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The construction of the oral health care network in the Federal District, Brazil

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Abstract *The Oral Health Policy of the Federal District State Health Secretariat was in a fragmented state, similarly to the entire health system. There was no integration between oral health teams and other Primary Care professionals and performance at the other levels was inconsistent and limited, preventing the effective establishment of the Care Network. In 2017, the head management chose to convert the system organically based on the family health strategy and the logic of the care networks. The aim of this study is to report on the main actions carried out so that oral health care would conform to the changes, developing into the construction of the specific Care Line in the area, allowing increased access and qualification of care.*

Key words *Oral health, Health policy, Primary health care, Delivery of health care, Health services*

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Introduction

Public dental care, performed in Brazil since the 1950s, was limited to the school-age population, considered to be epidemiologically more vulnerable and at the same time more sensitive to public health interventions[1]. Therefore, it provided low-complexity procedures and disregarded the adult population, which sometimes made the latter seek oral mutilation treatment with practical professionals[2]. At this historic moment, at national level, the model of hegemonic dental care that remained until the 1988 Constitution was predominantly of private practice, and social insurance offered dental care only to insured urban private workers[3].

The country's re-democratization process, the first National Conference on Oral Health in 1986[4], followed by the creation of the National Oral Health Policy in 1989 and the second National Conference on Oral Health in 1993[5] resulted in a change of paradigm in the Collective Oral Health within the context of the Brazilian Unified Health System (SUS) that culminated, in 2004, in the implementation of the National Oral Health Policy Guidelines, guided by the principles of the Unified Health System: universal care, integrality, equity, territorialization, social control and decentralization[6].

The inclusion of dental care into Primary Health Care (PHC) occurred only in 2000, when the Minister of Health, considering the need to expand oral health care for the Brazilian population, established a financial incentive for the creation of teams consisting ofdental surgeons (DS), dental office assistants (DOA) and dental hygiene technicians (DHT)[7].

The creation of Primary Care referral units, called Dental Specialty Centers (DSC), occurred in 2004 with the *Brasil Sorridente* policy. The DSC meet the demand for specialized procedures and counter-refer these patients to the Basic Health Units to complete the treatment. The DSC offer no less than services in the areas of Endodontics, Periodontics, Patients with Special Needs and Minor Oral Surgery[8].

Regarding high complexity procedures at national level, dentistry was incorporated into the ICU in 2005 at *Santa Casa de Misericórdia de Barretos*, state of São Paulo, due to evidence that its performance represented better patient care, decreased the ICU length of stay and reduced hospital costs[9].

In 2010, the GM/MS Ordinance Number 4,279 established the guidelines for the organization of health care networks within the scope of SUS, defining them as *organizational measures for health actions and services of different technological densities, which are integrated through technical, logistical and management support systems, seeking to guarantee the integrality of health care*[10].

The standardization of Hospital Dentistry practice started in 2011, with meetings being carried out in the states Minas Gerais, Rio de Janeiro and Rio Grande do Norte, aiming to regulate the teaching and practice of Dentistry within hospitals[11]. In 2013, the National Sanitary Surveillance Agency (ANVISA) released the update of RDC Number 7 of 2010, which guarantees bedside dental care in ICUs[12].

In the Federal District, the Public Health System originated in 1960, with the proposal of Bandeira de Mello plan and the creation of the Federal District Hospital Foundation (FHDF), implementing a conception that was consistent with the political ideology of that time, which privileged the incorporation of technologies into Medicine, under the inflows of the hospital-centric and biologicist paradigm[13].

Regarding Oral Health, the plan proposed by Jofran Frejat in 1979 was the first to predict dentistry as a public policy in the Federal District, based on the primary care strategy provided in Basic Health Unitslocated in rural areas and in Health Centers, offering basic specialties in dentistry for every 30,000 inhabitants[13].

At that time, in line with the practices adopted throughout the national territory, structured actions appeared, based on the preventive and incremental models that favored the gradual and ascending coverage from the lower age ranges, based on the epidemiological fact that the prevalence of caries in permanent teeth is lower at the younger age ranges[14]. The school-aged population then becomes the priority target of the actions, resulting in an exclusionary policy, with the provision of services to only one population range, relegating the adult population to emergency treatment only. Such conduct was shown to be highly mutilating and unsuccessful.

