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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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List of Abbreviations

CACI: *Centro de Atividades e Capacitação para a Inclusão*

CAPDM: *Centro de Apoio a Pessoas com Incapacidade/Deficiência Moderada*

CAPEX: *Capital Expenditures*

CCSIM: *Cuidados Continuados Integrados de Saúde Mental*

CVPaz: *Comunidade Vida e Paz*

IPSS: *Instituições Particulares de Solidariedade Social*

ISS: *Instituto de Segurança Social*

KPIs: *Key Performance Indicators*

LR: *Lar Residencial*

OPEX: *Operational Expenditures*

PRR: *Plano de Recuperação e Resiliência*

QES: *Quinta do Espírito Santo*

SS: *Social Security*

TAP: *Permanent Monitoring & Management Technician*

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 – 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. 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*. Moreover, *Emprego Primeiro* and numerous projects in the catering area, such as *É UM RESTAURANTE*, are promoting job market integration (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.

Regarding **CVPaz's revenues**, 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**, 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. 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. 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. 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. 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. 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. 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. 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.

1.3.3. SWOT Analysis

The previous external benchmarking exercise, combined with internal strategic and financial analysis, facilitated the development of a SWOT analysis for CVPaz. **Key strengths** include its low dependency on subsidies, with only 33% of its revenue sourced from such streams, compared to a peer average of 40%, and its consistently high innovation in program development and service delivery. Furthermore, CVPaz maintains a strong reputation in its field, alongside one of the highest ratios of volunteers per people supported among peers.

However, the financial analysis highlighted some **weaknesses**, such as the heavy burden of staff expenses, which account for 54% of the cost structure, exceeding the peer average of 46%. Income from self-sustaining activities remains limited, indicating underutilized revenue opportunities. Furthermore, CVPaz's liquidity position is weaker compared to larger and more established organizations.

On the **opportunity side**, CVPaz has room to increase its self-generated revenue with sales

associated with occupational activities and therapy work done by users and to address gaps in the social services market by creating more programs targeting underserved needs. Moreover, strengthening partnerships with similar organizations offers valuable opportunities for growth and knowledge-sharing.

Finally, **threats** include the risk of reduced funding availability due to increasing competition among organizations and potential changes in government policies, which could impact subsidy schemes. Broader economic challenges, such as housing crises or financial downturns, may also exert pressure on CVPaz's operations.

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. Conducting an External Analysis

What are the industry best practices among CAPDM peers?

After investigating the purpose, the objectives, and the initial plan of CAPDM, an external analysis is the next step to design a comprehensive operational framework and service delivery model for this center. Thus, Chapter 2 delves deeper into how similar associations operate in various areas and identifies the key elements that should be incorporated into this new center.

2.1. Benchmark Methodology

The benchmark analysis starts with an outline of **practices currently being adopted worldwide.** Hence, Subchapter 2.2. presents extensive research to identify institutions addressing the exact same challenges that CVPaz aims to tackle with the implementation of CAPDM. Indeed, only 4 international centers were identified as having very similar operations as CAPDM's proposal, located in the United States and in the United Kingdom.

Due to the lack of responses to the specific problem identified by CVPaz in Portugal and the scarcity of international organizations addressing these needs, a broader set of institutions was analyzed. Therefore Subchapter 3.3. **extends the research to worldwide organizations** with a strong focus on supporting individuals with various levels of disabilities. Some organizations address homelessness, others substance abuse, but all of them are deeply committed to social integration, offering **valuable parallels** for this thesis. A benchmark analysis of Portuguese organizations was also conducted given the importance of aligning CAPDM with the Portuguese specific legislation, particularly ISS, which will be explored in Chapter 3. Hence, best practices were collected from 25 institutions were analyzed: 13 international and 12 nationals. After contacting all the institutions, 8 interviews were conducted, while the remaining were studied through exploratory and descriptive investigation due to lack of response or availability for a visit and/or interview.

2.2. Benchmarking Beyond CAPDM's Scope

As explained in Subchapter 2.1., 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.

2.2.1. 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.

2.2.1.1. 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.

2.2.1.2. 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.

2.2.1.3. 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.

2.2.2. 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.

2.2.2.1. 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.

2.2.2.2. 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).

2.2.2.3. 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.

2.2.2.4. 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.

2.2.3. 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.

2.2.3.1. 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).

2.2.3.2. 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.

3. Defining Social Security & CAPDM Collaboration Model

How can CVPaz work with SS to secure funding for CAPDM and ensure its sustainability?

3.1. Social Security's Role

As highlighted in Chapter 2, most Portuguese organizations analyzed collaborate with ***Instituto da Segurança Social*** **(ISS)** and rely on its financial support. Similarly, given CAPDM's anticipated user base and CVPaz's limited financial resources, ISS funding is essential to support the center's operations. This support may come through monthly contributions to CAPDM directly or by granting pensions to eligible CAPDM users, helping to cover service expenses. To better understand how that support may be provided, it is first important to understand how ISS collaborates with institutions like CVPaz to deliver social protection and inclusion.

3.1.1. Social Security and IPSS Collaboration Models

ISS, one of the 7 key institutes within Portugal's Social Security (SS) framework, is specifically tasked with safeguarding individuals' social protection and fostering inclusion (Segurança Social 2024). Operating under the *Ministério do Trabalho, Solidariedade e Segurança Social* (MTSSS), ISS fulfills its mission by recognizing citizens' rights, ensuring compliance with contribution obligations, and promoting social solidarity. A key component of ISS's work is the *Rede de Serviços e Equipamentos Sociais* (RSES), which offers a range of **social responses** and services targeted primarily at **vulnerable groups**. While these social support services are managed and operated by various entities, such as IPSSs and similar organizations, ISS plays a vital role in funding these initiatives and standardizing procedures and services offered. In fact, according to *Carta Social*, in 2022, public spending used for funding the RSES reached €1779 million, reflecting a 207.2% increase since 2000, as shown in **Appendix** (Ministério do Trabalho, Solidariedade e Segurança Social 2024).

Moreover, as established in *Portaria nº. 196-A/2015*, partnerships between the State and social

sector entities are based on a model of shared goals and responsibilities, primarily achieved through **3 forms of agreements** (Diário da República 2015). The first, **cooperation agreements**, are formal contracts aimed at developing a social service or response and can be either **typical or atypical**. Typical cooperation agreements follow established guidelines, whereas atypical agreements allow for more flexibility and adaptation to specific needs. The second form of agreement is **management agreements**, which grant institutions operational control of public social facilities, enabling them to manage resources and services efficiently. This transfer of responsibilities can involve managing only the operation or both the operation and the building through its free concession. The third refers to **protocols** which are used for innovative projects that address specific local needs, allowing for tailored approaches to social challenges and encouraging creativity and adaptability in service delivery. In these cooperation models, each party takes on specific roles: ISS provides essential funding, regulatory oversight, and strategic guidance, while partner institutions commit to delivering and managing social services according to established standards.

3.1.2. Social Security and CVPaz Current Collaboration Models

In fact, CVPaz has extensive experience collaborating with ISS across several types of agreements, managing multiple residential and support services tailored to the needs of vulnerable populations. This includes a **blend of typical, atypical and protocol agreements**, each catering to different types of facilities and support levels (Comunidade Vida e Paz 2024). Most of CVPaz's reinsertion facilities operate under a **typical cooperation agreement**, ensuring stable funding for the *Residência Autónoma* and 2 of the 4 *Apartamentos de Reinserção*. Additionally, ISS supports CVPaz's *Equipas Técnicas de Rua*. For its more specialized projects, CVPaz employs **atypical cooperation agreements**, which allow greater customization in terms and funding. QES, as well as *Comunidade de Inserção da Tomada*, are both supported under atypical agreements, where funding and operational flexibility is

negotiated directly to address the unique requirements of these facilities. Moreover, CVPaz also operates 6 out of its 7 *Apartamentos Partilhados de Primeira Linha* through **protocol agreements**. These agreements, renewed annually, offer a level of flexibility suitable for the short-term, crisis-oriented nature of the services.

CVPaz's long-standing experience with ISS agreements equips it to secure the most appropriate agreement model for CAPDM. However, given the center's specific objectives and the needs of its future users, a careful assessment is still required to identify the most suitable agreement.

3.2. Target Agreement Model

To determine the most suitable agreement model for CAPDM, a **three-step methodology** was employed. This comprehensive process assessed the suitability of each agreement type, narrowing down options to identify a structure that supports CAPDM's goals of providing long-term residential care for individuals with disabilities while offering flexibility to adapt to specific user needs, and ensuring sustainable funding.

