Report on networks of services and stakeholders involved in person-centered community-based care and strategies to link them to the CBITs

Liguria Region (IT)
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1 INTRODUCTION

1.1 Premises

With regional law no. 7/2025, issued on May 29, 2025, the Liguria Region implemented the reform of the Azienda Ligure Sanitaria (A.Li.Sa.), previously defined by regional law no. 17/2016, changing its name to "Liguria Salute". Furthermore, with regional law no. 18/2025, issued on December 12, 2025, the Liguria Region implemented the reform of the Regional Health System, establishing a single Metropolitan University Hospital and a single Territorial Health Authority, ATS Liguria, to replace the previous 5 Local Health Authorities (ASLs) from January 1st 2026 on. ATS Liguria replaced Liguria Salute with a new extended mission, keeping the same admnistrative references.
This report has been delivered by A.Li.Sa. in 2025, before the regional reform merged the 5 Local Health Authorities (ASL). Actually, from January 1st 2026 on, ATS Liguria is organized by Local Social and Health Areas (Territorial Branches – same acronym "ASL"): they correspond to the territories of the former Local Health Authorities (ASLs), each led by an Area Director for the operational management of services:

- Area 1 (Imperiese): Former ASL 1
- Area 2 (Savonese): Former ASL 2
- Area 3 (Genovese): Former ASL 3 (metropolitan area)
- Area 4 (Tigullio): Former ASL 4
- Area 5 (Spezzino): Former ASL 5

In this updated version released on January 15th some integrations have been provided to clarify the main changes introduced. Anyway, since the reform was an administrative one, the current service availability overlaps the ones described for 2025 as to each Area.
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1.2 Population in Liguria

The resident population in the Liguria Region, as of January 1, 2026, consists of about 1,509,900 people. Provincial Distribution (as of mid-2025) is the following:

- Genoa: 819,594 inhabitants (the most populous province)
- Savona: 266,887 inhabitants
- La Spezia: 214,792 inhabitants
- Imperia: 209,351 inhabitants

Liguria is the oldest region in Italy. The average age of the population has increased to 49.6 years at the beginning of 2026. The share of the population aged 65 and over has risen to 30.2%.The data for 2025 shows a significant number of residents in older age groups, with a combined total of approximately 145,000 people aged 80 and over. The old-age dependency ratio (people aged 65+ compared to those aged 15-64) was 50.3% As of January 1, 2025, the total population aged 70 and over in Liguria was 336,979 (140,768 males, 196,211 females). At birth, life expectancy is 81.8 years for men and 85.8 years for women.

The scenario for the coming years highlights a regional population that will grow at very modest rates, while its composition will maintain the aging trend, with projections for 2047 showing that those over 65 will approach 38% (elaborations from Demo.Istat.it - *Population projections, years 2018-2065*[1]).

2 REGULATORY REFERENCES

A list of all the regulatory references on which the Liguria Region general organization of the healthcare system is based can be found below:

- **Law No. 833/1978**[2], which establishes the guidelines for the organization of health services.
- **Legislative Decree of December 30, 1992, No. 502**[3], "Reorganization of health sector regulations pursuant to Article 1 of Law of October 23, 1992, No. 421," as amended, and in particular Article 1, paragraphs:
  - **(5)**, which provides that the Regions shall adopt Regional Health Plans in alignment with the guidelines of the National Health Plan and define service organization models according to the specific needs of the territory and the resources actually available;
  - **(14)**, which provides that the Regions and Autonomous Provinces shall submit their health plan drafts or schemes to the Minister of Health for an opinion on their consistency with the guidelines of the National Health Plan.
- **Decree of the Minister of Health, in agreement with the Minister of Economy and Finance, of May 23, 2022, No. 77**[4], "Regulation setting out models and standards for the development of territorial healthcare within the National Health Service."
- **Regional Law of December 7, 2006, No. 41**[5], "Reorganization of the Regional Health Service," as amended, and in particular Articles:
  - **Art 5**:
    1. The Regional Council approves the Regional Social and Health Plan (PSSR), after obtaining the opinion of the Standing Conference for Social and Health Planning referred to in Article 13.
    2. The Regional Social and Health Plan is drawn up in line with the National Health Plan, ensures integration with the Integrated Regional Social Plan (…) and identifies, among other things: a) health objectives, priority areas of intervention, and identified or