The disorderly population growth over the years, together with poor basic sanitation and food status in population centers, alarming levels of prevalence of oral health problems, and the model of care for specific population groups, have accentuated the need to offer oral health services over the years.

The first District Oral Health Policy was createdin 2005, which was structured in the areas of collective actions (Water Fluoridation, Health

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Education and Surveillance) and assistance actions aimed at specific groups (Zero Caries Program – 0 to 6 years; Oral Health Program – 7 to 19 years; Adult Oral Health Program – 20 years and over)[15].

Until then, a large part of oral health care in the Federal District was provided without organic-administrative differentiation of care levels. In primary care, oral health professionals followed the health center organization, based on the Semashko model, "which originated from the RussianBolshevik experience of primary care organization provided by a triad of medical specialists: general practitioner, gynecologist-obstetrician, and pediatrician (...)"[16].

The oral health teams worked totally apart from the other professionals of the unit, reflecting a preponderant organic segmentation in each unit. Taylorism established each worker'sfunctions, with specific professionals for the vaccine room, wound dressing room and collection room. Users who spontaneously sought the unit with clinical complaints in oral health were immediately directed to the dentistry room, without any prior embracement.The demand for elective dental treatment was organized through "waiting lists", that used a chronological prioritization criterion, resulting in inequalities and long waiting periodsto have access to care. The preponderant oral care feature was based on remedial curative actions, as well as promotion and preventionactions aimed at specific groups such as children aged 0 to 6 years and pregnant women.

Within the scope of specialized care, most of the Dental Specialty Centers (DSC) were established inside the Regional Hospitals. As a result, the professionals performed not only specialized outpatient secondary activities, but also in-hospital care (issuing dental opinions to hospitalized patients, in-hospital first aid and bedside care in infirmaries or ICUs).Moreover, carewas also providedat the Surgical Center for Persons with Disabilities and polytraumatized patients. Access regulation was deficient, without an effective system of referral and counter-referral or communication with Primary Care. The dental units in the Regional Hospitals were seen by the health system as an open door to any situation.

The inclusion of dental care in the ICU ofState Health Secretariat of the Federal District (SHS-DF) occurred in 2011 at the Regional Hospital of Ceilândia. Initially, the service was sporadic, being offered through Opinion requests to Dental professionals by the intensivist doctors. Starting in 2013, the HRC ICU started to regularly count on a dentist that was part of the intensive care team.Based on the professional's routine care actions, the Hospital Infection Control Committee of the hospital observed a dramatic decrease in the rates of mechanical ventilator-associated pneumonia (VAP) in HRC, and in 2016 the incidence density of VAP decreased to 1.1. In addition to the reduction of health-associated infections, this Intensive Dentistry practice allowed the reduction of hospital costs[17].

Regarding planning and management, the oral health in the Federal District followed the administrative structure of the 15 Health Regions, established by SHS-DF in 1998[18]. The regional coordinators of oral health centralized all actions related to dental care planning in their respective regions, reporting to a central manager, who had the monopoly of decisions concerning dentistry[13].

Considering the transition of the epidemiological profile in oral health and the reorientation of the Primary Care model in the Federal District, through the SESDF Ordinance Number 77 of February 14, 2017, we aimed at the reorganization of all organic processes concerning the formation of a line of care, based on the pillars of the Family Health Strategy and the Health Care Networks.

The present article aims to explain the process of creation of the oral health care network, through a specific institutional actor – the Dental Management (DM) of the SHS-DF, which is the main responsible for its creation and implementation. The aim is to identify elements, actions and strategies that contributed to the effectiveness of the process, in addition to outlining future perspectives for control, evaluation and planning.

Method

This research involves a qualitative case study. The case study is a particularly adequate methodological research approach when one attempts to understand, explore, or describe complex events and contexts, which involve several factors simultaneously.

All consulted documents can be accessed from official sources, either federal or districtones, or from databases such as SCIELO or BVS.

Planning, development and implementation of the Oral Health Guideline inthe SHS / DF

Aiming to consolidate the conversion and expansion of oral health coverage in the Federal District, a step-oriented project of the strategic management process was developed using the SWOT analysis – considering that the strengths and weaknesses of an organization are the results of individuals who comprise it, so that individual capacities are integrated into the collective work and the quality of the team's effortcoordination.

