



ITALIAN RECOMMENDATIONS

ON SOCIAL PRESCRIBING AND PROACTIVE COMMUNITIES





Recommendations: Consolidated proposal

Network "Communities, loneliness and health"

**Working draft for the conference
on presentation and sharing
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Note: this Release of the Recommendations incorporates the methodological observations, specific contributions and implementation proposals received from the members of the Network's Scientific Board and from experts working in the Working Groups for the Recommendation Annexes. The text remains open to amendments.

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■ Preamble

The recommendations that follow have been developed collectively by the Network “*Communities, loneliness and health*” (*Comunità, solitudini e salute*), a working group that brings together experts in public health, social services, the Third Sector and academic research.

The document represents the synthesis of a participatory process that has involved Italian institutions, practitioners and representatives of local communities.

The objective is to provide operational guidance for combating loneliness and social isolation — now widely recognised as significant health determinants — and for promoting an integrated community health model that connects healthcare services, social services and local resources.

The Recommendations will be supported by the following **Annexes**:

- **A Glossary of key terms** linked to the proposed Recommendations and to the international, national, regional and local experiences collected during the conference of June 2025.
- **A Self-assessment form for projects and experiences** grounded in the “Communities, loneliness and health” framework.
- **A Review of models, algorithms, indicators and standards** currently available, also linked to the experiences presented at the June 2025 conference.

■ Foundational principles

Before examining the individual recommendations, we set out the principles that guide their interpretation and application.

- **One Health approach.** Community health policies are situated within the broader framework that recognises the interdependence of human, animal and ecosystem health, with a focus on the social dimension and on acting on prevention through intersectoral and multidisciplinary measures, overcoming the current fragmentation across sectors.
- **Unambiguous identification of territorial intervention areas.** Integration across healthcare, social services and local resources is only possible if geographic alignment is guaranteed between the Distretti socio-sanitari (health districts) of the ASL (local health authorities) and the Ambiti Territoriali Sociali (social-care areas) of the municipalities, together with the mandatory definition of the catchment area of each Casa della Comunità (Community Health Home). This territory must be further subdivided into proximity units called Micro-areas (population between 4,000 and 10,000), corresponding to neighbourhoods, wards, hamlets or small municipalities.
- **Shared nomenclature for “social prescribing”.** To monitor and compare interventions on a national scale it is essential to develop a common language. This means collecting the codes already in use in the various Regions for the social activities prescribed by doctors, and then building and maintaining a reference nomenclature aligned with international standards, describing the needs of individuals and carers, the prescribable activities, and the efficacy and outcome indicators.
- **Economic sustainability.** To make integrated socio-health community promotion interventions replicable and comparable, it is necessary to define reference characteristics and costs, to be approved in the Conferenza Stato-Regioni (State-Regions Conference).
- **Operational tools and interoperability.** Implementing the recommendations requires organisational and information-technology tools capable of ensuring real-world application, traceability and evaluation over time. Socio-health integration and care continuity presuppose the consistent use of interoperable systems and standardised methods of registration and monitoring, coordinated with existing national and regional information infrastructures.

■ Structure of the recommendations

The recommendations are organised across four institutional levels, each with specific addressees and purposes.

1. **MACRO level — Policy recommendations.** Addressed to the national Government, Parliament and the relevant Ministries. They concern the definition of national policies, regulatory frameworks and resources for linking health promotion and the fight against loneliness, social isolation and the promotion of community health.
2. **MESO level — Programming and research criteria.** Addressed to Regions, Aziende Sanitarie (local health authorities), Distretti sociosanitari (health districts), Ambiti Territoriali Sociali (social-care areas), IRCCS (clinical-scientific research hospitals) and Research Institutes. They concern programming, organisation, research and the financing of local services.
3. **MICRO-1 level — Community activation models.** Addressed to Case della Comunità (Community Health Homes), municipalities, Third Sector organisations and active citizens. They concern the activation of local resources, neighbourhood networks and proximity services in micro-areas.
4. **MICRO-2 level — Professional competencies.** Addressed to healthcare, social-care and Third Sector practitioners and volunteers. They concern competencies, working methods and day-to-day operational practices.