[1] https://www.istat.it/it/files/2018/05/previsioni_demografiche.pdf (ISTAT, 2018)
[2] https://presidenza.governo.it/USRI/ufficio_studi/normativa/Legge%2023%20dicembre%201978,%20n.%20833.pdf
[3] https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:decreto.legislativo:1992-12-30;502
[4] https://www.gazzettaufficiale.it/eli/id/2022/06/22/22G00085/SG
[5] https://lrv.regione.liguria.it/liguriass_prod/articolo?urndoc=urn:nir:regione.liguria:legge:2006-12-07;41

expressed health needs;
c) the detailed organization of the Regional Health Service.

- **Art 13**:
  1. The Standing Conference for Regional Social and Health Planning referred to in Article 15 of Regional Law 12/2006 ensures an effective system of institutional relations, promoting forms of coordination and integration regarding the organizational structures of the health and social systems and in the areas of health, social-health, and social planning.

- **Regional Law of May 24, 2006, No. 12**[6], "Promotion of the Integrated System of Social and Social-Health Services," as amended.
- **Regional Government Resolution No. 1223 of December 6, 2022**[7], "Approval of the document 'Regional Planning of the Territorial Network pursuant to Ministerial Decree No. 77/2022'."

2.1 Regional Social-Health Plan 2023-25

The Regional Social-Health Plan 2023-25 aims to create a governance model based on a network of services capable of ensuring quality, motivation, and improvement in care for individuals. It identifies the following main development guidelines (*Direttrici di Sviluppo -DdS*), which guide the Social-Health Plan and represent key elements around which programming unfolds, embodied in the specificity of a "Ligurian model":

- Redefinition of the hospital and territorial mission within the new layout outlined by the PNRR and its reforms;
- Proximity in prevention, demand, response, and "care";
- Social-health integration in healthcare and social policy choices;
- Investments: community hospitals and community hubs (OdC and CdC), territorial operational centers (COT), and technologies;
- New professional profiles and innovation in care and organizational models;
- Interaction in care pathways;
- Development of a social-health information ecosystem.

The values pursued by the Regional Social-Health Plan 2023-25 are:

- Person-centered approach in care pathways and care management;
- Valorization of the territory;
- Innovation and digitalization;
- Sustainability.

[6] https://lrv.regione.liguria.it/liguriass_prod/articolo?urndoc=urn:nir:regione.liguria:legge:2006-05-24;12
[7] https://decretidigitali.regione.liguria.it/ArchivioFile/AMM20221380/REG_AMM_A_1380_2022.pdf

2.2 Reform of the Ligurian Healthcare System

The recent reform of the Ligurian healthcare system, officially effective from **January 1, 2026**, marks a profound structural change promoted by the Liguria Region President Marco Bucci and approved by the Regional Council with **Regional Law No. 18 of December 12, 2025**[8].
The stated goal is to overcome management fragmentation, creating a more efficient, equitable system capable of addressing the challenges of Europe's oldest population.

The core of the reform is a radical reorganization into two distinct levels, territorial healthcare and high-specialty hospital care, which will correspond to:

- **Liguria Health Protection Agency (ATS)**: The previous five ASLs are unified into a single regional Healthcare Agency. This "super-ASL" centralizes all "back-office" functions (administration, budgeting, procurement, logistics, staff recruitment) to eliminate duplications and reduce management costs. The former ASLs do not disappear but are transformed into **five Local Social-Health Areas (ASL)** with managerial and operational autonomy, tasked with ensuring service delivery and access to care at the territorial level.
- **Metropolitan Hospital Agency (AOM)**: In Genoa, a new agency merges the city's main hospital hubs: Policlinico San Martino, Villa Scassi Hospital, and the future Erzelli Hospital. Galliera Hospital will join the AOM but with an agreement ensuring its autonomy. The goal is to create a competitive high-specialty hub integrated with the University. The pediatric **Gaslini Institute** remains an autonomous center of excellence.

