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BRIDGING THE MARKET GAP IN DISABILITY CARE: A BENCHMARK-BASED BUSINESS MODEL

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Abstract

Comunidade Vida e Paz has identified a critical and urgent gap in care for individuals experiencing social exclusion, often triggered by disabilities, homelessness or substance abuse issues. CAPDM's project (*Centro de Apoio a Pessoas com Deficiência Moderada*) arises as the solution to restore hope and dignity for individuals living with such significant and deeply entrenched challenges. Hence, this comprehensive and benchmark-based study proposes a financially sustainable business model for a center that integrates residential care, clinical services, and daily activities. From vision to reality, pathways to brighter horizons are built with this project to ensure impactful and lasting change.

Keywords

Agreement, Benchmark, Business Plan, Clinical Services, Daily Activities, Development, Disability, Financial Analysis, Financing Plan, Homelessness, Hospitality, Implementation, Partnerships, Pioneering, Risk Analysis, Roadmap, Social Impact, Social Security

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0. Introduction

Disability, whether physical or mental, together with homelessness, represents a significant barrier hindering social inclusion. Although several programs already address homelessness and disability, *Comunidade Vida e Paz* (CVPaz) identified a critical gap in care services for individuals with moderate disability, mental or physical, who cannot live autonomously after completing their rehabilitation programs. As a response for this organizational challenge, CVPaz intends to develop a support center for disabled individuals with limited autonomy – CAPDM (*Centro de Apoio a Pessoas com Defiência Moderada*) – that provides high-quality care and addresses the complex needs of this minority. The challenge this study intends to address is how to create a financially sustainable business model that provides residential care, clinical services and daily activities by following the best practices of the sector to promote well-being, independence (as much as possible), and societal integration of disabled individuals.

This research aims to determine the characteristics and resources required for a future center that will support CVPaz in maximizing its social impact and value for core beneficiaries while minimizing costs. Thus, this study involves an extensive data collection effort through a benchmark analysis of current solutions, both at a national and an international level. Interviews and qualitative research were conducted to gather insights on current service outcomes, infrastructure requirements, operational processes, and cost drivers.

The final output comprises the recommended operating model of the center, the outline of relevant financing solutions and the design of the optimal Social Security (SS) agreement. Moreover, an action plan comprising implementation strategies and necessary resources was designed along with the development of relevant Key Performance Indicators (KPIs). The ultimate objective is to inform the design of a center that can help tackle the organizational challenge while optimally aligning with CVPaz's social mission and cost-efficiency goals.

1. Exploring Comunidade Vida e Paz and Adressing the Problem

Who are the benefiters of Comunidade Vida e Paz?

1.1. Homelessness Context in Portugal

In Portugal, a person in a homeless situation is someone who, regardless of their nationality, racial or ethnic origin, religion, age, sex, sexual orientation, socioeconomic condition, and physical and mental health condition, is either without a roof (living in public spaces, accommodated in emergency shelters, or with whereabouts in precarious locations) or without a home (residing in a temporary facility that provides accommodation to people who do not have access to permanent housing and promotes their reintegration) (ENIPSSA 2023). According to the most recent official data, **10,773 individuals were living in a homeless situation in 2022 in Portugal**, 5,975 were without a home, while the remaining without a roof (ENIPSSA 2022). Given the numbers reported by the 273 municipalities that participated in the data collection from December 31st 2021 to December 31st 2022, there was a 19% increase in the number of people in a homeless situation in the mainland territory. Moreover, considering the current context of the Portuguese economy, a new type of homelessness in Portugal has emerged from the increase in housing prices and inflation: socially integrated people who are now being pushed into exclusion. Given this trend, 1,099 couples were identified in a homelessness situation (Agência Lusa 2024). The 2022 Annual Report of *Estratégia Nacional Para a Integração das Pessoas em Situação Sem-Abrigo* (ENIPSSA) states that Lisboa and Porto are the most affected by the homelessness issue, concentrating the largest number of recorded cases (ENIPSSA 2022).

As the issue continues to grow, the ENIPSSA 2025-2030 was approved by the previous Government and focuses on the design of prevention actions and the creation of a risk situation alert system. The measures encompass, for example, an intervention with case managers at the local level and the increase of housing first solutions – prioritizes providing stable, permanent

housing as the initial step, rather than the final objective, being supported by policies and practices that ensure individuals experiencing homelessness, or at risk of it, can secure ordinary housing. (Housing First Europe n.d.) – and shared apartments. With a problem that impacts needs as fundamental as those at the base of the Maslow's pyramid (**Appendix *1***) – such as shelter, food, and sleep (Jorge 2022) – and extends to critical needs in the realms of safety, security, love, belonging, and even self-esteem (McLeod 2024), these people are dependent on society's help and good will to guarantee their basic human rights. Hence, a coordinated effort from multiple institutions is a must to mend their situation.

These organizations, often working in partnership with government bodies and local authorities, have a strong social mission – a cause that benefits society, the economy and/or the environment in various ways (Wharton School of the University of Pennsylvania 2019) – which must start from the overall vision and values of the enterprise (Kamono 2023). The organizations operating in the previous described environment have the social mission of helping homeless people to recover their dignity and (re)build their life, gaining autonomy. To achieve this social mission, specialized care and comprehensive support services are provided, ranging from immediate housing solutions to healthcare and social reintegration.

1.2. Organizational Landscape Tackling Homelessness

Such coordinated response to the homelessness issue has emerged through several Non-Governmental Organizations (NGOs) and *Instituições Particulares de Solidariedade Social* (IPSS). Having dedicated themselves to addressing the issue, such organizations either focus directly on homeless individuals or include them within a broader scope of vulnerable populations. This subchapter characterizes the **landscape in which these organizations operate**, showing their crucial role in the support system for addressing homelessness. Given the rising number of individuals in need, the expansion of institutions dedicated to this cause is not only justified but absolutely necessary. This growth is not solely in numbers, but also in the

increasing importance and relevance of these organizations.

Hence, **11 institutions** supporting homeless individuals were studied through the collection of key information from the websites and the Annual Reports and Accounts available (**Appendix 2** to **Appendix 6**). To develop a comprehensive view of their positioning and contributions within the homelessness support landscape, 5 key areas were covered: Services and Activities, Focus of Intervention, Impact, Human Resources, and Financials. Firstly, under Services and Activities, 21 service offerings were examined and divided into 3 main areas: First-line Intervention, Treatment & Rehabilitation, and Reintegration; determining whether each organization offered these services. In Focus of Intervention, 12 key social issues were reviewed, such as homelessness, disabilities, and substance abuse, identifying the range of problems each organization addresses. Impact relates to the reach and effectiveness of each organization through geographical coverage, the number of people and homeless individuals supported, and food services provided. Under Human Resources, volunteer numbers, hours, and staff ratios were evaluated to assess operational capacity. Finally, Financials comprise an analysis on revenue sources, personnel expenses, and growth metrics to understand the organizations' financial health.

Firstly, ***Associação CAIS*** **(CAIS)** established in 1994, aims to promote social inclusion by supporting job market reintegration through different projects such as *Revista CAIS* and *CAIS Recicla*. CAIS has an Insertion Community, which was financed through a Social Security (SS) Agreement (€279,128) and provides food item distribution as well as health services (CAIS 2024). In this context, it was recognized that the needs being addressed pertain to essential aspects such as nourishment, a sense of belonging, personal fulfillment, and hygiene. Furthermore, ***Assistência Médica Internacional*** **(AMI)** is a private, independent, non-profit, non-political, Portuguese NGO created in 1984 to mitigate inequality and suffering in the World, with human beings as the focus of concern. AMI develops a wide range of initiatives,

both at a national and international level. The NGO provides social advocacy, employment and home support as well as night shelters and open canteens. Finally, there is a team to aid homeless people through continuous psychosocial support to tackle social exclusion (AMI 2024). Thirdly, ***Santa Casa da Misericórdia de Lisboa*** **(SCML)** commits to improving the well-being of citizens in general, but especially of the most vulnerable. SCML provides shelter houses, social canteens, accommodation centers, occupational ateliers, transition houses and therapeutical support. Additionally, SCML provides specialized assistance for individuals with disabilities, including accommodation, healthcare, and rehabilitation for children, youth, and adults, while also supporting their families (Santa Casa da Misericórdia 2024). In addition, the organization assists immigrants and those affected by domestic violence. Moreover, ***Centro de Apoio ao Sem-Abrigo*** **(CASA)** was established in 2002 to aid homeless people, families at risk and families in need. CASA activities include meals, food baskets and clothing distribution, support in social reinsertion, accommodation, psychological assistance and primary healthcare. The organization operates in 5 mainland districts (Lisboa, Porto, Faro, Coimbra and Setúbal) and Madeira (CASA 2024). Another relevant non-governmental organization is ***Médicos do Mundo***, which is focused on humanitarian aid and development cooperation and based on the fundamental right of all human beings to have access to healthcare, regardless of their nationality, religion, ideology, race or economic possibilities. *Médicos do Mundo* supports homeless people through several projects: *Porto Escondido*, *Saúde a Girar*, *Centro de Alojamento Temporário Joaquim Urbano*, *Sem Abrigo* and *SOU+*. Finally, the NGO aids CVPaz in the *Unidade Integrativa para Pessoas em Situação de Sem-Abrigo* (UIPSSA) at a healthcare level (Médicos do Mundo 2024). In addition, the IPSS ***Orientar*** was founded in 2011 with the goal of fully integrating individuals facing social exclusion, through several programs. *Projeto Orientar* provides individual support to vulnerable people to promote their autonomy in different areas. *Residências Orientar* grants accomodation to men who are working on their

professional integration. Lastly, *Gabinete de Emprego e Formação* (GEF) aims to guide people entering the job market (Orientar 2024). ***Associação Vida Autónoma*** **(AVA)**, established in 2019, is aimed at fighting social exclusion in Lisboa and Beja. The IPSS has a technical team which assists homeless people at a psychosocial level, as well as residences and shared apartments. In fact, it also supports homeless people with disability by promoting professional training and medical treatment, in Alcântara (Associação Vida Autónoma 2024). The eighth organization under analysis is ***CRESCER***, created in 2001 to promote social inclusion among vulnerable populations in Lisboa. *CRESCER* works with migrants, refugees, homeless individuals and people with severe addictions and has been developing several projects. The initiatives aimed at tackling the homelessness issue comprise: *É UMA RUA*, *Espaço Ímpar*, *REACH_U* and *É UMA CASA* (CRESCER 2024). Additionally, ***VITAE***, founded in 1995, is focused on the intervention for populations in situations of vulnerability and social risk based on the person's acceptance of their individuality. *VITAE*'s initiatives comprise welcome centers, social canteens, technical teams, sustainable laundry and shared apartments. The organization also helps refugees, immigrants and people with addictive issues (VITAE 2024). Moreover, ***Associação Conversa Amiga*** was created in 2007 and aims to create innovative projects and offer psychosocial support by professionals to homeless people in Lisboa. Besides providing volunteering training, the organization also implemented *Cacifos Solidários* (private lockers in the street environment, accessible 24 hours a day for homeless people to store their belongings in a safe and dignified manner) and *Correio Solidário* (allocation of individual mailboxes to homeless people, with a safe and autonomous access of 24 hours/day and 7 days/week) (Associação Conversa Amiga 2024). The last organization under analysis is **CVPaz**, which is the focus of this Work Project and deeper research is presented in Subchapter 1.3.. Overall, the analysis conducted revealed a diverse landscape, characterized by significant variation in scope, size, and financial resources. For example, AMI, *Médicos do Mundo* and CASA are the

organizations with the highest numbers of volunteers (with AMI taking the first place, with 1,035), which can be explained by the fact that these are the leaders in supporting the most homeless individuals (more than 950 each). Apart from homelessness, only AVA, CAIS and SCML aid individuals with disabilities.

1.3. Comunidade Vida e Paz In-Depth Analysis

1.3.1. Strategic Pillars

Founded in 1989, CVPaz is an **IPSS** working under supervision of Lisboa's Patriarchate, dedicated to supporting and reintegrating homeless individuals and those struggling with addiction into society. Through a mission rooted in restoring dignity and helping people rebuild their lives, the organization takes a holistic approach that addresses the physical, emotional, and social needs of those in vulnerable situations. Moreover, CVPaz aims to be a leading force in creating **impactful solutions** for homelessness and social vulnerability. Guided by values such as hope, solidarity, and compassion, the IPSS works to create sustainable pathways for individuals to regain their independence. Support starts with the initial contact on the streets and extends to full reintegration into society, ensuring personalized care every step of the way. The assistance begins with the **First Line Intervention Center**, where dedicated teams engage directly with those living on the streets, offering immediate assistance, building trust, and assessing individual needs. This unit operates through 2 key teams: the volunteer street team and the technical street team. The first one is composed of around **600 volunteers** that play a vital role in creating connections with homeless individuals, offering daily support and distributing meals. The latter works closely with those identified by the volunteer team in providing tailored support plans aimed at fostering personal transformation. In addition to these teams, the First Line Intervention Center includes 3 main infrastructures: UIPSSA, *Espaço Aberto ao Diálogo* in Chelas, and *Apartamentos Partilhados de Primeira Linha*. UIPSSA offers a residential program focusing on social inclusion and quality of life of its residents, providing

a structured psychosocial support environment for up to 40 individuals and their pets. The *Espaço Aberto ao Diálogo* serves as a day center, complementing street interventions by offering services such as health care, hygiene support, legal assistance, and employment guidance, helping homeless individuals take the first steps towards reintegration. Finally, *Apartamentos Partilhados de Primeira Linha* provide immediate housing solutions, offering safe and supportive living environments for those beginning the journey of reintegration.

From there, individuals are guided through continuous care that includes **treatment and rehabilitation services** tailored to their specific circumstances. These programs address not only physical needs but also psychological, social, and emotional challenges, providing the tools necessary for personal growth and recovery. Such programs are provided by 2 Therapeutic Communities and 2 Insertion Communities. The Therapeutic Communities of *Centro de Fátima* and *Centro Quinta da Tomada* accommodate up to 135 residents, offering holistic, individualized treatment plans, supported by a diverse team of professionals. Meanwhile, the Insertion Communities of *Centro Quinta da Tomada* and *Quinta do Espírito Santo* (QES), which support up to 84 individuals, focus on equipping residents with essential personal and professional skills to promote their autonomy.

The final step is **reintegration**, where CVPaz works to equip individuals with the skills and support needed to re-enter society confidently, secure employment, and rebuild their lives. This crucial phase is facilitated through the *Unidade de Apoio À Reinserção e Pós Alta* (UAR) designed specifically for individuals who have completed their rehabilitation process and lack family support. To achieve this integration, CVPaz operates 5 *Apartamentos de Reinseção* across various locations, offering residential support to those who need it post-rehabilitation, as well as a *Residência Autónoma*, which is part of the *Cuidados Continuados Integrados de Saúde Mental* (CCISM) network. The organization also provides a program for post-discharge support (*Projeto MAPA*), offering structured assistance in areas such as employment, housing, and

psychosocial support, while also addressing relapse prevention. This holistic approach ensures that each person receives comprehensive support throughout their journey, empowering them to break the cycle of homelessness and achieve lasting change.

CVPaz operates through the combined efforts of 158 staff members and over 600 volunteers, delivering comprehensive services and care to those in need. At the top of its governance structure is the Lisboa's Patriarchate, followed by 3 key decision-making bodies: the General Council, the Fiscal Council, and the Board of Directors. Beneath these bodies, the organization is managed by a General Director and supported by a Spiritual Assistant. Operationally, CVPaz is structured into 8 core areas. The Direct Intervention area includes the First Line Intervention teams, Therapeutic Communities, Insertion Communities, and Reintegration Support. Spiritual Support is provided to promote personal well-being and dignity throughout the process. People Management focuses on overseeing human resources and volunteer coordination, while Communication and Marketing ensure public engagement and outreach. The Christmas PSSA initiative is one of the organization's key annual projects while AFAI Services – comprising administrative, financial, logistic support, and IT functions – ensure smooth internal operations. Finally, the last 2 core areas, Social Businesses and Fundraising, help CVPaz sustain its mission and operations financially. Overall, this structured approach allows CVPaz to deliver care and support efficiently, ensuring that its mission is achieved through a well-coordinated and responsive framework.

The landscape characterized in Subchapter 1.2. positions CVPaz as a key player in the homelessness support ecosystem, distinguished by its **comprehensive range of services**, particularly in **Treatment & Rehabilitation**. CVPaz excels in food service distribution and demonstrates effective volunteer engagement, leading in the ratios of volunteers and effective workers to those supported. The unique contributions and focus on marginalized populations highlight CVPaz's critical role in mitigating social exclusion. By addressing homelessness at

various critical stages, the organization can meet not only the basic needs for shelter and food, but also the psychological needs for love, belonging, and support.

1.3.2. Financial Analysis

Given the scale, complexity and scope of services offered, a financial analysis is essential to help ensure that CVPaz can maintain a level of independence and sustainability. Moreover, such analysis plays a pivotal role in optimizing resource allocation, ensuring that funds are efficiently directed towards areas of greatest need. It also facilitates effective risk management by identifying potential financial vulnerabilities that could impact service delivery. Furthermore, a financial analysis provides valuable insights into opportunities for expansion, allowing the organization to grow and enhance its capacity to meet increasing demands. Additionally, it helps to identify and secure new funding sources, ensuring the long-term viability and success of both current and future projects.

To understand the financial performance of CVPaz, the information of the **income statement** and the **balance sheet** was gathered for the period between 2019 and 2023 in the Annual Report and Accounts available on the website as well as from financial information sent by the organization. Moreover, a subset of 7 organizations with a similar offering and a strong support on the homelessness issue was selected from the landscape described in Subchapter 1.2. to position the financial performance of CVPaz within the industry. The aforementioned organizations comprise: CAIS, AMI, SCML, CASA, AVA, *CRESCER* and *VITAE*. Given their non-profit nature, these organizations are exempt from IRC (*Imposto sobre o Rendimento de Pessoas Coletivas*), IVA (*Imposto sobre o Valor Acrescentado*), IUC (*Imposto Único de Circulação*), ISV (*Imposto Sobre Veículos*) and IMI (*Imposto Municipal sobre Imóveis*) (Autoridade Tributária e Aduaneira 2015). Finally, different ratios and indicators were calculated, with the formulas displayed in **Appendix *7*** to **Appendix *16***.