The 5W2H methodology – a checklist for the detailing of actions (what, why and how to do, who and when to do, where to do and how much it will cost) and the Business Model Canvas[19]– a tool of strategic management that allows one to develop and draft new or existing business models – were associated.

The project, called "Expansion of Oral Health Coverage in PHC", was designed to optimize all the necessary resources aiming at excellence when providingthe public policy and the structuring of care network elements. The construction of the SHS/DF Oral Health Care Network aims to provide an effective response to acute and chronic health conditions, promoting a resolutive response at the appropriate level of care, based on the impartial prioritization of the demand by risk strata.

Based on these principles, the deliverables predicted in the Project were designed to cover the key management and assistance points, as follows:

1. Association of an Oral Health Team to a maximum of two Family Health Teams;

SHS/DF Ordinance Number 77 defined the oral health team as the "(…) health team responsible for a territory equivalent to a maximum of two family health teams, consisting of a dentist (40 hours) and one oral health technician (40 hours)".

With that, DM established the situational diagnosis of available human resources and those necessary to attain the project implementation, together with the Primary Health Care Coordination (COAPS). By crossing data, a table was obtained that showed the number of family health teams per health region, number of oral health teams and equivalent teams per health region, and the total resource deficit in order to reach a 1:2ratio. Arrangements were made with the local management to transfer employees, aiming at maximizing coverage.

2. Increased transfer of the qualification and subsidy funds related to the FNS Oral Health Teams (OHT)to the FSDF;

It aimed to attenuate the underfunding of the Unified Health System in the Federal District through the increase of the transfer of funds from the federal component related to the conversion of the system into the model used by the Ministry of Health (Family Health Strategy). For that purpose, there was a great effort aimed at monitoring the registration and updating of the teams at CNES, as well as sending letters requesting the accreditation of new teams with the Ministry.

3. Qualification of access, resolubility, service portfolio and continuity of care for the user of-PHC and optimization of the necessary means for the best service provision;

In August 2017, a Working Group was established to regulate oral health care at the three levels of care. As a result of the efforts, the produced documents comprised the Oral Health Guideline, the draft of the SHS / DF Ordinance Number 341 and the regulated access protocols for secondary and tertiary care.

The oral health structuringbased onthe guideline was built on the pillars of the Family Health Strategy and the principles of the Health Care Networks, with PHC as the driver of the demand and of the efficient communication between all levels of care, guided by a regulated referral and counter-referralsystem. Thus, it was intended to foster parameters and provide conditions for the appropriate establishment, organization and exercise of all the components of an oral health network.

The guideline defined the organization at the levels of attention in oral health, establishing objective criteria for the embracement and prioritization of the demand, in addition to the flow of users in the Health Care Networks (HCN). In Primary Care, the implementation of the Family Health Strategy model was the basis of the work process, aiming at resolubility and continuity of care.

Advanced access, based on qualifiedpatient embracement and listening, was developed in an unprecedented way, fully integrated into the FHS. For this purpose, the process of risk classification of spontaneous demand was structured into two moments: the user who comes tothe unit with a clinical complaint in oral health is directed to the embracement team of the respective FHS or follows the embracement method used by the unit; after the qualified listening process, a simplified questionnaire (Figure 1) is applied by the em-

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bracement team, in the form of a flowchart, aiming to direct the user to the oral health teams at the correct time, according to the severity of their condition and the information obtained during the listening process.

This tool was created for the main causes of spontaneous demand in the SHS-DF BHUs, namely: Dental trauma; Bleeding; Toothache; Problems in Prostheses or Restorations; Alterations in the temporomandibular joint; in the oral mucosa and in the gingiva.

The embracement team, after qualified listening and application of the aid toolfor the spontaneous demand classification, dialogues with the OHT for the clarification of doubts, accesses the shared agenda and provides the appropriate referral to the user, depending on the need indicated by the flowchart. During this process, the role of matrix support is crucial to the FHS, so that the aid toolcan be effectively applied to the classification of spontaneous demand, in a continuous flow of method improvement.

As for the programmed demand, the risk stratification of the population assigned to the BHUis used, with the definition of five groups of conditions for prioritization of demand. (Table 1).

The service portfolio was drawn up, organized according to the procedures described in the e-SUS files and predicted in the National Primary Care Policy (PNAB) 2017[20]. For the feasibility and strengthening of the work process, supplies, instruments, equipment and serviceswere acquired, by hiring companies for the maintenance of equipment and prosthetic laboratory services. The diagnostic support system was strengthened through the digitalization of the entire dental radiology network, increasing its efficiency (cost x benefit ratio) and effectiveness.

