CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Maternal Mental Health Month
Coming Together, Help is Here

Best Practices in Team-Based Care | May 20, 2025

Care Transformation Collaborative of RI

Agenda

Topic/ Presenters	Duration
Welcome / Announcements / Introductions Jody Vieira, LICSW	12:00-12:05 PM 5 Mins
RI MomsPRN, Erica Oliveira	12:05-12:13 PM 8 Mins
Family Service of Rhode Island Marie Palumbo-Hayes, and Sarah Kelly-Palmer	12:13-12:29 PM 16 Mins
Rhode Island Coalition to End Homelessness Lindsay Cutler	12:29-12:37 PM 8 Mins
Sojourner House Justine Mainville Pagano	12:37-12:45 PM 8 Mins
Questions for Panel	12:45-1:00 PM 15 Mins

Housekeeping

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
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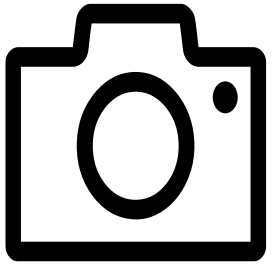
ADVANCING INTEGRATED HEALTHCARE

- Today's session will run for a total of 60 minutes.
- This session is being recorded and will be made available for future viewing.

Mute your microphone when not talking.

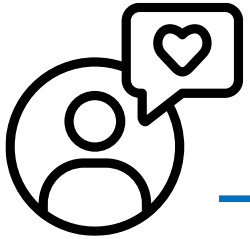
Limit distractions as best as possible.

Use reactions & the raise hand feature.



Engage and turn your camera on if you are able.

Use the chat to ask introduce yourself, ask questions and share resources.



Engage - ask questions, offer feedback, provide support.

Objectives

- Learn about mental health and health related social need supports that primary care and community-based organizations can effectively use to provide families with support during perinatal time period
- Learn how your team can build relationships with community-based organizations
- Learn how to quickly and effectively connect your client to resources based on family priorities

Speaker Introduction

Erica Oliveira, BA, CHW (CPH and MPH Candidate)

RI MomsPRN
Maternal Psychiatry Resource Network

With over 16 years of experience at Women & Infants Hospital, I have worked alongside world-renowned experts in Neonatology, Pediatrics, Developmental Psychology, Addiction Medicine, and Clinical Research. This experience has equipped me with the knowledge, leadership skills, and practical expertise necessary to coordinate multi-site research projects and engage equitably with diverse populations.

I have specialized experience and training in supporting perinatal patients with behavioral health needs including substance use disorders. Past research projects include maternal and infant mental health as well as advancing equitable access to healthcare. I have cultivated strong, ongoing partnerships with the Rhode Island Department of Health, the Department of Children, Youth, and Families (DCYF) of Rhode Island, and various community-based organizations to improve support services for patients' behavioral health needs. Active member in Care New England Hospital System Leadership Development Program, Substance Exposed Newborn (SEN) taskforce, RI Overdose Preventions Taskforce and community advisory board for RI Collaborative Care Model for Perinatal Wellness Support Services – Population-level Equity-Centered Solutions (COMPASS+) Program.

Currently, I serve as a Maternal Behavioral Health Resource and Referral Specialist with the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN), clinical navigator for perinatal patients with Opioid Use Disorder, and as the Lead Coordinator for an NIH-funded randomized controlled trial aimed at improving medical treatment and developmental outcomes for infants with Neonatal Opioid Withdrawal Syndrome (NOWS).

Workforce Supports For Maternal Mental Health

- Statewide program launched in September 2019 that is modeled after Rhode Island's successful Pediatric Psychiatry Resource Network (PediPRN)

- Two-levels of health professional supports are offered:
  - **Statewide mental health teleconsultation line that includes resource/referral support**
  - **Intensive practice-level quality improvement and professional education supports**

RI MomsPRN
Maternal Psychiatry Resource Network

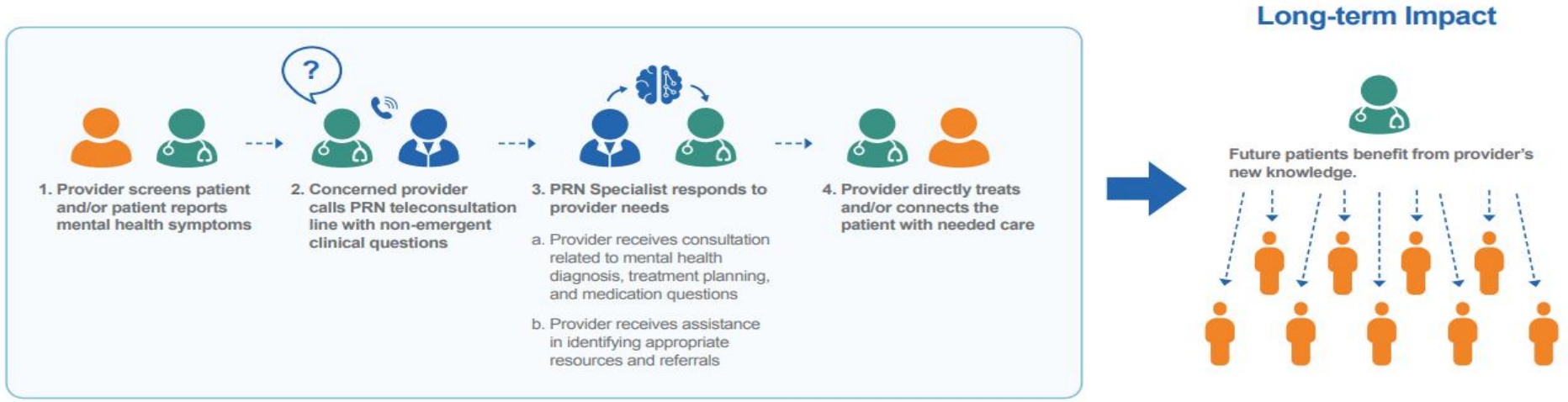
PediPRN
Pediatric Psychiatry Resource Network