Regarding **CVPaz's revenues**, detailed in **Appendix 17**, there are 3 main sources: Services

Provided (with *Comparticipações* being the main contributor – for instance, from the users or *Administração Regional da Saúde*), State Subsidies and Other Public Entities (where *Instituto da Segurança Social* (ISS) is the main source) and Donations and Heritages (both monetary and in kind). Sales, which has a very low representation on the total revenues (between 0.09% and 0.37% since 2019), includes sales associated with occupational activities and therapy work to train the users and enhance their skills. Regarding **costs**, illustrated in **Appendix *18***, Personnel Costs represent more than 50% of total costs since 2022, while Cost of Goods Sold and Materials Consumed (significantly impacted by inflation evolution) and External Supplies and Services range from 22% to 29% and 17% to 20%, respectively over the last 5 years. Given the 151 number of employees, an average cost of approximately €18,600 per worker was incurred in 2023. Furthermore, CVPaz can be analysed in terms of the ratio of subsidies to total revenues and the ratio of personnel expenses to total costs considering the landscape. Indeed, CVPaz shows a lower dependency on subsidies (33% against a peer average of 40%) and a larger staff costs burden (54% against a peer average of 46%), in 2023 (**Appendix *19***). Overall, total revenues present a compounded annual growth rate (CAGR) of approximately 6% while costs have been growing annually by 6.7% since 2019, which may rise concerns for CVPaz if this pattern remains in the future. Indeed, net income has presented a volatile evolution since 2019, as it fell from €53,139 to -€142,684 in 2022, remaining negative in 2023 (**Appendix *20***). Costs rose by 10% in 2022, due to several factors such as the higher inflation rate, a larger vehicle fleet and an expansion of the social responses which require more resources and, in turn, higher expenses. Revenues also increased, but only by 5%, thus leading to a large drop in net income in 2022. A more granular analysis can be conducted to grasp the performance of each area of CVPaz: First Line Intervention, Therapeutic Communities, Insertion Communities and Headquarters (**Appendix *21***). In 2022, CVPaz's **net income** became **negative**, mainly due to a large loss from Headquarters caused by a sharp drop in revenues and a slight increase in costs

of General Services – Alvalade. Both Communities presented a positive profit, where Therapeutic Communities dropped, and Insertion Communities displayed a slight rise. First Line Intervention registered a lower negative profit in absolute terms, as revenues increased significantly, particularly from UIPSSA and *Apartamentos Partilhados de Primeira Linha*. In 2023, CVPaz's overall profit was less negative, as both Communities displayed large increases in net income. Indeed, the profit rise in Insertion Communities was mainly driven by the performance of QES while both *Tomada* and *Fátima* contributed to the profit increase of Therapeutic Communities. Headquarters and First Line Intervention registered relatively large profit drops: Direct Intervention Team ceased to be profitable and General Services – Alvalade displayed a large rise in costs that was not compensated by an increase in revenues.

Since CVPaz is a non-profit organization, the short-term financial health is crucial to be assessed by evaluating **Net Debt** (ND), **Net Working Capital Requirements** (NWCR) and **Net Working Capital** (NWC) over the last 5 years (***Appendix 22*** and ***Appendix 23***). CVPaz does not rely significantly on bank loans to finance operations, a fact underlined by the negative ND observed (i.e. Cash & Cash Equivalents – such as bank deposits – are more than enough to cover financial obligations). Moreover, the negative NWCR observed in the last 5 years seems to be a great sign of operating efficiency, since the company's operations are being funded through its payables. Indeed, the average Days Sales Outstanding are lower than Days Payables Outstanding ***(*****Appendix *23).*** When looking at NWC, the negative values observed since 2022 mean that CVPaz's current liabilities surpass current assets. Thus, part of the fixed assets is being financed by short term liabilities, implying a high financing risk and possible liquidity issues in the future.

Moreover, 3 liquidity ratios were computed and compared across the industry landscape (**Appendix *24***). Firstly, the current ratio went below 1 in 2022, well below the industry average of 2.43. Indeed, Cash and Bank Deposits suffered a large drop while Accounts Payable rose.

The quick ratio allows to understand whether CVPaz's most liquid assets are sufficient to cover its short-term obligations while the cash ratio represents the fraction of Cash & Cash Equivalents relative to current liabilities. Once again, CVPaz displays values below the industry average for both ratios, where 2020 was a year of strong performance (the cash ratio was 0.96) and 2022 registered a fall in the ratios and consequently a deterioration of CVPaz's financial health. Organizations such as AMI, SCML, CAIS and CASA present high liquidity ratios, showing stronger ability to pay for short-term obligations. On the other hand, CRESCER presents a similar short-term financial health to CVPaz.

To further assess the **capital structure** of CVPaz, the Liabilities-to-Assets and Liabilities-to-Equity were computed (**Appendix 25**). CVPaz has presented values ranging between 25% and 35% for the first ratio and between 30% and 55% for the second ratio, always below the industry average, indicating a low insolvency risk. It is important to note that CRESCER and AVA are pushing the average upwards, given their extremely high values of these leverage ratios.

1.4. Disability Context in Portugal

Besides the homelessness issue, CVPaz recognizes the growing number of individuals with disabilities, often linked to alcohol dependency or drug abuse, who seek support through its services. Indeed, **disability**, whether physical or mental, constitutes another barrier hindering social inclusion. Assessing the broader scope of this issue across Portugal is relevant to better understand both its impact and the effectiveness of current responses.

In 2021, nearly 11% of the resident population in Portugal (above 5 years old) had at least 1 disability. In fact, the prevalence of severe disability in mobility and personal care has risen while the dimension related to cognition has fallen over the last decade (GEPMTSSS 2023). According to the Eurostat, in Portugal, the risk of poverty or social exclusion has remained significantly higher among people above 16 years old with disabilities: 62.3% faced the risk of poverty before social transfers, compared to only 35.5% of people without disabilities

(European Survey on Living Conditions and Income 2022).

Thus, understanding the **linkage between disabilities and social exclusion,** particularly triggered by homelessness and substance abuse, is required. Indeed, homeless people are likely to experience a 'tri-morbidity' of mental ill health, physical ill health, and addiction (Fitzpatrick, Bramley and Johnsen 2012). Regarding mental illness and substance abuse – the first and third morbidities – one cannot directly establish a causal or directional relationship (National Institute on Drug Abuse 2018). In fact, both can contribute to the other and there are several overlapping factors which contribute to the aforementioned issues, such as genetic and epigenetic vulnerabilities, problems with similar areas of the brain, and environmental influences. Such illnesses and disorders can be also linked with homelessness situations as there is a 25% to 50% risk of becoming homeless for single adults with a major mental illness (Bauer, et al. 2013). Furthermore, despite the lack of studies, the prevalence of mental illness among the homeless population is estimated to be around 30% in Portugal (Bastos, Bento and Caldas de Almeida 2024). Finally, works published in Portugal state that more than 50% of people in a homeless situation use drugs (Miranda and Norte 2021).

To address the challenges faced by people with disabilities, the *Sistema de Atribuição de Produtos de Apoio* (SAPA), whose budget has increased by 60.4% in 2022 (Pinto, et al. 2023), and the *Modelo de Apoio à Vida Independente* (MAVI), which provides personal assistance (Diário da República 2023), were set to support their inclusion and autonomy, respectively. Several measures under the *Estratégia Nacional para a Inclusão das Pessoas com Deficiência* (ENIPD 2021-2025) were also created, however, only 31% were implemented between 2021 and 2023 (Machado 2024).

Summing up, numerous institutions are currently committed to assisting individuals in regaining or achieving autonomy. However, significant gaps remain in addressing the needs of homeless individuals with disabilities who strive to attain a substantial degree of independence.

2. Unpacking CAPDM Proposal

What is the current structure proposal for CAPDM?

2.1. CAPDM Starting Point

2.1.1. CAPDM Emerging as a Solution

A **specific and critical gap** was identified by CVPaz in care services for individuals experiencing homelessness or social exclusion, that finish their rehabilitation programs and cannot live autonomously due to moderate disabilities. Due to the specificities of these individuals' situation – often struggling with substance abuse, homelessness, and a lack of autonomy – they face **heightened vulnerability**. Moreover, because most of them are still of working age, they are frequently excluded from shelters or other public and private care facilities that might assist others in similar situations, as these are not adequately equipped to target the complexity of these challenges, leaving individuals without proper care and support. Currently, while a few organizations abroad serve this target group, the intersection of homelessness and disability remains **largely overlooked** in Portugal, (C. P. Pinto 2017) making it an untapped area with significant potential for intervention.

CVPaz has been addressing the consequences of this service gap by allowing users to extend their stays when they have no other place to go, particularly at QES. However, this center lacks the **specialized treatment** required for these individuals, and users are also occupying spaces intended for those in need of rehabilitation and treatment who can then be reintegrated back into society. This gap in care motivated the creation of **C*entro de Apoio a Pessoas com Incapacidade/Deficiência Moderada*** (CAPDM), with the primary purpose of providing specialized assistance to individuals, ensuring they receive the necessary attention and resources to continue developing competencies and improving quality of life. The center aims to fill the void in adequate responses by offering an environment where the autonomy and quality of life achieved during treatment and rehabilitation can be maintained or enhanced

(CVPaz 2024).

The project was initiated a few years ago when the Municipality of Torres Vedras ceded a plot of land for the construction of the center. However, the COVID-19 pandemic combined with bureaucratic challenges and financial constraints, caused significant delays in its development. Despite these setbacks, the land remains available for construction, and the project is now being revived with plans to **begin operations in 2027**. The initial specifications of the project, such as its capacity, location, and overall goal, have already been defined (***Appendix***). The facility is planned to offer shelter for **54 male residents,** along with **15 spots** for **ambulatory care**, and provide specialized support services. These services will go beyond shelter and food, focusing on ensuring appropriate follow-up in key health areas, including psychological, psychosocial, psychomotor, and social activities that will foster continuous engagement with the community and support the individuals in maintaining and enhancing their autonomy. CAPDM project is not only expected to benefit its users directly but has also been recognized as essential by peers and other organizations. For instance, during a meeting with the IPSS *A Barragem*, the professional interviewed emphasized this project's significance, stating, "There is indeed this need; your project is incredible and addresses a gap that exists nationally; it is truly necessary".

2.1.2. Main Goals

CAPDM has been designed to support **disabled men** in situation of **homelessness** or **social exclusion**, whether suffering from mental illness or not. Hence, distinguishing between **disability and mental illness** is crucial: disabilities refer to a physical or mental impairment that substantially limits 1 or more major life activities (Americans with Disabilities Act n.d.), whereas mental illness pertains to conditions that affect a person's emotional, psychological, or behavioral well-being (Njoku 2022). Thus, **disability is a necessary condition** to be eligible to CAPDM while **mental illness is not**.

Indeed, CAPDM aims to support the individuals deemed technically exhausted in terms of

potential improvement in their skills, even after completing rehabilitation programs. These individuals did neither achieve the level of autonomy required to sustain the quality of life attained at the end of rehabilitation programs, nor the independence needed for integration into ERTI (Social Rehabilitation and Transitional Homes). ERTI are spaces designed for individuals capable of managing daily activities and requiring only minimal support during their initial steps toward life reconstruction. Therefore, additional and ongoing support is required to maintain their development and the quality of life they are entitled to.

According to CVPaz's initial plan, the intervention program of CAPDM encompasses **3 clear objectives**. Firstly, the individual should become aware (within the limits of their cognitive abilities) of their situation of dependence and its consequences for their daily life. Secondly, the user should maintain, to the highest possible degree, their personal and social skills and capabilities, adopting a logic of empowerment and a healthy lifestyle, while sustaining the functioning and relational patterns with society that they acquired during rehabilitation. Thirdly, the individual should be able to identify the risks faced due to their condition and develop and internalize appropriate basic self-regulation and protection mechanisms. To ensure that these objectives are successfully achieved, several conditions are required. The **workforce** is expected to have a comprehensive understanding of the residents' skills, limitations, needs, and expectations as well as master best practices in relational and therapeutic techniques for different situations. Also, all patients are required to actively participate and engage (within the limits of their cognitive and relational abilities) in individual or group activities and in the care provided. Thus, the individual's regular interaction with the **community** – to meet their needs, fulfil their obligations and have leisure time – will be an integral part of the intervention.

2.1.3. Treatment Journey

The success of CAPDM relies not only on securing the full engagement of both staff and users, but also on the progression of each patient through their treatment journey. This journey is

organized into **3 main stages**: first, individuals are **identified as potential users**; second, they undergo a **formal diagnosis** that assesses various levels, including motor, intellectual, and affective/relational aspects; finally, they proceed to the **tailored treatment phase** designed to meet their specific needs. Potential users are identified through referral channels, including the communities where CVPaz is actively engaged, its first line intervention area or even other institutions within Portugal. Once identified, each individual undergoes a diagnostic assessment, which classifies them as either residential or ambulatory users. **Residential users** typically require **more intensive support** due to greater limitations in autonomy, living at the facilities, whereas **ambulatory users, living in Torres Vedras**, retain a degree of independence in daily activities or family support and, therefore, rely on the center primarily for daytime care, only during weekdays (**Appendix**).

CAPDM's **primary objective** is to maximize the level of support provided to everyone, maintaining their care **without a predefined time limit**. Should the center reach a point where it lacks the resources or specialized technical support to meet the needs of users with escalating dependencies or disabilities, these individuals would be referred to institutions specializing in advanced care. Although setting a limit on care duration could potentially increase the number of individuals supported, as portrayed in **Appendix** , such a policy would conflict with CVPaz's core commitment to providing ongoing, needs-based support.

2.1.4. Target Segment Estimation

To accurately assess the potential demand for the center and hence understand the universe of individuals that require CAPDM's support, a clear definition of its primary target population is essential. The center was originally established to accommodate individuals experiencing homelessness or social exclusion that finish CVPaz's rehabilitation programs and cannot live autonomously due to moderate disabilities. However, following extensive analysis, it became evident that other individuals, not initially considered as part of the center's target group, might

also benefit from its services. Consequently, while the center's initial focus was on a specific population, its scope extends to meet the needs of a broader range of patients. Hence, regarding **residential users**, **3 potential types** were considered.

Firstly, as initially planned, the center would help individuals who have earlier **undergone CVPaz's rehabilitation** programs, specifically from QES, the largest Insertion Community. In fact, out of the 65 users accommodated in QES, 9 to 10 present a high incapacity level which does not allow them to live independently and thus require continuous support. Moreover, there are 27 individuals waiting to be integrated into a nursing home or a similar institution. Indeed, half of them are expected to be a target for CAPDM due to their inability to secure placement in other care facilities. This situation arises because either the facilities are currently full and have long waiting lists, or because there are no available institutions that provide the specific care these individuals require, intensified by the fact that they have no family support to rely on. Thus, CVPaz stated that 23 to 24 individuals, equivalent to around 35% of the individuals supported in QES, require permanent support and struggle to live independently, and hence would be directed to CAPDM.

Secondly, CAPDM would extend support to **people identified by frontline technicians** as having moderate incapacitation. To estimate the number of individuals that would be eligible for the center, data was retrieved from CVPaz annual reports since 2021. In 2023, first line intervention teams and infrastructures supported 1,854 individuals, showing a rising trend over time. The individuals aided by the street teams were excluded from the estimation due to lack of data and diagnosis. According to a study published by *Universidade de Lisboa*, which had the purpose of studying the sociodemographic profile of homeless people with mental illness, in Lisboa, in a sample of 500 homeless people – from which 77% are men – 62% had multiple psychiatric diagnosis, including substance abuse and various mental illnesses (Fernandes 2021). Assuming a similar pool of individuals entering rehabilitation programs (62%) and the

prevalence of individuals requiring support would be the same as in QES (35%), and considering the aforementioned proportion of male population, around 306 to 320 individuals would be eligible to CAPDM's support.

Thirdly, CAPDM may also welcome **individuals who have completed other rehabilitation programs** in Portugal. According to *Jornal Público*, 3,087 and 3,455 individuals were admitted in rehabilitation programs in Portugal (after deducting the ones admitted in CVPaz programs) in 2021 and 2022, respectively (Carmo 2024). Knowing that, on average, the ratio of people that complete rehabilitation programs relative to new admittances annually for CVPaz has been 58% over the past years, and considering similar rates would apply to other rehabilitation programs, around 1,908 individuals would complete these programs each year. Applying the same logic as before, where an average of 35% would require permanent support and 77% would be men, a result of 509 to 531 individuals eligible to CAPDM's support was reached.

In total, CAPDM would be a solution for around 837 to 875 men in Portugal, thus leading to a waiting list of approximately **783 to 821 residential users** where priority would be given to the individuals already supported by CVPaz, particularly the ones coming from QES.

Regarding the **ambulatory regime**, potential users are among the pool of male adults living in Torres Vedras Municipality who have disabilities, are not employed and have their family's or other institution's aid. Indeed, only Torres Vedras residents were considered since ambulatory users commute twice a day on weekdays to go to the center and go back home, thus, assuring a short distance between these 2 locations is crucial. To estimate the potential CAPDM ambulatory users, the following information was considered: Torres Vedras Municipality population number (88,020 individuals in 2023 (Pordata 2024)), the percentage of adults (21-65 years) in the country (58% in 2023 – extrapolated to the sample in question), the percentage of individuals with disabilities in the region (5.4% according to the latest data of Censos 2001 (Torres Vedras 2021)) and the percentage of individuals with disabilities that are men (38.80%

(GEPMTSSS 2023)). The computation reached a value of 1,012 male adults with disabilities living in Torres Vedras Municipality. In addition, 45.1% of individuals with disabilities in Torres Vedras are employed, hence not being potential users for CAPDM. Finally, considering that 32% of potential users have family support in QES and assuming this prevalence to the whole sample under analysis, the final number of potential ambulatory users of CAPDM is **178**. The calculations were performed according to the most recent available data and due to the lack of studies on the issue, the numbers may slightly deviate from reality. Nevertheless, the estimation provides a general perspective of the critical gap in care that exists in Portugal that CVPaz aims to tackle.

Although CVPaz prioritizes helping people already completing their programs, it has the overarching goal of reducing poverty and promoting reintegration in society. The rising trend that has been observed over the past years regarding the scale of the issue reveals that CAPDM is predicted to have an **occupancy rate of approximately 100%**.

2.2. Initial Plan Overview

After understanding the potential demand for CAPDM support, describing the initial plan designed by CVPaz is the next step. Besides the provision of **accommodation and meals**, CVPaz plans to deliver **comprehensive support services**, such as healthcare tailored to diverse needs, psychological support, psychosocial assistance, psychomotor maintenance training, occupational activities, and opportunities for continuous community engagement.

To realize this plan, an agreement was established with **Torres Vedras Municipality**, wherein the Municipality allocated a parcel of land to CVPaz for the construction of CAPDM. Under the terms of this agreement, CVPaz was responsible for submitting an architectural plan to the Municipality.

2.2.1. Main Services

To provide the appropriate support to the aforementioned population, and within the terms of

the initial plan, the services offered by CAPDM can be divided in **3 main types** within a centralized approach: residential care, clinical services and daily activities.

