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# Integrating social and healthcare in Community Homes: what architectural *topos* does the social and healthcare world need?

Abstract
The epidemiological changes of the last decades with the presence of an ever-increasing number of frail and multimorbid patients and the growing social problems of abandonment, loneliness, community disintegration, require a rethinking of treatment paths and structures and a strengthening of social and health policies . The Community Houses, foreseen by Ministerial Decree 77/2022, represent both an opportunity and a challenge. The territory of Parma has developed an inter-institutional project to guide this process. This article analyzes the socio-health context and the architectural-functional needs of the new Community Houses from the point of view of clinicians

Keywords
Community Houses — Multimorbility — Socio-health integration — Multidisciplinarity — Social pact

In industrialized countries, the epidemiological changes, the improvement of technologies and therapeutic and prevention strategies have led to an ever-increasing number of frail and multimorbid patients, often elderly and with multiple medical and social problems. These patients show a high need for care and present significant connotations of complexity as they suffer from multiple chronic diseases, stable or unstable. They take significant polypharmacy, are dependent on common life activities, live in residential facilities or alone, often with distant family members, cared for by strangers or foreign caregivers with poor empathic relationships also due to a language barrier. The scientific literature is progressively defining this new "biotype" (Realdi et al, Intern Emerg Med, 2011) whose clinical complexity and the absence of specific intra-hospital pathways can make these patients at high risk of becoming "bed-blockers".
Furthermore, the lack of specific territorial facilities-hospital pathways and often the frailty and lack of homogeneity of the local healthcare network expose this particular category of patients to a risk of improper hospitalization, longer hospital stays, inadequate care settings and further worsening of disability with other poor outcomes, including death (Buurman, Plos One, 2012).
Despite the strong component of frail, multimorbid, often elderly patients in the Emergency Departments , these latter are not always adequate to meet the needs of that type of patient. Generally, in fact, ED are designed and organized primarily to assist people with acute pathologies or serious injuries and not multimorbid patients with functional and cognitive impairments. In fact, the priority in the ED is placed on the speed of triage, which does not allow an accurate evaluation of subjects with multiple comorbidities, with polypharmacy, with cognitive disorders and chronic or

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**Figg. 1-2**
A UMM team from Parma (ph. Carlo Cozzoli)

UMM interventions. blood gas analysis and multispecialist home assessment of Covid (Ph. Carlo Cozzoli)

slow-onset pathologies.
From this perspective, and if we add the reduction in hospital beds in recent years, the cultural and management change that is required to the General Medicine and Emergency system become clear: if once the principle was "admit to work", today we have to deal with an opposite principle: "work to (do not) admit".
From a social point of view, these changes have reverberated in two clearly identifiable socio-anthropological phenomena: on the one hand, the growth of forms of neo-institutionalization and, on the other, the increase in the phenomena of isolation-abandonment of people and community disintegration. This is evident both in the increase in demand for residential hospitalization places and in growing demands not only for care but also for custody and even containment. On the other hand, we note phenomena such as the birth rate decline, disinvestment in young people, social abandonment, poverty, fragmentation and degradation of the environment. These trends are very dangerous for both people and communities due to the growing resources needed and to the quality of interventions that can be achieved.
In this context, international literature first, and then legislators, identified the need to identify the person's home as the first place of care and life, connected with the community, services and all sociality. Living in safety, harmony and beauty by enhancing the person, the family, the informal network, with a view to community welfare, allows us to prevent abandonment, isolation and loneliness which represent "per se" risk factors for health. The person's home must be connected with the Community Home through some Community and Proximity Services. These facilities have to be developed also through an institutional "alliance" between public Institutions, private Stakeholders, "Third Sector" Associations and the participation of volunteers. The initiative and proximity medicine is able to bring multiple social and health interventions to homes, even up to home hospitalization as happens in Parma with the Multidisciplinary Mobile Units and with other projects also through the use of new technologies. At the same time, for diagnostic, therapeutic and healthcare pathways, the person must be connected with the district, Rural hospital, Territorial facilities and University Hospital in order to ensure maximum competence. It has now been demonstrated that an improvement in home care reduces the use of hospital care for the elderly, disabled and mentally ill.
The Italian Ministerial Decree 77/2022 for the reorganization of territorial healthcare activities, has, among its guiding principles, a strong push towards home care and territorial medicine. In fact, the spirit of the legislator was to modify the classic paradigm by moving from the concept of "Healthcare" to the concept of "(protection of) Health/wellbeing" in its broadest sense. From this perspective, the traditional functions of control,