3.2.1. Agreement Models Assessment

In the **first step**, a comprehensive assessment was conducted to examine the **advantages and limitations of the 3 agreement models** – cooperation (typical and atypical), management, and protocol agreements. The objective was to identify which of these agreements align with CAPDM's core mission and to exclude those that do not meet the center's requirements.

The **typical cooperation agreement** enables CVPaz to operate CAPDM as a typified social response, providing the potential for stable, structured funding from ISS within an established regulatory framework that includes clear guidelines on funding and integration into the broader social support network. This allows for predictable financial support and smoother alignment with existing institutional standards. However, this agreement imposes stricter regulations that limit flexibility, potentially hindering CAPDM's ability to innovate or adapt its services to fit the specific needs of its target population.

The **atypical cooperation agreement** is characterized by greater flexibility, enabling CAPDM to tailor its services and admission criteria to better meet the needs of individuals with disabilities. This model allows terms to be negotiated directly with ISS, which could help CAPDM retain control over its unique structure and service model while still securing funding. However, this flexibility comes with potential challenges: funding stability under the atypical agreement may be less predictable, as adjustments are not automatically made annually. For instance, one of CVPaz's atypical agreements experienced only a 3.5% growth in 2024, compared to the 6% growth observed in most typical agreements (CNIS 2024). Furthermore, establishing the terms of this agreement requires more extensive negotiations, which could delay implementation.

The **management agreement** presents CAPDM with an opportunity to manage an existing facility rather than undertaking new construction, which could significantly reduce initial setup time and costs. Under this model, CVPaz would assume operational control over a state-owned facility, enabling CAPDM to focus on service delivery without the need to invest in property development. This agreement can streamline the process of launching services, providing CAPDM with immediate access to physical infrastructure. However, CAPDM's objectives emphasize ownership and establishing a dedicated center tailored to its users' needs (as stated in technical project), rather than merely managing an existing facility. Additionally, this model brings significant uncertainty, as the state retains ownership of the building, meaning the facility could be reclaimed at any time, potentially requiring CVPaz to secure an alternative location to continue operations. As such, the management agreement's focus on operational management within a predefined facility conflicts with CAPDM's long-term vision, making this model unsuitable.

Lastly, the **protocol agreement** is designed to support innovative, often short-term projects that test new approaches or models within the social support landscape. For CAPDM, this model

offers the advantage of flexibility to experiment with creative service delivery methods, potentially leading to the establishment of best practices in disability care. However, this agreement is inherently project-based and therefore lacks the sustainability and continuity needed to support a permanent residential center. Its temporary focus aligns poorly with CAPDM's goal of providing a stable, long-term care solution.

In conclusion, while each agreement model presents specific benefits, both the management agreement and the protocol agreement were excluded due to their misalignment with CAPDM's ownership requirements and long-term sustainability goals, respectively. Among the remaining options, both cooperation agreements were considered viable; however, the typical cooperation agreement stands out as the most promising solution at this stage due to its stability and alignment with CAPDM's objectives.

3.2.2. Typical Cooperation Agreement Feasibility

With only the typical and atypical cooperation agreements left as viable options, the **second step of the methodology** focuses on evaluating the typical cooperation agreement to determine if it is a feasible solution. For this to occur, CAPDM must fit within the existing social responses recognized by ISS under the typical cooperation agreement, and be able to operate as one. To assess this compatibility, a **further two-step analysis** was conducted.

3.2.2.1. Existing Responses Screening

In the **first sub-step**, an initial screening assessed the **41 social responses** offered by ISS across 5 selected vulnerable populations: the elderly, individuals with disabilities, dependent individuals, individuals with mental illness, and homeless individuals. These groups were chosen for their potential relevance to CAPDM's target user profile. Each response within these groups was then evaluated based on **4 key variables**: whether it offers residential care, target population, maximum capacity, and duration of care. The goal was to identify responses that share essential characteristics with CAPDM's model and classify them as either **not relevant**

or suitable for further analysis (detailed in **Appendix *1***).

This screening revealed a diverse range of social responses designed to address specific needs. Among the elderly, 6 responses were analyzed, primarily emphasizing autonomy, social inclusion, and quality of life, such as the *Estrutura Residencial para Pessoas Idosas* (ERPI), which offers residential care and social activities (Instituto da Segurança Social, I.P, 2017). For individuals with disabilities, 9 responses were reviewed, including CACI and LR, both focusing on fostering independence and social integration through tailored support services (Instituto da Segurança Social, I.P 2014). Dependent individuals were represented by 10 responses, many of which fall under the *Rede Nacional de Cuidados Continuados Integrados* (RNCCI), a system providing both short- and long-term care, rehabilitation, and palliative services (Instituto da Segurança Social, I.P., 2024). For mental illness, 14 responses were identified, many of which are part of the CCISM, a branch of the RNCCI specialized in mental health. These responses prioritize rehabilitation and reintegration, reflecting the RNCCI's dual role in addressing both physical dependency and mental health challenges. Lastly, 2 responses were dedicated to supporting homeless individuals, including interventions like street teams and occupational workshops, which aim to promote reintegration into society and skill-development for independent living (Segurança Social 2023).

From this initial screening, **35 responses were excluded** as they do not align with CAPDM's objectives, either in terms of services offered and duration, capacity or target population. Thus, **6 responses were identified as relevant for further investigation** based on their closer alignment with these criteria. Among the selected responses, 3 populations – elderly, individuals with disabilities, and individuals with mental illness – are represented. Specifically, 1 response for the elderly – **ERPI** –, 2 for disabilities – **CACI and LR** –, and 3 for mental illness – *Residência de Apoio Moderado* (**RAMo**)*, Residência de Apoio Máximo* (**RAMa**) and *Unidade Sócio-Ocupacional* (**USO**) – were selected. Of these, 4 responses focus on residential

care (ERPI, LR, RAMo and RAMa), while 2 are related to daily activities (CACI and USO).

3.2.2.2. Suitable Responses Study

In the **second sub-step**, a deeper comparative analysis was conducted on these 6 selected responses, examining their specific alignment with CAPDM's model across **4 additional variables**: admission criteria, types of services offered, staffing requirements, and facility areas. This closer analysis (depicted in **Appendix *2*** to **Appendix *7***) provides insights into the alignment and gaps between CAPDM's needs and these existing responses.

ERPI supports elderly users with limited family support, offering a capacity of 120 users with options for both temporary and permanent stays. While the ERPI provides a strong framework for elderly care, its admission criteria, staffing, and service provisions are focused on age-related conditions rather than disabilities. This limits its applicability to CAPDM, which is designed to serve individuals with disabilities who may have more complex care requirements. As such, although the residential care model is relevant, the scope of services and staffing does not align with CAPDM's needs.

LR provides long-term residential care for up to 30 individuals with moderate disabilities, emphasizing the integration of residents into daily living activities. While it shares similarities with CAPDM's residential care model, the limited capacity and absence of specialized medical aid differs from CAPDM initial plan, which requires a more extensive support structure for users with varying levels of disability and complexity.

CACI focuses on the development of skills and integration for individuals with disabilities. While CACI is highly relevant in terms of its approach to social integration and empowerment, it operates as a day service and lacks residential options. This creates a gap with CAPDM's residential model, which aims to offer a permanent living solution for its users.

The following 3 responses are integrated in the CCISM network, therefore tailoring their service offerings to individuals with mental illness, differing from the main focus of CAPDM.

RAMo caters to individuals with moderate psychosocial disabilities, particularly those stemming from severe mental illness, and operates with a multidisciplinary care model designed to provide clinical and psychological support. However, RAMo's focus on mental health conditions, its smaller capacity of just 16 users, and the temporary duration of care (12 months) do not align with CAPDM's need for long-term, residential care for individuals with disabilities across a broader spectrum. While both models share an emphasis on supporting vulnerable individuals with complex needs, RAMo's emphasis on severe mental illness and clinical interventions diverges from CAPDM's more holistic approach, which integrates residential care with daily activities and social integration.

Similarly, **RAMa** is tailored for individuals with severe psychosocial disabilities stemming from severe mental illness conditions, providing specialized staff and facilities for high-care needs. Its focus on more acute conditions makes it unsuitable for CAPDM, which supports individuals with a broader spectrum of disabilities, focusing on less severe conditions. Additionally, the misalignment in capacity (maximum of 24 users) and in duration of care (up to 12 months) further limits its applicability, as CAPDM requires a more flexible and sustainable model for long-term residential care.