Firstly, the **residential care** is planned to comprise accommodation and food services. The meal service is available to both residential and non-residential users and is organized to function efficiently with a fully equipped kitchen, pantry, storeroom, and a dining room that operates in a self-service format. This arrangement ensures that meal preparation and service can be conducted smoothly and in compliance with hygiene and dietary standards. Secondly, the **clinical service** provides support across various health fields (general and psychiatric) including psychology, psychotherapy, social support, physiotherapy, psychomotricity, sensory and cognitive stimulation. Lastly, **daily activities** include occupational activities focused on skills training and maintenance as well as cultural, leisure, and community engagement activities. Furthermore, users are also encouraged to participate in cleaning and maintenance of the facilities, laundry tasks, and meals preparation and distribution. To ensure all services provided obey the highest quality standards, CVPaz plans to establish partnerships both in the medical area (specialty medical appointments and/or general health and psychiatric treatment) and in the social care area (cultural and sports initiatives and transportation services).

Moreover, patients are continuously supported by a ***Técnico de Acompanhamento Permanente*** (TAP) – a technician that provides users with permanent support and monitoring. Under the supervision of CAPDM's technical managers, the TAP is responsible for leading the process of care/service provision and integrating the contributions of other services and complementary care provided within the framework of the program. Each TAP is assigned a group of 10 to 12 users to ensure not only an individualized approach but also a more comprehensive perspective that addresses the needs of the entire patient community. Thus, to support CAPDM's main responsibilities and objectives (**Appendix**), the TAP has the following duties: drafting, updating and monitoring the Individual Plan for each user entrusted to their care; ensuring the

supervision and control of users' hygiene, personal care, and social behaviour patterns; providing ongoing support to the user in their daily lives; organizing the collaboration plan for users in collective and complementary activities; promoting activities in the cultural, sports, leisure, community engagement, and free time entertainment areas; ensuring, whenever possible, that users maintain and strengthen ties with close family members.

A case study by The Commonwealth Fund highlights that customized services, like those CAPDM plans to offer, share key features. One such feature is **accessible care**: centralizing clinical services, daily activities, and residential care in a single location reduces transportation barriers, which are often significant for people with disabilities. Thus, easier accessibility to services needed to promote health and quality of life is ensured. In addition, having clinical services incorporated in residential care allows for **cost efficiencies** in terms of expenditure related to the transportation of patients to health-related appointments outside the center. Thirdly, this type of institution **engages and builds trust with patients** since there is a consistent and reliable care and residential component where they build long-term relationships with helpers, healthcare providers and the overall staff of the center. Lastly, the integration of long-term services and support **improves health and promotes independence and social inclusion**. Indeed, patients can have a sense of autonomy and impact in the community through different daily activities and regular coexistence with different people, both inside and outside the center. All these factors help users to manage their conditions, avoid medical complications and improve quality of life (Hostetter and Klein 2018).

2.2.2. Plant Description

Besides an initial outline of CAPDM key objectives and main services, CVPaz had already developed a technical project, in partnership with *Souto Moura Arquitectos S.A.* to design the infrastructure. The building was designed to have an **administrative space** and **2 complementary areas for users** – residential area and occupational area. ***Appendix*** shows the

details and the size of each area, which amounts to a total of **1,166 square meters** (sqm).

The residential area consists of 27 bedrooms for 2 people each and 27 bathrooms with shower unit, distributed in 3 different buildings. The occupational area incorporates different spaces for health care, food preparation, leisure and therapies. Thus, the area encompasses a reception, medical office, 2 therapeutic rooms, infirmary, common bathrooms, the canteen and the living room. Areas related to food preparation – kitchen, service and dirty dishes areas, cold cabinet and pantry – are also in this building. Finally, 2 staff balnearies and a dumpsters area should be located in the building's corner. The administrative area has 7 main spaces including 1 reception, 3 offices – where 1 has a meeting area – 1 bathroom and 1 storage room. A separate building that includes 2 ateliers is also included in CVPaz current plan.

2.3. The Challenge

The initial plan for CAPDM, which is described throughout Chapter 2, was developed by CVPaz with the primary focus on defining key service areas, designing the infrastructure, and outlining the services to be offered. However, to ensure the feasibility and sustainability of the center, a comprehensive analysis is now required. This analysis evaluates the viability of CAPDM by conducting a **detailed study of existing services offered by similar institutions**, both nationally and internationally, and assessing the impact these services generate. Moreover, the **technical project is critically evaluated** and several recommendations regarding space usage are provided. A critical aspect of this assessment is conducting a **financial analysis** to ensure the center's operations are guided by a cost-saving strategy. This strategy must uphold CAPDM's added value, sustain operational efficiency, and ensure the effectiveness of its service delivery. Moreover, an **implementation plan**, essential KPIs and a risk management framework are crucial to complete CAPDM project development.

3. Conducting an External Analysis

The first similar response identified is the *Copa Health SMI Transitional Housing* project, developed by ***Central Arizona Shelter Services*** **(CASS) –** an organization addressing the homelessness issue **–** in partnership with ***Copa Health*** **–** an organization providing mental health and disability services. The initiative was created after acknowledging that existing shelters and transitional facilities lack proper infrastructure to serve homeless individuals with Severe Mental Illness (SMI), comorbid medical conditions, or substance use disorders. In terms of mission and goals, the project is aligned with CAPDM, and its capacity is comparable, as CASS also plans to accommodate 54 residents. The project, to be activated in 2024, will be funded through an award by the State of Arizona (CASS 2024).

The second center is part of ***Continuum of Care Organization*** based in Connecticut, United States, and provides essential services, including food, shelter, and various forms of support to help homeless individuals regain stability and work towards rebuilding their lives. The highlight of *Continuum*'s Emergency Housing Program is placed in its comprehensive and multidisciplinary staff team, which is available 24/7 to ensure continuous support. The workforce includes nurses, clinical care providers, diet care workers and all are trained in trauma-informed care, therapy and de-escalation techniques (Continuum 2024).

Still in the United States, ***Georgia Department of Community Affairs*** **(GDCA)** has established a permanent supportive housing (PSH) program to provide stable housing for homeless individuals who also have disabilities and low incomes. This program aims to serve homeless individuals with disabilities, particularly those "hard-to-reach populations" with chronic mental illness, substance abuse, or diseases as AIDS. Priority is given to individuals with need for services determined by: a life-threatening health condition; frequent use of emergency services or multiple hospitalizations; or frequent contacts with law enforcement officials. Several types of support are provided to patients in these programs, such as mental health care, substance

abuse treatment, and employment services aimed at fostering independence and self-sufficiency, while always assuring the individual case management of each patient. The program is partially funded through contributions from participants, who allocate a portion of their income toward housing costs (Georgia Department of Community Affairs 2024).

Finally, in the United Kingdom, ***CaritasCare*** developed *Vicent House*, which aims to support homeless individuals in regaining independence by equipping them with essential life skills and providing structured assistance. With an operational staff team working 24/7, each resident is assigned a worker who helps create individual support plans and assists them in setting and achieving personal goals. A similar point between this center and CAPDM is the potential to promote the active engagement of patients in the center maintenance, by being involved in gardening, cooking and meal planning. This involvement fosters a sense of community and responsibility. However, unlike what is expected for CAPDM, residents at *Vincent House* typically stay for 6 to 9 months. This shorter duration is due to the practical resettlement support provided, which helps residents transition to independent living. Additionally, residents benefit from referrals to other agencies and resources, as well as in-house training and volunteering opportunities to gain experience and develop skills (Caritas Care 2024).

The analysis of the current offers worldwide that share CAPDM's exact vision shows the lack of responses available, since there are only 4 organizations focused on responding to this specific problem. Also, the study highlights crucial features that should be incorporated in a center of this sort: well-trained and organized staff, providing personalized support across all operating areas.

3.1. Benchmarking Beyond CAPDM's Scope

As explained in Subchapter 3.1., the scarcity of responses targeting CAPDM's specific challenge implied an extension of the benchmark study beyond the aforementioned institutions. Thus, best practices from organizations offering similar services were collected in **3 different areas**: Hospitality and Residential Services; Clinical Services; and Daily Activities.

3.1.1. Hospitality and Residential Services

The hospitality and residential services area, encompassing both **accommodation and food services**, caters to residents who utilize the overnight facilities and support, benefiting from a comprehensive range of offerings. However, certain services, such as the canteen and common areas, are also accessible to ambulatory patients for 8 hours per day, during weekdays. Thus, during the interviews, **3 key sub-areas emerged** within the hospitality and residential services area: canteen, infrastructure, and specialized care.

3.1.1.1. Canteen

Canteen services are recognized as one of the essential amenities provided by any institution. As emphasized by APCC's Director, all centers, whether residential or not, must meet the basic needs of their users, who often spend the entire day at these facilities, by providing adequate meals on-site. In general, residential users have access to **all necessary meals**, including breakfast, morning snack, lunch, afternoon snack, dinner, and a light supper. For ambulatory users, meal provision varies: most institutions offer meals from the morning snack through the afternoon snack, while others, like APCC, also provide breakfast and an early dinner, based on users' arrival and departing schedules. Meals are typically **simple yet nutritious** and healthy, with options tailored to specific dietary requirements when necessary (e.g., there are special dietary services at *Ability Beyond* and soup is made with substitutes for potato at AAJUDE).

Institutions like *CaritasCare* and *Shelter Plus Care* actively involve users in activities such as menu planning, assisting with food preparation, and learning about healthy eating habits

through nutrition workshops. However, because most users have limited capacities, their involvement in meal preparation is often minimal, making it hard for them to manage all cooking tasks. Consequently, most centers in Portugal **hire dedicated kitchen staff**, usually 1 to 2 cooks, often supported by 1 to 2 kitchen assistants.

For the initial setup, **kitchens must be equipped to meet ISS regulations**, including requirements such as stainless-steel appliances and other specified standards. Due to limited funding, different IPSS seek ways to reduce recurring food expenses by forming **partnerships with local markets, restaurants, or associations** to obtain groceries and household essentials at reduced or no cost. Some centers also collaborate with nearby schools or canteens to receive leftover meals, which facilitates operations and reduce costs.

3.1.1.2. Infrastructure & Additional Services

In terms of infrastructure, these institutions prioritize creating a comfortable, well-structured environment that feels familiar and less clinical, often resembling hotel-style accommodations, creating a welcoming environment that feels like a **true home for residents**. **Bedrooms** are a mix of private and shared spaces, typically housing from 2 to 4 beds, and, in most institutions, as *Casa de Betânia* and *Open Hands Community Care*, residents are encouraged to personalize their rooms by bringing in personal items and decor to achieve a home-like atmosphere. Rooms are furnished with regular beds and some emergency (adjustable or ergonomic) beds, which are available for patients who require additional care, since there have been examples of centers, such as QES, where patients unexpectedly and rapidly deteriorated their medical condition.

External areas, like those at *A Barragem* and QES, are designed to be open and welcoming, offering residents ample space to enjoy fresh air and engage in outdoor hangouts. **Inside, facilities** encompass a range of care environments, from standard nursing and residential spaces to areas that support independent living, integration, care, and transitional living services. **Lounges and common areas** serve as central hubs for gatherings, group therapy sessions, and

recreational activities, reinforcing a sense of community. At places with more physically disabled individuals, like *CaritasCare,* electric tracking hoists were built. Infrastructure must meet the physical needs of residents, while enabling stimulation and enhancing their overall quality of life by promoting autonomy, comfort, and social connections.

Another related service that is generally available for residents is **transportation**. Most institutions encourage patients to use their own means of transportation – such as public transport or walking, based on their autonomy. For those with greater limitations, such as a lack of family support or reduced mental and physical capacity, transportation is provided by the center using a 7 to 9 seat vehicle or through partnerships with municipalities or fire departments. For instance, APCC travels around 3,500 kilometers daily to support its users. In rare cases, staff may even use personal vehicles to assist patients.

3.1.1.3. Specialized Care

Specialized care in the benchmarked institutions revolves around **individualized support plans** (*Plano Individual de Inclusão* – PII), tailored to each user's needs, abilities, and goals. The plan begins with a detailed assessment to identify strengths, required support, and actionable steps for achieving objectives. As mentioned on *Look Ahead Care Support and Housing*'s website, the level of support per user varies from 24-hour support to a few hours per day. In Portugal, personalized care is mandatory by ISS, designed to sustain or improve residents' health and well-being, with a focus on independence and quality of life.

While institutions strive to provide comprehensive support, the level of **on-site medical staff** varies depending on demand. Nurses are typically present during the day or when patients show significant need, while direct-action assistants ensure round-the-clock care through shifts to help residents with daily routines and attend to any needs that may arise overnight. However, depending on the center's users, some organizations like *Turning Point* have 24-hour medical supervision. During the day, the ratio of staff to residents also fluctuates based on the needs and

complexity of the resident population – institutions may adjust staffing levels when dealing with more severely debilitated individuals compared to cases of residents with moderate disabilities. Thus, in Portuguese organizations, staff ratios do not necessarily follow ISS regulation. For example, the ratio of 1 assistant per 10 users is often surpassed: *Casa de Betânia* employs 16 General Service assistants for 22 users, while APPACDM-Porto operates with 13 for 33 users; APCC has 6 Direct-Action assistants for 17 users. So, personnel ratios vary according to the level of support needed by the residents, as well as the type of specialized staff requested by each ISS settlement.

Additionally, in centers where residents experience mental disabilities or other more severe conditions that limit their capabilities, institutions commonly take responsibility for **managing their bank accounts**. The goal is to safeguard users' funds while guaranteeing the timely payment of bills, hence ensuring residents can focus on their personal development without the added stress of financial management. Another common practice is the provision of **pocket money**, a small weekly allowance given to users for daily expenses (such as tobacco, coffee, etc.), which is withdrawn from their account. If a resident has insufficient funds in their bank account, the center may step in to cover the costs, like at QES.

3.1.2. Clinical Services

Upon admission to any clinic, center, or nursing home, evaluating each individual case thoroughly and establishing a personalized plan is a standard practice, as previously mentioned. Such plans define the specific support each person will require in terms of residential and specialized care, stimulation, or other necessary therapies and treatments. **Plans are designed to be dynamic, evolving in response to the recommendations of the TAP.** In this area, the range of therapies offered and the operating models tend to be similar across organizations. Nevertheless, some exceptions exist, such as APCC, which stands out for its extensive range of in-house treatments and therapies, which go well beyond what is typically available.

3.1.2.1. Psychological Services

Psychological support includes **mental health consultations** that address emotional, behavioral, and psychological needs. Additionally, institutions offer **psychoeducational and recreational groups**, which are structured groups that provide a safe space for residents to learn about their conditions, manage triggers, and develop coping mechanisms to build overall well-being in a supportive environment (The Pearl 2024). **Group-based support** is a central component, especially through evidence-based meetings that connect residents facing similar struggles. This is particularly emphasized in places like *A Barragem*, where residents are on a journey to overcome substance abuse and maintain sobriety, sharing common experiences with addiction. As their psychologist noted during the interview, *"*They benefit greatly from the group therapy model, as they can explore each other's life stories, substance use, family relationships, and relapses". Indeed, this group dynamics allow users to reflect on their own experiences while **finding strength and insights in the shared journeys of their peers**. In this sense, *CaritasCare, Continuum of Care*, and other institutions also help users **improve their personal relationships** (i.e., friends and family).

To enable such a comprehensive support system, a **multidisciplinary team** is essential. Each institution usually has 1 dedicated psychologist full-time and access to a psychiatrist. The arrangement of psychiatric support varies by institution: in *Projecto Homem*, the psychiatrist is part of the official workforce; in APCC and CECD, psychiatrics visit the center some hours per week; in *Casa de Betânia*, psychiatric services are fully outsourced.

3.1.2.2. Sensitive and Cognitive Stimulation

Sensitive and cognitive stimulation are essential in the process of helping residents maintain or improve their skills and independence to achieve certain goals. In this sense, **multidisciplinary rooms** – such as Snoezelen rooms – and educational programs are big supporters of stimulation, as they provide environments that foster cognitive and sensory development. These

methodologies are also instrumental in teaching essential daily skills, like hygiene, household tasks, and maintaining education levels, which are fundamental for residents' independence. **Regular counseling** and **workforce development** courses further support residents, preparing them for adapted labor tasks, contributing to their independence through meaningful, task-based activities. Institutions like *Casa de Betânia* and *Phoenix Rescue Mission* tailor these activities to individual capabilities, allowing even mentally impaired residents to engage in purposeful work tasks, often volunteer-based, impactful for self-esteem and sense of achievement.

Therapies, like **Snoezelen**, create multi-sensory environments that reduce anxiety, bring joy, allow the patient to be immersed in an environment where they feel safe and calm, and enhance cognitive development, being one of the most used methodologies for sensory rooms (Snoezelen 2024). These rooms are present in institutions like APPACDM, *CaritasCare*, and CECD, typically requiring materials such as special lighting, bubble tubes, tactile panels, aroma diffusers, projectors for calming visuals, soft seating, and sound systems. In fact, interviews conducted validated the positive effects of this setting on individuals with mental disabilities.

Furthermore, most of the benchmarked institutions invest in **occupational therapies**, which further promote engagement: in *Life Without Barriers* and *A Barragem*, residents are divided into rotating teams responsible for areas like laundry, yard cleaning, or cooking, where they develop skills through structured tasks. These activities not only promote skill development but also foster a sense of teamwork and accomplishment. *Casa de Betânia* also prioritizes having all activities provided externally (i.e., nursing and medical care, physical therapy, psychiatry, training, etc.), which encourages cognitive and social engagement and contributes to residents' overall development and well-being (Brocket Media 2023).

3.1.2.3. Physical Therapy

Physical rehabilitation is a key service aimed at enhancing strength, motor planning, balance, and safety awareness, promoting maximum independence both in-house and within the

community (World Health Organization 2024). Common therapies include physiotherapy, hydrotherapy, hydro kinesiotherapy, electrotherapy, mechanotherapy, kinesiotherapy, and thermotherapy. These services are provided according to the resources and the organizations within their communities, as they form collaborations to provide residents with access to external activities at reduced costs. For instance, *Casa de Betânia* allows residents to have hydrotherapy at *Complexo de Piscinas do Jamo*r through a cooperation with the local city council.

The **staffing model** often depends on the center's needs and available resources. Most organizations outsource physiotherapists or hire them to visit the center for specific weekly hours (e.g., 12 hours/week at AAJUDE). Other centers, like CECD, employ full-time physiotherapists to meet their residents' large demand. Alternative solutions encompass setting partnerships with nearby physical therapy centers and booking treatments through the *Serviço Nacional de Saúde* (SNS), which is free of charge and hence reduces the financial burden. Up to 2 psychomotricity technicians may also be hired to supplement the rehabilitation efforts.

