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CONSTRUCTION OF A HOME DENTAL CARE PROTOCOL AT THE ESF AND UBS

José Braz Tessaro Filho
Studentof the Dentistry course atFaculdade Anhanguera de Linhares

Kátia Uicker Storch
Studentof the Dentistry course atFaculdade Anhanguera de Linhares

Ludmila Freire da Silva
Studentof the Dentistry course atFaculdade Anhanguera de Linhares

Josimar Santorio da Silveira
Professor of the Dentistry course at:Faculdade Anhanguera de Linhares

Marcela Vieira Calmon
Professor of the Dentistry course at:Faculdade Anhanguera de Linhares

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Abstract: The SUS (Unified Health System) was instituted by Law 8080/1990 with the objective of guaranteeing the universal right to health as a responsibility of the State. The Basic Health Units (UBS) are the preferential gateway to the SUS. The objectives of health units are essential for the well-being of the population and play an extremely important role in people's quality of life, without the need for referral to other services, such as emergencies and hospitals. The home visit (HV) is a way for users to access SUS health services, carried out by UBS teams. This study sought to present a HV protocol in oral health for patients unable to access the service, whether permanent or momentary. Through the practice carried out in the curricular internships, it was observed the need to carry out an epidemiological survey through an intervention action by undergraduate students in Dentistry from Linhares-ES, in the first half of 2023. The protocols were adapted for use in home environments, to obtain health information relevant to the needs of patients restricted to the home, with the aim of raising the feasibility of clinical care. The elaboration of the instrument sought to facilitate the approach during the visits and raise the priorities of care for patients restricted to the home. The protocol presents data with personal information, such as identification (SUS card). As well as data from the patient's general health history, history of the oral cavity, extraoral clinical examination, intraoral clinical examination, odontogram, intervention plan and procedures performed. With the elaboration of this protocol, we can contribute to the practice of professionals working in the Unified Health System, as well as improving the needs of each individual who needs this model of care in clinical practice.

Keywords: Dentistry. Home visit. Family Health Strategy. SUS. Protocol.

INTRODUCTION

The Unified Health System (SUS) was created by Law 8080/1990, which has since led to a path of great effort and challenges faced daily to provide and guarantee the universal right to health as a duty of the State (BRAZIL, 2020).

The SUS is governed by six principles, the first three of which are doctrinal: Universality – everyone has rights; Equity – fairness and equality for the system; Comprehensiveness – attention to all needs; Regionalization and Hierarchization – services organized in a network; Decentralization – closer power; Popular Participation – population participating in management and control.

The Basic Health Units (UBS) are the preferential gateway to the SUS. The goal is to address up to 80% of the population's health problems, without the need for referral to other services, such as emergencies and hospitals. The expansion and qualification of the Basic Health Units aims to guarantee services closer to the citizens' homes, in the community, with a good structure to receive the patient well and in a welcoming way (BRAZIL, 2013).

The Family Health Strategy (ESF) started with the Family Health Program (PSF), conceived by the Ministry of Health in 1994. Since then it has been defined as a priority strategy for the organization and strengthening of Primary Health Care (PHC) in the country. Through this strategy, health care is provided by a team composed of professionals from different categories (multidisciplinary) working in an articulated manner (interdisciplinary) that considers people as a whole, taking into consideration, their working conditions, housing, their relationships with the family and the community (BRAZIL, 2009).

The National Home Care Policy defines Home Care (HC) in the SUS as a "modality of health care that replaces or complements

existing ones, characterized by a set of health promotion, prevention, disease treatment and rehabilitation actions provided in home, with guaranteed continuity of care and integrated into the Health Care Networks (RAS)" (BRAZIL, 2012).

According to Ordinance of the Ministry of Health nº 825, of 2016, in its chapter ii, which redefines home care within the scope of the SUS and its indication and organization of home care, it is organized into three modalities, with responsibility for care in HC 1 is from primary health care teams. In this category are individuals who have controlled or compensated diseases. Some kind of dependence on daily tasks or health problems that can be controlled or compensated.

The provision of health care in AD 2 is the responsibility of the care service - SAD, represented by Multiprofessional Home Care Teams (EMAD) and Multiprofessional Support Team (EMAP) specified for this purpose. User eligible for the AD 2 modality, which the AD indicates, are consultations with the intention of abbreviating or avoiding hospitalization (BRAZIL, 2016).