Lastly, **USO** supports up to 30 individuals with reduced to moderate disabilities stemming from mental illness, focusing on social integration through day services. While USO offers valuable skill-building and socialization opportunities, it operates solely as a non-residential program, which limits its relevance for CAPDM, as CVPaz requires a permanent residential solution alongside daily activities for its users. Additionally, its limited duration of stay and the restricted range of occupational activities offered make it unsuitable for the more comprehensive care needs of CAPDM's users.

From the 6 analyzed responses, none fully aligns with CAPDM's specific model, as illustrated in **Appendix *8***. Indeed, the **ERPI and RAMa were automatically excluded** due to their focus

on age-related needs and severe mental illness, respectively, which are outside the main scope of CAPDM. However, the remaining 4 responses – 2 residential (**LR and RAMo**) and 2 daily (**CACI and USO**) – present the possibility of being combined to meet CAPDM's requirements. Since LR and CACI serve the same population of individuals with disabilities, and RAMo and USO cater to individuals with mental illness, the logical combinations are LR with CACI and RAMo with USO. The combination of RAMo with USO demonstrates some relevant aspects, such as their structured care models and focus on skill-building, but their short-term duration of care and emphasis on users with higher medical needs make them less suitable for CAPDM. Moreover, the focus on individuals with severe mental illness is not fully aligned with CAPDM main target of individuals with moderate disabilities.

Conversely, the combination of LR and CACI shows potential, as their services complement each other to better meet CAPDM's user profile. LR offers the component of residential care, while CACI focuses on daily activities and integration in society, filling in the gaps of each other's scope and aligning more closely with CAPDM's envisioned response. Still, adjustments to their capacity would be required to fully meet CAPDM's needs.

Overall, the deeper comparative analysis identifies the combination of LR and CACI as the most promising option, assuming ISS allows for capacity adjustments, while the combination of USO and RAMo falls short of CAPDM's needs, as depicted in **Appendix *9***. If neither proves suitable, the atypical cooperation agreement remains an alternative, though less ideal, given the reasons mentioned in Subchapter 3.2.1..

3.2.3. Interviews Insights

Since the combination of LR with CACI appears to be the most suitable approach for operating CAPDM and given that combining responses may not be always straightforward, it is important to understand how this solution would work in practice. Therefore, the **third and final step** of the methodology involved leveraging insights from organizations that collaborate with ISS. For

this, the 8 interviews with organizations mentioned in Subchapter 2.1. also allowed to gather information on the different agreement models adopted and their practical implications. Of the 8 organizations, 4 (CECD, AAJUDE, AAPACDM Porto, and APCC) operate both LR and CACI responses; 1 (*Casa Betânia*) manages only LR, while the remaining 3 (*A Barragem*, *Abraço*, and ARIA) manage other types of agreements with ISS, as detailed in **Appendix *10***.

Regarding the **combination of RAMo and USO**, the interviews confirmed that it is not a viable solution for CAPDM. Beyond the previously identified challenges of mismatched capacity, duration of care, and admission criteria, additional issues emerged. Insights from ARIA, the only organization interviewed which operates responses within CCISM, revealed significant operational and financial hurdles. The referral process, which relies on healthcare professionals to integrate users in CCISM, was criticized for being slow and inefficient, a concern also highlighted in the *Relatório das Experiências-Piloto de Cuidados Continuados Integrados de Saúde Mental* (Cuidados Continuados 2020). This inefficiency complicates user placement and delays access to care. Financial concerns also surfaced, particularly for USO. Instead of the predictable monthly contributions common in other agreement models, payments for responses in CCISM depend on daily user attendance, resulting in highly variable revenue. This unpredictability is especially problematic during low-demand periods or holidays when services may temporarily close, as revenue streams are interrupted but fixed costs remain constant. Moreover, the same report emphasizes the need for clearer definitions of user profiles and the specific objectives of each care type, adding to the complexity of implementation. These combined financial and operational challenges reaffirm that RAMo and USO do not align with CAPDM’s requirements.

Conversely, regarding the **combination of LR and CACI**, the interviews confirmed that it represents the most viable solution for CAPDM. The 4 organizations operating both responses emphasized how these services complement each other, ensuring comprehensive care for

individuals with disabilities. Additionally, they acknowledged that this model generates the highest revenue among the options considered (as confirmed in ***Appendix 11***), though most noted that the funding provided by ISS is still insufficient to cover all expenses. However, AAJUDE stood out as an exception, reporting that financial viability is achievable through effective resource management. The interviews also highlighted that capacity adjustments are feasible within this model. For example, CECD operates multiple CACI agreements within a single facility to maximize efficiency, while APCC successfully negotiated an arrangement to serve users beyond the standard capacity limits. These adaptations demonstrate the model's flexibility and potential to align with CAPDM's operational and financial goals.

In conclusion, through the 3 steps of the methodology, it was possible to gradually rule out less suitable options, ultimately identifying the establishment of a **typical cooperation agreement** with ISS, through a **combination of LR and CACI responses, as the best fit for CAPDM.** Despite some capacity misalignments, this combination remains the most viable choice, providing a sustainable framework for long-term care.

3.3. Social Security Guidelines

For CAPDM to operate as both LR and CACI, it must adhere to the guidelines set by ISS. These guidelines provide the framework in which CAPDM must function, ensuring compliance with operational standards and an understanding of the financial support it is entitled to.

3.3.1. Operational Guidelines

Regarding **capacity**, LR typically accommodates up to 30 residents, while CACI supports a maximum of 60 daily users. CAPDM, however, exceeds these standard capacities, with a predicted maximum capacity of 54 residents and 69 daily service users (54 residential + extra 15 ambulatory). Interviews with organizations holding agreements with ISS revealed a general flexibility in adapting capacities to specific needs, as previously mentioned. For CACI, an adjustment to allow up to 69 users must be negotiated. For LR, a similar adjustment may be

possible, or alternatively, 2 agreements could be established for the same center. This approach has been successfully implemented by CECD, which accommodates 116 users within a single CACI facility by maintaining multiple agreements with ISS.

In terms of **duration**, both LR and CACI are designed for long-term stays, which aligns seamlessly with CAPDM's operational model.

Similarly, the **admission criteria** for users are largely aligned with both responses targeting individuals with disabilities. However, CAPDM’s focus is narrower, prioritizing men who have completed rehabilitation programs but face social exclusion or lack familiar support, addressing an underserved population with specific vulnerabilities.

As for **services provided**, LR primarily focuses on accommodation and assistance with activities of daily living, such as personal hygiene and medication management. CACI, meanwhile, emphasizes a diverse set of activities, including occupational and therapeutic programs, socially useful tasks, initiatives to foster interaction with the community, and activities designed to promote social and professional inclusion. These services complement each other and align with the needs outlined for CAPDM.

In terms of **human resources**, the responses complement each other but will require additional staff to meet CAPDM’s initial plan requirements. This includes hiring specialized professionals to ensure effective service delivery and that the needs of the target population are met.

Finally, the **facility areas** required by ISS largely align with CAPDM’s technical project. Both responses include spaces for reception, administration, staff facilities, activity and socialization areas, dining, kitchen, laundry, and support services, while LR also requires dedicated accommodation spaces. When integrated with LR, CACI’s areas of activity must remain separate, ensuring autonomy and clear differentiation in their functions.

3.3.2. Financing Guidelines

In addition to operational rules, ISS also applies financing rules for institutions operating under

typical cooperation agreements. These responses are entitled to **monthly contributions from ISS**, which are adjusted annually. Every 2 years, a report called the *Compromisso de Cooperação para o Setor Social e Solidário* is published, outlining the contribution for the following 2 years. While this report provides a baseline, an addendum – *Adenda ao Compromisso de Cooperação para o Setor Social e Solidário* – is published the following year to reflect further changes, particularly for the second year of the cycle. These periodic updates ensure that funding aligns with evolving economic conditions and institutional needs. **Appendix** ***12*** depicts the evolution of monthly contributions attributed to LR and CACI (previously *Centro de Atividades Ocupacionais* – CAO) from 2015 to 2024. The most recent report states that IPSS are entitled to receive €1,469 per month for each LR user and €686 per month for each CACI user (CNIS 2024). For users benefiting from both services, the organization is eligible to receive both monthly payments, as the funding is allocated per occupied vacancy at each social response rather than per individual. This reasoning has been validated by institutions such as AAJUDE and CECD, which operate both responses simultaneously.

