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CARE MANAGEMENT TOOLS IN PRIMARY HEALTH CARE IN SMALL MUNICIPALITIES IN THE STATE OF PARANÁ

FERRAMENTAS DE GESTÃO DO CUIDADO NA ATENÇÃO PRIMÁRIA DE MUNICÍPIOS DE PEQUENO PORTE DO PARANÁ

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ABSTRACT: **Aim:** To identify the use of health care management tools by Primary Health Care teams in small municipalities in the State of Paraná. **Methodology:** Participants were 797 health professionals, predominantly women (703), who answered an online questionnaire on sociodemographic characteristics, professional performance, and care management tools, which were analyzed descriptively and using the Chi-square test. **Results:** Home visits (73.1%) and matrix support (63.2%) were the most frequently reported tools. Nursing technicians, psychologists, and dental surgeons make frequent use of matrix support. Home visits were frequent for agents fighting endemic diseases, community health agents, nurses, and physicians. Shared consultations were commonly conducted by oral health technicians, and case discussions were frequently held by psychologists and nurses. Longer experience within the health unit was associated with the implementation of body practice/physical activity groups (p=0.03), while stable employment was linked to a higher incidence of shared consultations (p=0.01). **Conclusions:** In small municipalities in Paraná, home visits and matrix support were the predominant care management tools utilized by Primary Health Care professionals. In addition, both longer experience and stable employment were important factors associated with their use.

KEYWORDS: Care Management Tools. Primary Health Care. Small Municipalities.

RESUMO: **Objetivo:** Identificar o uso de ferramentas de gestão do cuidado por equipe da Atenção Primária à Saúde de municípios paranaenses de pequeno porte. **Metodologia:** Participaram 797 profissionais de saúde (703 mulheres), que responderam questionário *online* sobre caracterização sociodemográfica, atuação profissional e ferramentas de gestão do cuidado, analisadas descritivamente e pelo qui-quadrado. **Resultados:** Visita domiciliar (73,1%) e apoio matricial (63,2%) foram as ferramentas mais relatadas. Técnicas(os) de enfermagem, psicólogas (os) e cirurgiões dentistas faziam uso frequente do apoio matricial, enquanto a visita domiciliar foi frequente para agentes de combate a endemias, agentes comunitários de saúde, enfermeiras(os) e médicas(os). A consulta compartilhada foi frequente para técnicas(os) de saúde bucal e a discussão de casos foi para psicólogas (os) e enfermeiras(os). O maior tempo de atuação no estabelecimento de saúde foi associado com a realização de grupos de práticas corporais/atividades físicas (p=0,03), enquanto vínculo estável associou-se com consulta compartilhada (p=0,01). **Conclusões:** Em municípios paranaenses de pequeno porte, visita domiciliar e apoio matricial foram as ferramentas de gestão do cuidado mais utilizadas de forma conjunta pelos profissionais da Atenção Primária à Saúde, sendo que o maior tempo de atuação e o vínculo estável mostraram-se associados.

PALAVRAS-CHAVE: Ferramentas de Gestão do Cuidado. Atenção Primária à Saúde. Municípios de Pequeno Porte.

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INTRODUCTION

The coverage and integrality provided by Primary Health Care (PHC) help address the population's health problems and overcome the fragmentation of actions and the system[1]. The multidisciplinary teams of the Family Health Strategy, which are a priority for the growth and consolidation of PHC, and the e-Multi, which operate in a complementary and integrated manner with other teams, contribute to expanding access and problem-solving capacity, improving the quality of health care and promoting comprehensive care. However, this often requires a reorientation of the work process, as health teams face the challenge of operationalizing multi and interprofessional work through teamwork, interprofessional collaboration, and networking[1]. Teamwork involves integrating actions and sharing goals and values.

In teamwork, implementing care management tools can contribute to promoting more comprehensive and effective care[3]. Some of these tools in the PHC include matrix support, health education, and Territory Health Project[4,5], which were enhanced by the work of the NASF-AB3 teams, currently e-Multi[2].

The challenges of implementing teamwork include communication, collaboration, coordination and integration of strategies, involvement and interaction of teams, interaction with other professionals in the Health Care Network and other sectors; shared development of actions, and shared responsibility, among others.[1,6] In addition to these challenges, in small municipalities, other aspects may hinder the implementation of interprofessional work aimed at health promotion, disease prevention, recovery, or treatment. For example, the composition of multi-professional teams in small municipalities, which precedes interprofessional work, becomes challenging due to the difficulty of recruiting professionals, making professionals take up residence in these locations, managing multi-professional teams, and raising funds.

