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“I look forward to partnering with the University of Utah Health and rural affiliates to co-design interventions tailored to people living with dementia and their care partners during care transitions.”

Dr. Bristol is an assistant professor at the University of Utah College of Nursing. Dr. Bristol’s professional goal is to design and lead non-pharmacological research that addresses and supports social determinants of health and care coordination needs of people living with dementia (PLWD) and care partners (CPs) during care transitions. She has also been involved in research focused on implementing social determinants of health screening and identifying patient and CP readiness for hospital discharge. Dr. Bristol is currently conducting a study focused on developing a measure of hospital discharge readiness to identify CP needs and preferences at discharge.

Partnering with UHealth and Rural Facilities to Co-Design ePCT Interventions

The University of Utah Health (UHealth), based in Salt Lake City, Utah, provides care to 1.2 million people in Utah as well as residents from five neighboring states. UHealth established the Affiliate Network, which includes hospitals and providers within Utah and surrounding states, to partner in supporting quality care throughout the Mountain West.

As a HCS Scholar, Dr. Bristol will partner with UHealth and the Affiliate Network to assess current care transition processes and the unique needs of rural people living with dementia (PLWD) and their care partners (CPs) during transitions in care. Through employing community engagement strategies, the partnership aims to: 1) Assess existing practices and needs within UHealth and the Affiliate Network facilities regarding the care of rural hospitalized PLWD and the role of CPs during care transitions; 2) Establish an Alzheimer’s disease (AD) and AD-related dementias Community Advisory Board to define critical aspects of implementing a novel care transition focused embedded pragmatic clinical trial; and 3) Identify healthcare system outcomes relevant to care transitions and care coordination for PLWD and their CPs.