In the provision of health care in AD 3, any user who is inserted in the AD 2 modality becomes eligible, when multidisciplinary care is needed that is too frequent, use or aggregation of equipment that requires procedures of greater complexity. The responsibility for qualifying and helping qualified users in AD 2 and AD 3 is the responsibility of SAD. However, Primary Health Care (PHC) is the care coordinator and the articulation role of the Home Care Service (SAD) belongs to the PHC (BRAZIL, 2016).

An important point is the establishment of a multidisciplinary team (Family Health team - ESF) composed of, at least: (I) general practitioner, or specialist in Family Health, or Family and Community doctor; (II) generalist nurse or specialist in Family Health; (III) nursing assistant or technician; and (IV) community health agents. Oral Health professionals can be added to this composition: general dentist or specialist in Family Health, auxiliary and/or technician in Oral Health (BRAZIL, 2009).

Home care is the broadest form, it was defined as a general term that refers to actions carried out at home to promote health, prevent and treat diseases and heal. According to Anvisa (Brazil, 2006), home care is a set of outpatient activities carried out at home, planned and continued. Home care is characterized by a set of health promotion actions and services, providing disease prevention and treatment and rehabilitation services at home with continuity of care, in addition to being integrated into the health care network.

The home visit (HV) is presented as a form of user access to SUS health actions and services through UBS or ESF. Home health visits and oral health teams to the beneficiaries' homes to learn about the home environment. During the diagnosis of any pathology, be aware also of the family reality so that later in the rehabilitation of patients, subsidies are provided for the adequate planning of health operations (BRAZIL, 2006).

The HV enables the deinstitutionalization of users who are hospitalized in hospital services, in addition to avoiding unnecessary hospitalizations from emergency care services. It expands access, reception and humanization of people who are restricted to bed or home. (BRAZIL, 2012).

The national primary care policy designates as the responsibility of the FHS professionals the activity of Home Care aimed at people restricted to the home, because they have difficulty in locomotion and the lack of practice of the caregiver in oral hygiene, with this the home visit becomes very important for these users (BRAZIL, 2017).

People with special needs, such as elderly people of advanced age, most often with various pathologies such as high blood pressure, diabetes, pneumonia, heart disease, Alzheimer's disease, bacterial endocarditis and other diseases related to advanced age, and therefore need follow-up longitudinally by the FHS team (ROCHA; MIRANDA, 2013).

Other users who depend on care at home are: bedridden as victims of urban violence and accidents, users with special needs such as mental and motor disabilities, people with functional limitations and/or serious illnesses, morbidly obese, restricted to bed or home (BRAZIL, 2019).

MATERIALS AND METHODS

The experience of this study is based on a problem verified by students in the Internship in Collective Health - Family Health Strategy, and through reports from CHAs and dentists in the year 2021, in which several home visits were carried out in the Unit of Saúde do Bairro Planalto, which was observed considerable existence in the number of patients restricted to the home in need of dental care. From the observation of this reality, it was verified that few home visits were made by the oral health team, and the team's insecurity was observed, which there was no necessary guidance on how to proceed before, during and after the visit.

For the elaboration of this work, there was financial support from the Fundação de Amparo à Pesquisa e Inovação do Espírito Santo – FAPES, through the Institutional Program of Scientific Initiation Scholarships.

An epidemiological survey was carried out in the pilot region/neighborhood, and from that, patient data were analyzed through medical records provided by community health agents in the Planalto neighborhood, in the city of Linhares-ES. Home visits were then carried out to collect other relevant data and finally an initial protocol was developed that helped as a test. In the second stage, the pilot protocol was applied and new adjustments were necessary to then build the final protocol, available to other health units.

Linhares, municipality located in the north state of Espírito Santo, Brazil. With an estimated population, it has approximately 179,000 inhabitants, according to IBGE. Regarding rural communities, Linhares is known for having a strong agribusiness presence and has several rural communities. With regard to health infrastructure, Linhares has about 35 UBSs and ESF that provide dental care to the population, in addition to a mobile dental unit, there is also a Specialized Unit of Linhares - UEL, of secondary level, and emergency and emergency at the Hospital Geral de Linhares – HGL.

RESULTS AND DISCUSSION

Optimizing Oral Health actions for patients unable to access the service, whether permanent or momentary, a protocol was developed based on the clinical records used by the Dental Clinic of Faculdade Anhanguera de Linhares.

The protocols were adapted for use in home environments, to obtain health information relevant to the needs of patients confined to the home, with the aim of raising the feasibility of clinical care.