3.1.2.4. Others

Adding to the clinical services mentioned, institutions often provide additional services to ensure holistic care, focusing on **enhancing the overall well-being of residents**. Examples include the use of augmentative and alternative **communication systems**, as well as targeted voice and swallowing interventions (specialized tools and approaches within speech therapy). Such services, offered by *Ability Beyond* and *Life Without Barriers*, aim to address communication challenges and build confidence and safety during meals. Additionally, institutions like *Leonard Cheshire* and *Open Hands Community Care* deliver epilepsy care, rehabilitation programs, choking and dysphagia prevention, and regular monitoring of vital signs such as blood pressure, temperature, and glucose levels. Emotional well-being is equally prioritized, with outlets such as **music and art therapy** used to alleviate stress, depression, and

low moods. For more structured mental health care, cognitive-behavioral therapy offers frameworks for managing behavioral and psychological challenges and leads to significant improvement in functioning and quality of life for patients (APA 2017).

Technological innovations also significantly enhance access to services like online therapy and virtual consultations at *Ability Beyond* and *Turning Point*, reducing logistics related with trips to consultations. Partnerships with healthcare providers also play a key role; for instance, *San Juan de Dios* has several hospitals that ensure continuous care for their users at lower costs. For an effective delivery of these diverse services, each center needs the appropriate equipment. Therapy spaces must be equipped with tools for art and music activities while staff needs health monitoring devices, such as blood pressure cuffs, thermometers, and glucometers. In some institutions, the responsibility for bringing more **specialized medical equipment** is delegated to the visiting healthcare professionals – typically nurses or doctors hired on a part-time or agreement basis. Regarding medical staff, there is no standard practice: some institutions have always up to 3 in-house nurses during the day alongside general doctors available for common specialties; others have just a psychiatrist and a nurse or a general practitioner and a nurse visiting weekly. In certain cases, all medical services are **outsourced**, leveraging SNS' system, which many centers find effective in their regions. This arrangement provides access to specialized care for a modest fee, as maintaining an infirmary or employing in-house doctors is not legally mandated for centers in Portugal.

3.1.3. Daily Activities

Daily activities aim to keep residents engaged and entertained during the day while stimulating them and supporting their progress towards achieving developmental objectives. These activities are broadly divided into competence training and occupational activities, as well as leisure and cultural activities. As the next subchapters describe, many centers capitalize on the opportunities available within their networks and local communities, finding innovative ways

to simultaneously offset financial challenges and enhance the quality of services provided.

3.1.3.1. Competence Training and Occupational Activities

As noted earlier in section 3.3.2.2., much of the cognitive stimulation provided by institutions occurs through **competence training and occupational therapies**. These initiatives include basic education and financial literacy classes, as done by *Phoenix Rescue Mission*, for instance. Moreover, one-on-one sessions are conducted to identify patient's individual needs, preferences, and aspirations, enabling professionals to devise personalized strategies. In these sessions, participants' potential for professional integration is also assessed, determining whether they can benefit from external or in-house training programs in adapted fields.

Professional integration can be promoted through adapted **external work placements** or **remote tasks**. The first channel is often facilitated by networks of partner companies and institutions, such as inclusion programs by *Jerónimo Martins* and *Fnac*, or local schools and businesses. About the second channel, compelling examples comprise *Casa de Betânia*'s agreements for ironing services provided to nurseries and hotels, or *Elo Social*'s collaboration with *Transportes Aéreos Portugueses*, the airline, where residents who are unable to leave the facility do the cutlery packaging for a fee. Such opportunities – volunteer or paid adapted work – combat social exclusion while keeping patients active and boosting independent living skills. Centers focus on personal and social development, cultivating communication skills, teamwork, confidence, self-expression, activities of daily living – as using public transportation, self-care routines, basic computer skills –, and practical tasks – like cleaning, meal preparation, and yard maintenance. In this sense, *Open Hands Community Care* also promotes assistive technology – systems that help disabled individuals perform tasks that might otherwise be difficult for them (Britannica 2024) – supporting autonomy by enabling greater independence. To promote social development, *CaritasCare* encourages residents to explore the local areas with kindness-focused initiatives (e.g., leaving painted stones for the community).

3.1.3.2. Leisure and Cultural Activities

Regarding leisure and cultural activities, some of the best practices also heavily rely on **leveraging local opportunities** through community events facilitated by municipalities or church groups and partnerships to provide available free training or programs. These community outings should further promote integration, reduce isolation, and create valuable networks, serving also as a cognitive stimulus. **Sports** are a key feature to foster physical and mental stimuli, with options tailored to residents' abilities, such as adapted swimming, dance, padel, horse riding or yoga, as done in AAJUDE, *CaritasCare*, APCC, and *Turning Point*. Moreover, **visits** to libraries, museums, concerts, and interactive exhibitions, or even community trips to destinations like Taizé, promote broader cultural and spiritual engagement. **Nature-focused activities** like gardening, animal farming, and environment protection workshops help residents connect with the environment. **Creative arts** are considered another important avenue, hence, opportunities to join musical bands, choirs, and drama classes which encourage self-expression and collaboration are common across the organizations. Creative activities are also **leveraged to alleviate the financial burden**, since users make items – decorations for festive seasons, felt and fabric crafts, gardening, woodworking, personalized jams, liqueurs, etc. – to sell to the community through either a brand (like APPACDM *Coimbra'*s *Idem Aspas*), small church festivities (like *Casa de Betânia*), or by order (like *Elo Social*, which does carpentry, upholstery, and laundry by demand (Elo Social 2024)). For daily activities, the more basic classes happening in-house are usually taught by the direct-action assistants. Institutions like AAJUDE or *Casa de Betânia* have volunteers as workshop managers, while the majority hire sociocultural entertainer, being usually 1 per class. However, for centers with more population, as the legal ratio for workshop managers in Portugal is 1 for every 10 users, a rotational schedule was set, where in each room a different class is occurring and residents exchange from one to the other, to comply with regulation, as is the case in APCC.

4. Crafting the Financial Plan

What is the envisioned cost structure for CAPDM and how can a robust financing strategy be developed?

An **estimation of the costs entailed by CAPDM** and a **financing plan** are essential to compare against the ISS funding explored in Chapter 4. The fact that **financial management is crucial for nonprofit organizations to survive and fulfill their mission** (Stühlinger 2022) also highlights the importance of the financial plan designed in Chapter 5.

4.1. Cost Structure

To study the financial sustainability of CAPDM, a **breakdown of the costs** and an explanation of the assumptions behind its estimation are necessary. Firstly, costs were broken down into **CAPEX**, used to undertake new projects, and **OPEX**, used for the daily operations of a business (Fernando, James and Kvilhaug 2024). Considering the average construction time in Lisboa of 20 months (Instituto Nacional de Estatística 2023), the **first year of operation was assumed to be 2027** as the infrastructure would be built between 2025 and 2026. Costs were estimated until 2040, to provide a **15-year perspective** of the project.

4.1.1. CAPEX

CAPEX comprises construction, equipment acquisition and equipment replacement costs. Starting with **construction**, according to CVPaz and the technical project developed by this IPSS, the process is estimated to cost between €8,000 and €10,000 per sqm, totaling a range of €9,331,600 to €11,664,500, after considering 1,166.45 sqm of useful area. Assuming both the final project approval and the licensing process still need to be finalized, the construction process would start in May 2025. Considering the 20-months construction period, CAPDM would be ready at the end of 2026. Thus, 40% of the costs would be deployed in 2025 (8 out of the 20 months) while the remaining 60% would be spent in 2026 (12 out of the 20 months). The **ISS agreement**, which is key for the operation of CAPDM, requires an initial payment of €336

operations permit (Segurança Social 2023). Regarding construction licenses, CVPaz does not expect to incur any additional cost given the partnership with Torres Vedras Municipality.

In terms of **equipment**, which encompasses the remaining CAPEX components, estimations were performed based on the technical project provided by CVPaz, on the recommendations from Subchapter 3.4., and on ISS technical guidelines for a nursing home (Segurança Social 2012). Equipment prices were retrieved as of 2024, being adjusted to the expected Consumer Price Index (CPI) inflation rate to reach estimations for 2026 (O'Neill 2024).

The second component of CAPEX is **equipment acquisition**, comprising items necessary for CAPDM's spaces, lighting system, transportation vehicles, and fire security and gas requirements – totaling 29 captions. Air conditioning installation and electric infrastructure was assumed to be already incorporated in the aforementioned construction cost. Regarding **patients' use areas**, 27 bedrooms – each one accommodating 2 individuals – should be built, given the 54 residential users. Items prices were retrieved from *IKEA*, a global low-cost furniture brand. Furthermore, 3 types of bathrooms were considered: 27 private bathrooms – 1 per bedroom – with a shower unit and bidet included; 3 bathrooms without shower unit and bidet for the common areas; and 1 bathroom suited for people with reduced mobility. Items prices were mainly collected from *Leroy Merlin*, as it offers clients a satisfaction warranty, after sales service and minimum price guarantee (Leroy Merlin 2024). Concerning **common spaces**, both the living room and the canteen are designed to accommodate all 69 patients, either ambulatory or residential. The living room includes 1 TV, and the canteen has tables suited for 4 people each, as advised by ISS. The kitchen must obey very specific ISS requirements, such as having 2 distinct divisions for meat and fish preparations. All the items' prices were retrieved from *GGM Gastro*, leader in the European market for gastronomy equipment and kitchen accessories (GGM Gastro n.d.). Based on the technical project, CAPDM also incorporates kitchen counters for self-service and dirty dishes, a pantry, a specific room for the fridge and

freezer, a storage room and a dumpster area. Other basic equipment, such as kitchenware, was assumed to be a recurrent expense, thus included in OPEX computation, under the materials caption – will be detailed in Subchapter 5.1.2.. Furthermore, the team advises CVPaz to transform one atelier to build a gym and a laundry room which includes energy efficient washing and drying machines (graded at A and A+++, respectively). The other atelier has artistic purposes, allowing 16 people simultaneously. Concerning therapeutic rooms, the first requires office material essentially to allow for different therapies while the second is a Snoezelen room, which includes specific equipment chosen based on the benchmark conducted and research studies, with prices retrieved from *ZenSenses* store. Regarding **health-related areas**, the medical office requires office equipment, 1 articulated bed, and medical items, such as a defibrillator and blood pressure monitors. Except for the defibrillator, 3 items of each type we budgeted, as ISS guidelines suggest that quantities should correspond to 5% of the users' number. The infirmary has the same office equipment as the medical office and 2 extra examination tables. Concerning **administrative areas**, the center encompasses 3 offices – whose items' prices were collected from *IKEA* –, a meeting room – with a capacity for 8 people and a TV for presentations –, and an administrative reception. Finally, 2 areas are recommended to allow the staff to take a break, change clothing and store their belongings: the personnel room and the personnel balnearies (1 for men and 1 for women). Besides bedrooms and bathrooms, the **most expensive areas** are the living room – due to the large capacity required –, the kitchen, the medical office and the personnel office – given the expensive specific equipment, such as the dishwasher, the medicine refrigerator and the lockers (which are meant for personnel and ambulatory users). The **lighting cost** was estimated per room and according to the number of lux (i.e. the standardized unit of measurement of light level intensity) necessary per sqm for each area. The calculation was based on *Gold Energy* information (Gold Energy 2024), yielding a total of 232 lamps and amounting to €1,872. Regarding **fire security**, CAPDM should have

8 units of ABF Water Fire Extinguisher 6 lts Pack (1 per 200 m^2), an independent gas detector and a fireproof blanket, according to ISS regulations. To ensure the building is ready in 2027, a one-time inspection (*vistoria*) and several registration and accreditation processes are mandatory, representing a €814 total expense (República 2021). Initial **gas inspection** is also necessary in 2026 to ensure CAPDM is ready in 2027, costing €52 (Outeiro 2020). The last caption relates to the acquisition of vehicles to provide **transportation**. To allow for a comparison of different transportation services options, the lower bound assumes the acquisition of 1 vehicle and the upper bound considers the acquisition of 2. Research on second-hand diesel cars of 7 seats led to an average unitary cost of €15,000 (Costa 2024). So, total equipment acquisition cost ranges from €105,000 to €120,000, depending on the number of vehicles acquired.

Due to the limited lifespan of the aforementioned items, periodical replacement is expected to take place overtime. Thus, the third component of CAPEX is the **replacement costs of equipment**. Firstly, the different useful lives of products were retrieved considering various sources of information to enhance the rigorousness of the analysis. Secondly, the costs were calculated as the price of each item in the year required for them to be substituted, which is the last year of useful life. Since the minimum useful life is 2 years, replacement expenses are predicted to start in 2028, having an annual average of €7,350 (lower bound) and €8,700 (upper bound) between 2028 and 2040. In 2036, replacement expenses are exceptionally higher, due to the expected acquisition of a new vehicle.

4.1.2. OPEX

The second type of cost is OPEX, encompassing **9 categories**, with several evolving according to the expected CPI inflation rate – assumed to be constant after 2027 (O'Neill 2024). Moreover, the QES model was utilized to extrapolate some categories to CAPDM, given its similar

capacity and users' clinical profile, hence supporting a cost estimation aligned with CVPaz reality. **Error! Reference source not found.** to **Error! Reference source not found.Error! Reference source not found.** show the details of the computation of all the categories of costs. The first category is **personnel costs**, for which CVPaz provided a list of planned staff for CAPDM (**Error! Reference source not found.**), split between permanent and retainer base staff (explained in Subchapter 3.4.4.). Regarding **permanent staff**, the monthly base salary per job position was retrieved from the wage table which portrays the minimum salary to be paid by law and serves as current reference for CVPaz (CNIS and FEPCES 2023). The total payroll per worker is a sum of: 14 months of the aforementioned monthly salary, insurance expense (0.7981% of the annual base salary, according to CVPaz current practices), social tax (22.3% of the annual base salary, according to ISS legislation (Segurança Social 2024)), meal subsidy (€3.5 per working day, according to the aforesaid wage table), medicine at work expense (€26.25 per worker in the first year and then every 2 years, assuming that all new workers will be below 50 years and according to CVPaz current practices) and professional training (€20.20 per worker per year, estimated based on the average cost of CVPaz in 2023). Part of the direct-action assistant workforce is predicted to be working during the night, earning 25% more than the daily salary (CNIS and FEPCES 2023). Concerning **retainer base staff**, the monthly base salary per type of job was collected either from CVPaz's wage table, or salary tables negotiated with medical (Simedicos 2024) and nursing (SEP 2024) unions. The total payroll per worker comprises only 12 months of the aforementioned base salary – since employees are part of an agreement – and the staff ratios recommended in Subchapter 3.4.4. were followed to conclude the estimation.

Considering that, for each position, regardless of the type of contract, the wage may vary due to different levels and years of experience, a range of salaries was estimated. Thus, the upper bound assumes that all workers will have the highest experience, hence earning the highest

wage described in the aforesaid wage tables. The lower bound consists of the lowest levels of wages present in the legislation, given the lower experience in the area. To estimate the personnel costs for future years, the base salary was deemed to grow at the expected minimum wage growth rate, assumed to be constant after 2028 (Covita and Canas 2024). The annual costs of the meal subsidy, medicine at work and professional training were assumed to grow at the expected CPI inflation rate. Considering this approach, personnel costs are expected to amount approximately €905,000 (lower bound) to €990,000 (upper bound) in 2027. **Food supply costs** were computed in 2 different ways, considering that residential users would consume breakfast, morning snack, lunch, afternoon snack, dinner and supper for 365 days while the ambulatory users would only consume morning snack, lunch, and afternoon snack during weekdays. The first approach is based on the 2021 general diet plan from the Portuguese Association of Nutritionists (Ministério da Saúde 2021), which allowed to retrieve the ingredients and quantities required per user. Costs were computed using *Continente* as the main source of ingredients' prices, being then updated at the expected CPI inflation rate. In 2027, food supply costs are estimated to amount approximately €104,000 according to this approach. The second approach is based on a 2017 Master thesis, focused on hospital meals (Silva 2017), which allowed to retrieve meal costs per user at the end of 2016. Costs were then updated at the observed and expected CPI inflation rates. In 2027, food supply expenses are forecasted to be around €164,000 following this approach. Indeed, the first approach registers lower costs since it relies on less complex meal recipes as well as other cost-saving practices such as bulk purchasing. **Materials** comprise cleaning, hygiene and comfort; clothing; medical (general and specific to each user); recreational; and painting. All costs, except for painting, were estimated by extrapolating from current CVPaz practices in QES. Thus, the ratio per user of each type of material expense in QES in 2023 was calculated and then adjusted to CAPDM. Painting materials costs were additionally computed by collecting prices from *Continente*, since this

activity is recommended in CAPDM but is not present in QES. All CAPDM users are assumed to require cleaning, hygiene and comfort; medical (general and specific to each user); recreational and painting resources. Residential users were assumed to also use clothing materials. To guide CVPaz, a list of the required materials can be found in **Error! Reference source not found.** with the prices of 2024 from different sources. After updating the expenses at the expected CPI inflation rate, total materials costs are predicted to be approximately €20,000 in 2027. **Utilities costs** encompass electricity, gas and water expenses. The electricity expense was estimated assuming a constant 1,320 kWh average annual consumption of electricity per person (Repsol n.d.) and a €0.1559 average cost per kWh from *Iberdrola* (CVPaz supplier in QES) in 2024 (Fatela 2024). Costs were computed considering that ambulatory users only spend 8 out of 24 hours during weekdays in the center, while residential users live in CAPDM for the whole year. Other crucial assumptions are an annual cost increase of 2.1% (Suspiro 2024) and a €0.01 annual electricity tax per kWh (according to CVPaz bills). Regarding water and gas expenses, the costs incurred in QES in 2023 served as a reference. Thus, the ratio per user was computed and then extrapolated to CAPDM, with an adjustment between residential and ambulatory users considering the time spent at the center. Water prices were assumed to grow by 8.5% in 2024 (Oliveira 2023) and by 3.89% afterwards (Católica-Lisbon 2024) while gas prices are predicted to increase by 3.6% annually (Enerdata 2018). In 2027, total utilities costs are estimated to be approximately €29,500 – €13,400 of electricity, €5,400 of water and €10,700 of gas. **Maintenance costs** are divided into 2 major segments and were also estimated as a range: lower bound (if 1 vehicle is acquired), and upper bound (if 2 vehicles are acquired). The reference year for prices was 2024, being then adjusted to the expected CPI inflation rate. **Preventive maintenance** is the regular maintenance of equipment to keep them running and prevent any unplanned cost arising from its failure, hence covering 3 main areas: fire security, gas and transportation. Fire security annual inspections are mandatory

