old people, what corroborates to the variety of oral problems, reflecting a lifelong lack or precariousness of oral health and also the socio-economic factors and education levels in health of the population, which are the result of a health curative model.

The gradual decrease in the number of referrals to disciplines of Integrated Clinic IV and V and Surgery V was due to the recent change in the course program, which extinguished these disciplines and increased the hour load for the internships in health services. As informed by the coordination of the course, the other integrated clinics absorbed other procedures in their programs, such as: Integrated Clinic I started to provide endodontic treatments, Integrated Clinics II was destined to the production of fixed prosthesis and Integrated

Clinic now receives patients with multiple therapeutic and prosthetic needs. Besides Integrated Clinics II and III, the only clinics that also produce prosthesis are Complete Denture and Removable Partial Denture. The disciplines of Operative Dentistry II and III were identified in this work as a single discipline because during the Dental Manager software update, data before the second semester of 2017 was registered under the same name. The other clinics provide services according to their names and with an increased level of difficulty/complexity.

The present study has as main limiting elements the time period and the update of the Dental Manager software update (in 2014), which happened gradually. Besides, in this study it was not verified if the treatments initiated were completed, because it would be necessary access to the patients’ records and treatment plans and since such information is not unified, it would demand more time. Finally, as it is a descriptive observational study, there are no elements for comparison of the analyzed data.

5 CONCLUSIONS

The finding that more than 60% of the referrals made by the screening service between 2015 and 2017 were not absorbed by the clinics in the School of Dentistry at UFSM reveals the need of discussion about the structure of the clinics and the screening process, in addition to the training of health professionals. This type of evaluation is fundamental to the strategic planning of a health service, since it provides an analysis and mapping of the flow of patients screened in the course and allows a reflection about the alternatives of access to people who seek the service. Considering the teaching-service-community integration is fundamental in the training of a health professional, this type

of study allows a reflection on how we are interacting with the community that seeks service in an educational institution and on how to structure clinics and the form of access so that they meet the demands of patients and the learning needs of students.

RESUMO

Análise dos encaminhamentos realizados pela triagem quanto ao acesso às clínicas do curso de Odontologia da Universidade Federal de Santa Maria

O objetivo deste estudo foi descrever o acesso ao tratamento e as necessidades terapêuticas dos pacientes que buscam atendimento nas clínicas do Curso de Odontologia da Universidade Federal de Santa Maria (Brasil) por meio dos encaminhamentos realizados pelo Serviço de Triagem do curso, bem como verificar quantos desses pacientes efetivamente receberam atendimento. Trata-se de um estudo observacional descritivo de caráter quantitativo, baseado em dados secundários existentes nos registros das listas de espera do Serviço de Triagem do curso e nos dados do *software Gerenciador Odontológico* usado para registro de procedimentos. Foram incluídos no estudo os dados dos pacientes que buscaram o serviço entre 2015 e 2017. Os dados foram analisados utilizando o programa estatístico STATA 14.0, apresentando frequências relativas e absolutas. O número total de encaminhamentos realizados no período foi de 3.945, a maioria destes para pessoas do sexo feminino e com idade média de 51,2 anos. Do total de encaminhamentos, em 60,2% (2.377) dos casos o atendimento não se concretizou. Nas situações que resultaram em atendimento, em 77,6% (1.221) dos casos, este ocorreu no mesmo ano do encaminhamento. A maioria dos encaminhamentos foram para clínicas de atendimento integrado, indicando um acúmulo de necessidades terapêuticas. Esse tipo de avaliação é fundamental para o planejamento estratégico de um serviço de saúde, pois permite fazer uma análise e mapeamento do fluxo dos pacientes, além de uma reflexão sobre as possibilidades de acesso para as pessoas que

buscam o serviço.

Descritores: Instituições Acadêmicas. Assistência Odontológica. Triagem. Epidemiologia.

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