Small municipalities are the majority in Brazil. According to the 2010 census, of the 399 municipalities in Paraná, 312 (78.2%) had fewer than 20,000 inhabitants, 204 of which had fewer than 10,000 inhabitants, and 98 of these had fewer than 5,000 inhabitants[7]. Despite their numerical dominance and unique characteristics, knowledge production is concentrated in large and medium-sized urban centers[8]. Therefore, it is essential to evaluate the characteristics and daily routines of work processes, identify whether care management tools are developed collaboratively as a team, and assess their effectiveness with multidisciplinary PHC teams in small municipalities.

The identification of management tools, based on health professionals working in small municipalities, helps to shed light on the discussion of training attentive to possible future contexts of professional activity, which may be different from the contexts in which professionals are trained, as a rule, in medium and large municipalities. Furthermore, care management tools can enhance health promotion in small municipalities, specifically by promoting integrality, equity, knowledge of the territory, respecting cultural peculiarities, and focusing on supporting individual and community needs, as recommended by the Ottawa Charter and the National Health Promotion Policy.

The objective of this study was to identify the use of health care management tools by PHC teams in small municipalities in the state of Paraná.

METHODOLOGY

This cross-sectional study is part of the multicenter project entitled "Acesso ao tratamento multi e interprofissional e adesão ao tratamento em pessoas com DCNT em municípios de pequeno porte do estado do Paraná" ("Access to multi and interprofessional treatment and adherence to treatment in people with NCDs in small municipalities in the state of Paraná"), which was developed in three stages (1 - Census of health professionals working in PHC in small municipalities in Paraná; 2 - assessment of the daily teamwork of health professionals; and 3 - assessment of users' perception of health status and access to the service). Stage 2 is the focus of the present investigation, which involved the assessment of the daily teamwork of health professionals in small municipalities (<20,000 inhabitants) linked to five Health Regional Divisions (HRD) of Paraná (2nd HRD - Metropolitana/Curitiba, 4th HRD - Irati, 6th HRD - União da Vitória, 17th HRD – Londrina, and 22nd HRD - Ivaiporã), totaling 58 municipalities.

Among the data collection procedures, contact was initially made with regional health supporters and/or Intermunicipal Health Consortia, in addition to health secretaries from each municipality, explaining the objectives and procedures of the research. They forwarded a research invitation to PHC workers or passed on contacts of coordinators to act as multipliers of the invitation to professionals. The coordinators were contacted and information about the research was passed on. All contacts were made by three researchers via email, phone call, or WhatsApp message. The invitation included information about the study and procedures, as well as a link to Google Forms® of the data collection instrument with the initial text of the Informed Consent (IC). This form indicated that participation was voluntary after agreement and acceptance and that the health professional could refuse to participate, or even withdraw from the research at any time, without any burden or harm to their person. If the healthcare professional agreed to participate, they indicated their agreement to participate, indicated that they had read and agreed to the IC, and accessed the instrument on the next page of the electronic form. Weekly contacts were made with those responsible for disseminating the survey in each municipality, to pass on information on the number of responses, answer questions, and request that the invitation be reinforced among healthcare professionals. Data were collected from May to September 2022.

The inclusion criteria adopted were to be 18 years of age or older and to work in health care. Workers in administrative or support roles (drivers, receptionists, cleaning professionals) were excluded. Therefore, 797 health professionals, aged between 18 and 66 years, comprised the sample of this study.

The instrument contained 76 questions divided into five sections (characterization; general aspects of teamwork; daily teamwork; barriers and facilitators to collaborative interprofessional practice; and general information), and only the first two sections (19 questions) were used in this study.

The dependent variable was the frequency with which the team works using care management tools (matrix support, shared consultation, singular therapeutic project, and health project in the territory), which were provided for in 2010 in the guidelines of the Expanded Family Health Center – NASF-AB (Brasil, 2010), in addition to the other activities provided for the NASF-AB teams, such as health education, home visits, case discussions, and groups of body practices/physical activity[4]. The instrument applied covered the guidelines and tools of the daily work of the NASF-AB[4,5] which at the time of data collection still existed and has now been replaced by e-Multi[2]. Therefore, the question used for the outcome was "*Considering your daily work, indicate the frequency with which you carry out activities jointly ("teamwork" with other professionals)*" for matrix support, shared consultation, case discussions, health education, groups of body practices/physical activity, singular therapeutic project, health project in the territory, and home visits. The four response options were: I do not perform it, rarely, sometimes,

and frequently, being reorganized into two or three categories grouping, respectively, “rarely/sometimes” or “I do not perform it/rarely/sometimes” in the same category.

