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Performance of the oral health team in home care in the context of the Family Health Strategy: an integrative review

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Abstract *This is an integrative review that aimed to analyze the performance of the oral health team in home care within the Family Health Strategy, after the publication of the National Oral Health Policy Guidelines. Databases PubMed, Lilacs and SciELO were used in the 2004-2018 period. The selected papers (n=17) were organized in Excel sheet with data: author, year of publication, title, objectives, publishing journal, study location, type of study and thematic category. Two categories emerged from the thematic analysis: "Oral health practices in the household context and the work process of the oral health team" (n=11) and "Instruments for the management and evaluation of home care by the oral health team" (n=6). The scientific production showed low frequency of home visits, lack of prioritization and systematization of home care actions and weak interaction with the family health team. The home care protocols and instruments for the prioritization of home visits indicate the potential to overcome the clinical approach restricted to the dental office. Fourteen years into the publication of the National Oral Health Policy guidelines, the household is a territory to be conquered by the oral health team.*

Key words *Oral health, Home care, Family health*

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Introduction

The establishment of the Unified Health System (SUS) was a "founding letter" of a new social order that clashed with the historical legacy of a society marked by differentiation and segmentation in health care. The organization of care was the focus of the sector's performance since the beginning of SUS implantation, with the challenge of replacing the hospital-centered and on-demand model with a user-centered model[1].

In oral health care, the predominant model in the country is "market dentistry", which restricts the population's access by transforming dental care into a commodity, acquired only by those who can afford it. Of course, dental conditions are one of the most important signs of social exclusion. Addressing this problem requires intersectoral policies that integrate preventive, curative, rehabilitative and, above all, State commitment, as determined by the Constitution of the Republic[2].

With the aim of increasing the people's access to oral health actions, the Ministry of Health published Ordinance Nº 1,444 in December 2000, including Oral Health Teams (ESB) in the Family Health Strategy (ESF)[3]. The publication of Ordinance Nº 267, dated March 2001, regulated and established the Plan for Reorganization of Oral Health Actions in Primary Care[4]. These policies promoted an expanded service network throughout the country and an essential contribution of resources in the public financing of oral health[5].

In 2004, the publication of the National Oral Health Policy Guidelines (PNSB) represented the theoretical framework of Brazilian oral health[6]. These guidelines provide that oral health services and actions must result from an adequate knowledge of the population's health reality, and it is imperative to draw professionals closer to users and the territory. When discussing the expansion and qualification of oral health actions, they highlight home visits (HV) to people who are bedridden or with mobility difficulties to identify risks, follow-up and provide necessary treatment[7].

Publication *Caderno de Atenção Básica nº 17*, which reorients the oral health care model in the Unified Health System (SUS), indicates that the organization of home care (HC) is one of the main challenges for the ESB[8]. The home-based healthcare includes the HV, care and home hospitalization, each of which has specific objectives and characteristics[9].

The National Primary Care Policy (PNAB) defines the realization of HC as a common attribution of health teams[10], but these professionals suffer a significant conflict, given the difficulty of assuring families/users the home care and concomitantly being responsible for all the other households in the territory and the Primary Care routine[11].

HC can be understood as a replacement modality of health care organization and as a device for the production of innovation in care from a deinstitutionalized environment[11].

Changing the care model is a complex process, which depends on the incorporation of transformations in the health work process regarding its purposes, objects, means and, fundamentally, in the relationships between professionals and the service user population. Users must assume center-stage in the production of care, expressing their needs and holding the place of the subject in the construction of therapeutic projects[12] to make a change in the technical and care-related model effective.

Although the normative scenario has changed for more than a decade, within the ESB, the way of making health still reproduces a biomedical model, with actions centralized on the dental surgeon (DS), individual and curativist approach, negligible community inclusion and difficulties in the teamwork, in a scenario of exclusionary universalization and selective integrality of oral health actions and services[6,13,14].

