the COMMUNITY FOUNDATION FOR THE GREATER CAPITAL REGION

COMMUNITY THINK LAB

SUMMARY REPORT

Presented by

THE COMMUNITY FOUNDATION FOR THE GREATER CAPITAL REGION

MAY 2025

Overview

This report summarizes the key outcomes, insights, and recommended grantmaking priorities derived from the Community Think Lab focused on **Chronic Kidney Disease** (CKD) in the Capital Region. Hosted by **The Community Foundation for the Greater Capital Region** in April 2025, the event was specifically designed to inform strategic grantmaking for the Hortense and Louis Rubin Community Health Fund.

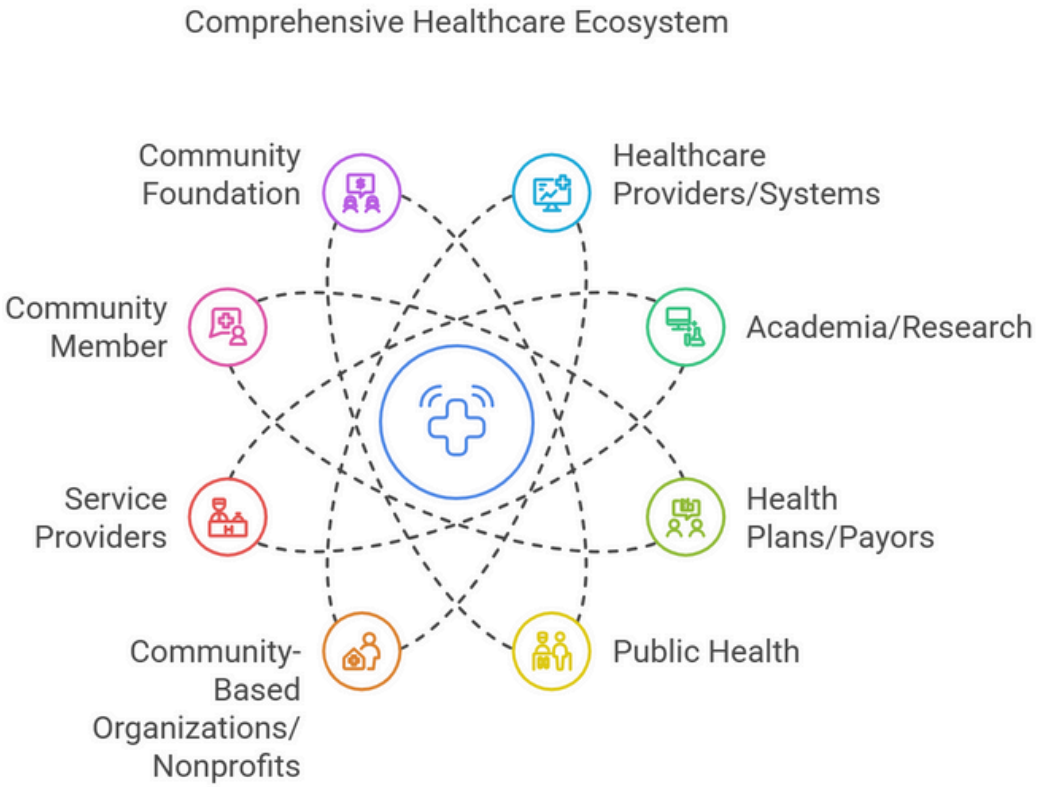
The Hortense and Louis Rubin Community Health Fund was established in 2016 by the Community Foundation for the Greater Capital Region using proceeds from the operation and sale of the Rubin Dialysis Centers. It is the largest fund managed by the foundation. Guided by a committee of healthcare experts, the fund's goal is to support programs focused on the prevention, management, and treatment of kidney disease and related health conditions.
Over $3.7 million has been granted to date, with $831,000 awarded to 17 organizations in 2025.

The Community Think Lab was designed with two primary goals in mind.

First, to **gather collective insight** by bringing together clinicians, researchers, and community stakeholders to develop a shared understanding of Chronic Kidney Disease (CKD) and the related risk factors contributing to CKD. This included examining data, identifying trends, and discussing contributing factors and community impact—intentionally pausing on solution-building to fully absorb the scope and complexity of the issue.