The other variables used were sociodemographic and professional performance: age (18 to 29 years, 30 to 39 years, 40 to 49 years, 50 to 59 years, 60 years or older); sex (male and female); education (complete high school, attending higher education, complete higher education, attending specialization, complete specialization, complete master's degree, attending doctorate, complete doctorate); race/color (yellow, white, indigenous, brown, black); marital status (married/stable union/living with a partner, divorced, single, widowed); time working in this health facility (less than one year; one to three years; four to five years, six to nine years, 10 years or more); time working in PHC (less than one year; one to three years; four to five years, six to nine years, 10 years or more); role performed (community health agent, disease control agent, art educator, social worker, dentist/odontologist, oral health technician, nurse, nursing technician, pharmacist, physical therapist, speech therapist, physician, veterinarian, nutritionist, physical education professional, sanitation professional, psychologist, occupational therapist, other); type of employment relationship (permanent/public/statutory, fixed-term/CLT contract, other). For data analysis, some response categories of the variables were grouped and reorganized: time working in the current health establishment and in PHC (up to 3 years; 4 years or more); type of relationship (stable [permanent, statutory]; fixed-term [temporary contract, CLT, commissioned position, outsourced company, and legal entity]).

The data were analyzed descriptively using the Statistical Package for the Social Sciences, version 15.0. Furthermore, the Chi-square test was applied to check for differences between the variables, adopting a significance level of 5%.

The research project complied with ethical precepts and was approved by the Research Ethics Committee involving human beings of the State University of Londrina (CAAE - 39012820.8.0000.5231, Opinion 4.414.235 of 11/23/2020).

RESULTS

The sample characterization indicated that the majority were women (88.2%), self-declared white (74.3%), married (69.5%), and with higher education (52.3%), with 24% having a specialization. The average age was 38.5 years (±9.1) and 68.1% were between 30 and 49 years old. The most frequent professional categories were community health agents (38.3%), nurses (17.7%), and nursing technicians (16.7%). The longest time of experience (10 years or more) was the most frequent for both the current health facility (30.0%) and for working in PHC (39.5%). Stable professional relationship was indicated by the majority (73.8%) (Table 1).

Table 1. Sociodemographic and performance characteristics of health professionals in small municipalities in the state of Paraná. 2022.

Variables	n	%
Sex		
Female	703	88.2
Male	94	11.8
Age		
18 to 29 years	155	19.4
30 to 39 years	302	37.9
40 to 49 years	241	30.2
50 to 59 years	92	11.5
60 years or older	07	9.0
Race/Skin Color		
Yellow	09	1.1
White	592	74.3
Indigenous	01	0.1
Brown	174	21.8
Black	21	2.6
Education		
Complete High School	339	42.5
Attending Higher Education	41	5.1
Complete Higher Education	172	21.6
Attending Specialization	45	5.6
Complete Specialization	192	24.1
Complete Master's Degree	05	0.6
Complete Doctorate	03	0.4
Marital Status		
Married / Stable Union / Living with a partner	554	69.5
Divorced	54	6.8
Single	180	22.6
Widow	09	1.1
Length of service in the current health care facility		
Less than 1 year	141	17.7
1 to 3 years	178	22.3
4 to 5 years	91	11.4
6 to 9 years	148	18.6
10 years or more	239	30.0
Professional category		
Community Health Agent	305	38.3
Disease Control Agent	43	5.4
Dental Surgeon	33	4.1
Oral Health Technician	24	3.0
Nurse	141	17.7
Nursing Technician	133	16.7
Pharmacist	24	3.0
Physical Therapist	25	3.1
Physician	19	2.4
Psychologist	19	2.4
Others*	31	3.9
Time working in Primary Health Care		
Less than 1 year	96	12.0
1 to 3 years	145	18.2
4 to 5 years	80	10.0
6 to 9 years	161	20.2
10 years or more	315	39.5
Type of employment relationship		
Permanent / Statutory	588	73.8
Fixed-term contract / CLT	197	24.7
Other	12	1.5

* Social Worker (n=11); Speech Therapist (n=03); Veterinarian (n=01); Nutritionist (n=08); Physical Education Professional (n=05); Sanitation Professional (n=03).