Users are also expected to contribute to the monthly expenses of their care, based on their personal income and that of their family (Diário da República 2019). **Family contributions** are calculated based on the per capita income of the household, which includes various sources of income such as wages, pensions, social benefits, scholarships, rental income, and other forms of earnings (formula is depicted in **Appendix** ***13***). However, the contribution is capped at a percentage of the total cost of the care provided. The percentage varies depending on the type of service. For LR, the maximum family contribution is set at 90% of the user's income, while for CACI, it is capped at 65% (**Appendix** ***14***). When both services are provided together, family contributions cannot exceed 100%. However, the majority of CAPDM users will likely lack family support, making them the primary contributors to their own family contributions.

Additionally, given their expected profile – individuals with limited work capacity and few income sources – these contributions are expected to be limited. As a result, the primary financial support for CAPDM comes from the monthly contributions provided by ISS associated with each type of social response.

3.4. Social Security Pensions

Another relevant aspect of SS's support to vulnerable populations is the **pensions** (financial benefits) granted to individuals who are unable to work or meet their basic needs. Given that users are expected to have few sources of income, pensions are likely to be the primary component in the calculation of family contributions for most individuals, highlighting their critical role. This financial assistance should not only support the users themselves but also help contribute to the operational costs of CAPDM. As such, it is recommended that CVPaz makes an effort to secure pensions for all eligible users. During the interviews, different organizations confirmed the importance of this revenue source, stating that it is relatively easy to obtain pensions for most, if not all, users. These pensions also help ensure that users have funds for essential personal needs, such as pocket money and medications specific to their conditions. The most relevant pensions for CAPDM users include *Pensão de Invalidez*, *Complemento por Dependência* and *Prestação Social para a Inclusão.*

3.4.1. *Pensão de Invalidez*

Pensão de Invalidez is a monthly benefit designed to provide financial support to individuals with permanent incapacity for work due to physical, sensory, or mental impairments. It is divided into **relative disability** – for those unable to perform their current or recent profession but capable of other work – and **absolute disability** – for those entirely unable to work. Eligibility requires confirmation of incapacity by ISS's verification systems and a minimum contribution period: for relative disability, the individual must have contributed for ISS at least 5 years, while for absolute disability, the required contribution period is 3 years. The calculation

of the amount to be received depends on multiple factors, such as the beneficiary's reference remuneration and the number of years of contributions. However, the minimum amount to be received for a relative or absolute disability pension is €462 per month.

Given the anticipated profile of CAPDM users – individuals who have completed rehabilitation programs but are still unable to reintegrate into society – it is highly likely that they will qualify for an absolute disability pension due to their inability to work (Instituto da Segurança Social, I.P 2024). However, eligibility will ultimately depend on other factors such as whether they have met the required minimum contribution period to ISS.

3.4.2. *Complemento por Dependência*

Complemento por Dependência is a monthly allowance provided to pensioners who are in a state of dependency and require assistance from another person to meet basic daily needs, such as hygiene, mobility, domestic tasks, and feeding (Instituto da Segurança Social 2024). Dependency is classified into 2 levels: **first degree**, for individuals unable to independently perform basic tasks, and **second degree**, for those who are bedridden or suffer from severe dementia in addition to first degree conditions.

For CAPDM users, only a small percentage, if any, are expected to qualify for this benefit, as it is intended for cases of significant dependency. As of 2024, individuals with first degree dependency receive €123, while those classified as second degree dependency are granted €221.

3.4.3. *Prestação Social para a Inclusão*

Prestação Social para a Inclusão (PSI) is a financial assistance program designed to support individuals with disabilities, aiming to promote their autonomy and social inclusion. PSI is made up of 3 components: the **base component, complement, and mark-up** (*Majoração*). The base component is provided to individuals with a disability degree of 60% or above while the complement aims to reduce poverty among adults with disabilities. To be eligible for the complement, users must face economic challenges and must not be institutionalized in a state-

funded social facility, in foster care, or incarcerated. Lastly, the mark-up is an additional benefit granted to individuals with specific needs related to their disability, such as higher care costs.

For CAPDM users, the most relevant component of the PSI would be the base component. The complement is not applicable to the center's users as they are institutionalized. Regarding the mark-up, which is for individuals with more severe disability-related needs, it could apply in certain cases but depends on individual circumstances. Overall, users with an incapacity degree of 60% or above are expected to be eligible for the PSI, which would grant users €316 per month (Instituto da Segurança Social, I.P 2024).

3.5. Recommendations

The analysis conducted in Chapter 3 allows to conclude that ISS, within the broader scope of SS, plays a pivotal role in CAPDM's operations, providing essential financial support mainly through monthly contributions but also with pensions for eligible users. The findings confirm that the **typical cooperation agreement** is the most suitable model for CAPDM, with a **combination of LR and CACI** responses being the recommended approach. This combination not only aligns with CAPDM's goals but also offers the most viable financial framework to ensure the center's sustainability and ability to meet its users' needs effectively.

While LR and CACI responses are common in the sector, it is important to note that these models are not typically designed to address the specific life experiences of CAPDM's users, particularly those who have faced homelessness and extreme adversity. The unique needs of CAPDM's user base require that the services within these frameworks be tailored specifically to their life journeys and needs, which sets CAPDM apart from existing models despite using similar structures.

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 3. 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 4.

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 Chapter 2., 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. 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.

The first category is **personnel costs**, for which CVPaz provided a list of planned staff for CAPDM, split between permanent and retainer base staff. 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 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. 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. 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.

4.2. 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%.

4.3. 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 3. 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. Moreover, total equipment acquisition would increase to over €110,000 in 2026 if inflation abruptly jumps to 8% in that year. 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. 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. 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". 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.

5. Understanding CAPDM Impact

How does CAPDM generate and measure its impact on stakeholders?

The last chapter aims to **summarize the key recommendations** provided throughout this thesis to **assess the impact** of CAPDM project on its main stakeholders.

5.1. Recommendations Summary

To aid the decision-making and project execution processes, a matrix was developed to compare the monetary costs and speed of implementation of each key recommendation. ***Figure 1*** portrays **12 measures** suggested in different chapters, where **half should be applied before CAPDM begins operations**.

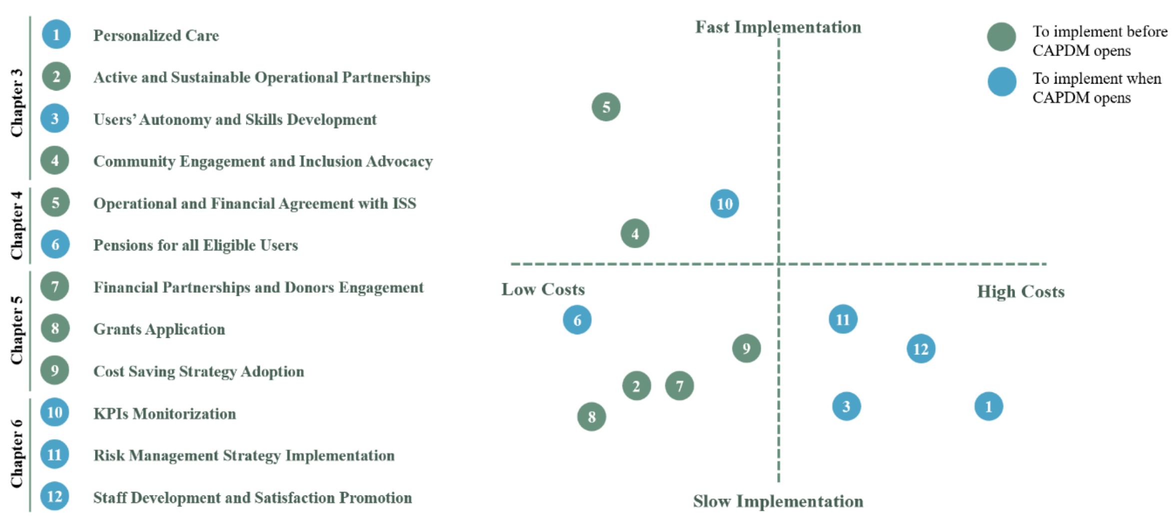

Figure 1: Recommendations Matrix - The cost vs. speed of implementation matrix aims to support the execution plan of CAPDM

In fact, all the aforementioned recommendations should be implemented in CAPDM, regardless of their speed and cost of execution. The **matrix aims to support the opening plan** of the center by highlighting the recommendations that require more time and/or financial resources. Indeed, all suggestions to be implemented before the opening of the center demand relatively low costs. Establishing partnerships (both financial and operational), actively engaging with the community, setting up the ISS agreement and applying for grants must be undergone in advance. Regarding the cost-saving strategy, not all measures require the same effort and/or time: installing solar panels and energy-efficient equipment is more costly than establishing an

agreement with *Valorsul* or negotiating a fuel price discount, for instance. Conversely, most initiatives planned for implementation once CAPDM opens involve higher costs and longer timelines for implementation. For instance, personalized care and staff development require substantial financial resources and extended execution periods due to their tailored and complex nature. Initiatives such as fostering user autonomy and implementing risk management strategies, while moderately costly, also demand careful planning and gradual integration. Even lower-cost measures, like obtaining pensions for eligible users, rely on administrative processes, hence the longer implementation timelines.

