

Attane Health Demonstration Project

Final Evaluation Report, December 2025

Overview: The Attane Health Demonstration Project tested whether providing nutritious groceries and nutrition coaching through an online platform to Medicaid members with low-incomes and high-risk pregnancies could improve food security, wellness, and health outcomes. This report outlines the key learnings from the evaluation.



The evaluation partnership included four organizations:

1. **A Healthcare Company (HC)** offered Attane services to all Medicaid members with a high-risk pregnancy.
2. **Attane Health** provided food and grocery shopping platform and tele-nutrition coaching to participants.
3. **Center for Community Health and Evaluation (CCHE)** led the evaluation.
4. **Health Forward** provided funding.

The Demonstration Project was implemented from October 2023–July 2025. HC social workers recruited patients for Attane who were pregnant, had low-income, and considered high-risk due to medical conditions like diabetes or hypertension. Participants received \$145/month for 6 months to spend at Attane-Health.com starting in their third trimester. Attane offered participants up to three online 1:1 nutritional coaching sessions with an additional \$75 benefit per session. All registrants received a monthly newsletter with recipes.

The evaluation sought to understand program reach, participant experience, and health/wellness effects. CCHE supported partners to create a logic model and develop metrics (Appendix A). Evaluation data sources included: participant registrations; purchase records including dates, content, quantity, and cost; mid-point and exit surveys querying program experiences and effects; and maternal and child birth outcome data from HC medical records. The evaluation sample included 211 HC members registered for Attane from January 2024 -May 2025. A control group included 382 HC patients who met criteria for Attane and gave birth in 2023.

Key Evaluation Findings

1. **Reach and Participation:** Attane reached its target audience of pregnant people with high needs. Individuals participated but many did not fully utilize their benefit.
2. **Order content and timing:** Participants ordered a variety of foods during their third trimester and three months post-partum; many participants placed most or all orders post-birth.
3. **Experience:** Preliminary data indicate high program satisfaction and acceptability among participants.
4. **Coaching:** Preliminary data indicate that coaching was acceptable and effective at supporting individual needs.
5. **Wellbeing:** Emerging data suggest that participants' experiences with Attane improved nutritional knowledge and self-efficacy, and decreased stress.
6. **Health Outcomes:** Preliminary data do not show Attane participation having a measurable effect on maternal and child birth outcomes.

Recommendations for future implementation and evaluation: The end of each key finding section below contains recommendations in blue boxes, mostly falling into two overarching suggestions:

- 1) Reexamine and update the Attane program logic model to capture the multiple levels and dimensions of anticipated program impact and explore validated instruments to track progress.
- 2) Conduct qualitative interviews with participants and program staff to better understand feasibility, daylight implementation barriers and challenges, generate ideas for program improvement, and descriptively capture program benefits.

1

Reach and Participation: Attane reached its target audience of pregnant people with high needs. Individuals participated, but many did not fully utilize their benefit.

Attane reached its target audience, at a slower rate than expected.

- Attane registrants reported high (~75%) rates of food insecurity, much higher than the national average of ~13% in households without children and ~17% in households with children.¹
- Patients were much slower to register for Attane than expected; after 17 months of enrollment, Attane achieved roughly 25% of the enrollment rates anticipated by program partners. Many eligible HC members who may have benefited from Attane did not participate.
- Demographically, Attane participants looked almost identical to registrants, indicating that once registered, there does not appear to be disparities in ability to use the Attane program.

Most registered participants placed orders but only half spent the full benefit. Coaching was associated with higher benefit spending, even given the additional funds for coaching participants.

- Once registered, 83% of individuals (N=175) placed an order. Of these, 31% of individuals (N=54) placed all six orders and the average number of orders was four orders per person (range 1-7 orders); 17% of people registered never placed an order.
- Only half of all participants spent the full \$145 standard benefit each month. This means that most people are underspending significantly from their total available benefit.
- Findings indicated that there is a population of individuals that like the program and are willing to spend their own money on it.
- Coaching seems to be related to the percent of total benefits spent, and willingness to spend more than the benefit on Attane-Health.com. Individuals who participated in coaching received an additional \$75 in benefits for each session. Their average monthly spending was \$164, with a range of \$117-234; 26% of them spent *more* than their full benefit.
- Among individuals who did *not* participate in coaching, the average monthly order cost was \$141, with a range of \$81-\$169. Only 11% of these individuals spent more than their full benefit.