We have located studies that analyze the work process of the ESBs in the timeline, but these studies do not highlight nor delve into the subject of HC. Given the relevance of the theme and the gap identified in the literature, we inquire: "What is the evidence of the ESB performance in the home context?". This paper aimed to analyze the performance of the ESB in HC within the ESF after the publication of PNSB Guidelines, based on the integrative review of the literature.

Methods

An evidenced-based integrative review of the literature was carried out, which contributes to in-depth knowledge about a theme. This type of review allows the collection and synthesis of research results systematically and orderly, facilitating the incorporation of evidence in the redirection of care practices[15]. The stages of this review were: 1 - elaboration of the guiding question, 2 - search in literature, 3 - data collection and elab-

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oration of spreadsheet in the Microsoft Excel® program with data related to scientific papers, 4 - critical review of included papers, 5 - discussion of the results and 6 - preparation of the final report underpinning the qualitative synthesis of the literature[16].

The bibliographic survey was performed simultaneously by two reviewers in PubMed (Public Medical Literature Analysis Online), Lilacs (*Literatura Latino-Americana e do Caribe em Ciências da Saúde*) and SciELO (Scientific Electronic Library Online) databases between May and June 2018. The following inclusion criteria were used: studies that addressed the performance of the ESB in the HC in the context of the ESF, originals, published between 2004 and June of 2018, available online in full, in Portuguese, English or Spanish. Theses, dissertations and opinion papers were excluded. The year 2004 was defined as a time selection due to the publication of the PNSB Guidelines[7]. The search key used was composed of descriptors belonging to the Medical Subject Headings (MeSH) or their analogs available in the DeCS (Health Sciences Descriptors), and they were: ("home care") AND ("oral health") AND ("Family health") used in English or Portuguese according to the database. The Boolean operator "AND" was used for the combinations.

Paper search and selection were performed concomitantly by two researchers, with the same criteria in all databases. The initial selection of papers was carried out reading the titles and abstracts; any concern regarding the paper's content ensued a full-text reading. Subsequently, duplicated papers were excluded and a thorough reading of each work was carried out in its entirety, evaluating its association with the topic. In the end, 17 papers were selected and organized into a Microsoft Excel® spreadsheet with the following data: author, year of publication, title, objectives, publishing journal, study location, type of study and thematic category. Works were analyzed by thematic analysis[17], which consisted of floating reading of content, coding, categorization and articulation with the following theoretical references: The PNSB Guidelines[7] and publication *Caderno de Atenção Básica nº 17*[8].

Results

The initial search in the databases returned a total of 477 publications, of which 430 in PubMed, 10 in LILACS and 37 in SciELO. Of this total, after reading the title, 439 papers were excluded. Then, of the remaining 38 papers, eight were excluded due to duplication, and after reading 30 abstracts, nine were excluded because they did not address aspects of HC in the ESB. A total of 21 scientific papers were read in full, of which four were excluded because they did not focus on the ESB's performance in the ESF. Finally, the body of analysis of this integrative review consisted of 17 papers (16 in Portuguese and 01 in English). Figure 1 shows the selection flowchart.

All papers selected were published in national journals, with emphasis on the journal *Ciência & Saúde Coletiva*, with a more significant number of papers published in the theme of this review (n = 8). There was a predominance of publications from the Northeast (n = 8), followed by the Southeast (n = 5), South (n = 2), North (n = 1) and a national paper. A balance was observed regarding the methodology used in the selected works: 47% were quantitative studies (n = 8), 41% qualitative (n = 7), and there was also an experience report and a study that sought to establish an HV systematization instrument for the ESB. The same balance is noted regarding the year of publication, with two publications on the subject in 2007, 2008, 2010, 2011, 2013, 2015 and 2016; 2006, 2012 and 2017 had one publication each.

After the thematic analysis, two categories emerged that contribute to the understanding of ESB performance in the home context in the ESF and will be detailed in the discussion in light of the theoretical references used for this review. Chart 1 summarizes the main contributions of each paper analyzed.