(Diário da República 2008), thus starting in 2027, while periodical gas inspections take place every 3 years, thus beginning in 2029 – considering that the first inspections occur in 2026 to ensure the building is ready. Lastly, vehicle maintenance only encompasses inspection and revision, since IPSS are exempt from IUC (Automóvel Clube de Portugal 2024). As the vehicle is expected to have more than 8 years after the date of its first license plate, inspection takes place every year (IMT n.d.). Moreover, revisions should happen every 2 years, assuming the vehicle will do short trips, thus having low millage (Norauto n.d.). Overall, the annual average cost of preventive maintenance is predicted to be €340 for the lower bound and €440 for the upper bound, between 2027 and 2040. **Corrective maintenance** accounts for the necessary repairs of equipment so that it can perform its intended function. A percentage-based estimation – ranging from 2 to 5% of the gross value added (UpKeep n.d.) – was applied to the costs per division, considering the equipment lifespan. For 2027 and 2028, corrective maintenance costs were assumed to be €0 assuming a warranty of 2 years, as all equipment is new. To calculate the annual corrective maintenance cost per area, a weighted average of the useful lives of products and their costs was used, ending up in replacement at the end of the product's lifespan. This process yielded the Averaged Useful Life, which served as the basis for deriving the corrective maintenance cost. The percentage of corrective maintenance to be applied depends on the equipment lifespan: as the useful life of products falls, the non-predictable maintenance costs are expected to rise (**Error! Reference source not found.**). However, corrective maintenance does not apply to certain products, such as bed clothing, as these are typically replaced rather than repaired. The overall costs of corrective maintenance are incremental during the period, representing an annual average of around €2,400 for the lower bound and €2,600 for the upper bound, between 2027 and 2040. **Waste management costs** were estimated based on the fees currently charged by Torres Vedras Municipality (Torres Vedras n.d.) and assuming no change in the future. The expenses comprise a fixed fee of €3,300 as well as a

variable fee that depends on the water consumption level in cubic meters – assumed to be similar to the average consumption per user in QES in August 2024 and adjusted based on the hours spent at CAPDM of each type of user. The variable fee is estimated at approximately €320 in 2027. The upper bound consists of the aforesaid fixed and variable costs while the lower bound assumes CVPaz can negotiate an exemption of the fixed fee, as IPSS are not entitled to pay it in some cities. To compute **transportation costs**, 2 scenarios were considered: offering transportation services with CVPaz's own car to all 69 users (upper bound) and to the 54 residential users only (lower bound). Costs of this category are variable, comprising fuel, tolls, parking and stay expenses, and depend on the type and frequency of service offered, rather than on the number of vehicles. Considering the expenses incurred in QES in 2023, a ratio per user was computed, extrapolated for each bound and updated at the expected CPI inflation rate. Thus, in 2027, transportation costs are expected to range from €9,500 (lower bound) to €12,000 (upper bound). **Administrative costs** comprise marketing and advertising costs and insurance, since legal, accounting and software costs were considered headquarters costs that do not expect a significant increment. Moreover, the EQUASS Certification, a European quality recognition (APQ n.d.), already present in QES, was not considered a current priority for CVPaz. **Marketing and advertising expenses** were assumed to equal to the ones observed in QES. **Insurance** encompasses *Ensino Seguro* and *Multirriscos*, considered to be equal to QES, and car insurance, which should be €750 per acquired car, according to CVPaz. After accounting for the expected CPI inflation rate, administrative costs range from €2,840 (lower bound – if 1 car is acquired) to €3,640 (upper bound – if 2 cars are acquired) in 2027. **Communication & technology costs** were calculated by extrapolating a ratio per user retrieved from QES expenses, assuming CAPDM would have the same practices and suppliers. Costs were then assumed to grow at the CAGR of 1.19%, which was registered from 2010 to 2022 (ANACOM 2023). Thus, communication costs are expected to be approximately €4,770 in 2027.

5. Performance Measurement

KPIs are **financial and non-financial indicators used to estimate and strengthen success**, aimed at achieving previously established long-lasting goals (Parmenter 2012). Several KPIs were developed to assist CVPaz when aligning CAPDM's operations to strategic objectives, support stakeholder engagement by demonstrating the center's progress and aid the application for PRR 2030 grant. To ensure the usefulness of this tool, the metrics were defined based on the benchmark study conducted as well as critical thinking. Afterwards, KPIs were presented to CVPaz to guarantee that all metrics and targets are in line with the projects' context and the IPSS reality. KPIs were developed in **8 areas**, comprising users, financial sustainability, partnerships, operations, satisfaction, staff, maintenance, and sustainability.

CAPDM's focus is the patients' care and positive evolution, so, **users KPIs** are aimed at measuring participation, engagement and success of the different activities. Thus, such metrics encompass: User participation in recreational activities (Percentage of participants engaging in recreational activities); User participation in therapeutical treatment (Percentage of participants engaging in therapeutical activities); User participation in competency training activities (Percentage of participants engaging in competency training activities); User participation in space maintenance activities (Percentage of participants engaging in space maintenance activities). All these KPIs have a goal of 50 to 60%, which is aligned with CVPaz's experience, as it depends on the initial assessment of CAPDMs users. Regarding activities implementation and organization, KPIs are Activities implementation rate (Percentage of activities planned and budgeted that took place), aiming 100%, and Community activities organization (Number of activities which engage with the local community), targeting 1 per month. Finally, the most important KPIs, according to CVPaz General Director, concern the success of users treatment: Clinical plan success rate (Percentage of participants who complete their assigned objectives in the individualized clinical plan), aiming 50 to 60%, although depending on each user's case,

and Life quality improvement rate (Percentage improvement of the life quality perception of each user – in physical, social and emotional terms – between each assessment conducted), targeting an increase of 20% to 30%.

With the goal of ensuring the financial health of CAPDM's project development, **financial sustainability** KPIs were defined: ISS coverage of OPEX (Percentage of operational costs covered by ISS financing), targeting 100%; Grants applications to CAPEX (Number of applications to grants to finance CAPEX), aiming 5 to 6 for both 2025 and 2026; Financing approval of CAPEX (Percentage of successful applications to finance CAPEX), targeting 60%; Users pension access rate (Percentage of users that have access to pension funds), targeting 90%; Cost saving strategy implementation (Percentage of cost reduction achieved by adopting cost saving measures relative to the baseline scenario), pointing to 10%.

Establishing **partnerships** has been highly recommended in this thesis, thus, to help ensure collaboration between CVPaz and other institutions, KPIs encompass: Partner retention rate (Percentage of partners that continue collaboration after the first year), targeting 80%; Daily activities partnerships (Number of formalized agreements), aiming 4; Clinical services partnerships (Number of formalized agreements), pointing to 3, including SNS; Partnerships diversification (Number of partnerships established to ensure diversification and avoid large dependency on a few partners), targeting 10.

To ensure smooth running of **operations**, the following KPIs should be tracked: Number of non-compliance incidents (Number of regulatory or accreditation breaches reported per year), ideally targeting 0; Supply chain delay rate (Percentage of delayed supplies affecting operations), aiming a maximum of 10% in the first year, and the following years should report lower values than the previous year ones – to ensure continuous efforts towards improvement.

To guarantee the **satisfaction** of all CAPDM's stakeholders, quarterly surveys should be conducted to measure the opinion of not only the users, but also partners and employees. Then,

the subsequent KPIs are crucial to be monitored: Partners satisfaction score (Gauges partners engagement and gratification); Employee satisfaction score (Gauges staff morale and workplace happiness); Customer Satisfaction Score – CSAT (Gauges user satisfaction with the service being provided), all targeting 80%; Net Promoter Score – NPS (Measure of user loyalty by asking how likely customers are to recommend CVPaz services), aiming 8. Additionally, Survey response rate (Percentage of users completing the satisfaction surveys), ideally targeting 100%; Feedback implementation (Percentage of actionable suggestions emerging from users' feedback which are implemented), pointing to 70%.

Moreover, guaranteeing workforce development through the creation of a supportive and engaging work environment is crucial. Thus, KPIs in the **staff** area encompass: Staff retention rate (Percentage of employees retained each year), targeting 75% (Randstad n.d.); Professional training requirements (Number of hours of training provided and attended by each employee), which should be 40 hours, according to current legislation (Diário da República n.d.); Professional training completion rate (Percentage of workers participating and complying with training requirements), ideally targeting 100%; Users satisfaction with staff performance (Evaluates staff skills and performance in the users' treatment process), pointing to 80%; Staff coverage rate (Percentage of shifts filled as scheduled), targeting 100%.

Furthermore, the maximum operational capacity of equipment and infrastructure should be safeguarded by effective **maintenance** to minimize damaging risks. Thus, tracking the following KPIs is crucial: Preventive maintenance compliance (Percentage of preventive maintenance initiatives conducted as scheduled) and Corrective maintenance compliance (Percentage of scheduled maintenance completed on time), both aiming 100%; Cleaning and hygiene plans compliance (Number of internal and external complaints), ideally below 8.

The last pillar is **sustainability**, given the importance of searching for an environmentally friendly approach and fulfilling with SDGs. Such pillar can be enhanced through donations

which promote a circular economy, hence, the KPI is Food donations achievements (Donations to CAPDM as a percentage of food supply costs), targeting 75%.

5.1. Risk Management Framework

A risk management framework was developed to **identify key risks** in CAPDM construction and operation processes, and hence **assist CVPaz** meeting organizational and compliance requirements and preparing for unexpected events. Risk management is highly recommended as it enhances the decision-making process by making it faster and more appropriate, accurate, and effective. Besides diminishing the probability of potential costly 'surprises', this framework helps prepare for challenging situations and promotes overall resilience. CVPaz stakeholders' confidence is also enhanced due to a clear definition of accountability and responsibility and the ability to focus on CAPDM core development (NSW n.d.).

To build the risk management framework, 3 steps were required. Firstly, key risks were identified in different areas. Then, all risks were analyzed, either in a quantitative or qualitative manner, to understand the impact on CVPaz. Finally, measures aimed at risk minimization were collected and a contingency plan was built to help CVPaz adapt to unforeseen events, always connecting with the aforementioned KPIs to ensure an effective monitoring. To guarantee the rigorousness and applicability of the risk management framework in the context of CVPaz, the recommendations are based on both the benchmark analysis conducted and the interviews with other organizations and CVPaz's members.

Risks were identified in **4 main areas**: reputational, financial, operational and stakeholder.

Reputational risks comprise "Quality concerns", "Compliance failures", and "Community relations deterioration". "Quality concerns" is the risk that program outcomes do not meet expectations and satisfaction levels of users, partners and staff fall. CAPDM's reputation may be impacted if the center is perceived to not fulfill its purpose, hence potentially weakening stakeholders' collaboration. To minimize such risk probability, CVPaz is advised to conduct

regular surveys, implement feedback and continuously track satisfaction KPIs. In case this risk materializes, CVPaz should focus on the feedback provided and improve CAPDM services accordingly. “Compliance failures” is the inadequate adherence to accreditation or regulatory standards, which might damage credibility of both CAPDM project and CVPaz and in turn cause a loss in support from partners. As prevention, CVPaz is advised to remain constantly updated in the legislation by scheduling regular meetings with ISS and nominating 1 person in charge of ensuring required compliance. Number of non-compliance incidents is a crucial KPI, and, in case there is a failure, CVPaz should conduct an immediate audit, identify the failure, rectify the non-compliance and communicate transparently to stakeholders. “Community relations deterioration” portrays the negative perceptions from the local community due to poor engagement, which could undermine CAPDM's integration efforts, decrease the potential development of social skills of patients and lead to a loss of community partnerships. The KPI which would be impacted is the Number of community activities organized, thus, continuously searching for initiatives within the community and ensuring a successful engagement is crucial. Otherwise, CVPaz would need to promote activities with other local communities.

Financial risks encompass “ISS Inflexibility”, “Insufficient ISS Funding Updates”, “Delayed ISS payments”, “Rising inflation rate”, “Rising wage growth”, “Rising maintenance requirements”, “Unanticipated deterioration in users’ conditions”, “Overreliance on grant funding” and “Rising CAPEX requirements”. “ISS Inflexibility” is the risk that ISS does not accept the typical cooperation agreement for CAPDM project, which may result in a lack of ISS funding to cover OPEX. To mitigate this, CVPaz is advised to thoroughly analyze the relevant legislation, schedule recurring meetings with ISS, and explore alternative agreement options, including those discussed in Chapter 4. In case the risk materializes, the KPI ISS coverage of OPEX should be used to assess and evaluate the viability and performance of these alternative agreements. “Insufficient ISS funding updates” refers to the risk that ISS payments

do not get sufficiently updated according to costs evolution, impacting CAPDM's financial sustainability and reducing available resources. Also, "Delayed ISS payments", meaning the late disbursement of funds from ISS, may reduce net working capital, impacting the center's ability to manage day-to-day expenses and provide high-quality services. If ISS does not fully cover OPEX, CVPaz may not be able to provide high-quality services to each user. Therefore, both risks can be minimized by reaching a clear agreement with ISS and designing a payments calendar. In case such risks materialize, CVPaz must find alternative funding sources through partnerships and donations to ensure the smooth running of CAPDM operations. Moreover, "Rising inflation rate" consists of the risk of rising costs of goods, services, and healthcare, which may strain the budget and hinder service provision. A sensitivity analysis considering different values of CPI inflation rate from 2027 onwards shows that if inflation suddenly spikes to 8%, total OPEX would rise, for instance, by 4% in 2030, since some cost categories were assumed to grow according to such variable (**Error! Reference source not found.**). Moreover, total equipment acquisition would increase to over €110,000 in 2026 if inflation abruptly jumps to 8% in that year (**Error! Reference source not found.**). To prevent such consequences, CVPaz is advised to establish effective operational partnerships with suppliers (restaurants, canteens, supermarkets, etc.) to have access to a stable and fixed price. If inflation starts rising, negotiating bulk purchases and discounted prices may help minimize the negative financial impact. Similarly, "Rising wage growth" is the risk of unanticipated increases in the minimum wage growth rate due to labor market conditions or union negotiations. Error! Reference source not found. shows that payroll expenses fluctuate widely with this variable, hence, exploring operational partnerships or shared services with other care providers is essential to minimize the risk. If wages start accelerating, CVPaz may need to outsource clinical services with local clinics that may offer discounts, or even free services. "Rising maintenance requirements" is the risk of an unexpected increase in costs related to maintaining infrastructure, healthcare

equipment, or housing facilities. Such a rise could strain the budget, however, given that maintenance costs only represent an average of 0.17% of total costs, the consequences would be relatively less impactful. To minimize the probability of the risk, raising awareness for the importance of equipment maintenance is crucial to reduce repair costs and disruptions. The contingency plan encompasses setting partnerships and agreements with suppliers to enjoy discounted prices. "Unanticipated deterioration in users' conditions" is the risk that users require more assistance than expected due to degrading health conditions. Such issue could result in service quality issues, inadequate staffing levels, misalignment between staff skills and program needs, or even burnout among employees. For instance, APCC mentioned in an interview that, since users demand a high level of support, they often require more direct-action assistants than the ratios mandated. **Error! Reference source not found.** shows the impact on personnel costs from a rise in the number of nurses and direct-action assistants. For instance, having 5 extra direct-action assistants – applying APCC current ratio – and 2 extra nurses may increase personnel expenses by 25%. More adjustable beds may also be required, raising the equipment acquisition costs. To minimize such risk, CVPaz should accurately plan and regularly update staffing allocations and equipment acquisition requirements, based on the users' quality of life assessments. In case the risk materializes, CVPaz is recommended to explore more partnerships or shared services with other care providers, adjust staffing levels and reorganize treatment plans. In an extreme case, users requiring more complex treatments may need to be integrated in other social responses. Indeed, all the aforementioned financial risks can be monitored through the KPI ISS coverage of OPEX. "Overreliance on grant funding" means a heavy dependence on external grants that may jeopardize financial stability if these sources are reduced, discontinued or if CVPaz is not able to win them. To minimize such risks, CVPaz should find alternative funds in *Geofundos* and with financial partners, to ensure that other stable financing sources are in place in case CAPDM cannot earn the expected

grants. Important KPIs to be tracked encompass Grants applications to CAPEX and Financing approval of CAPEX. Finally, "Rising CAPEX requirements" is the risk that construction costs surpass expectations in 2025 and 2026. Such an event could raise concerns about the viability of CAPDM project, as the anticipated funding may not be sufficient. Thus, CVPaz is recommended to conduct accurate construction planning and budgeting that allows for a safety margin as well as establish financial partnerships and agreements with suppliers during the construction phase. In case CAPEX starts rising suddenly, CVPaz should search for more funds and applications in *Geofundos* or look for a credit line for social organizations.

Regarding **operational risks**, "Service interruptions and infrastructure failures" and "Unmotivated and less qualified staff" should be considered. The first risk is related to disruptions caused by staff shortages, strikes, or supply chain issues (e.g., delays in medical supplies) as well as facility breakdowns or inadequate infrastructure maintenance. Care delivery and the quality and safety of accommodations and services may be impacted, and operational costs may rise due to emergency repairs or compensation claims. To minimize this risk, CVPaz should diversify supply chain sources, foster healthy labor relations through engagement and regular communication, perform regular inspections, and account for a contingency budget for unexpected repairs. Important KPIs associated with this risk comprise Staff coverage rate, Supply chain delay rate, and Maintenance compliance rate. As a contingency plan, CVPaz should hire additional workers, contact other suppliers, maintain a safety stock of critical materials to buffer against supply chain delays, and establish a rapid response team for urgent infrastructure repairs. The second operational risk consists of a decrease in the motivation of workers or a lower level of qualifications than expected, which may result in lower effectiveness and quality of the service provided and high turnover rates. To minimize the risk, promoting an organizational culture focused on inclusiveness and growth and tracking relevant KPIs, such as Employee satisfaction score and Training completion rate, are crucial. In case of

risk materialization, CVPaz should further acknowledge and cherish CAPDM achievements, implement feedback to improve operations and raise investment on staff training.

Regarding **stakeholders' risks**, "Lack of partner engagement" and "Dependency on specific partners" should be considered. The first risk means that current or potential partners may be unwilling to collaborate or invest due to conflicting priorities, which may lead to financial issues. Designing an effective stakeholder engagement strategy where regular communication is maintained, inviting partners to events and updating stakeholders through a regular newsletter may help minimize such risk. In case this situation happens, CVPaz should look for alternative partners and diversify the funding base. Relevant KPIs comprise Partnership retention rate and Number of active partners. The last risk is related to the overreliance on a small number of partners for critical services or funding, which could expose CAPDM to vulnerabilities if those partnerships falter, resulting in operational or financial instability. To minimize such vulnerability, a partner diversification strategy and a regular review and renegotiation of partnerships are crucial, along with tracking the KPI Number of partnerships. If the risk materializes, a contingency fund is required to cover temporary gaps in funding or services.