Second, to **inform strategic grantmaking** by using the insights, data, and community perspectives generated during the session to shape the Rubin Community Health Fund’s funding priorities.
Key priority areas identified for potential funding included strengthening early detection, prevention, and education efforts; addressing food and nutrition security; and improving data utilization and collaboration among stakeholders.

Who was Involved?



Allison A. Appleton, ScD, MPH
Associate Professor and Chair
Department of Epidemiology and Biostatistics
College of Integrated Health Sciences
University at Albany

Dr. Loay Hatam Salman, MD
Department of Medicine Nephrology, Nephrology and Hypertension
Interventional nephrologist, chief of the Division of Nephrology and Hypertension, and Thomas Ordway, MD Distinguished Chair in Medicine.
Albany Med Health System

Katie E. Cardone, PharmD, BCACP, FNKF, FASN, FCCP
Associate Professor
Albany College of Pharmacy and Health Sciences

Dr. Bruce Coplin MD FACC
EVP/Chief Medical Officer
CDPHP

Stacy Pettigrew, PhD, MS
Associate Professor, Department of Allied Health Sciences
Director, The Collaboratory
Albany College of Pharmacy and Health Sciences

Amanda Duff, PhD
Executive Director
Healthy Capital District

Natalie Newmeyer-Blunden MS, RD, LDN
Assistant Professor of Nutrition
Russell Sage College

Shelleisha Salmon-Gordon, MPH
Program Director of Chronic Disease Prevention and Management
Albany County Department of Health

Hayley Skinner, MPH, MSc
Director, Population Health Management,
Capital District Physicians' Health Plan

Wendy Weller, PhD, MHS
Associate Professor
College of Integrated Health Sciences
Department of Health Policy, Management and Behavior

Beth Richardson Wyman, MPH, RD
Food as Medicine Manager/FAM Registered Dietitian
The Food Pantries for the Capital District

Dr. Tina Omorogbe, APRN, DNP, MS, FNP-BC
Founder and CEO of Chasing Health Inc
Inpatient Medicine, Albany Med Health System

Akiko Hosler, PhD
Associate Professor & Graduate Program Director
College of Integrated Health Sciences
Department of Epidemiology & Biostatistics

Molly Klapp, MS, RD, CDN, CDCES
Albany Med Adult Outpatient Endocrinology
Certified Diabetes Care and Education Specialist

Dr. Gus Birkhead, MD, MPH
Professor Emeritus
College of Integrated Health Sciences
Department of Epidemiology & Biostatistics

The Challenge

Chronic Kidney Disease is recognized as a growing, silent health crisis both nationally and within the Capital Region. More than 1 in 7 American adults are estimated to have CKD, and as many as 9 in 10 adults with CKD are unaware, they have it, making it a silent killer often without symptoms until advanced stages. Early detection is crucial for saving lives by allowing for interventions that can slow or halt disease progression. Diabetes and high blood pressure are identified as the most common causes of CKD.

Several significant challenges related to chronic kidney disease (CKD) in the Capital Region were surfaced.

- Significant Gaps in Prevention, Early Detection, Education, and Referral Systems
- Challenges with Data Systems, Sharing, and Utilization
- Major Access Issues, Particularly Related to Healthy Foods and Nutrition

Approach

The Community Think Lab was structured as a working session utilizing a collaborative, design-thinking process. The agenda included several specific activities designed to move participants through a process of gathering information, sharing insights, and identifying priorities.

Guiding principles for this think lab emphasized a population health focus, valuing individual expertise and shared insight, recognizing the conversation as a starting point that complements rather than replaces ongoing community engagement, and balancing reflection with action.

