Edith, a strong and independent 81 year old woman, living alone, fell while at home and was unable to get to the phone for twelve hours. She wound up in rehab at Grace Cottage Hospital for a few weeks. Her doctor was adamant that she could no longer live at home. Thankfully, just a couple weeks prior, Edith’s SASH Coordinator, Alicia Moyer, had met with her to work on her Healthy Living Plan (HLP). Edith’s HLP included a comprehensive list of supportive people in her life and a transition plan. Edith and Alicia outlined who Edith’s SASH team members were, their contact information, and when and why they might be contacted. This foresight and planning was instrumental following her admission to the hospital. Edith’s team members had established a rapport with one another and were able to quickly work together on a plan to get Edith back home; where she desperately wanted to be.

With the support of her discharge planner, SASH Coordinator, power of attorney and friend, Edith was able to go back home with a plan and safety precautions in place. Edith received a Lifeline device to wear 24/7 and Meals on Wheels for balanced meals each day; both services strengthening her confidence at home. Staff from the Community Health Team (CHT) visited Edith at home after her discharge and her SASH team scheduled caregivers for regular visits. Edith’s Care Coordinator completed a cognitive screen with Edith and shared the results with her doctor, arranged for bubble packs for her medications, and offered suggestions regarding fall risk reduction. Railings were installed throughout Edith’s home for safety. Edith had a health coach visit to assess her nutritional situation and offer advice. After each visit, supporting team members reported back to one another on Edith’s wellbeing.

What transpired during Edith’s transition back home is an example of how SASH team members work collaboratively to support their participant in staying healthy and safely at home. As a result of the SASH team’s collective action and planning, Edith continues to improve and enjoy an independent life at home. She has scheduled to work with a physical therapist to “develop core strength” and has been consistently adhering to her exercises, she is sleeping in her bed again after some modifications were made, and reports feeling significantly stronger and more balanced.

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**SASH Team Partners – Townshend, Vermont**

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Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)
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