

SAMPLE DOCUMENT — For illustrative purposes only. Client details are fictional.

Clinical Care Roadmap

PREPARED FOR
The Hartley Family

CARE RECIPIENT
Margaret Hartley, 81

PRIMARY ADVOCATE
Waypoint Care Management

ROADMAP PERIOD
8 Weeks | Ongoing Retainer

DATE ISSUED
March 2026

A note on this document: This roadmap represents our commitment to Margaret and the Hartley family. Every step has been developed based on our clinical assessment findings. Nothing here is boilerplate — each recommendation reflects the specific risks, relationships, and goals we identified during the Initial Assessment process.

Questions at any time: (602) 341-5779 | info@waypointcaremanagement.com

Assessment Summary

The following findings were documented during the Initial Assessment conducted March 10–11, 2026. They form the clinical basis for every recommendation in this roadmap.

AGE 81	PRIMARY DX Moderate Vascular Dementia + Type 2 Diabetes	CURRENT SETTING Independent Living, Scottsdale, AZ	FAMILY 3 adult children, all out-of-state
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Clinical Findings & Risk Flags

Category	Finding	Priority
Medication	11 active medications across 4 prescribers — no single coordinating physician. Two identified drug interactions not yet flagged.	CRITICAL
Cognition	Moderate dementia confirmed. Current living placement inconsistent with observed safety needs. Falls risk elevated.	HIGH
Nutrition	Irregular meal patterns; blood sugar logs absent for 3 weeks. Diabetic care plan not updated since 2023.	HIGH
Social	Limited social contact. Primary daily interaction is facility staff. Signs of mild isolation and low mood.	MEDIUM
Legal/Financial	No healthcare proxy on file with current facility. PoA documentation outdated (2018).	HIGH
Care Team	4 specialists, 1 PCP — no shared care plan or communication protocol. Discharge summaries not shared across providers.	CRITICAL

The 8-Week Roadmap

WEEKS 1–2 Comprehensive Assessment & Documentation Review

IN PROGRESS

Objective

Establish a complete, accurate clinical picture before any recommendations or interventions are made. This phase is complete — findings drove all subsequent roadmap priorities.

Completed This Phase

- ✓ Reviewed 4 years of medical records, discharge summaries, and specialist notes
- ✓ Conducted in-person clinical observation visit (2.5 hours) at Margaret's residence
- ✓ Interviewed Margaret privately and separately with family present
- ✓ Mapped full medication list — cross-referenced for interactions and duplications
- ✓ Assessed current independent living environment for fall risk and safety gaps
- ✓ Documented family communication dynamics and existing decision-making structure
- ✓ Identified 2 critical drug interactions requiring immediate prescriber contact
- ✓ Confirmed advance directive / POA gaps — escalated to legal priority

Key Deliverable: Findings Summary (pages 2–3 of this document)

WEEKS 3–4 Care Team Coordination & Protocol Implementation

UPCOMING

Objective

Resolve the identified medication conflicts, establish a single coordinating physician, and implement a shared care protocol across all providers.

Action Items

Action Item	Owner	Target
Contact prescribing physicians for the two flagged drug interactions — request immediate review	Waypoint	Week 3, Day 1

Facilitate introduction of a geriatric care coordinator within Margaret's PCP practice	Waypoint + PCP	Week 3
Distribute unified medication list to all 4 specialists and PCP	Waypoint	Week 3
Draft and circulate shared care plan template for provider sign-off	Waypoint	Week 3–4
Coordinate updated diabetic care plan with endocrinologist	Waypoint + Endo	Week 4
Initiate referral for updated cognitive assessment (formal neuropsych)	Waypoint + PCP	Week 4
Review and recommend POA / healthcare proxy update with family-referred attorney	Family + Atty	Week 4

What to Expect

You will receive a written update at the end of Week 3 and Week 4 confirming which action items are complete, any provider responses received, and any items requiring family input or decision.

Objective

Establish a sustainable, low-conflict communication structure so that all three family members have clear visibility into Margaret's care — and a defined process for making decisions together.

Action Items

Action Item	Owner	Target
Conduct family strategy session (video) with all three siblings — review findings and align on priorities	Waypoint + Family	Week 5
Establish agreed-upon communication cadence (weekly digest vs. event-driven updates)	Waypoint + Family	Week 5
Define decision-making roles: who is consulted vs. who has final authority for various care decisions	Waypoint + Family	Week 5
Create shared family portal access for care updates, documents, and contact directory	Waypoint	Week 5–6
Facilitate placement review discussion — is current independent living setting appropriate?	Waypoint + Family	Week 6
Draft placement transition plan if family consensus supports a setting change	Waypoint	Week 6
Coordinate with Margaret's social worker re: social engagement options at current facility	Waypoint	Week 6

A note on family dynamics

Our assessment noted that the three siblings currently operate with limited shared information and have historically disagreed on care priorities. The Week 5 strategy session is designed to establish a clear framework before a crisis forces a rushed decision. This is one of the highest-value interventions we can make at this stage.

Objective

Shift from reactive to proactive. By Week 7, the acute risks have been addressed — this phase builds the systems that prevent the next crisis from occurring.

Action Items

Action Item	Owner	Target
Conduct in-home safety assessment — fall risk mitigation, medication storage, emergency access	Waypoint	Week 7
Install and configure medical alert system with 24/7 monitoring (vendor recommendations provided)	Family / Vendor	Week 7
Establish Waypoint's 24/7 crisis hotline protocol with facility staff and family contacts	Waypoint	Week 7
Complete quarterly health review framework — template and schedule established	Waypoint	Week 7–8
Deliver final 8-week summary report with ongoing retainer transition memo	Waypoint	Week 8
Confirm ongoing retainer scope with family — Essential Advocate or Comprehensive Care	Waypoint + Family	Week 8

Identified Crisis Triggers to Monitor

- ▶ Unplanned ER visit or hospitalization
- ▶ Blood glucose readings outside target range for 3+ consecutive days
- ▶ Fall — with or without injury
- ▶ Refusal of medications for more than 48 hours
- ▶ Significant behavioral change or increased confusion
- ▶ Any provider recommending a placement or level-of-care change

Ongoing Retainer Services

The 8-week roadmap addresses the immediate clinical priorities. Ongoing retainer services transition Margaret's care from intervention to partnership — with Waypoint actively monitoring, advocating, and keeping the family informed every step of the way.

<h3>Essential Advocate</h3> <p>\$1,500 / month</p> <ul style="list-style-type: none">✓ 24/7 clinical crisis hotline access✓ Monthly comprehensive health reviews✓ Medication management oversight✓ Care team coordination & communication✓ Quarterly family strategy sessions✓ Written monthly updates to family	<h3>Comprehensive Care</h3> <p>\$2,500 / month</p> <ul style="list-style-type: none">✓ Everything in Essential Advocate✓ Weekly proactive check-ins with Margaret✓ Unlimited care team meetings✓ Hospital & facility advocacy visits✓ Real-time health status updates✓ Advanced care planning support✓ Financial & legal resource coordination✓ Priority scheduling for all services
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Our Recommendation for the Hartley Family

Given Margaret's dual diagnosis, the identified provider coordination gaps, and the family's out-of-state situation, we recommend the Comprehensive Care retainer. The weekly check-ins and hospital advocacy visits are particularly important at this stage — vascular dementia is progressive, and the next 12 months will likely involve at least one significant care transition. You want Waypoint already embedded in the care team when that happens, not called in afterward.

Questions? We're here.

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