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A Better Model for Kidney Care: Earlier Identification, Smarter Coordination, Better Outcomes

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Kidney disease is a major driver of health care spending in the U.S., affecting more than 37 million adults — 15% of the adult population — yet about 90% of those with the condition aren't even aware they have it. As kidney function declines, care becomes increasingly complex and costly, with unmanaged chronic kidney disease (CKD) and end-stage kidney disease (ESKD) contributing to over $456 billion in annual health spending.

Kidney disease does not exist in isolation. Many patients with CKD also manage serious cardiometabolic comorbidities that can accelerate disease progression. Approximately 50% of patients with CKD also have congestive heart failure (CHF) and 60% have diabetes. These comorbidities often contribute to more advanced stages of kidney disease. Integrating cardiovascular, diabetes and broader cardiometabolic care into value-based kidney care models is necessary for treating the whole person, not just the disease — a critical step in protecting kidney health and slowing disease progression.

Since 2018, Strive Health has been changing the way kidney care is delivered by identifying patients sooner, prioritizing the right care at the right time and driving better outcomes — all while lowering costs.

Strive Health's Model

Strive partners with over 6,500 nephrologists and primary care providers on behalf of health plans and providers to identify shared patients, coordinate care management resources, deliver care and align care plans for patients with CKD. For those with early stage kidney disease, Strive Health addresses practical needs and closes care gaps that help keep patients out of the hospital and slow disease progression to keep people healthier for longer. As kidney disease advances, their predictive care model rapidly identifies rising risk and informs evidence-based clinical pathways designed to reduce avoidable readmissions. Strive is accountable for over 150,000 patients and manages nearly $5 billion in annual medical spending.

Every patient is unique. That's why Strive's Kidney Heroes® teams leverage the proprietary Care Multiplier™ technology platform to create individualized care plans. By meeting each patient where they are in their care journey, Strive addresses emerging needs in a timely manner to optimize clinical outcomes. The teams are led by nurse practitioners specialized in kidney care and include dietitians, care managers and social workers who deliver care via telehealth and in patients' homes. Care teams also collaborate with local community-based organizations to identify and address non-medical drivers of health such as transportation, financial support and access to healthy food.

This model is designed to support the whole person. For patients managing CKD alongside CHF, diabetes and other cardiometabolic conditions, Strive coordinates across specialties and care settings to close gaps earlier, reinforce adherence and help patients navigate the clinical and social barriers that can worsen outcomes over time.

Strive contracts with a range of partners, including national large and mid-sized health plans and VBC providers. Strive tracks process measures such as the percentage of referred patients they care for, the proportion of patients seen by a nephrologist within six months of starting dialysis, and the proportion of patients with advance care plans. Strive and its partners meet regularly to discuss both clinical care and operational processes and are highly aligned in their goal of improving clinical outcomes and quality of life for people with advanced CKD and ESKD.

Kidney Disease Does Not Exist in Isolation

50%

of CKD patients also have congestive heart failure

60%

of CKD patients also have diabetes

Financial Arrangements

Payers, health systems and medical groups partner with Strive through a variety of financial arrangements that include premium-based full-risk contacts, performance-based contracts and fee-based arrangements with pay-for-performance.

Strive also participates in Comprehensive Kidney Care Contracting (CKCC), a federal value-based care model run by the Center for Medicare and Medicaid Innovation (CMMI), which runs through 2027. The model aims to provide care coordination, support and education while delaying the onset of dialysis for people with CKD stages 4 and 5 and ESKD. Under CKCC, Strive takes responsibility for 100% of the total cost of care for all Part A and B services for Medicare beneficiaries.

Overall Outcomes

Strive's care model demonstrates how deep collaboration across a high-value provider network, earlier intervention, coordinated care and accountability for cost can improve outcomes for patients with CKD and ESKD.

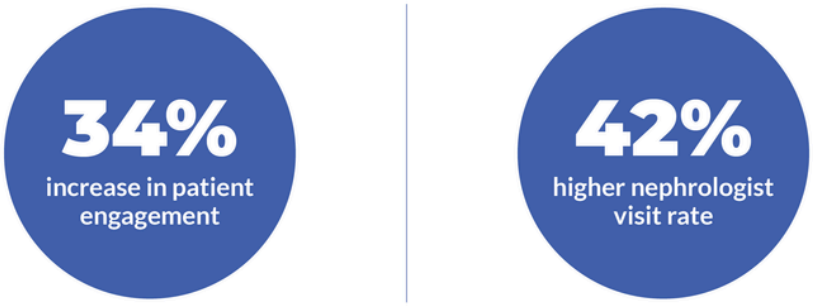
The model has produced measurable quality improvements across various arrangements, including:

- 41% Reduction in hospitalizations
- 34% Reduction in readmission rate
- 11% Reduction in ED visits
- 85% Increase in optimal dialysis starts
- 62% Increase in home dialysis adoption
- 94% Patient satisfaction
- 20% Reduction in total cost of care

Additionally, when Strive engages with nephrologists, patient engagement increases by up to 34%. Strive's patient population also has a 42% higher rate of nephrologist visits. When patients engage in earlier support, the Strive team can often slow progression, improve their quality of life and avoid more serious complications later.

In a published analysis of 623 patients with CKD stage 3b or 4, the median rate of eGFR decline was reduced by 77.2% for patients with CKD 3b and by 65.2% for patients with CKD 4 after enrollment in Strive's programs. The study also found slower kidney function decline 20 months after enrollment.

Strive + Nephrologist Collaboration Results



Replicating this Model

Payers, health systems, and provider practices can replicate this model by first aligning around a shared objective: enabling specialists to act as accountable “quarterbacks” for patients across the full care journey. That requires moving beyond incentive-only contracts to rethink workflows, staffing, and information flows, so nephrologists and other high-impact specialists have both visibility into patient risk and the support to intervene early, often and outside traditional visit windows.

Operationally, replication starts with building a unified data and intelligence layer that surfaces timely, actionable insights at the point of care. AI tools should aggregate EMR data, lab results, pharmacy claims and admission-discharge-transfer feeds to continuously flag rising-risk patients and recommend next best actions, while integrating seamlessly into existing clinical systems. Clear handoffs from physicians to care teams ensure that insights translate into concrete outreach, follow-up and coordination for a seamless and consistent patient experience that drives value.

Finally, organizations must pair this intelligence with a multidisciplinary care model and continuous, tech-enabled patient engagement. Dedicated care teams — nurse practitioners, nurses, social workers, dietitians and care coordinators — should be empowered with bi-directional texting, remote patient monitoring and community-based resources to address adherence, social barriers and comorbidities. When these elements are governed through joint performance management between payers and providers, value-based kidney care programs can be scaled reliably across markets while maintaining a consistent focus on outcomes, experience and total cost of care.