Finally, **risks were organized in a matrix** depending on the likelihood of happening and the potential consequences to classify them into "Extreme", "High", "Medium" and "Low". **Error! Reference source not found.** shows the risk matrix as well as the criteria applied in the analysis. In fact, "Rising CAPEX requirements", due to its critical consequences and "Insufficient ISS funding updates", due to its high likelihood, present a high-risk level. "Quality concerns", "ISS inflexibility" and "Rising wage growth" were also classified as high risks. While "Delayed ISS payments" presents critical impact, it appears to have a low likelihood according to CVPaz experience, being classified as a medium level risk. "Rising maintenance requirements" is the only risk that presents a low risk level. All the remaining risks present a medium level of concern.

After analyzing the different risks that CAPDM project is subject to, developing a risk treatment plan and communicating it to key stakeholders are the final steps. Indeed, different strategies may be adopted to minimize the impact in case an unexpected event occurs. Choosing to apply such strategies must weigh implementation costs against benefits, considering the required financial resources, the impact on CVPaz's values, and the feasibility and effectiveness of the measures. For the risk management framework to be effective and successful, regular risk assessment, monitoring, and rating are crucial.

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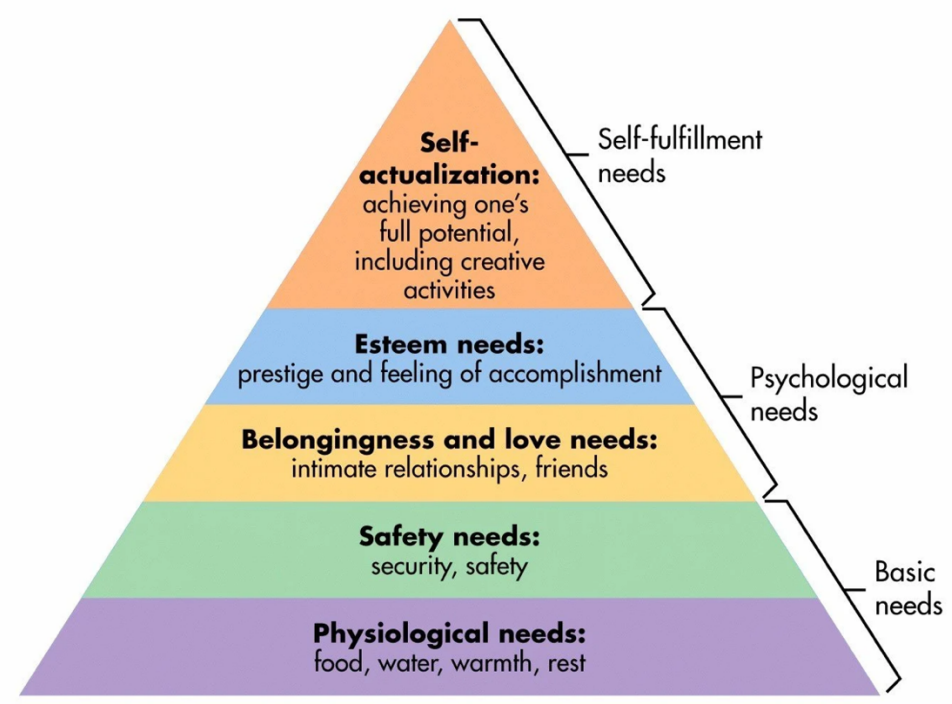
7. Appendix

Appendix 1: Maslow's hierarchy of needs

The pyramid is based on the idea that certain basic needs (at the base) must be met before individuals can progress up the hierarchy to more complex needs



Source: McLeod, 2024

Appendix 2: Benchmark analysis - Services and activities offered

All but 3 organizations provide service offering along the 3 identified key areas

SERVICES AND ACTIVITIES OFFERED				
Organizations	**Logo**	**First Line Intervention**	**Treatment and Rehabilitation**	**Reintegration**
Comunidade Vida e Paz		✓	✓	✓
Associação CAIS	CAIS	✓	✓	✓
Assistência Médica Internacional (AMI)	aMi	✓	✓	✓
Santa Casa da Misericórdia de Lisboa (SCML)	SANTA CASA	✓	✓	✓
Centro de Apoio ao Sem-Abrigo (CASA)	CASA	✓	✓	✓
Médicos do Mundo		✓	✓	✗
Orientar	Orientar	✗	✓	✓
Associação Vida Autónoma		✓	✓	✓
CRESCER	CRESCER	✓	✓	✓
VITAE		✓	✓	✓
Associação Conversa Amiga	ACA	✓	✗	✗

Source: Organizations' Websites

Appendix 3: Benchmark Analysis - Focus of intervention

Legend: All organizations analyzed address homelessness while also supporting various vulnerable populations

FOCUS OF INTERVENTION													
Organization	Logo	Homeless	Disabilities	Substance use	Domestic Violence	STDs	Sex Workers	Refugees	Immigrants	Elderly	Children (at risk)	Families in poverty	LT unemployment
Comunidade Vida e Paz		✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Associação CAIS	CAIS	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
Assistência Médica Internacional (AMI)	ami	✓	✗	✗	✓	✗	✗	✗	✓	✓	✓	✓	✓
Santa Casa da Misericórdia de Lisboa (SCML)	SANTA CASA	✓	✓	✗	✓	✗	✗	✗	✓	✓	✗	✓	✗
Centro de Apoio ao Sem-Abrigo (CASA)	CASA	✓	✗	✗	✗	✗	✗	✗	✗	✓	✗	✓	✗
Médicos do Mundo		✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗
Orientar	Orientar	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
Associação Vida Autónoma	AVA	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
CRESCER	CRES CER	✓	✗	✓	✗	✗	✓	✓	✓	✗	✗	✗	✗
VITAE		✓	✗	✓	✗	✗	✗	✓	✓	✗	✓	✓	✗
Associação Conversa Amiga	ACA	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

Sources: Organizations' Websites and Annual Reports

Appendix 4: Benchmark analysis – Impact

Organizations differ in their geographical reach and the societal impact they generate through the number of individuals they support

IMPACT						
Organizations	**Logo**	**Geographical Coverage - Portugal (districts/regions)**	**Geographical Coverage - Portugal (# districts/ regions)**	**# People Supported - Homeless**	**# People Supported - Total**	**Food Service**
Comunidade Vida e Paz		Lisboa	1	383	894	3200 (EAD Amadora) + 4030 (Christmas) + 157040 (street) meals
Associação CAIS		Porto and Lisboa	2	123	777	355 baskets + 10000 breakfasts
Assistência Médica Internacional (AMI)		Lisboa, Porto, Coimbra, Madeira and Açores	5	1350	11138	171619 meals + 1562 Christmas baskets
Santa Casa da Misericórdia de Lisboa (SCML)		Lisboa	1	*No information*	*No information*	918 people in social canteen
Centro de Apoio ao Sem-Abrigo (CASA)		Lisboa, Porto, Faro, Coimbra, Setúbal and Madeira	6	2218	6599	471369 meals + 18527 baskets
Médicos do Mundo		Lisboa, Porto, Leiria, Braga	4	965	4142	*No information*
Orientar		Lisboa	1	*No information*	120	7431 meals
Associação Vida Autónoma		Lisboa and Beja	2	494	672	*No information*
CRESCER		Lisboa	1	833	2200	*No information*
VITAE		Lisboa	1	*No information*	560	31 places in the canteen
Associação Conversa Amiga		Lisboa	1	*No information*	*No information*	*No information*
Industry average		*Not applicable*	2,27	909,43	3011,33	*Not applicable*

Sources: Organizations' Websites and Annual Reports

Appendix 5: Benchmark analysis - Human Resources

Organizations vary in their reliance on effective workers versus volunteers to support their operations

HUMAN RESOURCES						
Organizations	**Logo**	**# Volunteers**	**# Volunteering Hours**	**Volunteers Ratio**	**# Effective Workers**	**Effective Workers Ratio**
Comunidade Vida e Paz		619	*No information*	0,69	151	0,17
Associação CAIS		268	9 784,5	0,34	19	0,02
Assistência Médica Internacional (AMI)		1 035	1 411	0,09	246	0,02
Santa Casa da Misericórdia de Lisboa (SCML)		410	17 508	*No information*	6080	*No information*
Centro de Apoio ao Sem-Abrigo (CASA)		922	*No information*	0,14	48	0,01
Médicos do Mundo		530	799	0,13	71	0,02
Orientar		*No information*	*No information*	*No information*	*No information*	*No information*
Associação Vida Autónoma		*No information*	*No information*	*No information*	*No information*	*No information*
CRESCER		10	*No information*	*No information*	100	0,05
VITAE		*No information*	*No information*	*No information*	*No information*	*No information*
Associação Conversa Amiga		*No information*	*No information*	*No information*	*No information*	*No information*
Industry average		542	7376	0,28	959,29	0,05

Source: Organizations' Websites and Annual Reports

Appendix 6: Benchmark analysis - Financial performance

Organizations vary significantly in financial health, with subsidies often representing a large share of revenues and personnel expenses comprising a substantial portion of costs

FINANCIALS									
Organizations	**Logo**	**Total Revenues**	**Donations and Heritages (as a % of Revenues)**	**IRS Contrib. + IVA Deduct. (as a % of Revenues)**	**Subsidies (as a % of Revenues)**	**Sales and Services (as a % of Revenues)**	**Personnel Expenses (as a % of Costs)**	**Revenue Growth**	**Net Income Growth**
Comunidade Vida e Paz		5 105 577 €	29,25%	1,40%	32,78%	32,03%	53,66%	6,00%	Remained negative
Associação CAIS		790 088,92 €	23,66%	2,91%	61,43%	10,93%	56,59%	14,80%	446,50%
Assistência Médica Internacional (AMI)		9 867 173,73 €	14,25%	1,30%	27,95%	31,67%	38,39%	-1,00%	Remained negative
Santa Casa da Misericórdia de Lisboa (SCML)		268 787 236,00 €	*No information*	0,00%	0,65%	13,95%	52,50%	15,54%	Remained negative
Centro de Apoio ao Sem-Abrigo (CASA)		4 620 503,00 €	80,87%	2,36%	15,42%	0,22%	18,71%	-1,00%	-90,68%
Médicos do Mundo		1 326 268,31 €	57,49%	*No information*	31,32%	0,11%	58,71%	3,11%	Became negative
Orientar		237 216,00 €	n/a	0,00%	98,97%	0,27%	62,44%	2,25%	85,20%
Associação Vida Autónoma		562 937,30 €	5,73%	0,00%	64,62%	29,65%	52,80%	52,02%	Remained negative
CRESCER		3 358 978,37 €	*No information*	*No information*	69,06%	21,49%	44,73%	16,77%	594,92%
VITAE		4 989 520,69 €	*No information*	*No information*	*No information*	*No information*	56,14%	23,68%	17642,60%
Associação Conversa Amiga		*No information*	*No information*	*No information*	*No information*	*No information*	*No information*	*No information*	*No information*
Industry average		41 853 776,86 €	31%	1%	40%	18%	46%	17%	Not applicable

Sources: Organizations' Websites and Annual Reports

Appendix 7: Net Working Capital - Liquidity Formula 1

$$\text{Net Working Capital} = \text{Current Assets} - \text{Current Liabilities}$$

Appendix 8: Current Ratio - Liquidity Formula 2

$$\text{Current Ratio} = \frac{\text{Current Assets}}{\text{Current Liabilities}}$$

Appendix 9: Quick Ratio - Liquidity Formula 3

$$\text{Quick Ratio} = \frac{\text{Current Assets} - \text{Inventories} - \text{Prepaid Expenses}}{\text{Current Liabilities}}$$

Appendix 10: Cash Ratio - Liquidity Formula 4

$$\text{Cash Ratio} = \frac{\text{Cash and Bank Deposits}}{\text{Current Liabilities}}$$

Appendix 11: Days Sales Outstanding - Liquidity Formula 5

$$\text{Days Sales Outstanding} = \frac{\text{Total Accounts Receivable}}{\text{Total Revenues x 1,23}} \text{ x 365 days}$$

Appendix 12: Days Payable Outstanding - Liquidity Formula 6

$$\text{Days Payable Outstanding} = \frac{\text{Total Accounts Payables}}{(\text{COGS} + \text{External Suppliers and Services}) \text{ x 1,23}} \text{ x 365 days}$$

Appendix 13: Net Working Capital Requirements – Capital Structure Formula 1

$$\text{Net Working Capital Requirements} = \text{Operating Assets} - \text{Operating Liabilities}$$

Appendix 14: Net Debt - Capital Structure Formula 2

$$\text{Net Debt} = \text{Financial Liabilities} - \text{Financial Assets}$$

Appendix 15: Liabilities-to-Assets Ratio - Leverage Formula 1

$$\text{Liabilities} - \text{to} - \text{Assets Ratio} = \frac{\text{Total Liabilities}}{\text{Total Assets}}$$

Appendix 16: Liabilities-to-Equity Ratio - Leverage Formula 2

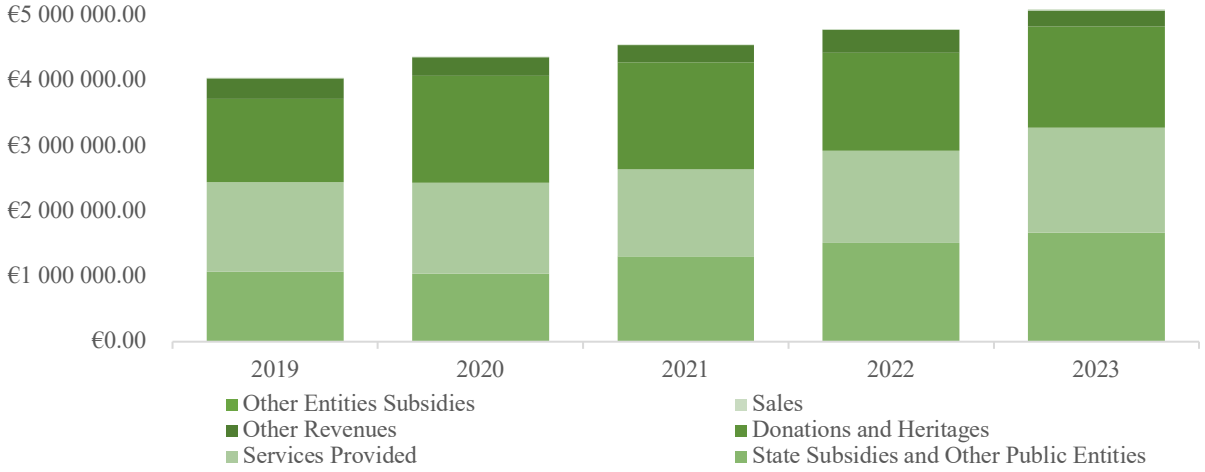
$$\text{Liabilities} - \text{to} - \text{Equity Ratio} = \frac{\text{Total Liabilities}}{\text{Total Equity}}$$

Source: Investopedia

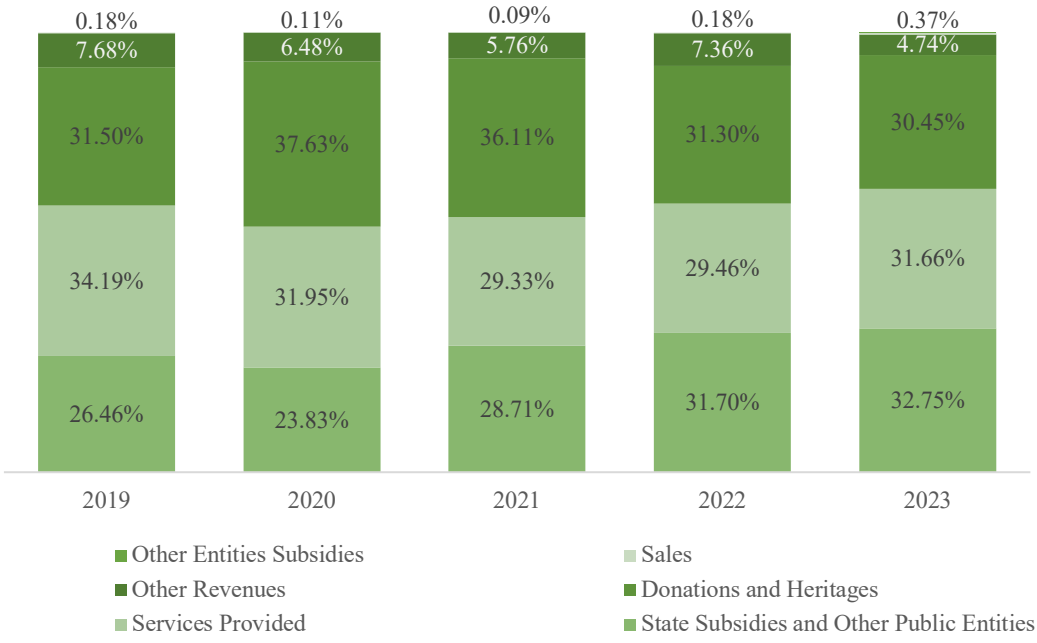
Appendix 17: Revenues historical evolution and breakdown (2019-2023)

Revenues have been steadily increasing and the main sources comprise State Subsidies and Other Public Entities, Services Provided and Donations and Heritages