For the development of the protocol, the following participated: a) Dental students from Anhanguera de Linhares; b) Faculty of Dentistry at Anhanguera de Linhares; c) ESB; d) ACS. First, a meeting was held with students and teachers to discuss the issues that must be included in the protocol and to schedule visits to some patients restricted to the home (to hear the perspectives of patients and caregivers about the protocol).

Subsequently, the dental team and the

nursing team visited the areas covered by UBS Planalto to listen to patients and their families, and learn about some of the needs of these users, in addition to providing guidance on the oral health of patients.

A second meeting was held with the team of health agents to analyze the visits made and verify the real need for implementing the protocol and drawing up the flowchart for the care of patients confined to the home (Figure 1).

The intervention was initially developed in the homes of homebound patients, covered by UBS Planalto at the beginning of the first half of 2023.

Even before the elaboration and standardization of the protocol, the following actions took place in the households: a) active search for lesions and alterations of oral tissues in the oral cavity (including self-examination of the oral cavity); b) oral health surveillance and education, with guidance on oral hygiene measures (including brushing and denture cleaning); and c) referral to specialized care, with the active participation of the dental surgeon working in the territory.

From this initial contact, in its consolidated composition, the protocol addresses aspects of general health, with information covering: a) identification data; b) data from anamnesis/health history; c) data from anamnesis/dental history; d) extraoral clinical examination; e) intraoral clinical examination; f) odontogram; g) intervention plan and procedures performed (Figures 2, 3 and 4).

About 35 patients received the HV and were examined using this protocol, patients restricted to the home such as the elderly with advanced age, users with special needs such as mental and motor disabilities, people with functional limitations and/or serious illnesses. With this, the anamnesis of the patients was carried out, guidance was given on oral health and for patients who had prostheses, the caregivers received instructions on how to properly clean them.

The materials to be used in the dental home visit will depend on the situation and procedure to be performed. In general, lab coats and PPE (gloves, mask, goggles and cap), the clinical instrument kit, flashlight, gauze, cotton, a package to put the instruments used during the procedures performed so that they can be discarded later in the Health; model educational materials for brushing guidance, folders on prevention of oral cancer, harm from smoking, alcoholism, care for pregnant women and baby clinic, etc.).

This protocol allows the elaboration of planning a comprehensive intervention, improving the oral and general health of patients based on personal and related data According to the specific situation of the patient, according to the personality individually or collectively.

It was observed during the visits that most of the patients confined to the home were bedridden at the time of the visits, with limited mobility and functional capacity, which created barriers to movement to carry out activities of daily living (SOUZA, 2011). These patients face some vulnerabilities due to chronic illness or other conditions that threaten their physical, social and economic integrity, resulting in a situation that requires the presence of other people for a long period (SILVA et al., 2011).

There are several reasons that contribute to difficulties in accessing health services, including lack of adequate transportation, the poor condition of urban roads, violence in cities and drug trafficking. These factors may result in an increase in the number of patients facing difficulties leaving home (BIZERRIL et al., 2015).

A study carried out in ESF units that participated in the National Program for the Improvement of Access and Quality of

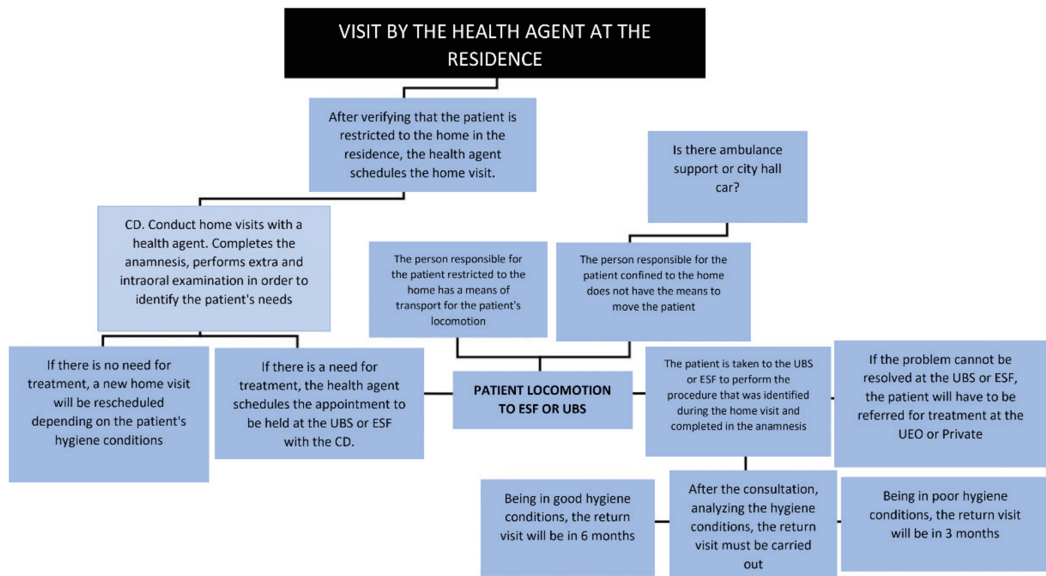

Figure 1. Flowchart. Linhares, 2023.