Discussion

The review evidenced the relevance of the discussion of the different themes that emerge from the performance of the ESB in the HC. We highlight the variety of methods used to investigate work processes in the home context, reinforcing the relevance and complexity of the issues that permeate the production of health care.

Oral health practices in the home context and the oral health teamwork process

This category brings evidence of the work process of the ESB in the HC in the ESF, regarding frequency, the direction of actions, practices performed at home, teamwork and the establishment of a bond between the health team and

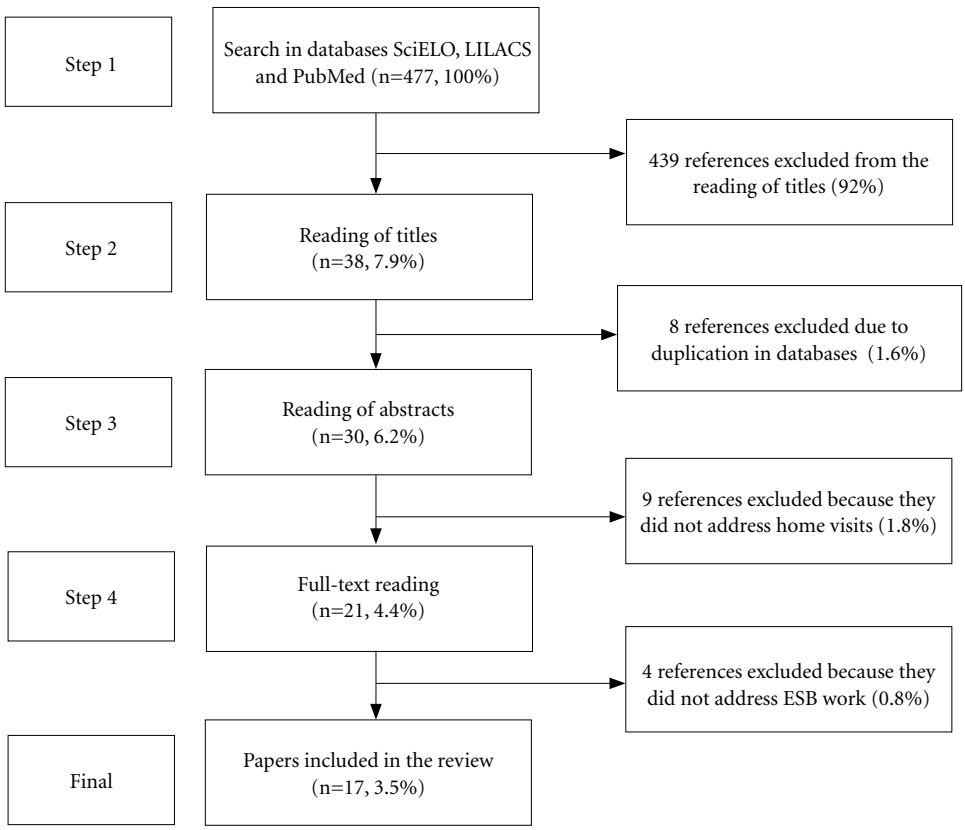

Figure 1. Flowchart of the selection of papers.

the population. Most of the studies[18-27] aimed to know the profile of practices and the work process of the ESB.

Only one study[28] focused on HV and home care developed by DS. In this study, data from the external evaluation of the 1st cycle of the National Program for Improving Access and Quality of Primary Care (PMAQ-AB) were used. Of the 17,202 health teams in the country, the number of family health teams assessed that carry out HV is close to 100%. Home care is performed by more than 90% of the minimum staff, and by 50% of oral health professionals, showing that the ESB still has challenges to carry out new practices in PHC.