5.2. Social Value Created

By adopting the aforementioned recommendations in CAPDM, a positive and lasting impact is expected to be generated on the users and the broader community. To fully realize and communicate this impact, assessing the **social value created by CAPDM** is essential – not only to **demonstrate to stakeholders the tangible impact of the project** but also to **support the application to grants** (e.g., PRR 2030). Thus, leveraging social impact metrics, both quantitative and qualitative, ensures accountability and alignment with CVPaz long-term goals. From a **quantitative perspective**, both the **Social Return on Investment (SROI)** and the **number of individuals supported** are valuable metrics. The first measure goes beyond financial returns by capturing social, health, environmental, and economic benefits, assigning financial values to outcomes defined by beneficiaries and calculating a ratio of benefits to costs (UNDP n.d.). Thus, CVPaz is advised to apply the SROI methodology when CAPDM starts its operations to allow for a complete understanding of its social value and continuously aid strategic decision-making – similar to the study conducted on Street Teams (Comunidade Vida e Paz 2015). Regarding the second measure, CVPaz prioritizes providing comprehensive and high-quality care to all users above maximizing the number of individuals supported. Hence, this metric should serves as a reference to measure social value created.

From a **qualitative perspective**, different frameworks can be adopted to measure the social value created, such as the Sustainable Development Goals (SDGs) and Corporate Social Responsibility (CSR). Firstly, **SDGs** were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity (United Nations Development Programme n.d.). CAPDM is expected to promote "No Poverty" (SDG 1), by providing a safe and stable home for individuals facing social exclusion, offering them a place to rebuild their lives when they otherwise have no suitable options. Moreover, the center makes "Good Health and Wellbeing" accessible for its users (SDG 2), as it ensures access to healthcare (including physical therapy, mental health support, and other wellness initiatives) and to a stable environment with community support. "Reduced Inequalities" (SDG 10) is also present on the roots of CAPDM, since one of its major goals is promoting the inclusion of people with disabilities in the community. Finally, "Sustainable Cities and Communities" (SDG 11) is enhanced by the center since providing access to adequate, safe and affordable housing and basic services should help reducing the number of homeless people (United Nations Department of Economic and Social Affairs n.d.). Lastly, partners, either operational or financial, can embrace CSR by collaborating with CAPDM. **CSR** is a business model in which companies integrate social and environmental concerns into their business operations and interactions with their stakeholders instead of only considering economic profits (HEC Paris n.d.). Within CAPDM context, partners show their CSR in the philanthropic field by donating a portion of their earnings to charities and nonprofits aiming to exert a positive impact on society (Stobierski 2023).

5.3. Impact on Stakeholders

After realizing how the social value created by CAPDM can be measured, identifying the social impact generated across various stakeholders – both internal and external – is crucial. **Social impact** refers to the changes brought about by an organization in the well-being of individuals

or communities, manifested across different dimensions (Comunidade Vida e Paz 2015).

5.3.1. Internal Stakeholders

5.3.1.1. CVPaz

CAPDM's development represents a **transformative project for CVPaz**, both in financial and organizational terms. From a **financial perspective**, the various scenarios and financing options examined in this study are expected to exert different impacts on CVPaz. In the baseline scenario, regarding CAPEX, CVPaz needs to raise around €4,199,556 in 2025 and €6,298,830 in 2026 to build CAPDM infrastructure and establish an ISS agreement. Moreover, €105,000 are required to acquire equipment in 2026 and, from 2028 onwards, an annual average of €7,350 was estimated as replacement expenses. The first financing option presented would imply a debt burden of over €15,000,000 on an IPSS that does not have a history of bank loans. The second option includes an application to PRR 2030 which could alleviate such a burden; however, it may still raise financing concerns as the debt burden still amounts to almost €2,500,000. Thus, the ideal option comprises a combination of PRR 2030 – which would cover almost €9,000,000 – and other grants, financial partnerships and income tax contributions – which would account for almost €1,800,000. Despite the larger effort to secure such funding sources, CVPaz's financial sustainability would not be placed at a high risk, as no bank loans are raised. Concerning OPEX, in 2027, the baseline scenario points to an average monthly cost of €1,572 per residential users and €738 per ambulatory user. Overall, ISS monthly contributions are predicted to be sufficient to cover CAPDM operations as long as the agreement recommended in Chapter 3 is reached. Still, other significant revenue sources should be considered, including users' pensions and income tax contributions. CVPaz's dependence on subsidies as a revenue source should rise with CAPDM project, requiring a careful monitoring of the funding stability. From an **organizational perspective**, CAPDM seamlessly integrates into CVPaz's structure and aligns deeply with its mission of empowering individuals

facing social vulnerability or exclusion to rebuild their lives. Additionally, the project supports CVPaz's vision of creating tailored responses that address the unique needs of the populations it serves. By addressing a critical gap in long-term care, CAPDM contributes to a more holistic approach, ensuring that the IPSS can provide continuous and comprehensive support to its users. Moreover, CAPDM embodies CVPaz's core values of compassion, community, and solidarity, reflecting the organization's commitment to dignity and equity for all individuals. The 7-S Framework explains in a more detailed manner how this integration is achieved (McKinsey and Company 2008).

5.3.1.2. Board Members

The development of CAPDM represents a significant strategic initiative for CVPaz, with direct implications for its board members, who are responsible for the strategic direction and governance of CVPaz. The board plays a crucial role in **overseeing the project's implementation**, ensuring it **aligns with the organization's mission and long-term strategic objectives**. However, the project's scale and novelty bring **additional challenges** that require strategic vision and decision-making from the board. These include securing funding, navigating regulatory frameworks, and mitigating risks associated with CAPEX and OPEX scenarios. Successfully addressing these challenges would position CVPaz as a leader in advancing innovative care solutions and reinforcing its role as a key player in the social sector.

5.3.1.3. Staff and Volunteers

For **contracted staff**, CAPDM creates **new roles and opportunities** for specialization in long-term care focused on individuals with moderate disabilities, alongside valuable training and skill development to enhance their expertise. For **volunteers**, the center provides meaningful opportunities to further contribute to the organization's mission, fostering a **sense of purpose and connection** while improving their understanding of social care and community support.

5.3.2. External Stakeholders

5.3.2.1. Users

CAPDM positively impacts its users by providing **continuous support, specialized care, and engaging activities** that address their unique needs and foster greater autonomy. Additionally, by introducing this new form of care into CVPaz's services, CAPDM streamlines the placement process, ensuring that users are placed in the most appropriate settings. The new center, in turn, **frees up valuable spaces at other facilities**, such as QES, which had previously been occupied by individuals in indefinite stays due to a lack of more suitable options. By offering long-term solutions for individuals who no longer fit other care models, CAPDM not only enhances the quality of care for its users, but also expands CVPaz's ability to meet the needs of a broader community, creating more space and opportunities for those in urgent need.

5.3.2.2. Donors and Partners

CAPDM's successful operation relies on the aid of donors and partners who support its mission by funding operations or providing essential resources and services. These partnerships enable CAPDM to deliver specialized care while offering these stakeholders the opportunity to make a tangible difference. By collaborating with CAPDM, they can further **strengthen their own social impact** and contribute to building a more inclusive and supportive community.

5.3.2.3. Government Agencies

Government agencies, particularly ISS and local authorities, are crucial external stakeholders in the development of CAPDM. For **ISS**, CAPDM represents an **innovative solution that complements its mission** to support vulnerable populations, particularly those with disabilities. By funding and regulating the center, ISS strengthens its role in addressing long-term care gaps and gains a model for future collaborations with similar initiatives. **Local authorities** benefit from CAPDM's **alignment with community welfare goals**, as the center reduces the pressure

on municipal services and enhances the authorities' contribution to social inclusion.