Rationalization also covers human resources: staff from the former agencies have been transferred to the new ATS or AOM, with guarantees of unchanged economic and legal treatment.

The reform promises healthcare that is 'closer, easier and faster'. The changes for citizens will take the form of renewed attention to the local area and new digital tools. Some of the main objectives are:

- **Strengthening Territorial Care**: A key pillar is enhancing proximity medicine through the upgrade of **Community Houses** and **Community Hospitals**, also funded by PNRR resources. These facilities will become the stable reference point for citizens' healthcare and social-health needs, integrating general practitioners, nurses, and specialists.
- **Social-Health Integration**: The regional law emphasizes greater integration between healthcare services (managed by the Region) and social services (under

[8] https://lrv.regione.liguria.it/liguriass_prod/articolo?urndoc=urn:nir:regione.liguria:legge:2025-12-12;18

Municipal competence). Agreements with Municipalities and involvement of the Third Sector are foreseen to ensure comprehensive person-centered care, with a central role for **Single Access Points (PUA)** within Community Houses.

- **New Digital and Support Services**: Tools have been introduced or enhanced to facilitate access and improve communication:
  - **Protection Pathway**: A mechanism ensuring a service within set timelines if standard booking is unavailable.
  - **116117 Number**: A single European number, activated in 2026, for non-urgent medical assistance.
  - **PS Tracker**: A digital system for real-time tracking of one's care pathway in the Emergency Department.
  - **Electronic Health Record**: Enhanced as a tool for always accessible and shareable medical history.

3 COMMUNITY-BASED INTERPROFESSIONAL TEAMS IN LIGURIA'S TERRITORIAL HEALTHCARE SYSTEM: AN INTEGRATED AND PROACTIVE APPROACH

The Ligurian healthcare system, faced with the challenges of one of the oldest populations in Italy and a high prevalence of chronic conditions and frailty, has undergone a profound reorganization. This restructuring, driven by the National Recovery and Resilience Plan (PNRR) and Ministerial Decree No. 77/2022, places **multidisciplinary and multiprofessional teamwork** at the core of its territorial care model. The primary goal is to shift the paradigm from a "diagnosis and care" model to one of "integrated, personalized care" that ensures continuity across health, socio-health, and social services.

The keystone of this system is the **Diagnostic Therapeutic Care Pathways (DTCPs)** . These are regionally defined protocols for specific conditions such as heart failure, diabetes, COPD, dementias, and ALS. Their objective is to standardize care across the region, facilitating communication between professionals and coordinating multidisciplinary teams to improve clinical outcomes, patient safety, and the appropriateness of interventions. Within this framework, the **General Practitioner (GP)** plays a central role as the "director" of the care pathway for their patients, particularly for those who are frail or have chronic conditions. The GP collaborates with specialists, nurses, psychologists, and social workers to co-design and implement an **Individual Care Plan (ICP)** , a personalized care project that considers the patient's unique clinical, social, and relational needs.

The organizational heart of this system is the **Community House (CH)**, a physically

identifiable structure under the leadership of the District. The CH serves as the primary point of reference for proximity care and acts as a gateway for citizens to access integrated health, socio-health, and social services. It is the physical hub where multidisciplinary and multiprofessional teams operate, promoting a medicine of "initiative" and proactivity.
To ensure maximum proximity and coverage, the "Ligurian model" is organized in a **Hub-and-Spoke system**:

- **Hub CHs** (approximately one per 40,000-50,000 inhabitants) offer a full range of services, including primary care, specialist outpatient services, nursing care, a Unified Access Point (UAP), and district management, with medical coverage typically 24/7.
- **Level II Spoke CHs** provide primary care, outpatient specialist services, basic diagnostic services, and nursing care (H12, 6/7 days).
- **Level I Spokes (Base)** correspond to the individual GP's office, ensuring basic primary care and continuity of care, connected to the Hub.

This organization is supported by the **Territorial Operational Centers (TOCs)** , which function as a "back-office" service. The TOC facilitates the activation and continuity of integrated care by coordinating patient transitions between different care settings (hospital, home, residential facilities) through a shared, interoperable IT platform.