WOMEN & INFANTS
Center for Women's Behavioral Health

BROWN Health UNIVERSITY
Bradley Hospital

RI MomsPRN is a Vital Resource

- Statewide clinical teleconsultation services help increase access to care



- Impacts since statewide teleconsultation services launched in Sept. '19

3,152 Calls

From **858** Healthcare Professionals

at **280** Practices

2,677 Perinatal People Helped

44.9% Reside in the Four Core Cities

WOMEN & INFANTS
Center for Women's Behavioral Health

RI MomsPRN
Maternal Psychiatry Resource Network

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Healthcare professionals supporting pregnant and postpartum women are welcome to call the RI MomsPRN teleconsultation line Monday – Friday for support

Resource and Referral (Social worker)

Any Healthcare professional or Relevant Staff

- Call intake and triage
- Make connections to treatment and support services
- Schedule provider teleconsultation with perinatal behavioral health experts

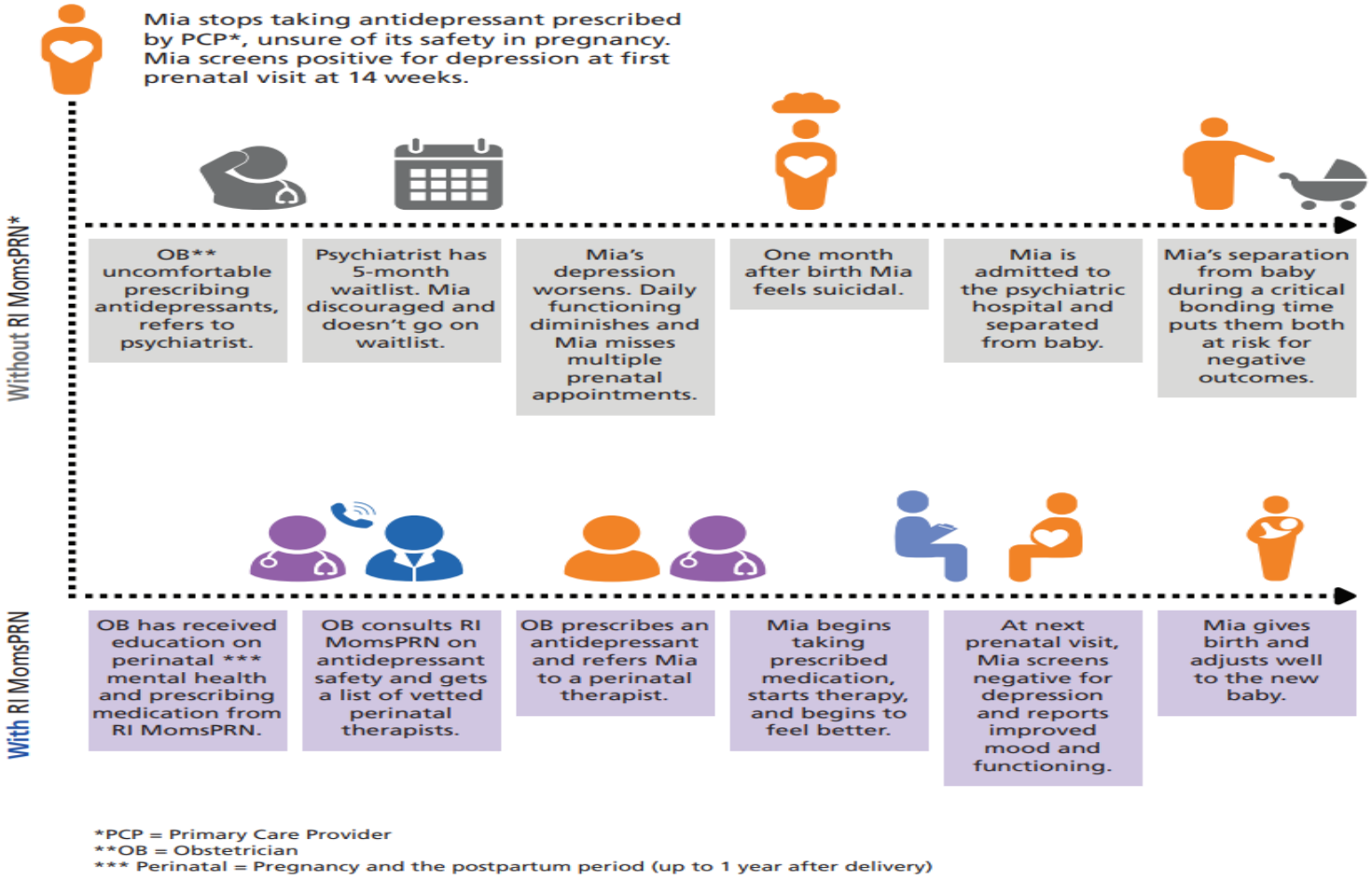
Clinical Consultation (Psychiatrist and Psychologist)