Source: Elaborated by the authors.

HOME CARE	
IDENTIFICATION DATA	
NAME:	
SUS CARD NUMBER:	
DATE OF BIRTH: / /	RECORD NO.

ANAMNESIS DATA / HEALTH HISTORY			
PA:	**SATURATION:**	**TEMPERATURE:**	**GLUCOSE:**
MAIN COMPLAINT:			
DO YOU HAVE ANY SYSTEMIC DISEASE? WHICH ONE(S)?			
ARE YOU UNDER ANY MEDICAL TREATMENT?			
MOTIVE:			
DO YOU USE ANY MEDICATION?			
WHICH ONE(S)?			
SMOKER?	DRINKING?	OBESE?	
NEED A CAREGIVER?		DO YOU HAVE A CAREGIVER?	
BEDROOM?	MOTIVE:		
UNABLE?		WHEELCHAIR USE?	
LOCOMOTION: ( ) LIMITED ( ) PARTIALLY LIMITED ( ) NOT LIMITED			
ANAMNESIS DATA/DENTAL HISTORY			
HAVE YOU EVER PERFORMED ANY PROCEDURE AT THE DENTIST?			
WHICH ONE(S)?			
DO YOU HAVE ANY TYPE OF ALLERGY? WHICH ONE(S)?			
PATIENT HAS ALREADY BEEN SERVED BY THE DENTAL SURGEON AT HIS HOME ( ) YES ( ) NO			
FREQUENCY OF BRUSHING PER DAY ( ) 1 ( ) 2 ( )3 OR ( ) MORE			
NEED ASSISTANCE FOR ORAL HYGIENE ( ) YES ( ) NO			
DO YOU USE A PROSTHESIS ( ) YES ( ) NO HOW LONG HAS IT BEEN?			
PROSTHESIS SITUATION:			

Figure 2. Form used in home visits. Linhares, 2023.

Source: Prepared by the authors.

EXTRA ORAL CLINICAL EXAMINATION
ATM: ( )NORMAL ( )ABNORMAL / DESCRIBE:
SKIN LESION: ( ) YES ( ) NO/ DESCRIBE:
ASYMMETRY-DEFORMITY: ( ) YES ( ) NO / DESCRIBE:

<table>
<tr><th colspan="8">INTRABUCAL CLINICAL EXAMINATION</th></tr>
<tr><td colspan="8">GINGIVA: ( ) NORMAL ( ) ABNORMAL / DESCRIBE:</td></tr>
<tr><td colspan="8">LANGUAGE: ( ) NORMAL ( ) ABNORMAL / DESCRIBE:</td></tr>
<tr><td colspan="8">FOUNDATION OF THE ENTRY: ( ) NORMAL ( ) ABNORMAL / DESCRIBE:</td></tr>
<tr><td colspan="8">FLOOR: ( ) NORMAL ( ) ABNORMAL / DESCRIBE:</td></tr>
<tr><td colspan="8">PALATE: ( )NORMAL ( ) ABNORMAL / DESCRIBE:</td></tr>
<tr><td colspan="4">LESION: ( ) YES ( ) NO/CHARACTERISTIC</td><td colspan="4">( ) PAPULE</td></tr>
<tr><td colspan="4"></td><td colspan="4">( ) BLAME</td></tr>
<tr><td colspan="4"></td><td colspan="4">( ) NODULE</td></tr>
<tr><td colspan="4"></td><td colspan="4">OTHERS:</td></tr>
<tr><td colspan="8">OBSERVATIONS:</td></tr>
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<tr><th colspan="8">ODONTOGRAM</th></tr>
<tr><td colspan="8">18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28
55 54 53 52 51 61 62 63 64 65
85 84 83 82 81 71 72 73 74 75
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38</td></tr>
<tr><td colspan="8">RELEVANT CLINICAL OBSERVATIONS AND EXISTING TREATMENTS:</td></tr>
</table>

Figure 3. Form used in home visits. Linhares, 2023.