Appendix 17.1: Revenues historical evolution



Appendix 17.2: Revenues breakdown

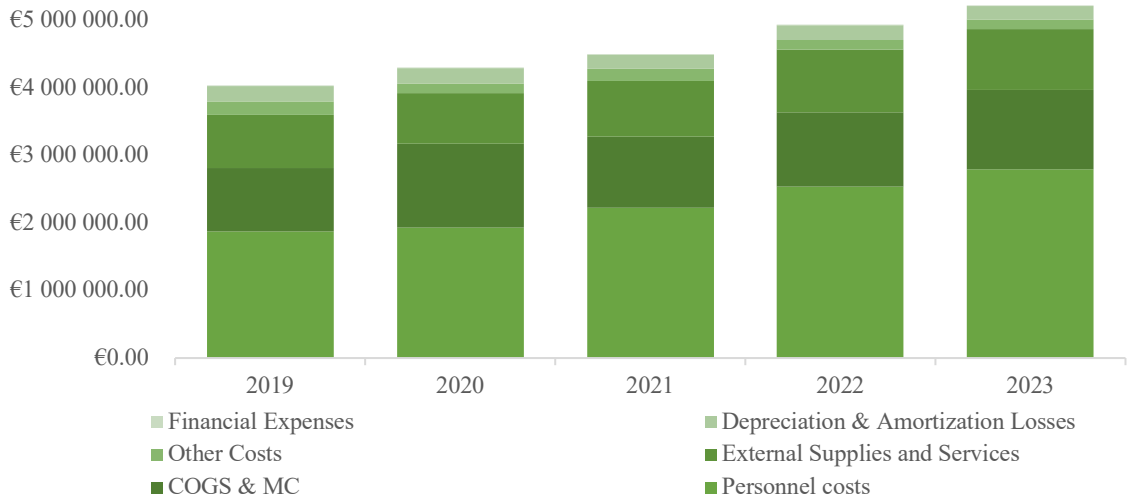


Source: CVPaz Annual Reports

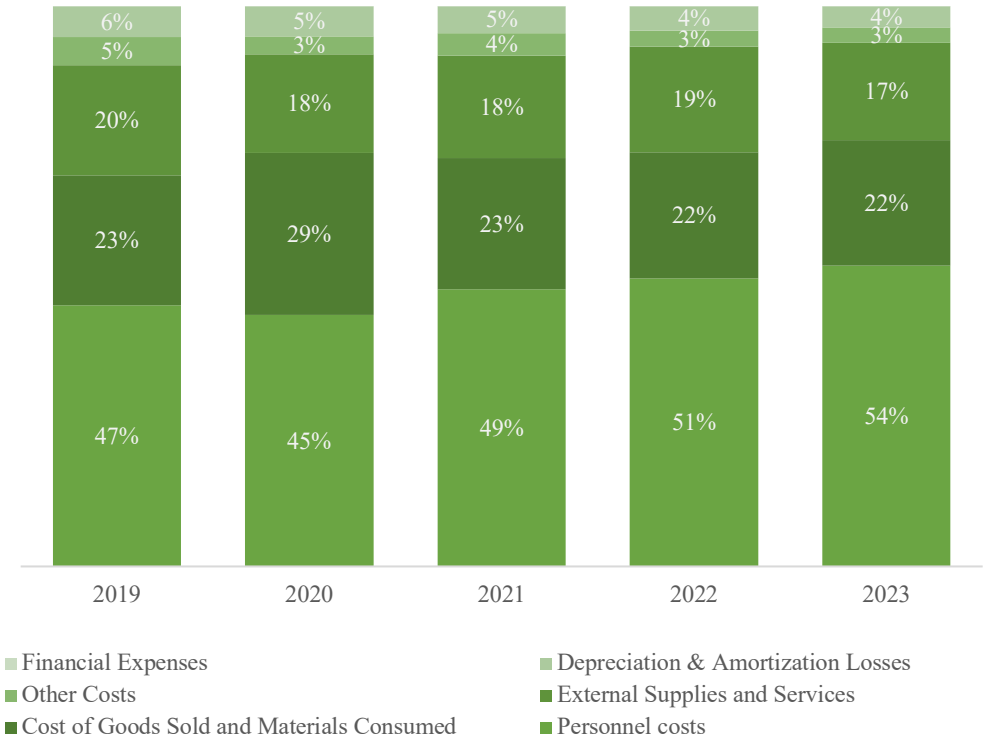
Appendix 18: Costs historical evolution and breakdown (2019-2023)

Costs have been steadily increasing and the personnel costs represent the highest burden

Appendix 18.1: Costs historical evolution



Appendix 18.2: Costs breakdown



Source: CVPaz Annual Reports

Appendix 19: Benchmark analysis of subsidies' dependence and of the share of personnel costs

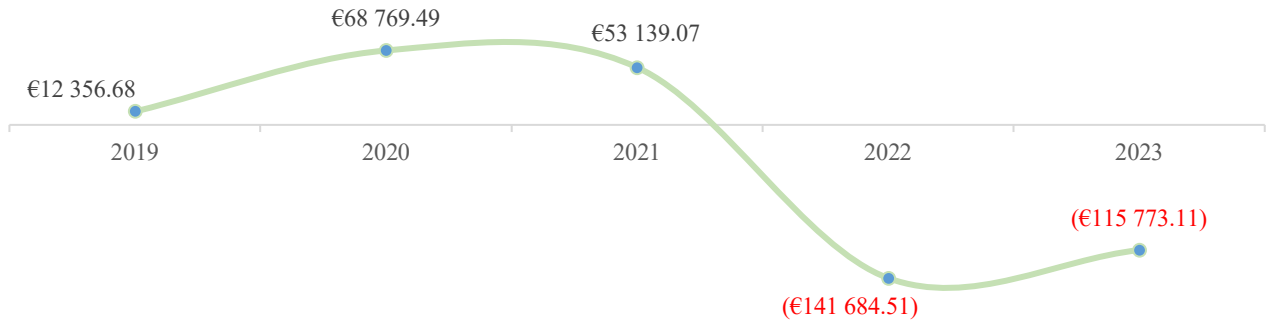
Compared to its peers, CVPaz presents a lower dependence on subsidies but a higher share of personnel costs on total costs

	Subsidies (as a % of revenues)	Personnel Costs (as a % of costs)
Associação CAIS	61,43%	56,59%
AMI	27,95%	38,39%
SCML	0,65%	52,50%
CASA	15,42%	18,71%
Associação Vida Autónoma	64,62%	52,80%
CRESCER	69,06%	44,73%
VITAE	No information	56,14%
Average	39,86%	45,69%

Source: Organizations' Latest Available Annual Reports

Appendix 20: Net Income historical evolution (2019-2023)

Net Income has presented a volatile evolution, becoming negative in 2022

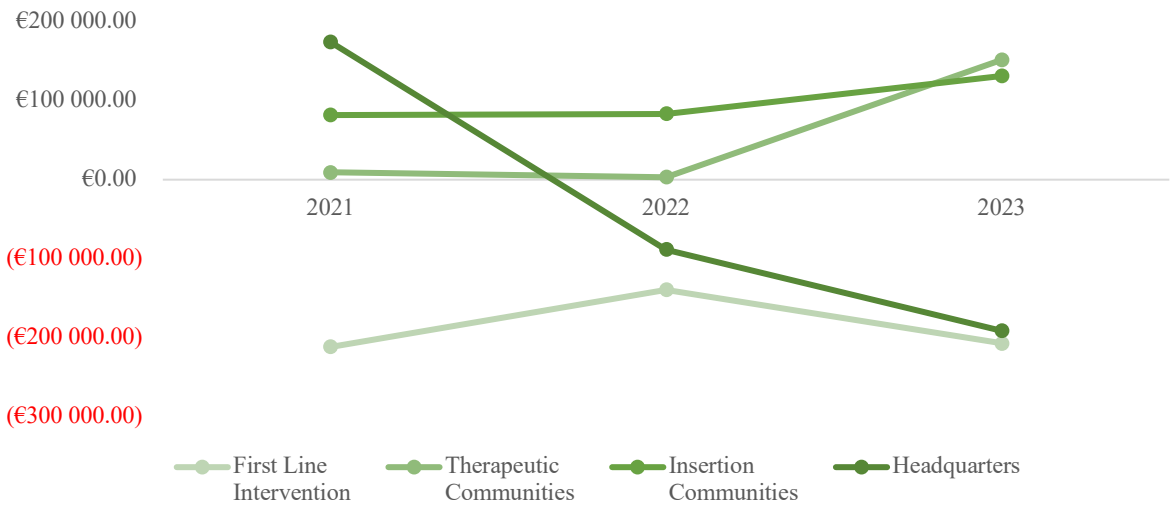


Source: CVPaz Annual Reports

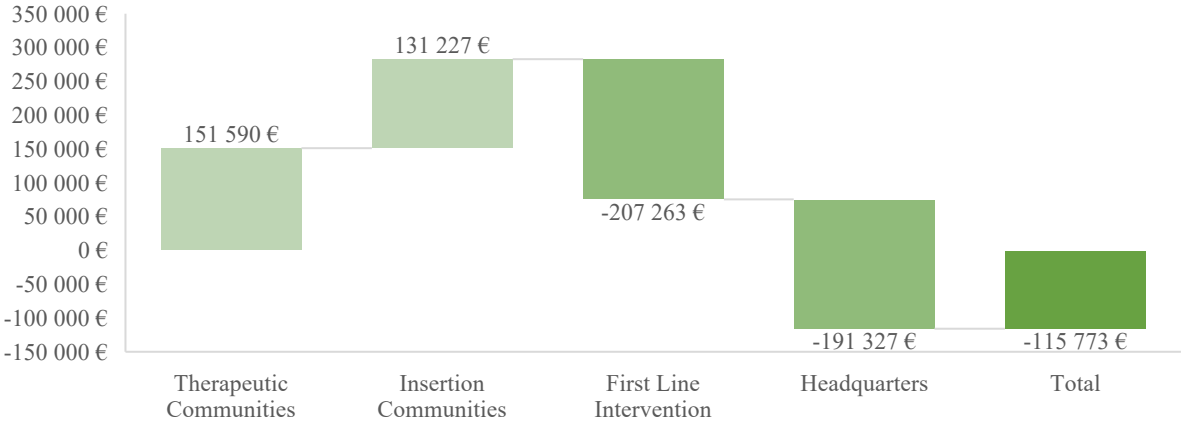
Appendix 21: Net Income historical evolution and breakdown per area

Sede and CIPL are the contributors to the loss displayed since 2022

Appendix 21.1: Net Income historical evolution per area



Appendix 21.2: Net Income breakdown per area - 2023



Source: CVPaz Annual Reports

Appendix 22: Restructured Balance Sheet

CVPaz has presented negative values for both the Net Debt and the NWCR

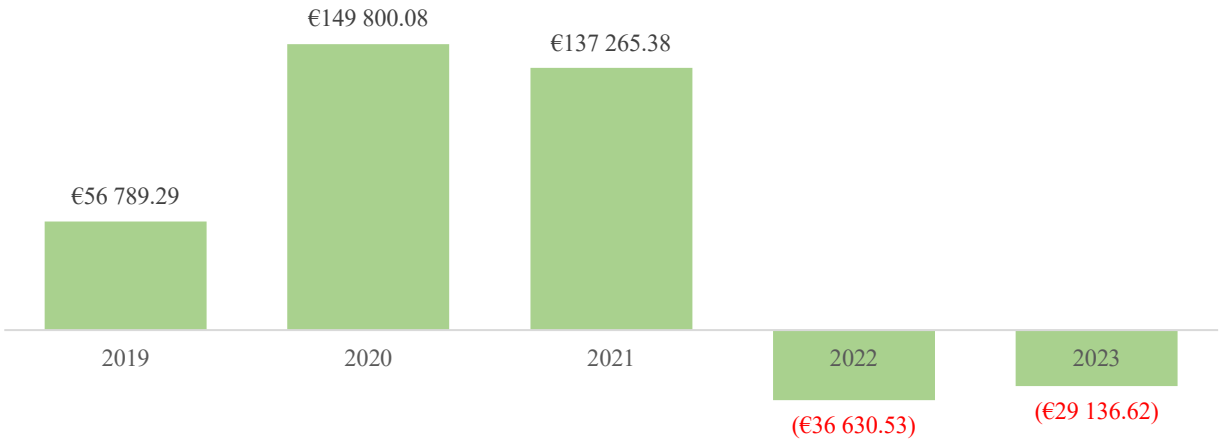
€	2019	2020	2021	2022	2023
Fixed Assets					
Tangible Fixed Assets	1 953 344 €	1 861 342 €	1 817 487 €	1 706 939 €	1 584 401 €
Intangible Assets	18 482 €	0 €	0 €	0 €	3 306 €
Financial Investments	8 744 €	12 445 €	17 218 €	24 717 €	22 695 €
Total Fixed Assets	**1 980 570 €**	**1 873 787 €**	**1 834 704 €**	**1 731 656 €**	**1 610 402 €**
NWCR					
Operating Assets					
Inventories	4 080 €	4 073 €	4 046 €	6 560 €	20 487 €
Accounts Receivable/ Customers	110 079 €	105 230 €	119 353 €	102 125 €	172 840 €
State and other public entitIes	5 959 €	7 247 €	8 208 €	12 585 €	8 600 €
Other Accounts Receivables	110 315 €	52 781 €	57 754 €	183 209 €	234 968 €
Prepaid Expenses	30 024 €	15 041 €	16 328 €	17 905 €	20 204 €
Operating Liabilities					
Accounts Payable/ Suppliers	104 779 €	71 588 €	68 604 €	96 353 €	105 208 €
State and other public entitIes	58 464 €	57 102 €	65 424 €	78 090 €	74 940 €
Unearned Revenues	135 277 €	359 051 €	142 882 €	84 112 €	129 396 €
Other Accounts Payable	378 456 €	423 359 €	457 745 €	454 993 €	529 740 €
NWCR = Oper. Assets - Oper. Liab.	**-416 518 €**	**-726 729 €**	**-528 967 €**	**-391 163 €**	**-382 186 €**
NET DEBT					
Financial Liabilities					
Bank Loans	10 105 €	163 €	853 €	5 253 €	1 959 €
Other Financial Liabilities	0 €	0 €	0 €	0 €	0 €
Financial Assets					
Cash and bank deposits	483 413 €	876 692 €	567 085 €	359 785 €	355 008 €
Other Financial Assets	0 €	0 €	100 000 €	0 €	0 €
Net Debt = Fin. Liab. - Fin. Assets	**-473 308 €**	**-876 529 €**	**-666 232 €**	**-354 533 €**	**-353 049 €**
Equity					
Fund	13 128 €	13 128 €	13 128 €	13 128 €	13 128 €
Retained Earnings	248 783 €	261 139 €	329 909 €	383 048 €	324 430 €
Other changes in the endowment funds	1 763 092 €	1 680 550 €	1 575 794 €	1 440 534 €	1 359 481 €
Net results for the period	12 357 €	68 769 €	53 139 €	-141 685 €	-115 773 €
Total Equity	**2 037 359 €**	**2 023 587 €**	**1 971 970 €**	**1 695 026 €**	**1 581 265 €**

Source: CVPaz Annual Reports

Appendix 23: NWC, DSO and DPO historical evolution

The negative NWC observed since 2022 implies that CVPaz's current liabilities surpass its current assets, and DPO are always higher than DSP

Appendix 23.1: NWC historical evolution



Appendix 23.2: DSO and DPO historical evolution

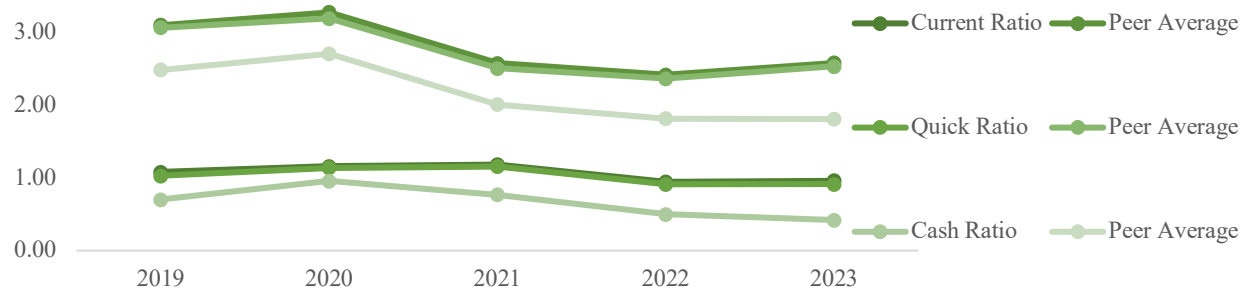
	2019	2020	2021	2022	2023
Days Sales Outstanding (DSO)	47,04	33,43	39,20	59,59	74,01
Days Payables Outstanding (DPO)	82,83	73,34	83,07	80,23	90,56

Source: CVPaz Annual Reports

Appendix 24: Liquidity ratios historical evolution and benchmark analysis

All liquidity ratios have displayed a downward trend, always below the peer average

Appendix 24.1: Liquidity ratios historical evolution



Appendix 24.2: Liquidity ratios benchmark analysis

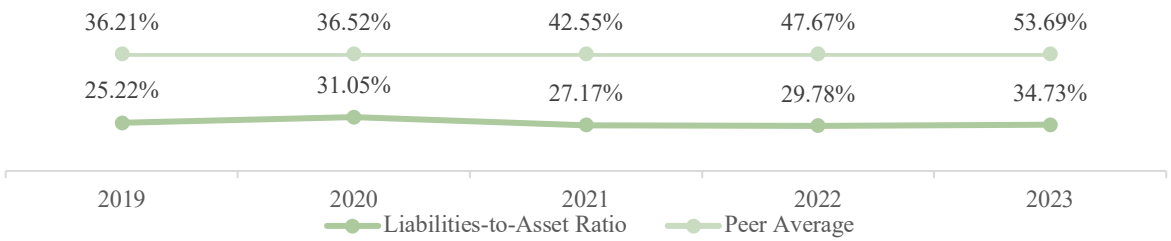
Liquidity Ratios	Current Ratio				
Benchmark analysis	**2019**	**2020**	**2021**	**2022**	**2023**
Associação CAIS	3,77	3,13	3,62	3,18	3,93
AMI	3,10	6,19	2,79	3,85	2,79
SCML	4,31	3,51	2,55	1,84	*No info.*
CASA	4,49	3,80	3,01	4,62	3,36
Associação Vida Autónoma	*No info.*	*No info.*	*No info*	1,07	1,46
CRESCER	1,09	0,97	0,99	0,87	0,92
VITAE	1,91	2,12	2,56	1,57	3,06
Average	3,11	3,29	2,59	2,43	2,59
	Quick Ratio				
	2019	**2020**	**2021**	**2022**	**2023**
Associação CAIS	3,75	3,09	3,59	3,15	3,89
AMI	3,01	5,83	2,48	3,68	2,71
SCML	4,29	3,47	2,51	1,79	*No info.*
CASA	4,40	3,76	2,99	4,52	3,22
Associação Vida Autónoma	*No info.*	*No info.*	*No info.*	1,07	1,46
CRESCER	1,08	0,96	0,99	0,85	0,91
VITAE	1,91	2,11	2,53	1,55	3,06
Average	3,07	3,20	2,51	2,37	2,54
	Cash Ratio				
	2019	**2020**	**2021**	**2022**	**2023**
Associação CAIS	3,19	2,90	3,34	2,86	3,61
AMI	2,70	5,02	2,29	3,07	2,17
SCML	3,37	2,55	1,57	0,85	*No info.*
CASA	3,98	3,59	2,08	3,33	2,30
Associação Vida Autónoma	*No info.*	*No info.*	*No info.*	0,93	0,35
CRESCER	0,84	0,95	0,97	0,82	0,88
VITAE	0,88	1,27	1,86	0,87	1,58
Average	2,49	2,71	2,02	1,82	1,81