Prescribers Only

- Same-day, provider-to-provider psychiatric teleconsultation services
- Diagnostic support
- Treatment planning
- Medication and dosage recommendations

Learn More: www.womenandinfants.org/ri-momsprn

RI MomsPRN Teleconsultation Example



*PCP = Primary Care Provider
**OB = Obstetrician
*** Perinatal = Pregnancy and the postpartum period (up to 1 year after delivery)

WIH Center for Women's Behavioral Health – Patient Services

ADVANCING INTEGRATED HEALTHCARE

Day Hospital Program

- More intensive mental health care for pregnant and postpartum mothers (Mon – Fri 9am-2pm)
- Mother-baby unit where infants accompany their mother to each treatment day
- Led by a multidisciplinary team of perinatal specialists incl. psychiatrists, clinical psychologists, clinical social workers, case managers and specialized nursery staff

Outpatient Perinatal Psychiatry

- Medication management by psychiatrists and psychiatric NPs with specialized training in how to prescribe medications safely during preconception, pregnancy and lactation

Moms MATTER

- Office-based MAT with buprenorphine (Suboxone) for Opioid Use Disorder
- Psychiatric medication management as needed
- Case management services
- Assistance in caring for babies with NAS/NOWS in collaboration with pediatricians at Women & Infants Hospital

Perinatal OCD Intensive Outpatient Program

- 3 days/wk x 3 hrs/day: Mon, Wed, Thur 9:30a – 12:30p
- Fully Virtual

WIH Prenatal Consultation, Family Care Unit, & Inpatient NOWS Treatment - Patient Services

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ADVANCING INTEGRATED HEALTHCARE

About NOWS

When a woman takes an opioid during pregnancy, the drug can pass from mother into the baby and may cause the baby to show signs of withdrawal after birth. This is called Neonatal Opioid Withdrawal Syndrome (NOWS), also known as Neonatal Abstinence Syndrome (NAS).

NOWS is a group of signs and symptoms in a newborn baby such as:

- Shaking
- Irritability
- Crying a lot
- Sweating
- Poor feeding
- Loose stools

A baby can have slight symptoms or can get very sick from NOWS. If the baby has NOWS, the baby's doctors will watch the baby closely. The baby's doctors may want to treat the baby to help them get better.

Prenatal Consultation:
Prenatal consultations can be arranged by phone, email or fax:
Phone: (401) 274-1122 x 47402
Email: NICUNAS-ConsultRefs@carene.org
Fax: (401) 453-7571

Prenatal Consultation, Family Care Unit and Inpatient NOWS Treatment:
101 Dudley Street
Providence, RI 02905

Family Care Follow-Up Clinic:
(401) 274-1122, ext. 48935
Center for Children and Families
50 Holden Street
Providence, RI 02905

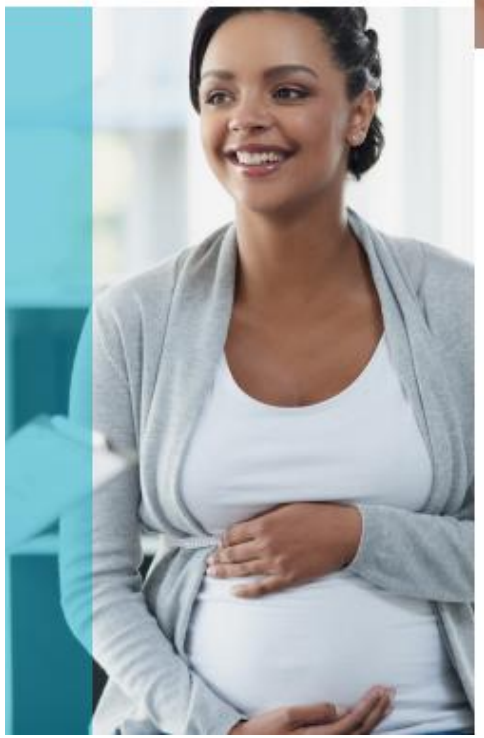
WOMEN & INFANTS

101 Dudley Street
Providence, Rhode Island 02905
(401) 274-1100
womenandinfants.org

Hover your phone's camera over the QR code below to visit our website:

Prenatal Consultation

Pregnant women taking opioid medications during pregnancy may meet with a member of the Family Care Unit team to discuss Neonatal Opioid Withdrawal Syndrome (NOWS), and receive a guided tour of the Family Care Unit. Patients have the opportunity to meet members of the newborn service team that will help care for their newborn and have the opportunity to ask questions that may ease anxiety prior to delivery.



Inpatient Observation in the Family Care Unit

Infants who were exposed to opioids during pregnancy will be observed for a minimum of five days in the Family Care Unit. During this time, parents will be involved in the care of their newborn. Babies identified with NOWS will receive additional inpatient care.