Activities

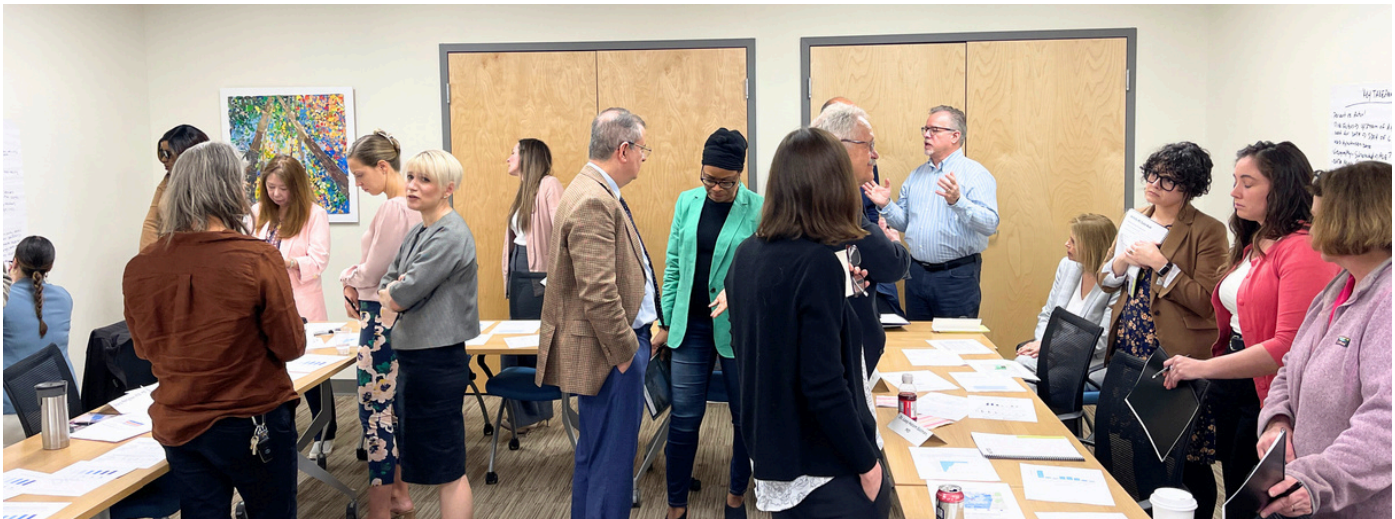
Activity #1: Expert Insights

- This initial session involved introductions where participants shared their name, organization, and role, specifically how their work connects to CKD or related risk factors like diabetes, hypertension, or health equity. Participants shared a key insight or experience from their field related to CKD causes, prevention, or treatment, highlighting critical issues, risk factors, challenges, or promising approaches. They also offered a call to action or an open question for the group to consider regarding priority areas or considerations for discussion.

Activity #2 & #3: Data Walk and Insights

- **This activity utilized a Data Walk, inspired by the Urban Institute*. They describe it as a method with several goals:**
  - Sharing Data: To present key information and findings to community residents and program participants.
  - Enhancing Understanding: To foster a deeper analysis and comprehension of the data.
  - Informing Action: To guide improved programming and policy-making that addresses the specific strengths and needs of a community or population.
  - Inspiring Change: To motivate both individual and collective action among community members.
- **Participants were split into two groups, each engaging in discussions and data analysis on chronic kidney disease (CKD) and its risk factors. In small groups, they explored the data, connected it to their personal experiences, and recorded key insights and questions on poster paper.**
- The Collective Debrief (Activity #3) followed the station rotations, with the whole group reconvening to share the key insights and observations captured at each station, aiming to connect findings across stations and identify overall trends or challenges.

*Urban Institue: Data Walks: An Innovative Way to Share Data with Communities | Urban Institute



Key Insights

Prevention & Education Gaps

There is a strong emphasis on primary prevention over treatment. Prevention and education are seen as a weakness in the current healthcare system. Patients are often not informed about their risk or diagnosis of CKD. There is a need to increase awareness of high-risk populations. Pre-diabetes is not flagged as a disease, preventing necessary referrals. Primary care physicians may lack the capacity or time for basic screening, testing, education, and referral due to reimbursement constraints. There is also a perception that necessary resources do not exist; Medicare coverage for dieticians, for example, doesn't begin until a patient is "sick enough." Education materials need to be generation-specific (e.g., apps, videos, print). More diabetes education is needed, potentially leveraging existing programs like the National Diabetes Program. Childhood obesity and the systems/culture feeding unhealthy habits are major issues, with a research question about what separates obese youth from healthy youth.

