BRIDGEPOINT+

Understanding Your Care: ICU · Telemetry · Med/Surg · SNF

A Guide for Patients & Families at Our Long-Term Acute Care Hospital (LTACH)

Welcome to Bridgepoint Continuing Care Hospital

Our facility is a Long-Term Acute Care Hospital (LTACH) with an onsite Skilled Nursing Facility (SNF). As you or your loved one's condition changes, they may move between different units within our campus. This guide explains each unit so you can better understand why you or your loved one might be staying on a certain unit. At Bridgepoint our goal is to keep you or your loved one from having to return to a traditional hospital setting, receiving the right care at the right time in the right place. When you move between units at our facility, our same medical team can provide you with different levels of care and keep you from having to change facilities.

About Us

An LTACH (Long-Term Acute Care Hospital) is a specialized hospital for patients with serious medical conditions who need extended hospital-level care, typically 25 days or more depending on their condition and insurance guidelines and requirements. Bridgepoint focuses on medically complex patients who require a high level of ongoing skilled treatment, monitoring, and rehabilitation. Both our National Harborside and Capitol Hill campuses along with their LTACH units, have on-site SNF units, which if selected at the time of discharge allow patients to transition smoothly to their next level of care without leaving the campus. Stanton Park Health and Rehabilitation is located within our Capitol Hill facility, and Harborside Health and Rehabilitation is located within our National Harborside facility.

At-a-Glance: Unit Comparison

Feature	ICU	Telemetry	Med/Surg	SNF
Level of Care	Highest / Most Intensive	High / Step-Down	Moderate	Rehabilitation/ Long-Term / Restorative
Nurse-to-Patient Ratio	1:3	1:4	1:5	Facility dependent and acuity based
Monitoring	Continuous bedside monitors, ventilators, invasive lines	Continuous cardiac & pulse-ox monitoring	Periodic vitals & assessments	Routine vitals; less frequent
Typical Patient	Life-threatening illness, organ failure, post-major surgery	Cardiac arrhythmia, post-ICU, close observation needed	Stabilizing but continues to need hospital level care prior to transitioning to SNF level. Includes patient needing extended IV antibiotics and wound care	Needs daily skilled nursing or rehab after acute illness. Higher intensity of care than home or outpatient services.
Goal of Stay	Stabilize & sustain life	Transition from ICU; monitor closely	Treat illness / manage conditions	Rehabilitation focused. Regain as much independence as possible; prepare for discharge

Unit Details

ICU	Telemetry	Med/Surg
• Requires life-support equipment (ventilators, IV drips, pressors) • Continuous monitoring 24/7 by critical care nurses • Physicians may be present at bedside frequently • PT/OT/Speech services may begin as medically appropriate	• Heart rhythm continuously monitored • Less equipment than ICU; more independence for patient • Physical therapy or occupational therapy may begin or continue if already started in the ICU • Can be a Step-down from ICU or step-up from Med/Surg depending on level of monitoring needed.	• Condition is stabilizing but still requires hospital level of care • Wound care, IV antibiotics, or complex medication management • Continued therapy sessions (PT/OT/Speech) as ordered • Large discharge planning focus and planning for the next steps in care plan

Skilled Nursing Facility (SNF) — Available Onsite at Our LTACH

Skilled Nursing services are for patients who are medically stable but need continued skilled care before returning home or to a lower level of care such as an assisted living or long-term care services. Bridgepoint works closely with many SNFs who can provide continued care and rehabilitation during your recovery. Your case manager will discuss with you SNF options prior to discharge. Both Bridgepoint locations offer onsite SNF services, and if selected, patients can continue their care and rehabilitation onsite. Stanton Park Health & Rehabilitation is located within our Capitol Hill campus, and Harborside Health & Rehabilitation is located within the National Harborside campus. You and your family may select either a SNF closer to home or one of our on-campus locations. Benefits of an onsite SNF include seamless transition (no ambulance transfer needed), familiar staff, and coordinated care plans. Acceptance to any SNF facility is dependent on several factors including clinical appropriateness, insurance, staffing and bed availability. Please reach out to your case manager if you have any questions. For a complete list of skilled nursing facilities in your area including current Medicare star ratings please visit: medicare.gov/care-compare

How & Why Patients Move Between Units

Transitions between units are a sign of progress, or a response to changing medical needs. Your care team monitors your loved one continuously and moves them to the appropriate level of care as their condition evolves or changes. If at any time you or your loved one needs closer medical support and monitoring unit changes can occur to provide optimal care.

Common pathways:

- ICU → Telemetry: Condition stabilizing; continuous life support is no longer needed, but heart monitoring continues.
- Telemetry → Med/Surg: Cardiac rhythms stable; ready for standard acute nursing care.
- Med/Surg → SNF: Acute illness stabilized; now focused on recovery and rebuilding strength.
- SNF → Home or Community: Goals met; patient and family ready for discharge with support plan in place.

Questions You Can Always Ask Your Care Team
What level of care is my loved one on right now, and why?
What are the goals for this unit stay? What needs to happen before a transfer?
How will I be notified if there is a serious change in my loved one's condition?
What does the discharge plan look like from here?
What can I do as a family member to support recovery?