■ MACRO level

R1. Include **loneliness and social isolation as health determinants** in national and regional health planning, defining **a national regulatory and strategic framework for prevention and counteraction** through Prime Ministerial Decrees (DPCM), inter-ministerial policy documents (Health, Labour and Social Policy, Education, Research, Environment, and others) and a dedicated National Strategy; promoting and carrying out national communication and awareness campaigns that present loneliness and isolation as risk factors for the health and wellbeing of individuals and communities.

R2. Regions shall ensure the **mandatory geographic alignment** between *Distretti sociosanitari* (health districts) and *Ambiti Territoriali Sociali — ATS* (social-care areas), and the mandatory definition of the catchment area of each *Casa della Comunità* (Community Health Home). This territory must be further subdivided into **Micro-areas** (population between 4,000 and 10,000), identified as the minimum units for community health planning and the monitoring of loneliness.

R3. Define the **Livelli Essenziali di Assistenza (LEA)** and the **Livelli Essenziali delle Prestazioni Sociali (LEPS)** to **explicitly include community health and anti-loneliness and anti-social-isolation interventions**, with reference also to the *Fondi FNA* and *FSE* for funding, providing full exemption from charges for people living in poverty, and **define reference characteristics and standard costs for integrated socio-health interventions** in community promotion, with a tariff nomenclature to be approved in the *Conferenza Stato-Regioni* (State-Regions Conference). A share of the *Fondi Sanitari Regionali* (Regional Health Funds) allocated to territorial medicine must be ring-fenced for social prescribing projects and proactive home-care support.

R4. **Issue national guidelines on “social prescribing”** in collaboration with *ISS* (National Institute of Health), *AGENAS* (National Agency for Regional Health Services), the National Federations of Professional Orders, Scientific Societies and national representatives of the Third Sector, defining operational models, quality standards and training pathways for practitioners. The guidelines shall provide for standardised registration of social prescribing in the *Fascicolo Sanitario Elettronico* (Electronic Health Record — FSE 2.0), ensuring traceability and integration into national information flows (NSIS), in order to guarantee monitoring, evaluation and interregional comparability according to SNOMED-CT standards.

R5. **Establish a National Observatory on Loneliness, Social Isolation and Community Health** within and with the support of Ministries, national Institutes and Agencies, with the task of collecting epidemiological data and monitoring the effectiveness of interventions, ensuring data accessibility to Universities and Research Institutes. The Observatory shall operate in coordination with the NSIS information flows and with the aggregated data from the FSE 2.0, ensuring the use of interoperable and standardised data for the monitoring of interventions and care pathways.

MESO level - Programming criteria

R6. Implement loneliness and social isolation screening systems at territorial points of contact (*Case della Comunità*, pharmacies, individual GP surgeries and group practices, social services, etc.) and in micro-areas, using validated scales (UCLA or De Jong Gierveld), with priority focus on the over-65 population and on vulnerable groups (young people, families in poverty, women living alone, etc.), developing consequent integrated active prevention projects, proactive outreach medicine (*medicina di iniziativa*), “social prescribing” and proximity service desks.

R7. Consolidate and expand the role of the Infermiere di Famiglia e di Comunità (Family and Community Nurse) as the stable territorial reference for early identification, light-touch case management and monitoring of frail individuals (with access to the FSE and to territorial information systems). Introduce, consolidate and **expand new community health roles**: professionals (group GPs — *MMG*, Family and Community Nurses, community psychologists, social workers, community educators and others) and volunteers (facilitators, social connectors, social community leaders, proximity network coordinators), appropriately trained to also act as community health workers.

R8. Ensure comprehensive care for vulnerable people, through the widespread activation of territorial **Punti Unici di Accesso (PUA — Single Points of Access)** in stable collaboration between *Distretti sociosanitari* (health districts) and *Ambiti Territoriali Sociali* (social-care areas), within the *Casa della Comunità* system and the *Centrali Operative Territoriali — COT* (Territorial Operations Centres), together with protected discharge protocols for hospital-to-community care continuity, with particular timeliness for patients who live alone and lack a family support network.

R9. Establish permanent joint health-social-Third Sector roundtables at district level for the co-programming, co-design and co-production of anti-loneliness and community health promotion interventions, formalising agreements under Legislative Decree 117/2017 with defined roles, resources and responsibilities.