Healthcare System Capacity & Approach

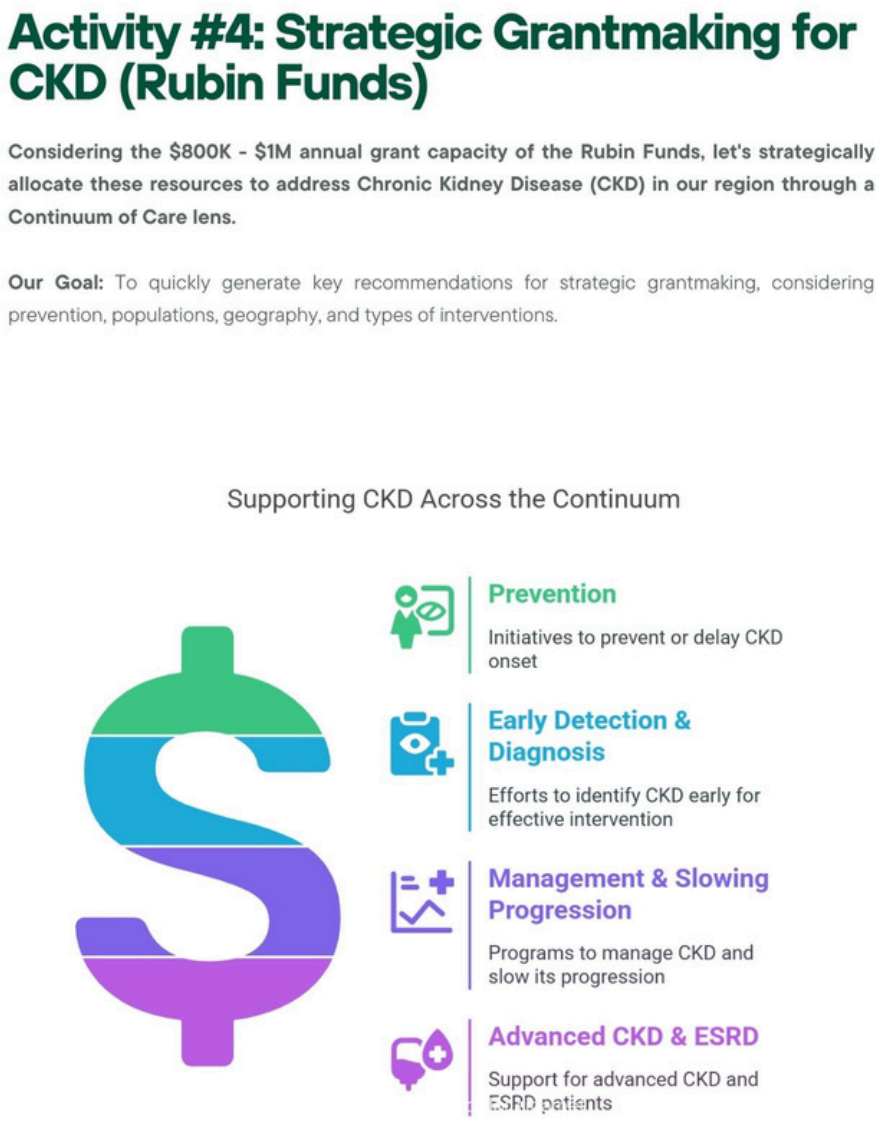
Primary care physicians need to screen for social determinants of health and have easy referral processes. Dieticians need to be integrated into primary care and endocrinology offices. Links are needed between healthcare providers and community providers to collaborate around patient health. More support is needed for providers through roles like Community Health Workers (CHWs), mental health counselors, and dieticians. CHWs are key for bringing assessments and services to people. There is a need to meet people where they are, using methods like working through churches as a prevention method. Participants emphasized the importance of providers who "look like them" with cultural competence. Access issues, particularly transportation in rural areas, need attention. The need for more medically tailored grocery programs including preparation instructions, and increased Food as medicine/medically tailored meals was highlighted. Food systems and their effects on health are a key issue, requiring a focus on food justice.