The system actively promotes **socio-health integration** through a **Unified Access Point (UAP)** and permanent **Integrated Teams**. The UAP serves as a "diffuse" access point on the territory, guaranteeing a unified pathway for highly complex situations. The Integrated Teams, permanently staffed by professionals from the Local Health Authority and the Municipalities, are responsible for taking charge of individual and family cases, elaborating the ICP, and ensuring continuity of care.

A significant innovative element is the introduction of the **"Medicine of Initiative"** approach. This involves the systematic identification of frail individuals, including through the use of specific assessment tools like InterRAI, to intervene with preventive and proactive actions, thereby preventing or delaying the onset of disability. In this context, the **Family and Community Nurse** plays a crucial role. They work proactively to identify risk factors, activate primary and secondary prevention pathways, and facilitate access to the DTCPs for managing major chronic diseases.

This entire system is supported by a **unique regional socio-health information ecosystem (IT-CURA)** . This platform enables integrated assessment, the drafting of the Health Project (PAI), the creation of work lists for professionals, population stratification for risk-based planning, and the sharing of information with the Electronic Health Record (EHR) and telemedicine services. This digital infrastructure is essential for ensuring continuity, interoperability, and active monitoring of care pathways, thereby strengthening the ability of multidisciplinary and multiprofessional teams to work effectively in the best interest of the citizen.

4 MAP OF SERVICES AND STAKEHOLDERS INVOLVED IN PERSON-CENTERED COMMUNITY-BASED CARE

In Liguria, territorial services are organized and delivered based on 4 main types:

- **social-health services**, managed by ASLs through Healthcare Districts;
- **social services**, managed by Municipalities or unions of Municipalities;
- **social-health interventions** aimed at complex cases, managed in collaboration between ASLs and Municipalities through Social-Health Districts;
- **healthcare services**, managed by ASLs.

Social-health services can be grouped considering two aspects: a) **territorial competence** and b) **type of service**

4.1 Territorial competence of social-health services

Social-health services are managed by **ATS Liguria** (Azienda Tutela Salute Liguria), a single regional health authority established on 1 January 2026, which incorporates the five former Ligurian Social-Health Companies. ATS Liguria delivers services through its territorial articulations — the Local Social-Health Areas — and ensures health and social-health integration, coordinating hospital, district and departmental activities across the region.
At the local level, health and social services are integrated within **Social-Health Districts**, which serve as the territorial unit where complex social functions and health functions converge. The boundaries of each Social-Health District coincide with those of the corresponding Healthcare District. Within each district, **Local Social Areas** (*Ambiti Territoriali Sociali*) group neighbouring municipalities for the delivery of basic social services.
In order to accommodate the specific needs and demands of the different territories, ATS Liguria is organized into **5 Local Social-Health Areas** (ASLs), which serve as operational and territorial articulations of ATS and act as organizational links between ATS management and the local structures (Districts, hospital facilities and departments), that are detailed below:

4.1.1 Ligurian Local Social-Health Areas

Ligurian Local Social-Health Areas (ASL) are the following:

- **Area 1 Imperiese** - Via Aurelia Ponente 97 – 18038 Bussana di Sanremo - website: www.asl1.liguria.it
- **Area 2 Savonese** - Via Manzoni 14 – 17100 Savona – website: www.asl2.liguria.it
- **Area 3 Genovese** - Via G. Maggio 6 – 16147 Genova - website: www.asl3.liguria.it

- **Area 4 Chiavarese** - Via G.B. Ghio 9 – 16043 Chiavari - website: www.asl4.liguria.it
- **Area 5 Spezzino** - Via XXIV Maggio 139 – 19121 La Spezia - website: www.asl5.liguria.it

Figure 1: The territories of previous Ligurian Local Health Authorities, now called Areas