R10. Implement a modular multidimensional assessment model, differentiated by age group and type of frailty, covering simple and complex needs, to be adopted by all *Unità di Valutazione Multidimensionale* (Multidimensional Assessment Units) of the *Distretti Socio Sanitari* (health districts), and by all practitioners in municipalities, *Case della Comunità*, proximity services and Third Sector organisations, working through integrated processes that overcome silo-based approaches, with personalised socio-health plans and pathways (see *PAI* — Individual Care Plans, or *PIdS* — Individual Health Programmes). The multidimensional assessment models adopted must be integrable with the FSE 2.0 and consistent with the NSIS information records, in order to ensure information continuity in care pathways and in the *transitional care* managed by the *COT* — *Centrali Operative Territoriali* (Territorial Operations Centres).

■ MICRO-1 level - Community activation models

R11. Systematically map community resources using standardised tools and models — associations, groups and social spaces — carried out by the *Distretti sociosanitari* (health districts) and the *ATS* (social-care areas), integrating the results with the information systems of the *PUA* — *Punti Unici di Accesso* (Single Points of Access), in order to build up-to-date territorial directories accessible to both practitioners and citizens, to be used in support of co-design, co-management and co-production of services.

R12. Activate community covenants in Micro-areas to mobilise local social resources (voluntary organisations, parishes, associations), with the explicit aim of building proactive and inclusive communities that go beyond service delivery, promoting reciprocity and neighbourhood support with the involvement of social connectors (*Link workers*), ensuring accessibility and free-of-charge access to services.

R13. Transform traditional community centres into **multifunctional community laboratories** offering proximity services, intergenerational socialisation and support for frail individuals, fostering the development of **peer learning**, neighbourhood workshops, accompaniment and peer exchange to build widespread relational competencies and facilitate socialisation.


R14. Promote peer activities — physical, motor, cultural, recreational and creative — in micro-areas and in mutual-aid groups, free of charge or at subsidised rates, adapted and inclusive for older people and individuals experiencing frailty and loneliness, designed as effective social prescriptions for combating isolation.

■ MICRO-2 level - Competenze professionali

R15. Activate inter- and transdisciplinary teams focused on proximity interventions, specifying their composition and coordination methods, collaborating with the new community professional roles in the promotion of proactive communities, including through building stable, ongoing relationships between frail and isolated individuals and their reference team, avoiding the fragmentation of contacts.

R16. Define, for every healthcare and social-care practitioner in the *Distretto Sociosanitario* (health district), the *Ambito Territoriale Sociale* (social-care area) or Third Sector organisations:

- a) a) **a specific reference territory**, maintaining operational continuity for appropriate periods and establishing decentralised contact points;
- b) b) **competency acquisition** relating to work in multi-professional and multi-sectoral teams, to the development of generative welfare, to the mapping of population needs and resources, to community-building initiatives, through training pathways.



R17. Plan proactive home visits (light-touch case management) by *IFeC* (Family and Community Nurses) and social-care practitioners, at a frequency defined in the *PAI* (Individual Care Plan), for older people living alone, frail individuals and families in poverty, with active monitoring of rural settings and areas of urban deprivation, systematically flagging conditions of frailty and loneliness. The outcomes of home visits must be recorded in interoperable territorial information systems linked to the FSE 2.0 and shared with the *COT* — *Centrali Operative Territoriali* (Territorial Operations Centres) in cases of hospital-community care continuity. In clinically appropriate cases, monitoring and follow-up may be supported by telemedicine tools.

R18. Practise “social prescribing”, following the characteristics of the integrated socio-health community promotion interventions approved in the *Conferenza Stato-Regioni* (State-Regions Conference), with particular attention to low-income individuals and residents in disadvantaged or marginal urban, peri-urban and inner areas.

R19. Launch health promotion projects agreed between schools and community services, involving younger generations in the life of micro-areas through intergenerational initiatives and active prevention.

R20. Involve citizens and volunteers from local **OdV** (voluntary organisations) and **APS** (social promotion associations) **in co-design processes** for territorial services based on a peer-support approach, covering all types of frailty and loneliness, valuing the lived experience of service users and contributing to the training of volunteers to support frail and isolated people through visits, phone calls and accompaniment.