In order to line up all the information described in the guideline and create pacts with the regional management, meetings were organized in the seven health regions of the FD. Initially, working with the Primary Health Care Boards (DIRAPS), assessments of physical and human resources, clarification of possible transfers of professionals, and registration of the teams at CNES were carried out, and the need for expansion of the units was mapped according to the

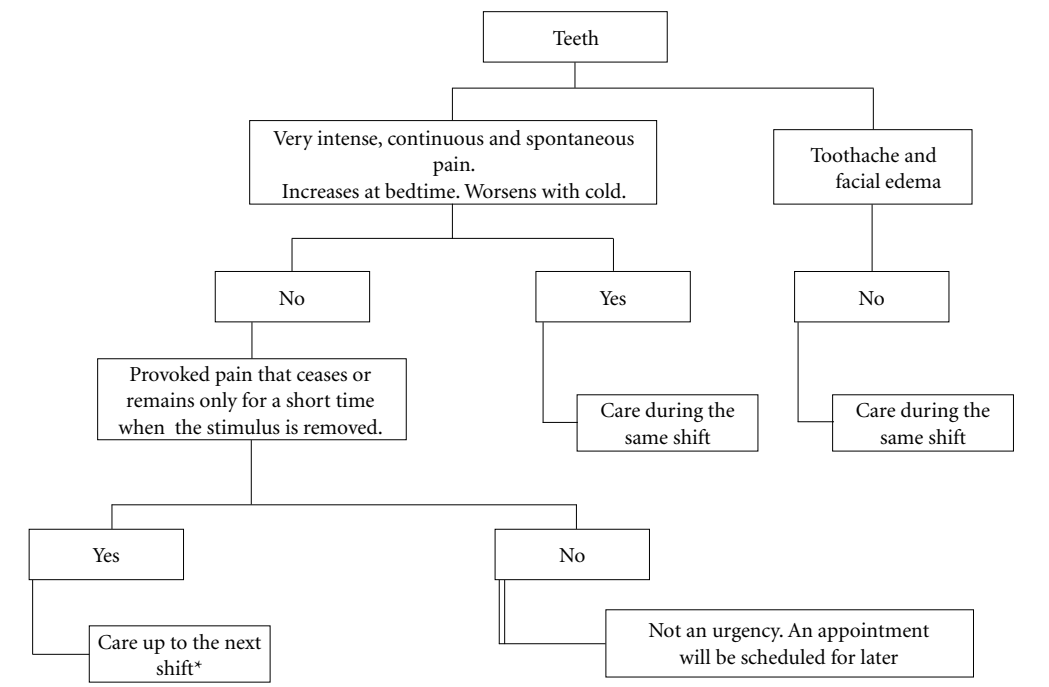

Figure 1. Aid tool used for the classification of spontaneous demand in dentistry in PHC for professionals other than dental surgeons in SHS-DF, 2018.

Table 1. Risk stratification for programmed demand in dentistry in PHC of SHS-DF, 2018.

Socioeconomic and cultural criteria	Score
The head of the Family is unemployed, or the family is in living in extreme poverty (beneficiary of the government's social assistance programs)	2
User or head of the family is not literate or is functionally illiterate	2
Total	4
Maximum score: 4	
Biological and systemic criteria	**Score**
DecompensatedDiabetes	3
Immunosuppressed patient	3
Individual with disabilities that prevents oral self-care	3
Bedridden patient	2
Total	11
Maximum score: 11	
Risk factors for oral pathologies	**Score**
User has no access to fluoridated water or fluoridated dentifrice	2
User does not have the habit of brushing their teeth daily	3
Frequent consumption of sucrose	3
User of alcohol, tobacco or other drugs	2
Total	10
Maximum score:10	
Risk factors for children aged 0-5 years old	**Score**
The child isbottle-fed without subsequent hygiene.	3
The child uses a pacifier coated with sugar or honey	3
The child has a non-cooperative behavior during oral hygiene	3
The child carries out their hygiene without the supervision / complementation of an adult person	3
The child has hypocalcified and / or hypoplastic teeth and / or congenital defects	2
Total	14
Dental Conditions	**Score**
Presence of visible tooth plaque	1
The user has active carious lesion	3
Presence of gingival bleeding	2
Presence of permanent tooth mobility	3
Presence of mouth sore for more than 15 days	4
Total	13
Maximum score: 13 Overall total score: 52	