4.1.2 Social-Health Districts in Liguria

The district is the headquarters where the management and functional and organizational coordination of the network of territorial social-health and healthcare services are carried out, as well as the reference centre for access to all ASL services, tasked with facilitating integration between healthcare, social-healthcare, and social assistance structures.
It is allocated defined resources in relation to the health objectives of the reference population. Within the assigned resources, the District has technical-management and economic-financial autonomy. The definition of homogeneous structural, organizational, and technological standards for territorial care outlined by the PNRR leads to a rationalization model of the network that concentrates territorial outpatient facilities in Community Houses, strengthening them in terms of spaces, volumes and types of services, technologies, professional skills, and public accessibility. Therefore, due to its strategic importance, the District reports directly to the management of Local Health Authorities.
In particular, the organization of the District must ensure:

- **primary care**, including continuity of care, through the necessary coordination and multidisciplinary approach, both in outpatient settings and at home, among general practitioners, pediatricians of free choice, night and holiday emergency medical services, family or community nurses, and specialist outpatient facilities;
- **coordination** of general practitioners and pediatricians of free choice with directly managed operational structures, organized according to the departmental model, as well as with specialist outpatient services and accredited hospital and extra-hospital facilities;
- **delivery of healthcare services** with significant social relevance, characterized by specific and high integration, as well as social services with healthcare

relevance, in coordination with territorial social services if delegated by the municipalities.

The District is the operational structure through which the Local Social-Health Areas (ASL) ensures a coordinated, unified, and continuous response to the health needs of the population in a given territory. The District is responsible for the health status of the population and provides, through its operators and particularly through general practitioners (GPs) and pediatricians of free choice (*pediatri di libera scelta* - PLS), primary care services related to healthcare and social-healthcare activities, directing its efforts toward an effective policy of managing demand and evaluating the services provided to the reference population.

The District therefore analyzes demand and channels it accordingly, ensuring therapeutic continuity regardless of the different treatment locations.

Districts are organized under the Local Social-Health Areas (ASL) as follows:

ASL 1

Distretto sociosanitario 1 - Asl1 (Ventimiglia, Camporosso, Vallecrosia, Bordighera)
Distretto sociosanitario 2 - Asl1 (Sanremo, Taggia, Riva Trigoso)
Distretto sociosanitario 3 - Asl1 (San Lorenzo al mare, Imperia, Diano Marina, Pontedassio, Comunità montana Valle Arroscia)

ASL2

Distretto sociosanitario 4 - Asl2 (Andora, Alassio, Comunità montana Ingauna)
Distretto sociosanitario 5 - Asl2 (Loano, Pietra Ligure, Finale Ligure)
Distretto sociosanitario 6 - Asl2 (Millesimo, Carcare, Cairo Montenotte)
Distretto sociosanitario 7 - Asl2 (Vado Ligure, Savona, Albisola superiore, Varazze, Sassello)

ASL3

Distretto sociosanitario 8 - Asl3 (Cogoleto, Arenzano, Masone, Voltri-Prà-Pegli-Mele)
Distretto sociosanitario 9 - Asl3 (Sampierdarena e San Teodoro, Cornigliano e Sestri Ponente)
Distretto sociosanitario 10 - Asl3 (Busalla, Savignone, Campomorone, Serra Riccò, Rivarolo-Bolzaneto-Pontedecimo)
Distretto sociosanitario 11 - Asl3 (Prè-Molo-Maddalena-Portoria-Oregina-Lagaccio-Castelletto, S.Martino-Albaro-Foce)
Distretto sociosanitario 12 - Asl3 (Comunità montana alta Val Trebbia, Davagna, Marassi-S.Fruttuoso, Staglieno-Molassana-Struppa)
Distretto sociosanitario 13 - Asl3 (Bogliasco, Recco, Camogli, Valle Stura-Nervi-Quarto-Quinto)

ASL4

Distretto Sociosanitario 14 - Asl4 (Santa Margherita Ligure, Rapallo)
Distretto Sociosanitario 15 - Asl4 (Cicagna, Borzonasca, Chiavari, Lavagna)
Distretto Sociosanitario 16 - Asl4 (Sestri Levante, Varese Ligure)

ASL5

Distretto sociosanitario 17 - Asl5 (Beverino, Bolano, Levanto)
Distretto sociosanitario 18 - Asl5 (La Spezia, Lerici, Portovenere)
Distretto sociosanitario 19 - Asl5 (Ortonovo, Arcola, Sarzana)

Figure 2: Social-Health Districts in Liguria

4.2 Social-health services by type

The main social-health services provided in the various Districts are listed below.