Appendix — Guide to Italian institutional terminology

Healthcare governance

SSN — Servizio Sanitario Nazionale (National Health Service). Italy's universal, publicly funded healthcare system, established in 1978. Comparable in principle to the UK's NHS, but administered at regional level.

ASL — Azienda Sanitaria Locale (Local Health Authority). The operational arm of the SSN in each territory. Each ASL manages hospitals, community services and primary care within its geographic area.

Distretto sociosanitario (Health and Social-Care District). A sub-division of the ASL responsible for organising and delivering primary care, community health and integrated social-health services within a defined geographic area.

AGENAS — National Agency for Regional Health Services. A national technical agency that supports the Ministry of Health and the Regions in planning and monitoring healthcare delivery.

ISS — Istituto Superiore di Sanità (National Institute of Health). Italy's leading public research institution in the biomedical and public-health field.

IRCCS — Scientific Hospitalisation and Treatment Institute. Hospitals that combine clinical care with biomedical research, recognised and partly funded by the Ministry of Health.

Territorial structures and instruments

Casa della Comunità — CdC (Community Health Home). A new model of territorial health facility introduced by Ministerial Decree 77/2022, intended as the physical hub for primary care, integrated social-health services and community-based prevention.

Centrale Operativa Territoriale — COT (Territorial Operations Centre). A coordination hub that manages transitions between hospital and community care, monitors home-care patients and ensures care continuity.

Punto Unico di Accesso — PUA (Single Point of Access). A gateway — usually located within a Casa della Comunità — where citizens can access an integrated assessment of their health and social-care needs.

Microarea (Micro-area). A neighbourhood-scale territorial unit (4,000–10,000 inhabitants) identified as the minimum area for community health programming, loneliness monitoring and proximity service delivery.

Planning and assessment tools

PAI — Piano Assistenziale Individuale (Individual Care Plan). A personalised care programme agreed upon by a multidisciplinary team for a patient with complex health and social needs.

PIdS — Programma Individuale di Salute (Individual Health Programme). A broader personal health project that sets out the long-term management strategy for a person receiving integrated care.

UVM — Unità di Valutazione Multidimensionale (Multidimensional Assessment Unit). A multi-professional team that assesses the health, social and functional needs of a person to determine the appropriate level of care.

FSE 2.0 — Fascicolo Sanitario Elettronico (Electronic Health Record). Italy's national electronic health record system.

NSIS — Nuovo Sistema Informativo Sanitario (National Health Information System). The national framework for collecting, standardising and sharing health data.

Regulatory and financial framework

LEA — Livelli Essenziali di Assistenza (Essential Levels of Care). The minimum set of health services that the SSN is required to provide to all citizens, defined nationally and implemented regionally.

LEPS — Livelli Essenziali delle Prestazioni Sociali (Essential Levels of Social Services). The minimum set of social services guaranteed to all citizens, the social-rights counterpart to the LEA.

Conferenza Stato-Regioni (State-Regions Conference). The institutional forum where the national Government and the twenty Regions negotiate and approve agreements on health and social policy, tariffs and standards.

DM 77/2022 (Ministerial Decree 77/2022). The decree that defines the standards for territorial healthcare, including the Casa della Comunità, the COT and the Ospedale di Comunità.

D.Lgs. 117/2017 (Legislative Decree 117/2017). The Third Sector Code, which regulates voluntary organisations, social promotion associations and other non-profit entities.

Professional roles

MMG — Medico di Medicina Generale (General Practitioner / Family Doctor). The primary-care physician who acts as the main point of contact for patients.

IFeC — Infermiere di Famiglia e di Comunità (Family and Community Nurse). A nursing role focused on proactive territorial care, early identification of frailty and light-touch case management.

Link worker / Connettore sociale (Social Connector). A professional or trained volunteer who connects individuals to community resources and activities. The key operational figure in social prescribing.

Third Sector organisations

Terzo Settore (Third Sector). The ensemble of non-profit organisations regulated by D.Lgs. 117/2017.

OdV — Organizzazione di Volontariato (Voluntary Organisation). A non-profit organisation whose activities are carried out primarily by volunteers.

APS — Associazione di Promozione Sociale (Social Promotion Association). A non-profit association that carries out activities of general interest.

ETS — Ente del Terzo Settore (Third Sector Entity). The general legal category for all organisations registered in the Single National Register of the Third Sector.



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