Inpatient NOWS Treatment

If NOWS treatment is needed for a baby after mom is discharged, Women & Infants will, as available, provide a hospital room for mom and baby to stay together. Mom is supported and encouraged to help care for her baby during NOWS treatment. Daily family care rounds are held at 1:10 p.m. with a multidisciplinary care team that includes physicians, nurses, occupational therapists, physical therapists, researchers, and social work.

Family Care Follow-Up Clinic

Services and evaluation are offered for all infants cared for at Women & Infants and other hospitals across the region who were exposed to opiates during pregnancy. Services from hospital discharge into childhood include medical, psychosocial, and developmental evaluation, family therapy, and assessment of baby's developmental milestones.

Speaker Introduction

Marie Palumbo-Hayes,
LICSW, Chief of Community Health

FSRI Family Service OF RHODE ISLAND
healthy families • strong communities

Marie Palumbo-Hayes, LICSW is the Chief of Community Health overseeing the Health Division at Family Service of Rhode Island. For the past 38 years Marie has worked closely as an executive member, clinician, trainer and consultant with programs and staff who deliver trauma informed interventions for clients from birth to elder years in Rhode Island and Massachusetts. Marie received her Master in Social Work degree from Boston College in Massachusetts. She holds Post Graduate Certificates in the areas of Family Systems Therapy and in Childhood Trauma and Treatment. She has also been trained in several Evidence Based Practice Models working with children, youth, adults and families. She was awarded the Manuel Carbal Commonwealth of Massachusetts Citation for Outstanding Performance in Clinical Social Work. Marie currently provides consultation for two of the Care Transformation Collaborative Rhode Island's (CTC-RI) initiatives that support infants, children, adults and families: the DULCE Planning Team and the Developmental Delay/Autism ECHO Project.

At Family Service of Rhode Island, Marie currently oversees Maternal and Child Health Initiatives: Early Intervention, First Connections, Healthy Families America, DCYF Best Start Program, Cedar; and Community Health work with CTC-RI. She also oversees the AIDS Project Rhode Island program and Housing Support and Economic Mobility services. Additionally, Marie is involved with initiatives lead by the Vice President of Equity and Community Development such as: The South Providence Health Equity Zone in 02905 neighborhoods; Healthy Start at Jenks Pediatrics; and the DCYF Juvenile Justice Planning Grant.

FSRI Early Childhood Programs

- **Early Intervention (EI)**

  Early Intervention supports children from birth to age three who have, or at risk for, developmental delays. Our team – including educators, speech-language pathologists, physical and occupational therapists, and other specialists – provide personalized, home-based therapeutic services.

  * ***Referrals can be made directly to Veronica Ogazon:***

    ogazonve@familyserviceri.org or call the EI referral number: 401-519-2280

FSRI Early Childhood Programs

- **Cedar Family Center**

  The Cedar Family Center program provides support to families of children who have special healthcare needs from birth – 21 years of age. Cedar staff work closely with families to complete a needs assessment, develop a plan with family-driven goals, and create a coordinated network of support for the family.

* Children with Medicaid who have two or more chronic conditions, one chronic condition and a risk of developing a second, or severe mental illness/severe emotional disturbance are eligible

  * ***For referrals, call FSRI intake at 401-400-6574 or email intake@familyserviceri.org***

FSRI Early Childhood Programs

- **First Connections(FC)**

  First Connections is a short-term (1-3 visits) home visiting program with a team of Registered Nurses, Community Health Workers, and Social Workers.

  * Prenatal persons and families with children up to 3 years of age are eligible; FSRI serves families in Providence, Cranston, Kent County and Washington County

  * ***Referrals can be made by calling the FSRI's FC Intake Line at 401-519-2308***

FSRI Early Childhood Programs

- **Healthy Families America (HFA)**

  Healthy Families America is an evidence-based long-term family home visiting program for children up to 5 years old.

  *Mothers who are prenatal and postnatal are eligible for HFA

  * FSRI serves families in Providence, Kent County, and Washington County

  * ***For referrals contact the Health Information Line at RIDOH: 401-222-5960 or contact Fiona Nicholson, FSRI HFA Program Director at 401-692-3326***

Speaker Introduction

Sarah Kelly-Palmer,
LICSW, Chief of Behavioral Health

Family Service of Rhode Island
healthy families • strong communities

Sarah is a Licensed Independent Clinical Social Worker and Chief of Behavioral Health Services at Family Service of Rhode Island (FSRI) where she oversees the implementation of FSRI's Certified Community Behavioral Health Clinic (CCBHC). Sarah received her Master's Degree in Social Work at the State University of New York at Albany. Sarah specializes in the implementation of evidence-based treatments and trauma-informed care in mental health and child welfare systems. Sarah is an adjunct faculty member at Fordham University, where she teaches classes in child and adolescent trauma. Sarah provides training and consultation in trauma-informed treatment and practices in mental health, education, and child welfare settings and presents nationally on the subject of trauma-informed practice. Sarah has been the Project Director and/or Principal Investigator on several federal grants related to CCBHC and trauma-informed treatment. Sarah has worked at FSRI for 22 years and lives in North Kingstown, RI with her husband and son.