population figures, the number of teams and the social vulnerability. Afterwards, the content of the guideline was presented to Managers of Primary Health Care Units, highlighting the jurisdiction of this position considering the work of the OHT together with the FHT, as well as the specific competences of dentists and oral health technicians. Subsequently, the presentation was carried out for the OHT, focusing on the concepts of effectiveness of actions, resolution of oral health emergencies, prioritization of demand with equitable justice and ethical responsibility regarding the professional aspect.The presentation occurred as a dialogue, in order to provide the necessary explanations and to align the work processes according to the guidelines of the National Oral Health Policy.

The guideline also dealt with Oral Health in Home Care, Careof the Homeless Population, Care of Juvenile Inmates undergoing Socio-educational Measures and Care of Prison System Inmates. It innovated by encouraging the de-

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velopment of Integrative and Complementary Practices to Oral Health as a complement form of carethat is already offered. It coordinated the diagnostic support system and established indicators, goals, agreements and parameters for the planning, programming and evaluation of actions in oral health and knowledge of the profile of the territory users.

Decree number 38.982, of April 10, 2018, organically established the secondary level of care in the health system of the Federal District. Then, the protocols of regulated access to specialized outpatient care and the highly complex actions carried out at the Surgical Center were developed, resulting in the clear organization of the demand and clarity for internal, external and social controls. Based on an initial diagnosis of human resources available in specialized care, evident forms of differentiation between secondary and tertiary actions were established, with objective protocols of specialties.

The specific allocation of working hours was determined for each professional to a level of care. The aim was to reorganize the present scenario, effectively establishing the work ofDSin secondary care in the Centers of Dental Specialties, following the parameters and goals offered by the Ministry of Health and, thus, guaranteeing the qualification and funding of costs.Moreover, the Dental Surgeonprofessional was addedto the lines of care of theElderly, the Child, the Pregnant Woman and the user with Chronic Noncommunicable Diseases. Access to specialized outpatient treatment occurs through the regulatory complex, respecting the inclusion and exclusion criteria, in addition to the developed risk classification.

In the hospital setting, the dental units were responsible for the actions of bedside care in the infirmary and in the intensive careunits, hospitalizations, issuance of opinions and high-complexity procedures, such as care for people with disabilities, trauma and facial deformities in a Surgical Center. The hospitals that offered Emergency Dental Care, now have a specific group of professionals, with a workload assigned exclusively to that function, avoiding the use of human resources from outpatient services, a constant factor of imbalance.

District Law Number 5.744, dated of December 9, 2016, established the mandatory presence of dental professionals in the ICU and other public and private institutions that maintain patients under hospitalization, in medium and large hospitals in the Federal District. The Federal District health system now has dental surgeons in all the intensive care units of the capital, extrapolating the results obtained at the Ceilândia Regional Hospital to all other units.

To improve the logistics chain of input distribution, simple and concise flows of requests were established through an electronic control and dispensing system. The oral health teams are responsible for controlling the unit inventory, making the requests to the local pharmacists, who inserts the request into the system. The regional pharmaceutical logistics centers collect requests from all BHU in the region and make the request to the central pharmacy, which processes and establishes the logistics for the distribution of requests throughout the Federal District. The chain is similar in specialized care, changing only the actors involved regionally.

4. Establish conditionstolink 1 OHTto 1 FHT;

The National Primary Care Policy (PNAB 2017)[20] establishes that "regardless of the modality used, Oral Health professionals are linked to a Primary Care team (PCT) or Family Health team (FHT)and must share the team'smanagement and work process, having sanitary responsibility for the same population and ascribed territory of the Family Health or Primary Care team,being part of it."

Much of the physical structure of the Basic Health Units dates back to the 1970s and 1980s, failing to meet the growing needs for oral health care. The OHT have minimal technological density to provide care, and the primary care capacity has reached close to its limit, with the appointment of 91 new dental surgeons in June 2018.

As the final delivery, the project predicted the establishment of a situational diagnosis of physical and human resources, with the development of a plan that would establish the actual needs in terms of restructurings, expansions or construction of new units, in order to establish the ratioof 1 OHT to 1 FHT. The situational diagnosis of the physical and human resources necessary to attainthe goal was then obtained.