The evidence in this review reaffirmed the diagnosis brought by this study[28]. Despite being considered an indicator of change in the care model, the HV performed by the DS shows that it was not incorporated into the ESB routine, evidencing low periodicity[18-20,22,23,26] and occurring in isolation from the other professionals of the team[24,26]. This performance in the HV is contrary to PNSB Guidelines, which indicates that the ESB must be – and feel – part of the multidisciplinary team in health units of any level of care, working in an interdisciplinary way[7]. Only one study addressed the work of oral health technicians (TSBs) in HVs[27]. From the analysis of self-reported functions performed by 231 TSBs in the state of Minas Gerais, a high proportion reported performing HVs (77.9%), evidencing the strength of spending time in preventive/collective activities, as well as care activities, while reorganizing oral health care practices in PHC[27].

The PNSB Guidelines[7] indicate that health education actions can be developed by HC, TSB, oral health assistant community health workers (ACS), especially during HVs. Thus, a study[25] sought to analyze the interference of oral health education actions for adolescents in the ESF, because it is an age group that rarely attends the PHC facility (UBS). The adolescents were divided into three groups: those who participated in

Chart 1. List of selected studies: Author(s), year of publication, study title, publishing scientific journal, type and place of study and main evidence of studies.

Author (s)/Year of publication	Title	Journal	Type and place of study	Main evidence of studies
Araújo e Dimenstein (2006)[18]	Estrutura e organização do trabalho do CD no PSF de municípios do Rio Grande do Norte (RN).	Ciência & Saúde Coletiva	Qualitative/ RN	HVs were poorly executed, without prioritization according to the risk of families, and were a reproduction of traditional practices, fragmented and isolated in the DS work process.
Vilarinho et al. (2007)[21]	Perfil dos cirurgiões-dentistas integrantes do Programa Saúde da Família em Teresina (PI).	Revista Odonto Ciência	Quantitative/ PI	70.8% of the DS performed scheduled HVs through the ACS and/or the ESB, and the HV was an instrument for the new dynamics of the ESF. The main challenge for model change is the high demand for clinical care.
Chaves e Silva (2007)[20]	As práticas profissionais no campo público de atenção à saúde bucal: o caso de dois municípios da Bahia	Ciência & Saúde Coletiva	Qualitative/ BA	In practice, the laws of the private subfield predominate individual action restricted to the practice. Only 1 CD reported performing RV in its typical week. Lack of consolidation of the link between professional and users of the service.
Barbosa et al. (2007)[19]	Saúde bucal no PSF, da inclusão ao momento atual: percepções de cirurgiões-dentistas e auxiliares no contexto de um município.	Ciência Odont. Brasil	Qualitative/ RN	The professionals showed interaction with the community. However, only 4.65% of the respondents highlighted the HV, emphasizing the prevention of oral cancer. HVs are geared to pregnant, older adults and bedridden. The main approach is oral hygiene guidelines and identification of oral injuries.
Almeida e Ferreira (2008)[22]	Saúde bucal no contexto do Programa Saúde da Família: práticas de prevenção orientadas ao indivíduo e ao coletivo.	Cad. de Saúde Pública	Quantitative/ RN	Of the 91 DS, 43 performed HV, for the groups of: bedridden, older adults and individuals without mobility; pregnant women, mothers and newborns. The ACS identifies the individuals to be visited. Regarding home practices, the following is performed: oral hygiene and diet orientation; evaluation of living conditions and habits; incentive to self-examination of oral cancer. Regarding the proportion of HVs performed by physicians, nurses and other higher education professionals, ESB's HV represented only 20.5% when compared to other categories. The high demand for clinical care was one of the limitations to the performance of HVs.
Faccin et al. (2010)[23]	Processo de trabalho em saúde bucal: em busca de diferentes olhares para compreender e transformar a realidade	Ciência & Saúde Coletiva	Qualitative/ SC	Professionals express concerns about what to do in the HV. The HV is a useful resource for oral health if well delimited, such as in situations whose family dynamics interfere in the health-disease process, and the presence of the DS in loco brings benefits in understanding the user's reality. It establishes or strengthens the bond and can also be used for curative interventions in patients unable to move to the UBS, when equipment is available.