How FSRI Impacts the Community

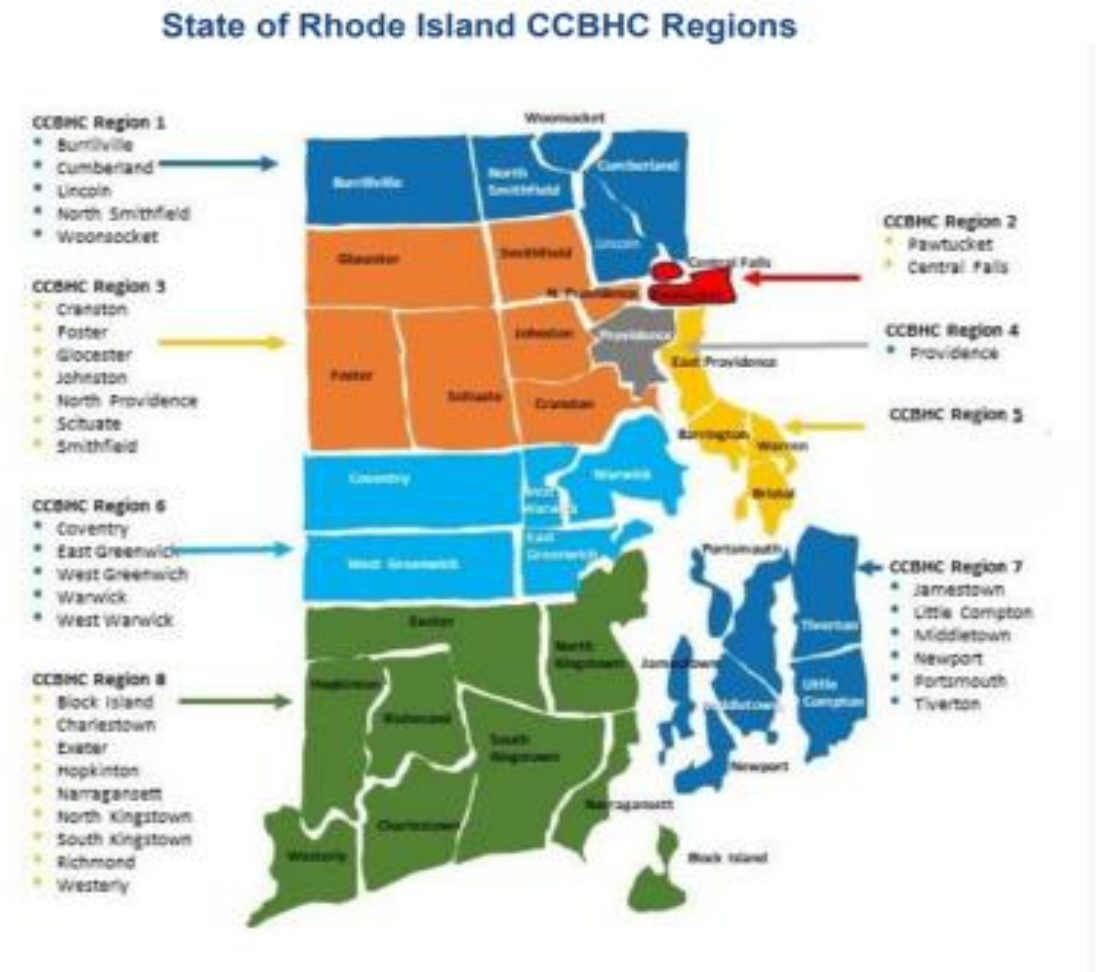
Health	Healing	Hope	Home	Help
Improving health and well-being throughout the lifespan.	Delivering trauma-informed behavioral health response and recovery.	Building safety and resilience after crisis.	Fostering safe and loving homes.	Providing systems and support.
AIDS Project RI	CCBHC	Go Team™	Enhanced Case Management	Advancement
Best Start RI	Emergency Response Services and Mobile Crisis	Lucy's Hearth	Family Care Community Partnership	Facilities
Caring Dads	Intake	Mount Pleasant Academy	Family Coaching & Visitation	Finance
Cedar	Intensive Care – Dialectical Behavior Therapy	NCTSN Center for Trauma Informed Policing	Foster Care	Human Resources
Early Intervention	Mental Health Awareness and Training Grant	OJJDP Central Falls School Support	Kinship Cares	Information Systems
First Connections	NCTSN Children's Treatment and Recovery Center	Victim Services	Residential	Training
Healthy Families America	Psychiatry	Youth and Young Adult Housing Advocacy	SafeCare	Quality Management
Housing & Economic Mobility	School Based		TST Community Health Team	
South Providence 02905 Health Equity Zone	TST Community			

Certified Community Behavioral Health Clinics (CCBHCs)

- CCBHCs play a significant role in the Behavioral Health Service array in Rhode Island
- Eight state CCBHCs were certified on October, 1, 2024
- All CCBHC's must offer a specific set of services including:
  - Screening, assessment, and diagnosis
  - Patient-centered treatment planning
  - Outpatient Behavioral Health
  - 24/7/365 Crisis Services
  - Medication Management
  - Targeted Case Management
  - Primary Health Screening
  - Veteran's Services
  - Care Coordination

CCBHCs in Rhode Island

- There are eight state-certified CCBHCs across the State.
  - Community Care Alliance- Region 1
  - Gateway-Pawtucket- Region 2
  - Gateway-Johnston-Region 3
  - FSRI & The Providence Center- Region 4
  - Thrive- Region 6
  - Newport Mental Health- Region 7
  - Gateway- South County- Region 8
- CCBHCs can serve clients out of their catchment area (except for mobile crisis & MRSS)
- There is currently not a Certified CCBHC in the East Bay (Region 5)



How can a person access a CCBHC?