5. Other Performed Actions

With the proposal of skilled training of the future SHS-DF professionals, Multiprofessional Residencies were created, under the responsibility of *Fundação de Ensino e Pesquisa em Ciências da Saúde* of the Federal District, which include, among several other professionals, Dental Surgeons. Thus, we have the Multiprofessional Residency in Collective Health, Family Health, Oncology Care and Intensive Care.

Aiming at the training of professionals already included in the HCN, within the scope of continuing education, courses were developed for Dental Surgeons, such as Pediatric Dentistry, Care for Patients with Special Needs and Temporomandibular Disorders, through the Continuing Education School of SUS (EAPSUS), and Biosafety for Oral Hygiene Technicians, through *Escola Técnica de Saúde de Brasília* (ETESB).

The start ofanother important management tool was also planned: the epidemiological survey of oral health problems in the population of the Federal District (SBDF 2019). This action will provide data on the prevalence, which are crucialso thatHCNresources and training efforts can be rationally and efficiently directed.

The monitoring aimed to measure the effects of the proposed changes is carried out through the health information systems of the Ministry of Health (e-SUS, SIA - SUS and SIH), TABWIN and control of the indicators proposed by the Guideline (Percentage of spontaneous demand consultations; Percentage of scheduled consultations; Coverage of first dental programmatic consultation; Percentage of referrals to specialized service; Ratio between completed treatments and firstprogrammatic dental appointments and Percentage of services offered by the Oral Health Team).

Results

The reorganization of the OHT to work together with the FHT promoted the change in theparadigm of the work process, characterized by the connection with community and multiprofessional performance. Between 2017 and 2019, 95 OHTs were connected to FHTs and registered at CNES.

At SHS-DF, the careers of DS and DHT have a workload of 20 hours a week. However, in order to fit the model recommended by the Ministry of Health (MoH) and aiming at maximizing the connection of the team members to their assigned population, it was sought to increase the weekly workload of the team members to 40 hours. During the same period, 125 professionals were appointed to PHC and 35 workload extensions were granted for DS in PHC, as well as the transfer of 40-hour professionalsfrom other levels of care to PHC. With such an increase in human resources, the FHT x OHT ratio, which in February of 2017 was 01 OHT: 2.59 FHT in the FD, increased to 01 OHT: 2.1 FHT in October of 2018 (Table 2).

In February of 2017, the National Health Fund (FSDF)[21] recorded a transfer of costsassociatedwith the oral health teams of R$ 210,735.00; in January of 2019, the transfer was R$ 418,185.00. As an incentive to implement new teams, the FSDF recorded a total of R$ 707,000.00 in the year 2018, increasing the possibilities of funding the oral health programs, taking into consideration the counterpart of the federation entity.

The Guideline was approved by the Management Collegiate of the SHS / DF (collegiate body equivalent to state CIBs), with the subsequent publication of SHS-DF Ordinance N. 341, dated of May 10, 2018. Thus, the concepts presentedtherein were officially established, institutionalizing them as a State Public Policy.

Discussion

In recent years, Oral Health Care in the Federal District has shown numerous signs that the organization of services, functioning and the model of care management have not been able to adequately meet the health needs of the local population. In February 2017, the Federal District showed a coverage of Oral Health in Primary Care of 24.83%, with only 10.66% coverage by oral health teams[22]. A poor-resolution care approach was offered, under precarious working

Table 2. Distribution of the number of Oral Health Teams in Primary Health Care – Federal District – 2017-2018.

Primary Health Care teams	Feb/2017 (n./coverage*)[21]	Feb/2019 (n./coverage**)[21]
Oral Health Teams	92 (10.66%)	187 (21.22%)
Equivalent Oral Health Teams	140 (14.10%)	92 (10.16%)
BCCoverage ConsolidatedOral Health	24.76%	31.66%

Source: eGESTORBC and SESDF, 2018. *Coverage calculated based on the population (2,977,216) IBGE, 2016; ** Coverage calculation based on the population (3,039,444) IBGE, 2017.

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conditions, with no specialtysupport and disconnected from hospital care.