5.3.2.4. Torres Vedras Community

Locally, CAPDM has a direct and positive impact on the community of Torres Vedras. By providing accessible and specialized care options, including tailored day services, the center supports individuals who may otherwise face significant barriers in the community. Additionally, CAPDM plays a key role in fostering social inclusion and challenging societal perceptions regarding individuals with disabilities. By encouraging community engagement and showcasing the rising autonomy of its users, the center helps **shifting societal mindsets and promoting greater acceptance and integration** within the community.

5.3.2.5. Similar Organizations

As a pioneering initiative filling a crucial gap in the market, CAPDM serves as a **model that other institutions may replicate or draw inspiration from**. Its innovative framework has the potential to influence how similar organizations approach care for individuals with disabilities, inspiring the creation of more centers and expanding the reach of services to a larger segment of the population in need. **Opportunities for collaboration** with other organization may also arise, facilitating knowledge exchange, improving the user journey between care facilities, enhancing service delivery, and fostering a more integrated and effective care network.

The development of CAPDM and the potential role model the center might foster will position CVPaz as an innovative association continuously seeking to promote social inclusion and tackle poverty. The construction of this center will certainly pave the way for a more inclusive and open society: one brick at a time, CVPaz brings hope and dignity while combating the stigma surrounding a population experiencing severe social exclusion.

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7. Appendix

Appendix 1: Evolution of operating expenditure with cooperation agreements in Mainland Portugal from 2000 to 2022

Expenditure has been increasing steadily since 2000, reaching €1779M in 2022

Source: Carta Social 2022

Appendix 1: Screening of 41 responses identified for analysis

35 responses were deemed not relevant for further analysis while 6 responses were selected for further analysis

	Screening 1 (Basic criteria)				Takeaway	Explanation
	Residential Care	Target	Capacity	Duration of stay		
Elderly						
Centro de Convívio	No	Elderly (65+)	*Not disclosed*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Centro de Dia	No	Elderly (65+)	60 users	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Centro de Noite	Yes	Elderly (65+)	20 users	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Estrutura Residencial para Pessoas Idosas (ERPI)	Yes	Elderly (65+)	120 users	Temporary or Permanent	Relevant for Further Analysis	Similar service offerings, capacity and duration of care
Serviço de Apoio Domiciliário	No	Elderly and Disabled	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Acolhimento Familiar para Pessoas Idosas e Adultas com Deficiência	Yes	Elderly (60+)	3 individuals	Temporary or Permanent	Not Relevant for Further Analysis	Different target and service offerings
Individuals with disabilities						
Centro de Atendimento, Acompanhamento e Reabilitação Social para Pessoas com Deficiência e Incapacidade (CAARPD)	No	Disabled and Families	*Not disclosed*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Centro de Atividades e Capacitação para a Inclusão (CACI)	No	Disabled (18+)	60 users	*Not applicable*	Relevant for Further Analysis	Similar target, duration of care and partialy similar service offerings
Lar Residencial	Yes	Disabled (16+)	30 users	Temporary or Permanent	Relevant for Further Analysis	Similar target, duration of care and partialy similar service offerings
Residência de Autonomização e Inclusão (RAI)	Yes	Disabled (with autonomy)	5 users	Temporary or Permanent	Not Relevant for Further Analysis	Different service offerings
Serviço de Apoio Domiciliário	No	Disabled	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Serviço de Apoio à Vida Independente (SAVI)	No	Disabled	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Transporte de Pessoas com Deficiência	No	Disabled	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Acolhimento Familiar para Pessoas com Deficiência	Yes	Disabled (18+)	1	Temporary or Permanent	Not Relevant for Further Analysis	Different service offerings
Centro de Férias e Lazer	No	Disabled and Families	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Dependent individuals						
Unidade de Convaslecença (UC)	Yes	After-hospital care	*Not disclosed*	30 days	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Média Duração e Reabilitação (UMDR)	Yes	After-hospital care	*Not disclosed*	30 to 90 days	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Longa Duração e Manuntenção (ULDM)	Yes	After-hospital care	*Not disclosed*	90 days +	Not Relevant for Further Analysis	Different target and service offerings
Equipa de Cuidados Continuados Integrados (ECCI)	No	After-hospital care	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Apoio Domiciliário Integrado	No	Dependent individuals	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Serviço de Apoio Domiciliário	No	Dependent individuals	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Apoio Integrado	No	Dependent individuals	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Cuidados Paliativos (UCP)	Yes	End-of-life care	*Not disclosed*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Unidade Ambulatória Pediátrica (UAP)	No	Children	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Cuidados Integrados Pediátricos (UCIP)	Yes	Children	*Not disclosed*	*Not disclosed*	Not Relevant for Further Analysis	Different target and service offerings
Individuals with mental illness						
Residência de Treino de Autonomia (RTA)	Yes	Reduced/Moderate disability	12 users	12 months	Not Relevant for Further Analysis	Different target and service offerings
Residência Autónoma de Saúde Mental (RA)	Yes	Reduced disability	7 users	12 months	Not Relevant for Further Analysis	Different target and service offerings
Residência de Apoio Moderado (RAMo)	Yes	Moderate disability	16 users	12 months	Relevant for Further Analysis	Partialy similar target and service offerings
Residência de Apoio Máximo (RAMa)	Yes	Severe disability	24 users	12 months	Relevant for Further Analysis	Partialy similar target and service offerings
Unidade Sócio-Ocupacional (USOa)	No	Reduced/Moderate disability	30 users	12 months	Relevant for Further Analysis	Partialy similar target and service offerings
Equipa de Apoio Domiciliário de CCI em Saúde Mental (EAD)	No	Severe disability	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Residência de Treino de Autonomia tipo A - infância e adolescência (RTA-A)	Yes	Children	12 users	12 months	Not Relevant for Further Analysis	Different target and service offerings
Residência de Apoio Máximo (RAMa-IA)	Yes	Children	12 users	12 months	Not Relevant for Further Analysis	Different target and service offerings
Unidade Sócio-Ocupacional infância e adolescência (USO/IA)	No	Children	20 users	12 months	Not Relevant for Further Analysis	Different target and service offerings
Equipa de Apoio Domiciliário de CCI em Saúde Mental (EAD) - infância e juventude	No	Children	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Vida Apoiada	Yes	Severe disability	20 users	*Not disclosed*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Vida Autónoma	Yes	Reduced disability	5 to 7 users	*Not disclosed*	Not Relevant for Further Analysis	Different target and service offerings
Unidade de Vida Protegida	Yes	Moderate disability	5 to 7 users	*Not disclosed*	Not Relevant for Further Analysis	Different target and service offerings
Fórum Sócio-Ocupacional	No	Reduced/moderate disability	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different target and service offerings
Homeless individuals						
Atelier Ocupacional	No	Homeless	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings
Equipas de Rua para Pessoas Sem-Abrigo	No	Homeless	*Not applicable*	*Not applicable*	Not Relevant for Further Analysis	Different service offerings

Source: Diário da República

Appendix 2: Detailed analysis of ERPI

ERPI accommodates up to 120 elderly users, supported by a dedicated team and comprehensive service offerings

***Estrutura Residencial para Pessoas Idosas* (ERPI)**	
Target	Elderly
Capacity	120 users
Duration of Stay	Temporary or permanent
Admission Criteria	- Admission is for individuals over 65 years who lack adequate family or social support - Residents must also demonstrate clinical stability and the ability to participate in personal care and daily activities with some level of supervision
Human Resources	- 1 technical director - 1 sociocultural animator or social educator or geriatric technician, part-time for every 40 residents - 1 nurse for every 40 residents - 1 direct action assistant for every 8 residents - 1 direct action assistant for every 20 residents, as a reinforcement during the night - 1 person in charge of domestic services in establishments with a capacity of 40 or more residents - 1 cook per establishment - 1 cook's assistant for every 20 residents - 1 auxiliary employee for every 20 residents
Services	- Accommodation - Food provision, appropriate to the needs of the residents, respecting medical prescriptions - Assistance with personal hygiene - Laundry services - Room hygiene - Socio-cultural, recreational and occupational activities - Support with activities of daily living - Nursing care, as well as access to health care - Administration of drugs, when prescribed
Facility Areas	- Reception - Management, technical and administrative services - Staff facilities - Socializing and activities - Dining area - Accommodation - Kitchen and laundry - Nursing services - Support services

Source: Diário da República 2012

Appendix 3: Detailed analysis of LR

LR accommodates up to 30 users with disabilities providing care and support for daily living