CCBHCs strive to be easily accessible in their communities

- All CCBHC's have walk-in hours where clients can receive immediate assistance
- All CCBHC's have mobile crisis services for adults and children (24/7)
- Referral sources can make direct referrals for service
- CCBHCs must serve clients regardless of place of residence and ability to pay (slide fee scale applies)
- CCBHCs are held to certain timeframes regarding access to care:
  - Potential clients should be offered an appointment within ten business days from the request.
  - Mobile crisis & MRSS response are expected to respond within an hour for emergency calls

Family Care Community Partnership (FCCP)

- Primary Prevention Program for RI's Child Welfare Program
- Broken-up by catchment areas
  - FSRI- Providence, Cranston
  - Communities for People- East Providence, Central Falls, Pawtucket
  - Child & Family- East Bay
  - Tri-County- Washington/Kent
  - Community Care Alliance- Northern RI
- Can support perinatal and post-natal parents whose children are at-risk of abuse or neglect.
- Utilizes a wrap-around model of care to support caregivers and families.

FSRI Services

- To access FSRI services:
  - Call our intake department at 401-519-2280
  - Crisis Line: 401-854-6678

  - Sarah Kelly-Palmer, kellysa@familyserviceri.org
    401-954-1782

Speaker Introduction

Lindsay Cutler, Community Programs Manager, Rhode Island Coalition to End Homelessness

The Rhode Island Coalition to End Homelessness

I have over 8 years of experience working to improve access to housing, health, and support services for people experiencing homelessness. Earlier in my career, I served as an AmeriCorps VISTA working in disaster response, where I coordinated rebuild efforts and volunteer services for survivors. My work focuses on building strong partnerships, developing effective programs, and ensuring services are practical, equitable, and grounded in the needs of the people they serve.

As Community Programs Manager at the Rhode Island Coalition to End Homelessness, I lead a team dedicated to centering the voices of people with lived experience of homelessness in shaping policies and programs. Our work also includes expanding access to disability benefits, supporting service providers, and delivering community training on homelessness and the Housing First Model to strengthen the homelessness response system. I collaborate with public agencies, service providers, and community partners to strengthen Rhode Island's response to homelessness.

I am passionate about embedding the belief that housing is a human right into every aspect of my work, striving to make this fundamental truth a guiding principle for policies, programs, and practices across the system.


The Rhode Island Coalition to End Homelessness

The Rhode Island Coalition to End Homelessness

Who we are and what we do

Mission

The Coalition works collaboratively to create and advance lasting solutions to ***prevent and end homelessness in Rhode Island***.

Vision

We are a dynamic Coalition committed to ensuring that no Rhode Islander experiences homelessness.

Guiding Principles

- Safe and Affordable Housing is a Basic Human Right
- A Person's Worth is not Determined by their Housing Status
- Informed by Lived Experience & Data

Areas of Work

- Policy & Advocacy
- Constituent Engagement
- Systems Transformation
- Training & Support for Service Providers

The Coalition's Work

The Coalition typically serves as a leader, convener, and/or coordinator for initiatives that involve multiple partners and stakeholders

Coordinated Entry System (CES)	Centralized access to housing and shelter resources for people experiencing homelessness
Constituent Engagement	People with lived experience sharing their stories and shaping policies and programs.
Homeless Management Information System (HMIS)	Data collection and analysis tool to used support service coordination and policy.
Housing is Health Collaborative	Integrates housing with healthcare to improve outcomes.
Pay For Success (PFS)	Pilot program using private investment to fund permanent supportive housing. Clients Identified from predetermined list of high utilizers of crisis services
Policy & Advocacy	Legislative work and lobbying to secure resources and protect rights.
SOAR	Supporting individuals to access Social Security disability benefits
Statewide Street Outreach Coordination	Coordinating statewide efforts to connect unsheltered individuals with services.

Coordinated Entry System

WHAT is the Coordinated Entry System?

A "CES" (Coordinated Entry System) is a nationwide process designed to provide equitable access to housing and support services for individuals facing a housing crisis.

The Coordinated Entry System provides a single access point + "No Wrong Door" approach and a standard assessment + prioritized referral process for individuals and families facing a housing crisis who are seeking Emergency Shelter or Permanent Housing opportunities.

4 components are considered essential to an effective CES:

Access > Assessment > Prioritization > Referral

Rhode Island Coalition to End Homelessness

ACCESS

CES Help Center Hours

Mon – Fri: 9AM - 7PM
Holidays & Weekends: 2PM - 7PM

CALL
(401) 277-4316

Any language can be accommodated via our language line.

Callers may avoid wait times by submitting their number to our "Callback Queue"! Simply press 2 after choosing your language choice and an agent will call back as soon as they are available.

CHAT

Our **website** offers a chat feature to speak to a Help Center agent in the client's preferred language.

EMAIL

Primarily used for follow up by shelter providers with inquiries about the CES process.