Elderly

The objective of the services is to enable non-autonomous individuals in daily life activities to continue living in their own home, supported by a set of daytime and home-based services. Only if the elderly person can no longer be cared for at home, admission to the most suitable residential facility is promoted and supported. Policies toward the elderly population also aim to safeguard their autonomy and well-being, primarily supporting activities promoted by associations and volunteers that allow elderly individuals to maintain social ties and a serene use of free time. This involves a wide range of services whose access methods are defined by individual ASLs.

Family Counseling Centers

Family counseling centers are public social-health facilities established to address the various needs of families, women, couples, children, and adolescents. Activities and services are organized through teamwork by a group of professionals specialized in

various fields (gynecologist, midwife, nurse, psychologist, social worker) who collaborate to help all citizens meet their needs and ensure health protection.

Home Care
The National Health Service ensures home care pathways for non-self-sufficient individuals and those in fragile conditions with ongoing pathologies or their sequelae, consisting of an organized set of medical, rehabilitative, nursing, and nursing assistance treatments necessary to stabilize the clinical condition, limit functional decline, and improve quality of life).
ASLs ensure continuity between hospital care phases and home-based territorial care. Clinical, functional, and social needs are assessed through appropriate multidimensional evaluation tools that enable the person's care management and the definition of the Individual Assistance Plan (PAI).
Depending on the assisted person's health needs and the level of intensity, complexity, and duration of the care intervention, **home care** is structured into the following levels:

- **Basic home care**: consisting of professional services in response to low-complexity healthcare needs of a medical, nursing, and/or rehabilitative type, which may be repeated over time.
- **Integrated home care (ADI) Level I and Level II**: consisting of predominantly medical-nursing-care services or predominantly rehabilitative-care services for individuals with pathologies or functional conditions requiring care continuity and scheduled interventions; the level depends on the criticality and complexity of the case.
- **Integrated home care (ADI) Level III**: consisting of medical, nursing, and rehabilitative professional services, diagnostic tests, provision of medications and medical devices, as well as preparations for artificial nutrition, for individuals with pathologies that, due to high complexity, clinical instability, and difficult-to-control symptoms, require care continuity and scheduled interventions, including support for the family and/or caregiver.

Additionally, certain services prescribed by the General Practitioner (e.g., blood draws, urinary catheter replacements, etc.) can be provided at home to non-ambulatory users. Home care is activated by the General Practitioner.

Palliative Care
Palliative care consists of therapeutic and assistance interventions aimed, as a whole, at the active and total care of patients whose underlying disease, characterized by rapid progression and unfavorable prognosis, no longer responds to specific treatments. The goal is to prevent and contain as much as possible the painful and disabling symptoms that may characterize the terminal phase of irreversible diseases, such as oncology, and many other non-oncological pathologies of the respiratory, neurological, and cardiovascular systems.

Addictions

In all districts, services are active for the management, treatment, and prevention of issues related to addiction to psychoactive substances (legal and illegal), alcohol, and abusive behaviors (gambling, etc.). Access to services is free and open.

Adult Disability
In every District, a service is active for disabled persons and/or those in fragile conditions. The service targets specifically:

- disabled individuals with physical, mental, or sensory deficits, where the disability causes personal, social, and family distress that prevents an integrated and autonomous life;
- family members and caregivers who care for disabled and fragile persons.

The service provides support, assistance, and accompaniment actions, enhancing the person's skills and strengthening the role of formal and informal networks, while preventing and containing situations of distress. The fundamental objective is the development of appropriate individualized assistance projects tailored to the specific issues presented by disabled individuals.

Minors
Joint assessment and integrated interventions through multidimensional integrated teams within the Community House, aimed at meeting social and health needs.