***Lar Residencial* (LR)**	
Target	Individuals with disabilities
Capacity	30 users
Duration of Stay	Temporary or permanent
Admission Criteria	- Individuals (16+) with disabilities who are unable to live with their families or live in situation of social exclusion - Residents must be actively integrated into society through participation in education, training, or community programs
Human Resources	- 1 technical director - 1 direct action assistant for every 10 residents - 1 general services assistant for every 3 residents - 1 sociocultural animator during the weekend - 1 cook per establishment - 1 cook's assistant for every 20 residents
Services	- Accommodation - Food provision, appropriate to the needs of the residents, respecting medical prescriptions - Assistance with personal hygiene - Support with activities of daily living - Laundry services - Support with medication plans, as well as planning and attending medical appointments and other healthcare services - Sports, socio-cultural and recreational activities
Facility Areas	- Reception - Management, technical and administrative services - Staff facilities - Socializing and activities - Dining area - Accommodation - Kitchen and laundry - Support services

Source: Diário da República 2015

Appendix 4: Detailed analysis of CACI

CACI provides day services for up to 60 users with disabilities, focusing on societal integration and skill-building activities

Centro de Atividades e Capacitação para a Inclusão **(CACI)**	
Target	Individuals with disabilities
Capacity	60 users (30 users per functional unity)
Duration of Stay	Temporary or permanent
Admission Criteria	- Individuals aged 18 or older with disabilities who are unable, temporarily or permanently, to continue education, pursue employment, or are in the process of socio-professional inclusion
Human Resources	- 1 technical director - 1 psychologist - 4 physical, social or professional rehabilitation professionals - 2 general services assistant - 1 monitor for every 10 residents - 1 direct action assistant for every 10 residents - 1 cook per establishment - 1 cook's assistant for every 20 residents
Services	- Food provision and personal care - Therapeutical support - Promotion of physical, emotional, psychological, and social well-being - Transportation - Training of caregivers - Occupational, therapeutical, community engagement, social beneficial and skill-building activities
Facility Areas	- Reception - Management, technical and administrative services - Staff facilities - Socializing and activities areas - Dining area - Kitchen - Support services

Source: Diário da República 2021

Appendix 5: Detailed analysis of RAMo

RAMo provides accommodation for up to 16 individuals with mental illness, offering daily rehabilitation and medical care for a duration of 12 months

Residência de Apoio Moderado **(RAMo)**	
Target	Individuals with mental illness
Capacity	16 users
Duration of Stay	12 months
Admission Criteria	- Moderate degree of psychosocial disability due to severe mental illness - Lack of adequate family or social support - Clinical stabilization of the acute phase of the illness; - Preserved or acquired instrumental functionality through previous rehabilitation processes in areas such as spatial-temporal orientation, personal care, physical mobility, interpersonal relationships, domestic life activities, and community mobility - Significant relational difficulties, without impairments in community mobility or the ability to recognize danger and initiate preventive safety measures for oneself and others - Need for regular supervision in basic and instrumental activities of daily living - Acceptance of the rehabilitation program - Acceptance of the payment terms
Human Resources	- 1 technical director - 1 nurse specializing in mental health and psychiatric nursing or a nurse with recognized experience in the field (6h/week) - 1 social worker (6h/week) - 1 psychologist (6h/week) - 1 psychosocial rehabilitation technician (35h/week) - 1 monitor (35h/week) - Direct action assistants (168h/week)
Services	- Accommodation - Daily psychosocial rehabilitation activities - Support and guidance in daily life activities - Psychosocial support, including for family members and other informal caregivers - Awareness-raising and training for family members and informal caregivers - Access to general healthcare and psychiatric specialty care - Nursing care - Supervision in medication management - Food provision - Hygiene and comfort care - Laundry services - Social interaction and leisure activities
Facility Areas	- Reception - Management, technical and administrative services - Socializing and activities - Dining - Accommodation - Kitchen and laundry - Support services

Source: Diário da República 2021

Appendix 6: Detailed analysis of RAMa

RAMa provides accommodation and intensive support for up to 24 individuals with severe mental illness, offering rehabilitation and medical care for a 12-month stay

Residência de Apoio Máximo **(RAMa)**	
Target	Individuals with mental illness
Capacity	24 users
Duration of Stay	12 months
Admission Criteria	- High degree of psychosocial disability due to severe mental illness - Lack of adequate family or social support - Clinical stabilization of the acute phase of the illness; - Need for assistance with hygiene, meals, personal care, financial management, and medication administration - Severe functional or cognitive impairments, significant relational difficulties, inability to recognize danger, inability to initiate preventive safety measures for oneself or others, and limited community mobility - Acceptance of the rehabilitation program - Acceptance of the payment terms
Human Resources	- 1 technical director - 1 nurse specializing in mental health and psychiatric nursing or a nurse with recognized experience in the field (112h/week) - 1 social worker (7h/week) - 1 psychosocial rehabilitation technician (35h/week) - 1 monitor (35h/week) - Direct action assistants (280h/week)
Services	- Accommodation - Daily psychosocial rehabilitation activities - Support and guidance in daily life activities - Psychosocial support, including for family members and other informal caregivers - Awareness-raising and training for family members and informal caregivers - Access to general healthcare and psychiatric specialty care - Daily nursing care - Administration of medication - Food provision - Hygiene and comfort care - Laundry services - Social interaction and leisure activities
Facility Areas	- Reception - Management, technical and administrative services - Health services area - Socializing and activities - Dining - Accommodation - Kitchen and laundry - Support services

Source: Diário da República 2021

Appendix 7: Detailed analysis of USO

USO provides day services for up to 30 users with mental illness for 12-month stays, focusing on rehabilitation and community integration activities

***Unidade Sócio-Ocupacional* (USO)**	
Target	Individuals with mental illness
Capacity	30 users
Duration of Stay	12 months
Admission Criteria	- Moderate degree of psychosocial disability due to severe mental illness - Clinical stabilization of the acute phase of the illness; - Preserved or acquired instrumental functionality through previous rehabilitation processes in areas such as spatial-temporal orientation, personal care and physical mobility - Behaviors that do not disrupt coexistence with other users or hinder group activities - Impaired functionality in relational, occupational, and/or professional areas - Acceptance of the rehabilitation program - Acceptance of the payment terms
Human Resources	- 1 technical director - 1 social worker (17,5h/week) - 1 psychologist (17,5h/week) - Psychosocial rehabilitation technicians (70h/week) - Monitors (70h/week)
Services	- Support and guidance in daily life activities - Psychosocial support - Awareness-raising and training for family members and informal caregivers - Support for self-help groups, including family members and informal caregivers - Support and referral to training and professional integration services - Promotion of socio-cultural and sports activities in collaboration with the community - Supervision of medication management - Food provision - Social interaction and leisure activities
Facility Areas	- Reception - Management, technical and administrative services - Socializing and activities - Dining - Kitchen - Support services

Source: Diário da República 2021

Appendix 8: Comparison of criteria analyzed for each suitable response

Colored cells indicate an alignment between the response and the requirements of CAPDM; no response fully aligns with CAPDM requirements

ESTRUTURA RESIDENCIAL PARA IDOSOS **(ERPI)**	***LAR RESIDENCIAL*** **(LR)**	***CENTRO DE ATIVIDADES E CAPACITAÇÃO PARA A INCLUSÃO*** **(CACI)**	***RESIDÊNCIA DE APOIO MODERADO*** **(RAMo)**	***RESIDÊNCIA DE APOIO MÁXIMO*** **(RAMa)**	***UNIDADE SÓCIO-OCUPACIONAL*** **(USO)**
MAXIMUM CAPACITY	MAXIMUM CAPACITY	MAXIMUM CAPACITY	MAXIMUM CAPACITY	MAXIMUM CAPACITY	MAXIMUM CAPACITY
DURATION OF STAY	DURATION OF STAY	DURATION OF STAY	DURATION OF STAY	DURATION OF STAY	DURATION OF STAY
ADMISSION CRITERIA	ADMISSION CRITERIA	ADMISSION CRITERIA	ADMISSION CRITERIA	ADMISSION CRITERIA	ADMISSION CRITERIA
HUMAN RESOURCES	HUMAN RESOURCES	HUMAN RESOURCES	HUMAN RESOURCES	HUMAN RESOURCES	HUMAN RESOURCES
SERVICES	SERVICES	SERVICES	SERVICES	SERVICES	SERVICES
FACILITY AREAS	FACILITY AREAS	FACILITY AREAS	FACILITY AREAS	FACILITY AREAS	FACILITY AREAS

Source: Diário da República

Appendix 9: Overview of combination of most suitable responses

Colored cells indicate an alignment between the response and the requirements of CAPDM with the combination of LR and CACI showing the closest match