Among the health care tools frequently used with other professionals, home visits (73.1%) and matrix support (63.2%) were the most mentioned (Table 2).

Table 2. Utilization of health care tools with other health professionals in small municipalities in Paraná. 2022.

Variables	n	%
Matrix support		
Do not perform	31	3.9
Rarely	83	10.4
Sometimes	179	22.5
Frequently	504	63.2
Shared consultation		
Do not perform	137	17.2
Rarely	130	16.3
Sometimes	289	36.3
Frequently	241	30.2
Case discussion		
Do not perform	47	5.9
Rarely	136	17.1
Sometimes	270	33.9
Frequently	344	43.2
Health Education		
Do not perform	158	19.8
Rarely	126	15.8
Sometimes	250	31.4
Frequently	263	33.0
Physical activity/body practice groups		
Do not perform	488	61.2
Rarely	143	17.9
Sometimes	95	11.9
Frequently	71	8.9
Singular therapeutic project		
Do not perform	584	73.3
Rarely	98	12.3
Sometimes	83	10.4
Frequently	32	4.0
Health project in the territory		
Do not perform	212	26.6
Rarely	183	23.0
Sometimes	258	32.4
Frequently	144	18.1
Home visit		
Do not perform	62	7.8
Rarely	57	7.2
Sometimes	95	11.9
Frequently	583	73.1

Table 3 lists that matrix support was the most often used tool by nursing technicians, psychologists, and dental surgeons. Home visits were frequently used by community health agents, disease control agents, nurses, and physicians. Shared consultations were the most commonly used tool by oral health technicians, while case discussions were more frequent for psychologists and nurses.

A statistically significant difference between the professional categories was detected for the frequent use of all management tools. Matrix support and home visits were the tools most frequently used (> 50%) by seven and five professional categories, respectively. For technical level categories, the frequency of use of the different tools ranged from 2.6% to 97.7%, while for those with higher education, a variation from 1.5% to 77.3% was observed (Table 3).

Table 3. Frequency of utilization of team health care management tools, according to professional categories in small municipalities in Paraná. 2022.

	CHA (n=305)	Nursing Tech. (n=133)	DCA (n=43)	Oral health Tech. (n=24)	Nurse (n=141)	Dental surgeon (n=33)	Physical therapist (n=25)	Pharmacist (n=24)	Physician (n=19)	Psychologist (n=19)	Others* (n=31)	
	%	%	%	%	%	%	%	%	%	%	%	*p*-value
Matrix support	62.6	78.9	41.9	62.5	71.6	54.5	24.0	45.8	57.9	63.2	51.6	<0.001
Shared consultation	21.3	45.1	20.9	66.7	48.9	39.4	12.0	8.3	26.3	15.8	9.7	<0.001
Case discussion	43.9	45.1	32.6	37.5	53.9	12.1	32.0	12.5	36.8	57.9	45.2	0.003
Health education	41.0	30.1	7.0	33.3	33.3	48.5	8.0	12.5	26.3	31.6	25.8	<0.001
BP/PA Groups	8.9	7.5	0	8.3	8.5	3.0	40.0	0	5.3	5.3	22.6	<0.001
Singular therapeutic project	2.6	3.8	0	0	4.3	3.0	16.0	0	15.8	15.8	6.5	0.001
Health project in the territory	13.1	7.5	41.9	45.8	24.8	1.5	8.0	0	5.3	15.8	22.6	<0.001
Home visit	96.1	63.9	97.7	4.2	77.3	18.2	44.0	0	68.4	42.1	48.4	<0.001

BP/PA Groups = Body Practice and Physical Activity Groups; CHA = Community Health Agent; DCA = Disease Control Agent; Tech. = Technician.

* Social Worker (n=11); Speech Therapist (n=03); Veterinarian (n=01); Nutritionist (n=08); Physical Education Professional (n=05); Sanitation Professional (n=03)

Table 4. Utilization of health care tools with other professionals, according to the time of experience in the current health establishment in small municipalities in Paraná. 2022.