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Chart 1. List of selected studies: Author(s), year of publication, study title, publishing scientific journal, type and place of study and main evidence of studies.

Author (s)/Year of publication	Title	Journal	Type and place of study	Main evidence of studies
Emmi e Barroso (2008)[39]	Avaliação das ações de saúde bucal no Programa Saúde da Família no distrito de Mosqueiro, Pará.	Ciência & Saúde Coletiva	Quantitative/ PA	The home visits, mentioned by 30 users, enabled a greater contact with the professional, facilitated the attendance, and user travel to the facility in search of care was avoided. Major improvements for the sample population are, in this order: oral hygiene guidelines, greater access to care and HVs.
Pimentel et al. (2010)[24]	Análise da atenção à saúde bucal na Estratégia de Saúde da Família do Distrito Sanitário VI, Recife (PE)	Ciência & Saúde Coletiva	Qualitative/ PE	It was evidenced that several professionals of the team see the DS geared only to clinical care and that when he/she is attending at the clinic "he/she is doing nothing". Team believes that the DS should be inside the clinic only doing restoration, outpatient service and that he/she does not have to do HVs or go to school to give a lecture.
Moura et al. (2013)[26]	Saúde bucal na Estratégia de Saúde da Família em um colegiado gestor regional do estado do Piauí	Ciência & Saúde Coletiva	Quantitative/ PI	Only 27% carry out a multidisciplinary HV and in 48.6% of the cases the population is visited regardless of need. The HV has not yet been incorporated in the routine of the DS, its periodicity is irregular, and sites are designated by the ACS. The obstacles for multidisciplinary HV are: the team's priority for the activity; the availability of vehicles to drive the professionals; HV territories that are unsafe to walk to by foot.
Sanglard-Oliveira et al. (2013)[27]	Atribuições dos Técnicos em Saúde Bucal na Estratégia Saúde da Família em Minas Gerais, Brasil.	Ciência & Saúde Coletiva	Quantitative/ MG	Of the 231 OHT participants, 77.9% performed HVs and 15.2% performed clinical activities in the HVs, and the OHT is a multiplier agent and health educator, with direct extra-clinical intervention, participating in and collaborating in HV programming and in collective health actions. OHT have employed their time more into extra-clinical preventive/collective activities than into individual care activities.
Colussi e Calvo (2011)[37]	Modelo de avaliação da saúde bucal na atenção básica.	Cad. de Saúde Pública	Quantitative/ SC	11 municipalities in the state of Santa Catarina did not respond, and 71 said that none of their UBS performed oral health HV for elderly people with no mobility (bedridden). Disabling limitation should not be a deterrent to the provision of oral health care.

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educational activities developed at the school; those who had oral health orientations during monthly HVs of ACS, previously trained by the ESB and those who participated in a weekly orientation group to improve the quality of life. There was an increasing number of adolescents with healthy gingiva or mild inflammation in the HV and school groups. This finding corroborates the importance of joint planning of oral health education actions oriented to an age group that challenges the ESB regarding systematization and access to actions and services.

The publications pointed out that the HV was oriented to bedridden, pregnant women[19,21], puerperae/newborns[21], older adults[19], and users with a mobility impairment to visit the UBS[21].

Chart 1. List of selected studies: Author(s), year of publication, study title, publishing scientific journal, type and place of study and main evidence of studies.