Aiming at the reassignment of the health processes and consequent breakin paradigm, the current management proposed the project *Brasília Saudável*[23]. It comprises a set of actions aligned and coordinated by SHS / DF aimedat strengthening Primary Health Care as a strategy for the health care systemorganization, articulating and optimizing the Urgency and Emergency Services, Specialized Ambulatory Care and Hospital Care.

The process of reformulation of the Oral Health Policy in the Federal District occurred in a similar way to the creation of the National Oral Health Guidelines published in 2004, taking advantage of the windows of opportunities opened by the emphasis on Primary Health Care and the adoption of the Family Health Strategy model by the Health Care Coordination in the SHS-DF, in addition to the inclusion of several professionals in the group, from a overall health perspective.

The Oral Health Teams were included in the context of the Family Health Program in 2000, through Ministerial Ordinance N. 1.444[24]. Since then, the proposed model of care has been funded by the Union, with proven effectiveness regarding the management of the population's health conditions. Oral health in the Federal District had never been systematically organized according to the strategy logic model, and a considerable increase in the number of established teams (104%) will contribute to the improvement of epidemiological indices and the control of acute events and chronic conditions involving oral pathologies.

The WHO recommends a public health investment of at least 6% of the country's Gross Domestic Product (GDP) in order to achieve universal access to health. Brazil's public health expenditure is 3.8% of its GDP[25]. In this context, it is expected that the increase of available resources for public policies will have an impact on the actions necessary for their implementation. With double the funds transferred from fund to fund (from the Union to the Federal District) focused on oral health, the necessary counterpart of the federation entity tends to decrease, thus resulting in a more robust and effectivecare, although the budget execution process remains a challenge for the public manager.

The Health Care Networks (HCN) consist of three essential elements: a population and the health regions, an operational structure and a health caremodel[26]. In the HCN model, the concept of hierarchy is replaced by polyarchy. The system is organized as a horizontal network, without order and degree of importance between them, only differentiating them by the respective technological densities that characterize them[16]. Therefore, "it will be possible to break with the concept of supply-based management, characteristic of fragmented systems and institute the management based on the population'shealth needs, or population-based management, an essential element of HCN"[26]. The design of care flows by the Oral Health Guideline and the structuring of the regulation protocols will allow the materialization of the principles of integrality and continuity of care, making the user'smovement through the network points a more fluid and effective one.

Regarding the organization of access and embracement in PHC, the Oral Health Team (OHT) professionals should be involved in the first listening process, not only regarding the dental care problems. The other Primary Care professionals, during the listening process, should also be attentive to the user's oral health needs and be aware of both the risk classification of dental urgencies and the referral flow of this user to the oral health team[27]. For the embracement in oral healthcare to be able to occur properly, it is essential that all the professionals of the unit work together, as well as supporters and managers, employees working in regulation and other health care services[27].

The integrated embracement seeks to reverse the isolation of the oral health teams, building interfaces and promoting constant dialogue among the members of the family health strategy, reaching the integrality at any BHU service offers.

Final considerations

The demographic and epidemiological transition of the FD population is also present in oral health problems. Acute events coexist with chronic conditions, with diseases that are characteristic of low-income countries (caries and periodontal disease, in addition to the sequelae of these diseases), coexisting with stress-related diseases or other chronic non-communicable diseases (such as Temporomandibular Disorders, dental sensibility and dental wear).

It is imperative that the oral health care model provided by the Federal District Health Secretariat overcome the obstacles of its limitations and implement effective solutions, as well as continue to invest in the structuring and implementation

of a network of oral health services guided not only by principles of universality of access, integrality and equity, but also and mainly characterized by the resolutivecharacteristic of its actions.

The conversion of the oral health care system to the health care network model will have irreversible impacts on the way the service is provided at all levels of care. By the end of 2018, the goal is to achieve 35% of PHC adherence to the proposed instruments, reaching 80% in the second quarter of 2020. Regarding specialized care, 100% of access must be regulated by the end of 2019. It is expected that, with defined territories, integrated macro-regions with communication capacity, emphasis on promotion and prevention actions, rehabilitation assistance based on the classification and risk stratification instruments, a fair and effective system will beattained for the usersseeking solution to their health problems.

Collaborations

MB Basso coordinated the project, planning and implementation of the actions described herein; NB Nunes performed the literature review and organized the body of the article; LBC Corrêa, CN Vieira, and JLPS Vilarinho performed the research in the field of specialized care and GA Pucca Júnior. was the expert consulted on the content of the entire project.

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