CESShelter@rihomeless.org

HUD's Categories of Homelessness

Category 1- Literally Homeless (shelter/street)

Category 2 - Imminent Risk of Homelessness (14 days)

Category 3 - Homeless under other Federal statutes

Category 4 - Fleeing/Attempting to Flee Domestic Violence

**These categories determine eligibility for most housing, shelter, or services for people experiencing homelessness

Housing Problem Solving

Resources aimed at preventing households that are at imminent risk of becoming homeless from entering the shelter system and assisting households who are homeless to ensure a rapid move into stable housing. Services can range from individuals accessing benefits to providing one-time financial support for first month's rent, move- in supplies, groceries, or car repairs.

Referrals for Housing Problem solving come through the CES call center and are managed by Crossroads

Additional resources exist in the community with various agencies that can help with housing stability

For example:

- DHS Housing Stability Pilot (referrals can still be made through crossroads)
- CAP agencies - utility assistance and may offer rental or mortgage assistance for their region
- Population specific resources (i.e. for veterans, etc) through agencies serving those populations
- RI Legal Services Eviction Prevention
- Home Stabilization Services (offered through many different service providers including CCBHCs and Homeless Service Providers)
- 2-1-1 is a great great avenue for additional resources and referrals

Many resources can take several weeks to access from the time of referral, referrals should be made as soon as the need is identified.

The Subsidized Housing Trifecta

1. Centralized Waiting List: www.waitlistcentralri.com
2. Rental Resource Guide:
3. Rhode Island Coordinated Entry System

Rhode Island Coalition to End Homelessness

What kind of Housing is out there?

Private Market

- Private landlords
- No subsidy
- Credit/Criminal checks
- Best for individuals with high income and few/no barriers

Homeless Specific Subsidies (through CES)

- COC
- CHF
- 811
- New Lease
- PFS
- Best for individuals with significant barriers

Mainstream/Traditional Subsidies

- Hundred of separate applications
- Different tenant selection plans
- Rental Resource Guide
- Best for individuals with low income and few/no barriers

Centralized Waitlist

- Common application style
- HCVP (new term for Section 8)
- Project Based Voucher (PBV)
- Best for individuals with few/moderate barriers

Considerations for Family Homelessness

Impacts of trauma on both adults & children

Intersection of homelessness as traumatic event as well as high potential for experiences of domestic violence or other forms of violence/oppression already impacting family

Hidden Homelessness

Many families experiencing homelessness are forced to double up or find alternative places to stay due to capacity issues of the shelter system - which then impacts their prioritization for shelter, fear of bringing children to shelter, behavioral needs of children, makeup of family, etc.

Capacity

There are less family shelter beds than individual beds available in RI, making it more difficult to find space, especially for larger households.

The majority of subsidized housing opportunities are allocated for elderly and disabled individuals

SOAR

SSI/SSDI Outreach, Access, and Recovery (SOAR) uses a national best practice model to support SSI and SSDI applications for people experiencing or at-risk of homelessness. SOAR Specialists follow clients throughout the application process, evaluating eligibility, developing medical evidence, and advocating with Social Security. SOAR is far more than completing paperwork and can be an alternative to working with a disability attorney for people submitting new applications.

Currently the Coalition and Sojourner House both accept referrals for SOAR

The Coalition's SOAR program eligibility:

- Category 1 homeless (in shelter, sleeping in a place not meant for human habitation) and individuals who are now in rapid rehousing (RRH) or permanent supportive housing (PSH) programs.
    - OR: transition aged youth (TAY), aged 18-24) experiencing homelessness
    - OR: fleeing or attempting to flee domestic violence (DV)
- Has a condition that has lasted or will last at least 12 months that directly prevents them from working at any job
- Not currently working
- Does not currently have a pending Social Security claim

Referrals at https://www.rihomeless.org/soar-portal. Referrals should be made by a case manager or provider who knows the client well and has the ability to help support the application process. SOAR is meant to be an expedited process but can still take around 6 months or longer.

Questions?