Geographic Areas / Populations

Hamilton Hill in Schenectady County was noted for experiencing the highest percentages of mortality rates by neighborhood, as well as significantly higher diabetes hospitalization/ED visit rates. The National Diabetes Program is targeting Hilltown communities. Rural areas need a focus on access. There is a need for more clinics and outreach in underserved communities. Geriatric fragility is a concern. The need to focus on "the forgotten and burdened people" was raised. Female heads of households were identified as making health decisions and could potentially be used as a data collection hub.

Activity #4: Strategic Grantmaking for CKD (Rubin Funds)

- Building on the insights from previous activities, this session focused on generating recommendations for strategic grantmaking, keeping the Rubin Funds' annual capacity ($800K - $1M) in mind. A large group brainstorm allowed participants to share ideas for grantmaking initiatives across the continuum of care (Prevention, Early Detection, Management, Advanced CKD/ESRD), identifying target populations, geographic focuses, and types of interventions. This was followed by a prioritization discussion to identify the top 2-3 key priority areas for the Rubin Funds' greatest impact, considering unmet needs, leveraging existing resources, and potential for long-term positive change.



Ideas Generated

Activity 4- the question asked to the group: Considering the opportunity to invest $800-$1M in annual funding the generate a list of ideas for grantmaking initiatives.

1. Early Detection and Prevention

- Early detection (like blood pressure machines in public spaces)
- Educating primary care providers
- Awareness and education for high-risk people
- Early identification and treatment
- Collaborative initiatives to include community health workers around early detection

2. Education and Support

- Patient education that is age- and stage-specific
- Education and resources that meet people where they are (literally go to them)
- Children's education and behavioral programs
- Programs that include dieticians, pharmacists, CHWs, and mental health support
- Supporting caregivers
- Peer models of support

3. Addressing Social Determinants of Health

- Food justice
- Food access
- Food system convening
- Upstream risk factors like childhood obesity

4. System-Level Collaboration

- Clinical-community connections (this was a big theme)
- Collaborating with payers and insurance
- Establish a food coalition in Albany and Capital Region

Recomended Grant-Making Priorties

The ideas generated in the brainstorming session were then analyzed by the group to identify key themes and priorities. This analysis led to the following recommendations for grantmaking.

Based on the Think Lab's findings, the following grantmaking priorities are recommended:

- **Early Detection, Prevention, and Education:** Funding initiatives that improve screening, such as bringing back free blood pressure machines in community locations. Supporting targeted education programs that are generation-specific (apps, videos, print), focus on behavior change through motivational learning, and address habits, non-utilizers, service resistance, and compliance issues. Increasing diabetes education. Focusing on childhood diabetes and obesity prevention, including kids' health nutrition and cooking classes. Participants noted the need for more funding for prevention efforts.
- **Addressing Food & Nutrition Security:** Providing access to technology, digital literacy training, and affordable internet.
- **Enhancing Access and Community-Based Support:** Funding programs that meet people where they are, such as working through churches. Supporting the work of Community Health Workers who can bring assessments and services directly to people. Increasing support for providers like dieticians and mental health counselors. Addressing access issues in rural areas.
- **Empowering community-based organizations:** Providing resources and technical assistance to strengthen local organizations.
- **Promoting cross-sector collaboration:** Fostering partnerships between government, non-profits, and businesses.

Next Steps

The following steps are recommended:

- **Share the Think Lab's Summary Report** with other funders and stakeholders to promote collaboration and learning.
- **Explore ideas for co-funding and collaboration** seen as key to leveraging existing work and funding effectively.
- **Use the insights gathered to inform and guide the strategic grantmaking priorities** Especially prevention of CKD and risk factors, early detection, and education.
- **Continue to engage with the community** to ensure ongoing feedback and refinement of strategies.
- Consider how we might start and/or support a **Food Coalition** for the Capital Region

Conclusion

The Community Think Lab has provided valuable insights into the evolving needs of our community. By embracing a collaborative and data-driven approach, we can ensure that our grantmaking efforts are aligned with the most pressing challenges and opportunities. The recommended grantmaking priorities offer a roadmap for creating a more equitable and resilient community.


the
COMMUNITY
FOUNDATION
FOR THE GREATER CAPITAL REGION