Author (s)/Year of publication	Title	Journal	Type and place of study	Main evidence of studies
Szpilman e Oliveira (2011)[40]	A Percepção dos usuários sobre os serviços de odontologia em UBS de Vila Velha (ES), Brasil.	Revista Espaço para a Saúde	Qualitative/ ES	Users reported a high level of satisfaction with the HV, mainly the ACS. However, HVs were not performed by other professionals (doctors, nurses or dentists) due to lack of transportation, showing a barrier in access to users who did not have access to UBS.
Turrioni et al. (2012)[25]	Avaliação das ações de educação na saúde bucal de adolescentes dentro da Estratégia de Saúde da Família.	Ciência & Saúde Coletiva	Quantitative/ SP	Of the 3 groups of adolescents who participated, an increased number of adolescents with healthy gingiva or mild inflammation in the groups that received a HV by the ACS trained by the ESB and the activity at school was noted. It revealed the importance of joint planning of oral health education actions among health professionals and also for an age group that does not seek dental care, and which challenges ESB to systematize this access.
De-Carli et al. (2015)[28]	Visita domiciliar e cuidado domiciliar na Atenção Básica: um olhar sobre a saúde bucal.	Saúde em Debate	Quantitative	Of the 17,202 health teams that joined the first cycle of the PMAQ, almost 100% of the evaluated EqSF performed HV. Home care is performed by more than 90% of EqSF professionals, and by approximately 50% of EqSB professionals. However, there are still challenges to be overcome to change ESB routine.
Kobayashi et al. (2015)[32]	Risco familiar como elemento para organização da demanda em saúde bucal na ESF.	Revista Odontol. UNESP	Quantitative/ SP	Card A was used as an instrument in the organization of the demand for HV by ESB according to the family risk to caries. People at risk would be twice as likely to have the disease compared to those without risk.
Maciel et al. (2016)[35]	Quando a saúde bucal bate à porta: protocolo para a atenção domiciliar em odontologia.	Revista Bras. Promo. Saúde	Protocol/CE	The HVs focused on health education and promotion, the motivation for self-care and the stratification of risk for the intervention of the EqSB. The protocol included general health aspects, ascription to the ESF, information regarding oral health, indication of the need for intervention at home and/or at the UBS and referral to the secondary care service. The instrument evidenced good capacity of use in the work process in oral health provided by the teaching-service integration, qualifying the HV of the ESB.
Ferraz e Leite (2017)[34]	Instrumentos de visita domiciliar: abordagem da Odontologia na ESF.	Revista de APS	Protocol/MG	The protocols were based on actions of health surveillance and directed to the HVs for patients with disabilities, puerperae/newborn and bedridden. A need for systematization of the HV by the DS was found, in the establishment of a more accurate diagnosis of the oral health situation of the population of the area of coverage of the UBS to reduce the stock of oral disease accumulated needs of these users.

The ESB does not prioritize HVs by family risk[18], and the ACS must indicate the users/households requiring this care[22]; there was no evidence of case discussion with other staff members.

Publication *Caderno de Atenção Básica nº 17* indicates that the operationalization of the HVs must be performed by the team, considering the attributions of each member, based on planning built together and agreed with the user-household. Planning should cover the participation and frequency of all professionals in the execution of the actions, based on the needs of users/household, seeking to distribute the professionals to streamline team work[8].

Oral health practices developed in the home context were: oral hygiene guidelines and diet[19,22,25,26], guidelines on healthy living habits[22] and diagnosis of oral cancer[19,22], which is as per the PNSB Guidelines, which suggest that the ESB should provide opportunities for the identification of oral lesions (active search) through HVs[7]. There have also been reports of professionals who have shown concerns and insecurities as to what approach should be performed in the HVs[20,23]. For ESB's HVs to be effective, it is first of all essential to set clear objectives for achieving them. This is indicated in cases where household's dynamics strongly influence the health-disease process; when there are problems of adherence to treatment and the need to strengthen the bond; and for curative interventions when users cannot go to the UBS, taking into account the availability of professionals and the appropriate equipment[23].

There was no evidence on the performance of curative procedures, with or without the presence of portable dental equipment (mobile equipment or cars equipped with an office) that contribute to the clinical action of the DS. The home care requires the DS' possible work adaptations, supporting materials and multidisciplinary action. There are few reports in the literature about this specific dental practice, probably due to the lack of professional qualification or adaptation, or the lack of knowledge about the possibility of such services by the users, their families and other professionals involved[29].