Source: Prepared by the authors.

<table>
<tr><th>DATE VISIT</th><th>INTERVENTION PLAN</th></tr>
<tr><td></td><td></td></tr>
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<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><th>DATE VISIT</th><th>PROCEDURES CARRIED OUT</th></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">OBS:</td></tr>
<tr><td colspan="2"></td></tr>
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Figure 4. Form used in home visits. Linhares, 2023.

Source: Prepared by the authors.

Primary Care (PMAQ-AB) revealed that approximately half of the professionals of the Oral Health Teams (ESBs) provide home care. This highlights the challenges faced by these teams to implement new home care practices in Primary Health Care (PHC) (DE-CARL et al., 2015).

In the territory, home care actions have the main objective of combating inequalities resulting from an unequal health system, where access to services is one of the main barriers. Access is a multifaceted concept, encompassing not only the ability to enter and use services, but also accessibility, which refers to the availability and suitability of resources for the population. Therefore, the accessibility of services plays a crucial role in explaining disparities in the use of services by different population groups, being an important dimension in studies on equity in health systems (TRAVASSOS; MARTINS, 2004).

Home care within the scope of the ESF is more common in the work performed by nurses, doctors and nursing technicians/assistants, compared to the work performed by dentists and oral health technicians/assistants. This is possibly due to factors such as the late integration of oral health professionals into the ESF and the dependence on biomedical approaches and traditional technologies, which still predominate in Dentistry training. These factors result in difficulties in team collaboration and in facing collective problems (NORO; TORQUATO, 2015) (EQUILANTE; SILVA, 2016). Even if the guidelines of the National Oral Health Policy (PNSB), from 2004, establish the reorientation of the care model, with the expansion of access to oral health care at all levels of care (BRAZIL, 2004).

It is important to highlight that, in this study, the success of home visits (HVs) was facilitated by the mediation of Community Health Agents (ACS), who assist in carrying out interventions, in local coordination and, especially, in establishing links between the Centers of Family Health (CSF), the territory and the community. The work of the CHA increases users' access to services, improves their understanding of them and identifies health needs, enabling better integration between health professionals and the community (MUNIZ et al., 2014).

A relevant finding of this experience was the negative perception of oral health by patients and caregivers. Although oral pain and infections can aggravate systemic conditions, unfortunately, oral health is still considered a low priority compared to other medical care offered to these users (FERRAZ; LEITE, 2016). The experience showed that most patients confined at home do not see the importance of oral health care. Therefore, it is essential to promote a better understanding of the duties of the dentist as a health professional, going beyond the stereotype of someone who just "takes care of the teeth". The patient receives comprehensive care that improves their overall health.

In training activities that involve health services and the community as teaching-learning spaces, it is essential that professors and students emphasize the humanization of health care and develop strategies so that the care proposed by the Undergraduate Course in Dentistry can effectively meet the needs community needs. However, this achievement is still far from the reality of most Brazilian municipalities, including the ESF itself (NORO; TORQUATO, 2015).

It is important to emphasize that this article is an experience report, which limits the presentation of results from the use of the protocol in question in the long term, since the intervention took place only during one semester. However, the health team demonstrated a positive acceptance of the instrument, which indicates the possibility

of monitoring it in other experiences within undergraduate courses in Dentistry. Another limitation refers to the lack of visits to all patients restricted to the home during the intervention, due to the high work demand faced by ESF or UBS professionals. Therefore, further follow-up is required to assess the feasibility of this protocol.

CONCLUSION

Through the research, it was possible to identify that home care has positive implications for oral health, as it affects part of the population that cannot access medical services due to restrictions at home. Through home visits, ESB members can reflect on their work processes to develop strategies that encourage community health actions and reduce inequalities in access to health services.

Thus, the results of using this protocol show that the link between the population and the ESB is strengthened. Home care helps diagnose diseases, raises awareness about oral hygiene, promotes well-being and contributes to a better quality of life for patients.

Integration of home care and ESB activities is evolving and it must be emphasized that such actions must be integrated into workflows to allow for more effective interfaces between ESBs and the communities they serve, resulting in greater health benefits and humanization of care. This integration with the community is essential to facilitate the development of a care plan for each patient through disease prevention and health promotion actions and to increase the number of home visits by patients restricted to homes in the coverage area.

In the long term, it is expected to provide continuous care for each patient, enhancing the necessary interventions and reducing the need for therapeutic procedures in the ESF.

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