Speaker Introduction

Justine Mainville Pagano,
Violence Prevention & Education Manager

Sojourner House

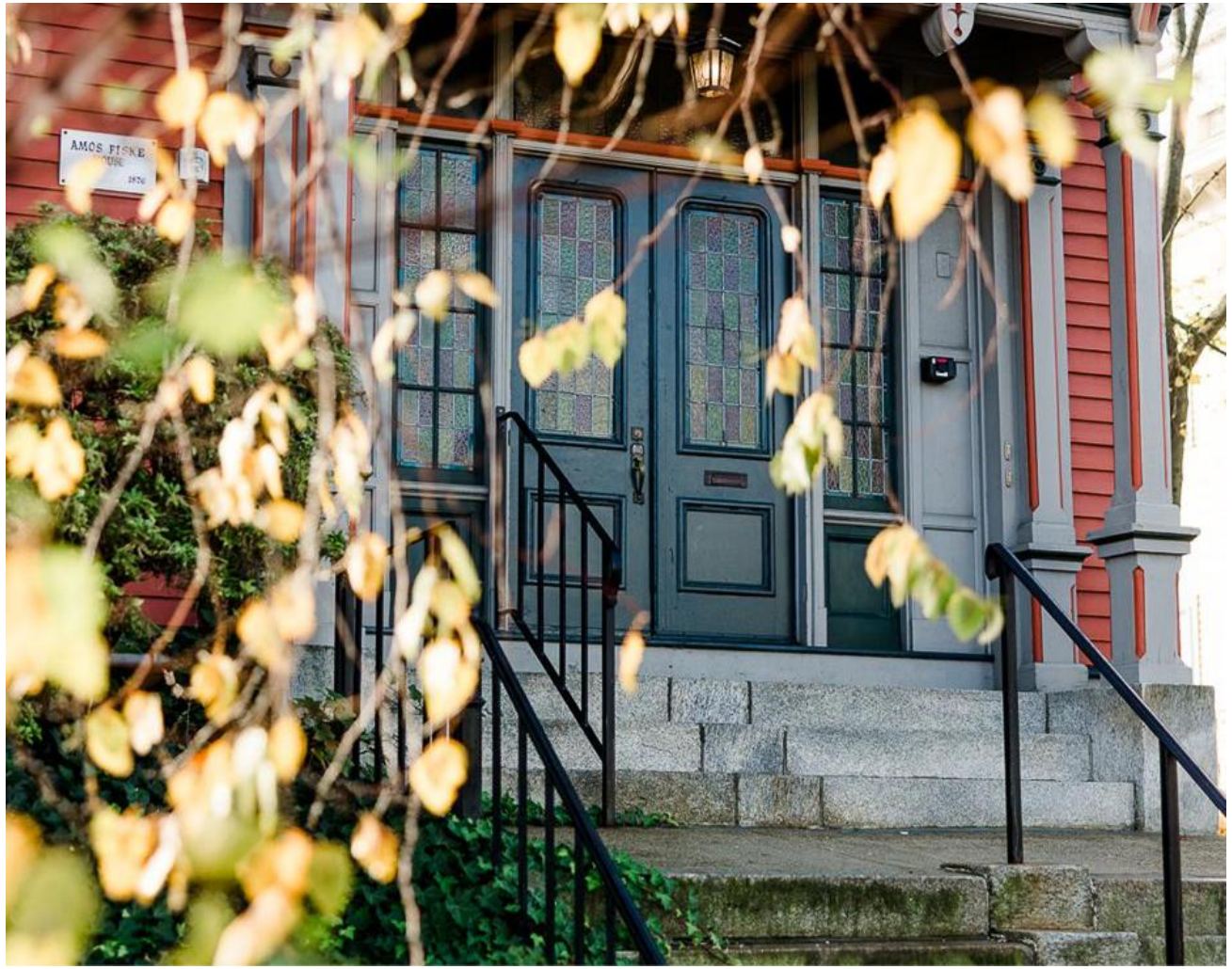
Justine Mainville Pagano has been a part of Sojourner House since 2022 and serves as the Violence Prevention & Education Manager. In this role, she works with community partners, schools, private companies and healthcare providers to lead conversations and workshops about interpersonal violence, harassment and more. As a member of the MOSAIC team, she works with the healthcare sector to examine and improve upon screening practices to better identify and serve birthing people experiencing intimate partner violence. As a survivor of DV, this work is dear to her.

Prior to joining Sojourner House, Justine completed her Masters in the Art of Teaching at Brown University and had the honor of teaching young folks in Providence for 7 years. She's an alum of Rhode Island College and has worked and volunteered in non-profit settings since she arrived in Providence in 2007. She looks forward to welcoming her first child later this summer.

Sojourner House

For over 45 years, Sojourner House has served thousands of victims and survivors of domestic abuse, sexual violence, and human trafficking.

We offer wraparound services such as support groups, emergency shelter, transitional and permanent supportive housing, sexual health advocacy, and emotional support.



Sojourner House provides:

- advocacy
- shelter & housing
- clinical support
- legal services
- support groups
- sexual violence support
- education
- mother-to-mother mentoring

Sojourner House
Committed to Ending
Domestic Violence, Sexual Assault
and Human Trafficking

MOSAIC - MOther'S Advocate In the Community

MOSAIC Mentors

Assist identifying mothers of young children who are experiencing difficulties due to stress and/or isolation by listening and providing resources

We match mentors to mothers in the community, to assure they are getting their needs met.

To refer a patient:

Call the helpline

401-765-3232

Visit the Drop In Center

1570 Westminster St. | Providence, RI

Email Vicky (without identifying information about the patient)

vdepena@sojournerri.org

MOSAIC also aims to create meaningful connections & conversations in the community to help address & respond to perinatal IPV through:

- training
- resources
- campaigns
- advocacy

Sojourner House
Committed to Ending
Domestic Violence, Sexual Assault,
& Human Trafficking

MOSAIC PROGRAM

Sojourner House

ATTENTION

The MOSAIC Program is a mentorship initiative aimed at reducing stress and depression among expectant mothers. In this program, mothers-to-be are paired with volunteer mothers who undergo a comprehensive five-week training before they are matched. MOSAIC Volunteer Moms offer advocacy, emotional support, safety planning, and guidance throughout the pregnancy journey. If you are interested in joining the program, please contact the MOSAIC Intervention Coordinator for more information.

Vicky
MOSAIC Intervention Coordinator
Email: vdepena@sojournerri.org
Phone: 401-270-7748

Questions?

CME Credits

- (applied for MDs, PAs, Rx, RNs, NPs, PhD)
  - CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.
  - Evaluation/Credit Request Form:
  - https://www.surveymonkey.com/r/Team-based-Care-CME-evaluation
  - Evaluations must be completed to receive credit
  - Certificates will be mailed ~ 1 month after event

THANK YOU

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