Variables	Até 3 anos n (%)	4 anos ou mais n (%)	*p*-value
Matrix support			0,31
Do not perform/Rarely - Sometimes	124 (38.9)	169 (35.4)	
Frequently	195 (61.1)	309 (64.6)	
Shared consultation			0.07
Do not perform/Rarely - Sometimes	234 (73.4)	322 (67.4)	
Frequently	85 (26.6)	156 (32.6)	
Case discussion			0.26
Do not perform/Rarely - Sometimes	189 (59.2)	264 (55.2)	
Frequently	130 (40.8)	214 (44.8)	
Health education			0.73
Do not perform/Rarely - Sometimes	216 (67.7)	318 (66.5)	
Frequently	103 (32.3)	160 (33.5)	
Body practice/Physical activity groups			0.03
Do not perform/Rarely - Sometimes	299 (93.7)	427 (89.3)	
Frequently	20 (6.3)	51 (10.7)	
Singular Therapeutic Project			0.77
Do not perform/Rarely - Sometimes	307 (96.2)	458 (95.8)	
Frequently	12 (3.8)	20 (4.2)	
Health project in the territory			0.76
Do not perform/Rarely - Sometimes	263 (82.4)	390 (81.6)	
Frequently	56 (17.6)	88 (18.4)	
Home visit			0.09
Do not perform/Rarely - Sometimes	96 (30.1)	118 (24.7)	
Frequently	223 (69.9)	360 (75.3)	

The stable employment relationship was associated with frequent shared consultation (p=0.01) together with other health professionals (Table 5)

Table 5. Utilization of health care tools with other professionals, according to the employment relationship in the current health establishment, in small municipalities in Paraná. 2022.

Variables	Stable relationship n (%)	Fixed-term relationship n (%)	*p*-value
Matrix support			0.62
Do not perform/Rarely - Sometimes	205 (34.9)	88 (42.1)	
Frequently	383 (65.1)	121 (57.9)	
Shared consultation			0.01
Do not perform/Rarely - Sometimes	396 (67.3)	160 (76.6)	
Frequently	192 (32.7)	49 (23.4)	
Case discussion			0.18
Do not perform/Rarely - Sometimes	326 (55.4)	127 (60.8)	
Frequently	262 (44.6)	82 (39.2)	
Health education			0.86
Do not perform/Rarely - Sometimes	395 (67.2)	139 (66.5)	
Frequently	193 (32.8)	70 (33.5)	
Body practice/Physical activity groups			
Do not perform/Rarely - Sometimes	532 (90.5)	194 (92.8)	
Frequently	56 (9.5)	15 (7.2)	
Singular Therapeutic Project			0.80
Do not perform/Rarely - Sometimes	565 (96.1)	200 (95.7)	
Frequently	23 (3.9)	09 (4.3)	
Health project in the territory			0.71
Do not perform/Rarely - Sometimes	480 (81.6)	173 (82.8)	
Frequently	108 (18.4)	36 (17.2)	
Home visit			0.48
Do not perform/Rarely - Sometimes	154 (26.2)	60 (28.7)	
Frequently	434 (73.8)	149 (71.3)	

Health professionals who reported a stable employment relationship presented a higher frequency of shared consultations (32.7%) compared to those with a temporary employment relationship (23.4%) (Table 5).

DISCUSSION

This study aimed to identify the use of health care management tools by PHC teams in small municipalities in Paraná. The sociodemographic profile depicts the feminization of the service, young people, with stable professional contracts and 10 or more years of experience. The results indicate that home visits and matrix support were the most frequently used tools. When analyzed by professional categories, nursing technicians, psychologists, and dental surgeons make more frequent use of matrix support. In turn, disease control agents, community health agents, nurses, and physicians recurrently utilize home visits. Oral health technicians reported more frequent use of shared consultation, while case discussions were more frequent among psychologists and nurses. Longer time working in the current health facility was associated with the implementation of body practice/physical activity groups (BP/PA). In addition, the type of employment relationship was associated with the use of shared consultation.

Home visits, one of the tools most used by health professionals in PHC teams of small municipalities in Paraná, are based on home care. This provides the opportunity to understand people's life context, and adapt and coordinate care based on the real possibilities of people and their caregivers and family members[9], promoting equity, autonomy, and empowerment of users.

According to Cunha and Sá[10], this activity still seems to be concentrated among community health agents, and there is difficulty in including other professionals. However, this study showed that both technical-level professionals (endemic disease control agents and community health agents) and higher-level professionals (nurses and physicians) reported frequent use of this tool along with other health professionals. The potential of home visits for planning health actions and reorienting practices appropriate to the living and working conditions of users is recognized, as well as the challenges of dealing with the demands of the territory in an unexpected and diverse context[10].