Among the main potentialities of the performance of ESB's HV, worth highlighting is knowledge of the reality experienced by the user/household, which contributes to an approach directed to their primary health needs. Also, the HV favored the creation of a bond between team professionals and users. Bonding is a light relational-type technology that can transform the way health is produced and must be increasingly exercised by the ESB, so accustomed to hard technologies (dental equipment) in its work process[30].

At home, users may feel more confident to address issues that they would hardly bring to professionals at the UBS, besides being more valued by the presence of professionals in their homes. However, one must not confuse bond with user dependence on the presence of health professionals. Oral health practices must be emancipatory, oriented to promote the autonomy of users on how to live life[31].

The excessive demand for curative care in a dental office was the most cited obstacle to the difficulty of the ESB professionals leaving their practice to perform HVs[18,26]. One study[26] cited the population itself demanding a curative approach, and another[24] showed that although the DS moves towards the territory, such as in the realization of HVs, the other professionals of the team understand that the focus of this professional's performance should be directed to the clinic and clinical procedures. Also, the relevance of each team to the achievement of HVs and the availability of a car to drive professionals[26] to and from homes were also barriers to these actions.

The model strictly geared to curative-restorative actions in ESB's work is still predominant[18,20,21,23,24,26,28] and reduces the time of community approach in the professionals' agenda, although it is outlined in the PNSB Guidelines. Simply carrying out the HV does not indicate a model change. Neither talking about care instead of assistance. In the dental office, the DS is the owner of the equipment and knowledge, and within homes, practices must be redefined, reaffirming a close look at emerging health demands and household's dynamics[31].

Home care management and evaluation tools for the oral health team

This category brings evidence that contributes to the management and evaluation of the work process of the ESB in the HC, orchestrating professionals with different ways of reorganizing services to improve access to oral health actions.

Because they require more significant time, travel, high-cost professionals and have reduced coverage, it is necessary to prioritize and plan the ESB's HV as per the particular needs of each territory of action. Publication *Caderno de Atenção Básica nº 17*, when addressing the HC organization, points out as a resource the household

registration, carried out by the ACS, through the "Card A" of the PHC Information System (SIAB)[8]. However, the publication does not detail how "Card A" can contribute to this ESB organization.

One of the studies selected by this review[32] sought to evaluate the relationship between family risk and oral health conditions in the prioritization of HV, to organize the oral health demand in the ESF. The "Card A" was used to verify the family risk and the oral health conditions of 1,165 people (608 aged 12-19 years and 557 aged 35-44 years) were examined by eleven DS, which classified them into six codes from A to F. Household risk was significantly associated with the presence of caries disease requiring treatment. It was possible to conclude that people with household risk are twice as likely to show caries disease when compared to those without risk.

The study[32] used the Coelho-Savassi scale[33], which proposes household risk stratification for HV prioritization from Card A. These results show that the use of epidemiological tools of HV prioritization are essential in the detection of oral diseases, in a simple, established and qualified way, using a card known by professionals, directed to users who, in the face of their living conditions, may not have access to oral health actions, requiring a proactive attitude of the team. It should be noted that it is necessary to follow the implementation process of the E-SUS Information System in order to adapt this prioritization model due to changes in the individual and household records.

Publication *Caderno de Atenção Básica nº 17* shows that, in the care actions, the definition of priorities in the HVs contributes to a household-oriented approach by the ESB. Also, it highlights that the HV should be planned based on the diagnosis of community needs, with actions carried out by an interdisciplinary team in the user-family's residence, realizing the potentials and limitations of their context[8].

In this thematic category of HC management tools, two studies have created protocols for the ESB. The establishment of one of the protocols[34] was motivated by the need to systematize the HV, by the DS with the insertion of a Multidisciplinary Residency Family Health Family group, in a municipality of the macro-regional care center, in the southeast region of the country. The elaboration of the instrument was based on health surveillance actions aimed at three specific groups: patients with special needs; bedridden and puerperae/newborns. Besides seeking a diagnosis and reduction of oral health needs to be accumulated in these users, the protocol aimed to highlight oral health care as an essential part of the ESF routine.