Sources: CVPaz and Benchmark Organizations' Annual Reports

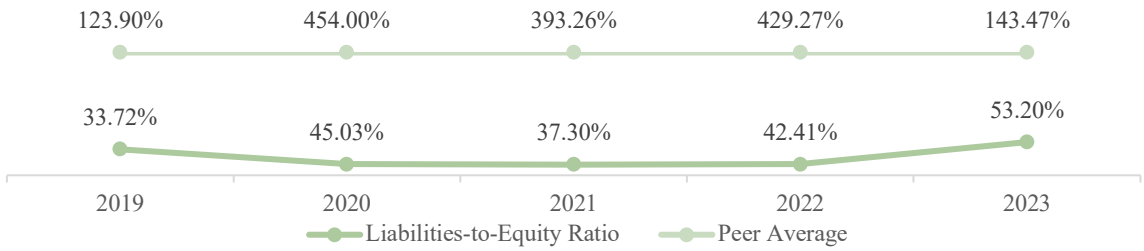
Appendix 25: Leverage ratios historical evolution and benchmark analysis

All leverage ratios have been below the industry average, indicating a low insolvency risk

Appendix 25.1: Liability-to-Asset ratios historical evolution



Appendix 25.2: Liability-to-Equity ratios historical evolution



Appendix 25.3: Liability-to-Equity and Liability-to-Asset ratios benchmark analysis

Leverage Ratios Benchmark analysis	**Liabilities-to-Assets Ratio**				
	2019	**2020**	**2021**	**2022**	**2023**
Associação CAIS	20,07%	25,24%	21,90%	25,59%	19,88%
AMI	43,51%	20,12%	44,88%	30,97%	35,87%
SCML	9,93%	10,57%	10,85%	10,91%	*No info.*
CASA	9,96%	18,12%	27,04%	24,02%	10,37%
Associação Vida Autónoma	*No info.*	*No Info.*	*No info.*	90,42%	119,29%
CRESCER	85,72%	96,24%	95,57%	94,86%	93,15%
VITAE	48,09%	48,86%	55,07%	56,89%	43,58%
Average	36,21%	36,52%	42,55%	47,67%	53,69%

	Liabilities-to-Equity Ratio				
	2019	**2020**	**2021**	**2022**	**2023**
Associação CAIS	25,10%	33,76%	28,05%	34,39%	24,81%
AMI	3,32%	4,33%	4,19%	5,27%	5,61%
SCML	11,02%	11,81%	12,17%	12,24%	*No info.*
CASA	11,06%	22,13%	37,06%	31,61%	11,57%
Associação Vida Autónoma	*No Info,*	*No Info.*	*No Info.*	*943,74%*	*-618,47%*
CRESCER	600,27%	2556,42%	2155,51%	1845,68%	1360,09%
VITAE					77,23%
					3,47%

Sources: CVPaz and Benchmark Organizations' Annual Reports

Appendix 26: Technical project

Initial technical project proposed by CVPaz for the construction of CAPDM, including main goals, responsibilities, and objectives

1. The Residential Treatment and Rehabilitation Programs for People in Homeless Situations (PSSA) or social exclusion, who seek support from the Community Vida e Paz, are developed/operate in their own facilities at the Centers located in Venda do Pinheiro/Mafra (Therapeutic Community), Moimento/Fátima (Therapeutic Community), and Sapataria/Sobral de Monte Agraço (Integration Community), with a total of 200 spots. These programs are subject to agreements/conventions with the Ministries of Health and Labor, Solidarity, and Social Security since their inception (the first in 1993, and the latter two in 1997).

The average number of admissions over recent years is approximately 120 cases in the Therapeutic Communities and 75 in the Integration Communities. The corresponding average stay is 15 months and 24 months, respectively. The average age ranges between 45 and 50 years in the Therapeutic Communities and between 50 and 55 years in the Integration Communities. The average number of individuals completing the programs is around 70 in the first case and 40 in the second.

2. The users who complete the treatment/rehabilitation process can be divided into three categories:

2.1. A significant number – most of those who are of working age – manage to organize themselves autonomously and, after professional qualification in some cases, integrate into the labor market and society, even if with family or institutional support during the initial period after completing the Treatment/Rehabilitation program.

2.2. Of the remainder:

2.2.1. An estimated 50% – although achieving a level of autonomy equivalent to/close to that of the general population of their age group – either due to not being of working age or being covered by early retirement schemes, and generally without family support – require institutional support within the framework of the general population in ERTIs or, alternatively, in Shared Apartments within the Community with the support of CVPaz;

2.2.2. The other 50% – due to having limitations/disabilities considered insurmountable, including various types of biological, psychological, and social disabilities, often with a mental illness diagnosis – require an institutional response that, considering their limitations, ensures the necessary care due to their lack of autonomy, specifically maintaining the achievements attained during the Treatment/Rehabilitation Program, monitoring, and support in hygiene and healthcare that enable them to sustain – for the longest period possible – the quality of life

acquired at the end of the rehabilitation period.

3. CVPaz has developed responses to support cases included in category 2.1 in the area of housing and psychosocial support (Reintegration Support Unit); promotes, with very limited success, the integration of cases from category 2.2.1 into the public network of ERTIs and the National Network for Integrated Mental Health Care (RNCCISM); but has not yet found a solution for cases in category 2.2.2.

Resorting to other institutions and RNCCISM units has not prevented most of them from remaining in the Integration Communities and Therapeutic Communities, "awaiting placement," thus occupying spots that could serve other candidates.

It is to address this need and these types of cases that the Board decided to establish an appropriate response – a Support Center for People with Moderate Disabilities/Impairments (CAPI/DM).

1. Target Population

The CAPDM is intended for People in Homeless Situations (PSSA) or social exclusion, without family support, with or without mental illness, who, regardless of age, have completed the rehabilitation process in the Therapeutic Communities or Integration Communities of CVPaz or similar institutions. These individuals, having exhausted the technical possibilities for improvement and not achieving a level of autonomy compatible with independent integration into ERTIs designed for the "normal" population, require complementary, permanent, and continuous support to maintain the level of development and quality of life they have acquired and to which they are entitled.

2. Program: Assumptions, Objectives, and Duration

The support and care provided by the CAPDM – the content of the Intervention Program to be developed – is based on the "functional diagnosis" of the candidates at various levels (motor, intellectual, emotional/relational), the technical approach model adopted, and the institution's spirit and ethical principles guiding care for the individuals it supports.

2.1. Assumptions

The basic assumptions of the Intervention Program are as follows:

2.1.1. The technical staff of the Unit must have as consistent an understanding as possible of the user's achievements and limitations, needs, potential, and expectations (obtained from the information provided by the user, often revised through continuous observation of their functioning and interactions within the Center and society). The professionals involved in the intervention must master the best relational and technical/therapeutic practices for different situations.

2.1.2. The user's active participation/engagement – within the limits allowed by cognitive and relational limitations – in individual or group activities proposed to them (occupational, socializing) and the care provided to them is a prerequisite for achieving the objectives of both. Regular user interaction with open-access citizen services – to meet their needs (health services, social security) or fulfill their obligations (social security, tax offices) – and engagement in spaces for productive, cultural, recreational, or leisure activities will be an integral part of the intervention.

2.2. Objectives

The objectives of the intervention at the Center are for the user to:

2.2.1. Maintain/Develop awareness – within their cognitive abilities – of their dependency situation and its implications for organizing their daily life;

2.2.2. Maintain, to the greatest extent possible, their personal and social skills in a logic of empowerment, a healthy lifestyle, and functioning/interaction patterns acquired during rehabilitation;

2.2.3. Identify risks associated with their situation and develop and internalize basic self-regulation and protection mechanisms tailored to their circumstances.

2.3. Duration

The user's stay at the Center has no time limit, except if, due to worsening limitations/dependencies, it is determined that the Center lacks the technical means to adequately respond to their needs.

3. Resources: Care and Services to Be Provided

In addition to housing and meals, the Center will provide appropriate healthcare for different situations, psychological support, psychosocial support, maintenance psychomotor training, and occupational activities with ongoing community contact.

The provision of care and services will be ensured by a team of professionals distributed across the following areas:

- Permanent monitoring/case management,
- Healthcare (general and psychiatry),
- Psychology/psychotherapy,
- Social support,
- Physical therapy, psychomotricity, sensory and cognitive stimulation,
- Occupational activities and training/maintenance of skills,
- Cultural, leisure, and community contact activities.

The modalities of access to different services, as well as the intensity/frequency of their intervention and participation in various activities, will be determined by the Center's technical direction, upon proposal by the monitoring technician, based on the nature/diversity of diagnoses—centered on the individual, their needs, potential, and expectations—and will be recorded in each user's Individual Process (IP).

3.1. Permanent Monitoring/Case Management

The User's Permanent Monitoring/Case Management Technician (TAP) will lead the care/service delivery process and integrate contributions from other complementary services and care provided under the Program, under the coordination of the Center's technical direction. Each TAP will be assigned a manageable number of users by the Technical Direction (10-12). The TAP's responsibilities include, but are not limited to:

- Developing the Individual Plan [IP] for each user under their care (with the user's participation/adherence and input from professionals from other services) and monitoring it according to defined schedules;
- Proposing each user's participation in complementary activities deemed recommended, ensuring their scheduling, integration, and evaluation of results;
- Supervising and controlling hygiene, personal grooming, and users' social behavior standards;
- Permanently supporting users in resolving/overcoming daily issues/problems/conflicts arising in their relationships with others or with the institution's rules;
- Organizing the collaboration plan for users in collective activities for maintaining open spaces, considering each user's diagnosis, resources, limitations, and expectations, and promoting/organizing cultural, sports, leisure, and community contact activities as part of the overall intervention;
- Ensuring, whenever possible, users' ties with their close family members and strengthening them;
- Keeping the Individual Process of users under their care up-to-date.

3.2. Complementary Support Services

3.2.1. Psychological Support

Psychological evaluations and individual or group follow-up, based on the evaluation and identified needs, with a frequency deemed advisable, will be an integral part of the intervention.

3.2.2. Medical-Psychiatric Support

Regular access to general and mental health services will be provided either directly at the

facility or through the local Health Center, as per agreements between the two entities, without prejudice to external consultations at various specialties. Continuous medication control will be ensured under the supervision of the facility's nurse.

3.2.3. Social Services

The social services department will work closely with permanent case management services to address all social dimensions, including users' connections with their families and public services where they have rights or obligations.

3.2.4. Psychomotricity/Physical Therapy/Sensory Stimulation

Activities/support in psychomotricity, physical therapy, motor, and sensory stimulation—individual or group—at the frequency deemed necessary for users' development will be carried out by external specialists. For sensory stimulation, instrumental music in collaboration with a local music training school will be incorporated under a partnership.

3.2.5. Occupational, Cultural, Recreational, and Community Activities

The structuring of occupational activities, organization of workshops (pottery, etc.), and participation in cultural and recreational initiatives will fall under the coordination of permanent case management services, with implementation by designated professionals.

3.2.6. User Collaboration in Center Maintenance

Users are invited to collaborate in cleaning/organizing the premises, laundry, and meal preparation/distribution. The TAP is responsible for planning user participation, with execution supervised by assigned staff.

4. Intervention Methodology

The permanent monitoring of users by the TAP involves individual interventions and group work with users under their care, or with larger/smaller groups, depending on service organization/coordination. Complementary care and services by professionals from various areas will be monitored and integrated by the TAP, ensuring unified intervention with the user.

5. Organizational Aspects

Although residential, the CAPDM will operate dynamically, with as lightweight a structure as possible.

5.1. Direction/Coordination of Intervention

The overall direction/coordination of interventions at the Center is the responsibility of the Technical Director, as per the Internal Regulations, ensuring proper functioning, service quality, and well-being for users and staff.

Responsibilities of the Technical Director include:

- Adopting the organizational model that best fulfills the Center's objectives;

- Organizing reflection/training spaces, professional articulation/exchange, and case studies;
- Determining procedures for evaluating serious user infractions and applying sanctions;
- Defining data to include in users' Individual Processes and safeguarding personal data protection;
- Approving Individual Intervention Plans;
- Determining record-keeping models and reporting schedules.

Relevant occurrences involving users must be reported to their respective TAP for evaluation, action, and potential recording in the Individual Process.

6. Facilities – General Characteristics

The Center will consist of two complementary, functionally interconnected areas:

6.1. Residential Area

Composed of modular units (3-5), each accommodating 10-12 users [alternative: residential pavilion]: rooms with 2-3 beds and corresponding bathrooms.

6.2. Occupational/Therapeutic Area

Includes dining services (self-service), occupational activities (2-3 workshops), leisure and social spaces, and therapeutic maintenance activities (individual/group). This area serves both resident and external users with similar diagnoses and needs. External users may receive services as deemed appropriate.

Additional spaces:

- Dining area (kitchen, pantry, dining room – self-service);
- Leisure/social space;
- Group activity rooms (treatment/nursing, physical therapy, psychomotricity, stimulation, workshops);
- Individual care rooms (medicine/psychiatry, psychology, social services, physical therapy, stimulation) – 4-6;
- Storage/staff areas according to functional needs.

7. Miscellaneous Aspects

7.1. Health/Psychiatry Services

General and psychiatric health monitoring will occur at the local Health Center or on-site, per a cooperation agreement. Specialty consultations will be attended at public hospitals, with users accompanied when necessary.

7.2. Community Contact

Users, even with varying autonomy limitations, will engage with public services and cultural,

sports, or other activities (markets, fairs, malls) for societal integration. The Center will provide suitable transportation and storage facilities.

7.3. Partnerships

Local partnerships in arts, music, and physical activities will support care and user engagement.

Appendix 27: CAPDM users characteristics

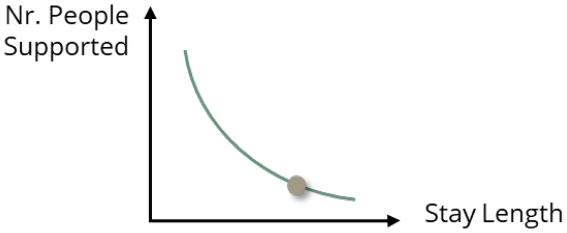
Residential users present lack of family aid and low autonomy while ambulatory users count with family support and no require of permanent care

Residential and Ambulatory Users Characteristics	
Medical Condition	CAPDM users have disabilities that prevent them from engaging in work or pursuing educational degrees and require varying degrees of support, ranging from assistance with daily living activities to monitoring and supervision
User Sources	CAPDM prioritizes individuals from three main sources: those who have completed CVPaz rehabilitation programs, individuals identified by frontline intervention teams as having moderate incapacitation, and those who have completed rehabilitation programs at other institutions
Social Condition	Residential users lack family or social support, face significant social exclusion, and may experience or have experienced homelessness
	Ambulatory users have some family or social support and reside in Torres Vedras, enabling daily commuting between home and CADPM
Policy Adherence	All CAPDM users must demonstrate a commitment to their recovery by actively participating in the rehabilitation program, adhering to its terms, and complying with any payment obligations when financially feasible

Source: CVPaz Technical Project for CAPDM

Appendix 28: Customer journey - stay length

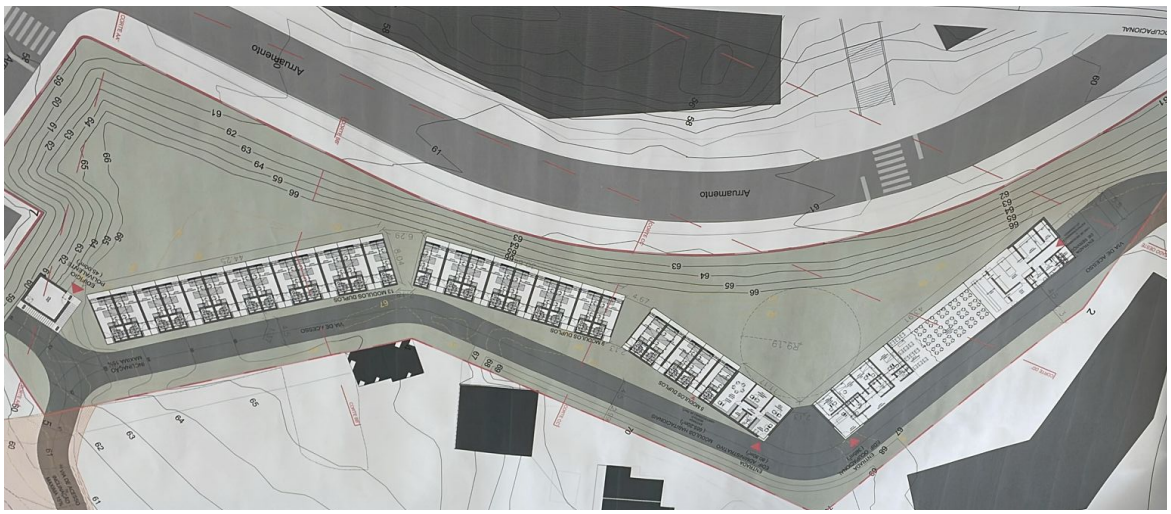
Although more individuals would be supported if CVPaz established a limit on the stay length, it would go against its overarching goal



Appendix 29: Architectural plan

Appendix 29.1: Architectural plan design

The Architectural plan was already designed for CAPDM totaling 1166 sqm



Appendix 29.2: Areas per division

Bedrooms and Bathrooms are the division with the highest number of square meters.

Module	Divisão - Projeto Técnico	Type of room	Total sqm
Residential	Quarto Duplo	Bedrooms, Bathrooms and hallways	665.2
Occupational	Receção	Reception	16.1
Occupational	Gabinete Médico/ Arm Medicamentos	Medical Office	11.9
Occupational	Sala Terapêutica 1	Therapeutic Rooms 1	13.25
Occupational	Sala Terapêutica 2	Therapeutic Rooms 2	13.42
Occupational	Sala Enfermagem	Infirmary	22.82
Occupational	IS (F/M/MC)	Bathrooms	18.39
Occupational	Sala Polivalente	Canteen	113.08
Occupational	Sala de Estar	Living Room	31.15
Occupational	Cozinha	Kitchen	28.27
Occupational	Copa Suja	Dirty Pantry	7.67
Occupational	Copa Self Service	Self Service Pantry	23.25
Occupational	Armário Frio	Cold Cabinet	6.75
Occupational	Despensa	Pantry	12.9
Occupational	Balneário	Staff Balnearies	11.48
Occupational	Lixos	Dumpsters Area	4.16
Occupational	Distribuições	Hallways	31.22
Administrative	Receção	Reception	10.37
Administrative	Atendimento Social	Social Services Room	11.52
Administrative	Gabinete Direção/Sala de Reuniões	Management Office and Meeting Room	23.91
Administrative	Gabinete Administração	Administration Office	11.19
Administrative	Arrumos	Storage Area	3.81
Administrative	IS	Bathrooms	3.56
Administrative	Distribuição	Hallways	4.75
Ateliers	Atelier 1	Atelier 1	23.62
Ateliers	Atelier 2	Atelier 2	22.73

Source: CVPaz Architectural Plan for CAPDM