Matrix support, which was also reported as one of the frequently used tools, especially for nursing technicians, psychologists, and dental surgeons, aims to share knowledge through interdisciplinary relationships[11]. Despite the need to overcome everyday problems in the SUS, matrix support is an important articulating tool for producing changes in interprofessional relationships[11]. Nevertheless, disparities in the way teams work can make dialogue between them unfeasible, resulting in the production of individualized and fragmented health care[12].

Peduzzi and Agreli[1] emphasize that building a team is hard work, a dynamic process demanding collaboration, mutual learning, and understanding diverse professional roles. Such a process also requires understanding the demands and needs of the population and the territory, recognizing their singularities and specificities, as well as acting in a shared and collaborative manner in setting goals, planning, and constructing actions, among others.

Thus, multi- and interprofessional work is relevant in PHC because it has teams as its core and focuses on patient-centered care[1]. Therefore, the resumption of multi-professional teams is strategic to promote comprehensive care for the population, contributing to expanding the scope of practices and the resolvability of PHC[13], considering that interprofessionality is one of the guidelines of eMulti[13]. It is worth highlighting the importance of interprofessional education in professional training in health, contributing to integral and humanized care, providing teamwork experiences, and exchanging shared knowledge. However, there are challenges to be overcome[14].

Moreover, longer experience in the health facility and the type of employment relationship positively influenced the joint use of some health care management tools with other professionals.

Professionals with longer experience (4 years or more) in the current health facility reported frequently using BP/PA groups (together with other professionals). Teamwork requires relational and interactive arrangements between professionals, in addition to effective and frequent communication[6], which can be improved with longer time working together, strengthening the team bond. In addition, holding BP/PA groups together with other professionals (among those with longer experience) indicates an important aspect, which is the shared responsibility of different health professionals for promoting BP/PA in PHC, which is not exclusive to Physical Education professionals (PEp). It is worth mentioning that only five Pep participated in this study, and that despite the increase in the number of these professionals in PHC over the last few years, their distribution is still uneven among the different regions of the country[15]. In 2024, approximately 11,400 PEp have been working in the SUS, and besides regional inequalities, it is also worth considering the differences in hiring these professionals in large urban centers and small municipalities.

Stable employment contracts were also associated with a higher frequency of shared consultations than those with fixed-term employment relationships. This is a frequent tool in the work routine of the multidisciplinary team (currently e-Multi) that, when asked to provide support, shares care with the Family Health Strategy team[5]. Stable employment relationships favor the maintenance of workers in PHC, providing chances for strengthening bonds (with the team; with users, families, and the

community), reinforcing work relationships, co-responsibility, and the opportunity to improve communication for shared and collaborative action, aiming at integral care.

Our findings point to the ongoing need to rethink the training of health professionals so that they have the opportunity to have experiences during their undergraduate studies that prepare them for the diverse contexts they will face when working in small municipalities, in addition to the characteristics of the municipalities in which they are usually trained (medium and large municipalities).

Further, continuing education that is understood as a policy and not as a government program[16], and that also addresses the management tools indicated as little used by professionals here, can help to expand and make professional practice more effective, based on collaboration between different professionals in their own context of work.

As a limitation, the assessed teamwork was limited to collaboration with professionals from the teams working directly in the care of that health facility, not including other services of the Health Care Network or other sectors. The lack of research with a similar objective, in addition to the limited number of studies conducted in small municipalities, specifically on this topic, made it impossible to compare the results. However, it reinforces the originality of the present investigation.

CONCLUSION

In small municipalities in the state of Paraná, the most frequently used health care management tools in PHC were home visits and matrix support. Nursing technicians, psychologists, and dental surgeons make more frequent use of matrix support. Disease control agents, community health agents, nurses, and physicians utilize more home visits. Shared consultation was the most frequent among oral health technicians, and case discussions were more frequent for psychologists and nurses. A statistically significant difference was detected in the frequent utilization of all management tools among the professional categories. Longer time in the field and stable employment relationships were associated with groups of body practices/physical activities and shared consultation, respectively, which were carried out jointly with other health professionals.

Additional studies in small municipalities are suggested to evaluate the use of care management tools considering teamwork and interprofessional collaboration in a broad way, as well as the health care network and other sectors, in addition to involving managers, users, family, and community.

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CONFLICT OF INTEREST

The authors indicate that there is no conflict of interest.

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