LR + CACI	RAMa + USO
MAXIMUM CAPACITY	MAXIMUM CAPACITY
DURATION OF STAY	DURATION OF STAY
ADMISSION CRITERIA	ADMISSION CRITERIA
HUMAN RESOURCES	HUMAN RESOURCES
SERVICES	SERVICES
FACILITY AREAS	FACILITY AREAS

Source: Diário da República

Appendix 10: Overview of social responses of interviewed organizations

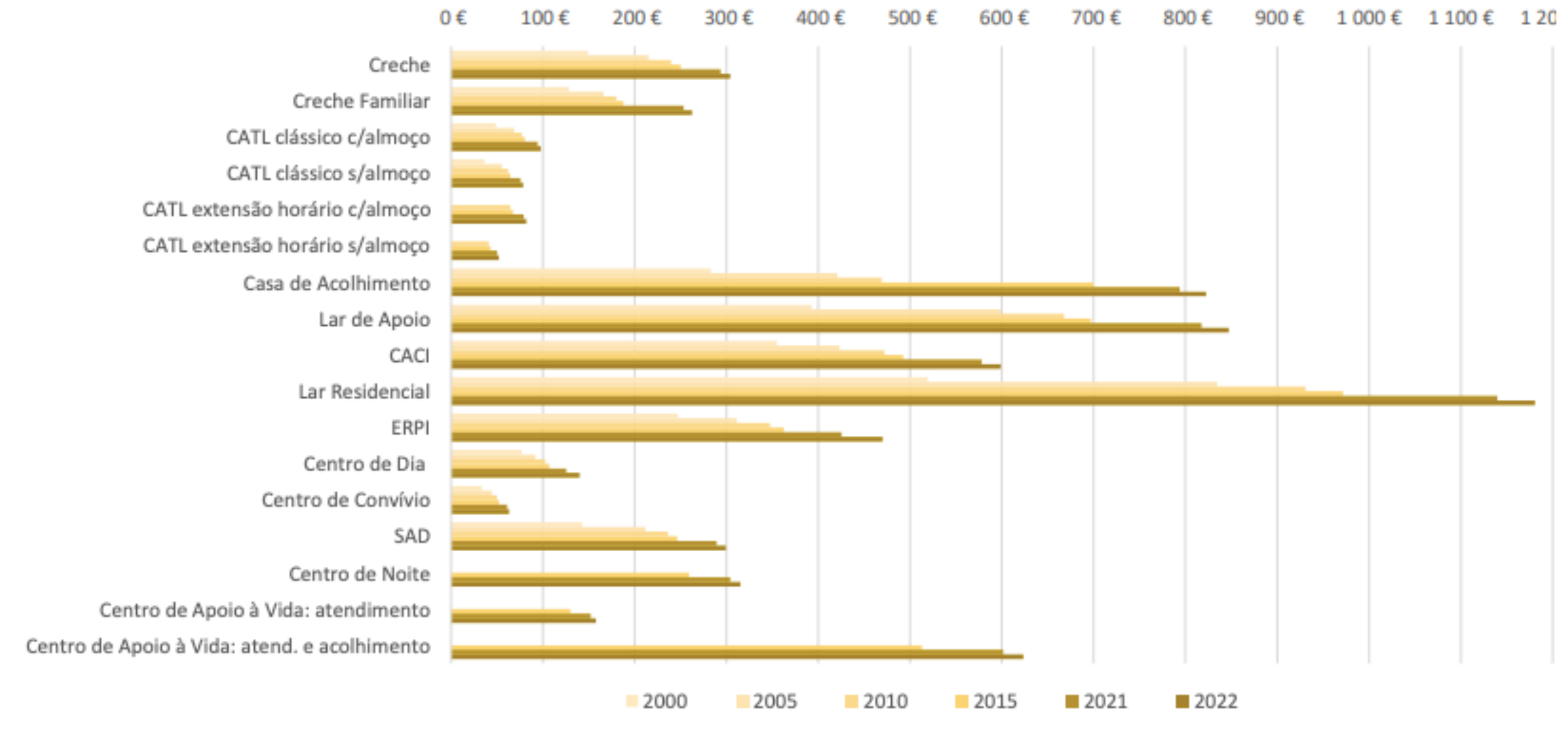
4 out of 8 interviewed organizations operate both LR and CACI responses

Organization		LR	CACI	Other
A Barragem	A Barragem	No	No	- *Comunidade Terapêutica* (Management Agreement) - *Apartamento de Reinserção*
Abraço	abraço	No	No	- *Centro de Atendimento e Acompanhamento Psicossocial* - *Unidade Residencial*
ARIA	aria	No	No	- *Fórum Sócio-Ocupacional* - *Residência de Treino de Autonomia* (RTA - RNCCISM) - *Equipa de Apoio Domiciliário* (RNCCISM)
CECD	cecd	Yes	Yes	- *Serviço de Apoio Domiciliário*
AAJUDE	AAJUDE	Yes	Yes	
APPACDM Porto	APPACDM PORTO	Yes	Yes	- *Centro de Atendimento, Acompanhamento e Reabilitação Social para Pessoas com Deficiência e Incapacidade* (CAARPD) - *Centro de Apoio à Vida Independente* (CAVI)
APCC	apcc	Yes	Yes	- *Centro de Atendimento, Acompanhamento e Reabilitação Social para Pessoas com Deficiência e Incapacidade* (CAARPD) - *Centro de Apoio à Vida Independente* (CAVI) - *Serviço de Apoio Domiciliário*
Casa Betânia	Casa de BETÂNIA	Yes	No	

Source: A Barragem 2024, Abraço 2024, ARIA 2024, CECD 2024, AAJUDE 2024, APPACDM Porto 2024, APPC 2024, Casa Betânia 2024

Appendix 11: Evolution of Social Security's monthly contributions per user for Mainland Portugal from 2000 to 2022

LR and CACI are among the highest monthly contributions provided by SS



Source: Carta Social 2022

Appendix 12: Evolution of monthly contributions provided by SS for LR and CACI responses from 2015 to 2024

Yearly contribution adjustments drive consistent growth for both LR and CACI, with LR achieving a higher CAGR of 4.70%

ISS annual historic payments	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Lar Residencial	€971,62	€984,25	€1 004,92	€1 027,03	€1 062,98	€1 100,18	€1 162,58	€1 204,43	€1 340,53	€1 469,22
Growth		*1,3%*	*2,1%*	*2,2%*	*3,5%*	*3%*	*5,7%*	*3,6%*	*11%*	*9,6%*
CAGR	*4,70%*									
CACI	€492,63	€499,03	€509,51	€520,72	€538,95	€557,81	€577,89	€598,69	€647,49	€686,24
Growth		*1,3%*	*2,1%*	*2,2%*	*3,5%*	*3,5%*	*3,6%*	*3,6%*	*8,2%*	*6,0%*
CAGR	*3,75%*									

Source: Compromisso de Cooperação para o Setor Social e Solidário 2015-2024

Appendix 13: Formula used by ISS to calculate monthly household income per capita

Household income is determined by considering total household income, monthly fixed expenses, and the number of members in the household

$$RC = \frac{RAF/12 - D}{n}$$

sendo:

RC = Rendimento *per capita* mensal
RAF = Rendimento do agregado familiar (anual ou anualizado)
D = Despesas mensais fixas
n = Número de elementos do agregado familiar

Source: Diário da República 2019

Appendix 14: Maximum percentage of monthly per capita income charged for family contributions by social response

Ambulatory users (CACI, previously CAO) contribute 65% of their income towards family contributions, while residential users (LR and CACI) contribute a percentage to be determined but not higher than 100%

Resposta Social	Percentagem máxima de rendimento *per capita*
Serviço de Apoio Domiciliário	75 %.
Centro de Dia	60 %.
Centro de Noite	25 %.
Lar Residencial (sem frequência de CAO)	90 %.

Resposta Social	Percentagem máxima de rendimento *per capita*
Serviço de Apoio Domiciliário	75 %.
Centro de Dia	60 %.
Centro de Noite	25 %.
Lar Residencial (sem frequência de CAO)	90 %.
Lar Residencial (com frequência de CAO)	60 %.
Centro de Atividades Ocupacionais (da comunidade)	65 %.
Centro de Atividades Ocupacionais (utente em lar residencial)	A % a estabelecer deve ter em conta a aplicada no lar residencial, não podendo o seu somatório exceder 100 %.
Residências Autónomas	40 %.

Source: Diário da República 2019