Child and Adolescent Neuropsychiatry
The Territorial Services for Child and Adolescent Neuropsychiatry (NPIA) in Liguria serve as reference healthcare services across the Region for the early diagnosis, treatment, and rehabilitation of neurological, neuropsychological, psychological, psychiatric disorders, and neurodevelopmental issues in developmental age (0-18 years). They work in close collaboration with other services addressing children's physical and mental health, both in territorial and hospital settings, and network with other institutions responsible for the social inclusion of children and adolescents (Schools, Local Authorities, Third Sector Entities, Juvenile Justice Bodies, Disability Committees, etc.), given the relevance of neuropsychiatric health in these contexts.

Mental Health → Mental Health Services ensure reception, assessment, and treatment for all individuals with psychological distress or mental disorders at every stage and age of life, and are structured as follows:

- daytime assistance services - Mental Health Centers (CSM);
- semi-residential services - Day Centers;
- residential services - residential facilities divided into therapeutic-rehabilitative and socio-rehabilitative residences;
- hospital services - Psychiatric Diagnosis and Care Services (SPDC) and Day Hospitals (DH).

Access to Mental Health Centers (CSMs) can be requested directly by the individual concerned, upon request of the attending physician, or based on recommendations/referrals from healthcare facilities, local authorities, and agencies.

Eating and Nutrition Disorders (EDs): Regional program for managing individuals with eating and nutrition disorders to ensure continuity of care across various settings.

Pain Therapy: The term "Pain Therapy" does not denote mere treatment provision but a specialist discipline encompassing specific diagnostic, therapeutic, rehabilitative, and management pathways for persistent acute, recurrent, or chronic pain. Specifically, it should be viewed as "Pain Medicine and Therapy," emphasizing complementary phases of diagnosis and treatment.

Access to Services:

- Level I: Via general practitioners (GPs) and territorial pain therapy clinics.
- Level II (Spoke): Via regional referral from GPs and territorial pain therapy clinics.
- Level III (Hub): Via direct liaison between Spoke and Hub.

4.3 Social Services

Pursuant to Law 328/2000[9], the Regions are mandated to define territorial arrangements, i.e., the subdivision of the territory into Territorial Social Areas, each responsible for managing basic social services, coinciding with the territorial boundaries of Healthcare Districts.
The territorial coincidence between the healthcare area and the social area is an essential prerequisite for the integration and continuity of services, where the objective is to build dialogue between social and health services and social policy services.

Territorial Social Areas provide the organizational framework necessary for the planning, coordination, and implementation of interventions and services that realize social policies in their complexity, enabling the best delivery of the **essential levels of performance** associated with them (Essential Levels of Performance (LEP) refer to all minimum social services that everyone can rely on, regardless of place of residence, region, or Social Area, just as they can rely on certain healthcare and welfare benefits). Municipalities, necessarily associated within the Territorial Social Area, hold administrative functions for implementing social interventions at the local level.
The social services intervention system is aimed at promoting and ensuring social protection for individuals in need.

The following interventions constitute the essential levels of social performance:

- measures to **combat poverty** and **support income**, and accompaniment services, with particular reference to homeless persons;
- economic measures to promote **autonomous living** and **home stay** for totally dependent persons or those unable to perform daily life activities;

[9] https://www.gazzettaufficiale.it/eli/id/2000/11/13/000G0369/s

- support interventions for **minors in distress** through assistance to the family of origin and placement with families, individuals, and family-type community reception structures, as well as promotion of children's and adolescents' rights;
- measures to **support family responsibilities** to facilitate harmonization of work and family care time;
- support measures for **women in difficulty**;
- interventions for the full **integration of disabled persons**, establishment of socio-rehabilitative centers and group homes, and community and reception services for those without family support, as well as provision of temporary family substitution services;
- interventions for **elderly and disabled persons** to promote **home stay**, placement with families, individuals, and family-type community reception structures, as well as reception and socialization in residential and semi-residential facilities for those who, due to high personal fragility or limited autonomy, cannot be cared for at home;
- integrated socio-educational services to **combat addictions** to drugs, alcohol, and medications, promoting **social reintegration**.

The functions of Social Districts are therefore assumed by Territorial Social Areas, which will comprise neighboring Municipalities and/or districts included therein.