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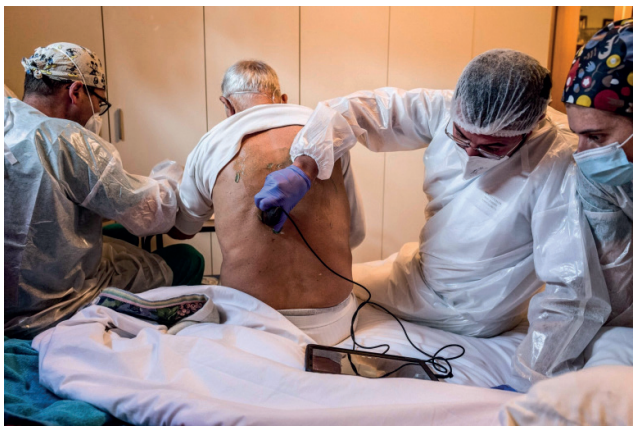

**Figg. 3-4**
Ultrasound and UMM visit in the elderly home (Ph. Carlo Cozzoli)

UMM Parma (Ph. Carlo Cozzoli)

planning and provision of services of healthcare companies have been enriched by proactive, monitoring and management functions, particularly on the social and healthcare side.
Therefore, the design/construction of Community Houses becomes particularly challenging because it requires that the Architect have a multidisciplinary vision of his action which include urban-environmental aspects, urban regeneration. sustainability, architectural composition, aesthetics, biomedical engineering and the social function. And this is even more difficult in the territories where the Community Houses must be created through the transformation of the Health Houses which, essentially, had been conceived with an eminently healthcare connotation, with architectural-functional stylistic features similar to a small hospital or a large clinic. In other words, the required architectural challenge is to build the Community House as a place that contains both highly qualified healthcare functions and social functions of proximity, training and community. The Community House is almost a sort of "third millennium agorà", a place that is experienced in everyday life by the neighborhood, populated by citizens, families, volunteers and professionals from both the social and healthcare sectors.
The Municipality of Parma, to face and overcome these challenges, leading and not undergoing the changes, has decided to engage and reconnect its local community of reference, calling them to sign the "Social Pact for Parma".
The Social Pact for Parma is an "open" operational document that will be progressively implemented and enriched by new ideas, projects and interlocutors in the coming years. Annual monitoring and qualitative-quantitative evaluation activities will be carried out on the outcomes and objectives achieved. The Social Pact is coordinated by a Control Room, a joint body for the governance of the process of analysis and proposal for revision of existing paths and practices with the aim of facilitating project participation and the implementation of co-programming and co- designs. The Control Room, chaired by the Councilor for Social Policies, is made up of representatives of the top management of University Hospital and territorial healthcare companies, the municipality, the third sector, social cooperation, trade union organizations and other components depending on the needs and projects.
In conclusion, the ultimate objective of the Community Houses is to contribute to strengthening a socio-health pact that avoids anomie and the privatization of suffering, through processes of reception, inclusion, prevention and care that give meaning and value to the person, to the time and to the relationships. It is necessary to integrate the "cure/treatments" centered on the medical, psychological and social components underlying the diseases, and the "care", the "taking care", of the suffering, the subjectivity and the needs of the person and his family, always included in the community. The architectural declination of these principles and actions will be the

challenge of the coming years and it will require a process of cultural change that must be improved and must involve many actors: researchers, healthcare professionals, social workers, universities, administrators and politics.

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