Another proposed HC protocol for the ESB[35] was targeted at home-based users. In this experience report, the tool was constructed during the module on Primary Care Internship of the Dentistry Course, in the municipality of Sobral-CE, Brazil, by students, preceptors and teachers from HVs with a focus on health education and promotion, the motivation for self-care and risk stratification for ESB intervention. Besides information on general health, personal data and oral health information, the tool addressed health education for the user and/or caregiver, indication of need for dental intervention at home or the UBS and referral to oral health secondary care, contributing to the qualification of oral health care provided at home based on a situational diagnosis that can subsidize the development of Unique Therapeutic Projects (PTS) and interventions according to the risk stratification at the time of the HV.

This evidence shows the importance of the teaching-service-community integration, qualifying the practices of management of ESB work process with the creation of tools that can contribute to the reorientation of the health care model in the services. Also, the realization of HV during the professional training of the DS is a pedagogical practice capable of contributing to a broader vision of the health-disease process, humanization of care, facilitating extensive clinical practice in the ESF and training future professionals for the approach in the home context[36].

In the scope of service evaluation, a study[37] showed a model for evaluating the quality of primary oral health care, with 40 indicators, and tested its applicability in municipalities of Santa Catarina. A response rate of 70.6% was obtained in the 207 municipalities that participated in the evaluation. When assessing "oral health care for older adults with an incapacitating limitation" as an indicator of effectiveness, 71 municipalities responded that none of their health facilities performed HV for mobility-impaired (bedridden) seniors. This indicator represents that the incapacitating limitation impeded the supply of oral health care. Besides being included in the PNSB Guidelines[7] and publication *Caderno de Atenção Básica nº 17*[8], the demand for this type of HC is guaranteed by the Statute of the Older Adults[38].

The evaluation of the users is also fundamental for the qualification of health care in the

ESF. In this category, two studies presented this approach[39,40]. After insertion of the ESB into the ESF, a study[39] showed that among the improvements perceived by the users are oral hygiene guidelines, in the lectures, the HVs or the consultation itself. Of the 103 users who participated, 30 reported that the HVs provide more significant contact with professionals, facilitating care and avoiding trips to the UBS. Another highlight was HVs[40] with a high level of satisfaction, mainly by the ACS. However, users require these HVs to be performed by other team members as well. These findings point to the realization of HV as an action that can qualify the evaluation of oral health practices in the ESF by the population regarding the access of users, as well as the recognition of the ESB performance outside the dental office.

Final considerations

The scientific production shows that the organization of HC by the ESB is still a challenge, as indicated by the PNSB Guidelines in 2004. The incipient frequency, the concerns regarding actions taken at homes, the lack of prioritization and systematization, the low interaction with the family health team and the perception of the DS work focused on the clinical procedure in the office, both by the team and users portray a situation in which "feeling part of the health team" and working out the issues of the territory are weaknesses in the performance of the ESB in the ESF.

Home is a deinstitutionalized, complex and multiple-potentiality environment, which requires oral health practices replacing the exclusively clinical and procedural approach. It is a territory to be conquered by the ESB, with management support, to generate innovations in the work process, in the relationships between professionals and users. In HC, the user or household take the centrality of care production back, evidencing the insufficient hard dentistry technologies and traditional professional practices. The HC protocols and HV prioritization tools indicate potential pathways that lead ESB to users/households who have difficulty accessing the UBS.

New studies are required to further analyze the issues regarding the specific action of the ESB in HC, to follow the development, to improve the access and, mainly, direct the prioritized and systematized actions, advancing in the reorientation of oral health practices in the ESF.

Collaborations

RM Silva and ACO Peres participated in the conception, analysis and interpretation of data, writing of the article, and final approval of the version to be published. DL Carcereri contributed with a relevant critical review of the intellectual content and final approval of the version to be published.

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