Implementation suggestions: Continue identifying enrollment barriers and updating recruitment protocols to increase registration. Consider ways to increase utilization of the benefit among those registered for Attane.

Opportunities for evaluation: To help increase registration rates, compare demographics of Attane registrants to the demographics of everyone referred to the program, which may help identify subgroups to target. Conduct a survey or interviews with HC social workers and/or with people who do not register or fully utilize the benefit to understand barriers/challenges to participation.

¹ USDA Economic Research Services. Food Security in the U.S. - Key Statistics & Graphics. <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics>

2 **Order content and timing:** Participants ordered a variety of foods over time; many participants placed most or all orders post-birth.

Attane participants placed 734 orders from January 2024 to May 2025, many post-birth.

- Most participants did not start participating in Attane until their third trimester of pregnancy at the earliest. The program was designed so that participants placed half of all orders before birth, and half after. Therefore, any effect of Attane on birth outcomes was based on at most three food orders and three coaching sessions, and often much less.
- 15% of participants did not place any orders until post-partum, meaning food ordered from Attane by these individuals would have no effect on their birth outcomes. However, post-birth may be the time when they had the most need for extra support because of stressors such as reduced income or decreased time.

Attane envisioned influencing and improving participant health through a nutrient pathway of increased fruit and vegetable consumption. However, most participants did not include fruit and vegetables in their online food orders.

- Over 90% of orders included pantry items, dry goods, and snacks, 70% included meat or fish, 62% included beverages, and almost 40% included baby or kid foods. Almost 40% of orders included “kid” snacks and produce (e.g., pouches), and were likely for people in the household besides the mother and new baby. Supporting a food insecure household with an open-ended benefit to use as they see fit rather than being proscriptive with purchase options is an evidence-based practice that is gaining traction.
- Attane expected that the program would improve the diet of pregnant individuals, anticipating individuals would order and consume more fruits and vegetables through the program than they would have otherwise (**See Appendix A**). However, only 42% of orders contained any produce (including canned), and only 15% of orders included fresh produce. Younger Attane participants were much less likely to include produce in their orders; increasing engagement and outreach to younger participants may be an area of opportunity.
- Participants with the highest food bank usage most frequently included produce and meat in their food orders, suggesting participants with the highest financial needs are using the benefit for more expensive, harder to access high-quality foods.

Implementation suggestions: Consider offering Attane earlier in pregnancy or encouraging more usage pre-birth, if influencing birth outcomes is a key goal. Consider ways to reach out to younger participants, or stock fresh foods that appeal more to younger participants to increase their purchasing of produce (if produce consumption is an intended pathway for improved health outcomes).

Opportunities for further evaluation: Conduct qualitative interviews to understand why some individuals do not use their full benefit, why they skip months, or why they discontinue using Attane. Understanding barriers, challenges, and what types of foods/benefits would be most helpful, may increase utilization.

3

Experience: Early data suggest high overall satisfaction and acceptability among participants and suggest this program is feasible.

Indirect data suggest that it was feasible for Attane to partner with HC to implement this program.

- 211 individuals enrolled, and 175 participated as of May 2025. All midpoint survey respondents (N=12, not generalizable) indicated that they received their orders within 5-7 business days to the correct address, and 85% indicated their orders were complete and accurate.
- Implementation appears to be feasible. As described above, additional evaluation around program processes could help better understand implementation opportunities.

Both midpoint and exit surveys were positive.

- In the midpoint survey, 100% (N=12) were satisfied or very satisfied with the quality of food, 83% with food types, 92% with the checkout experience, and 100% were satisfied or very satisfied with the overall experience. While the number of respondents was too low to be generalizable, it suggests that Attane met participants' expectations.
- In the exit survey (N=30), participants reported positive program experiences, with 96% rating their likelihood of recommending Attane to a friend/family member at least 3 out of 5. Most respondents (84%) indicated they would be likely or very likely to re-enroll in their healthcare plan if it meant having access to a program like this. Participating in Attane appears to be a net positive experience.

Implementation suggestions: None at this time.

Opportunities for further evaluation: We recommend ongoing improvements to the participant surveys, and interviews with participants. Specifically: Add the overall satisfaction question from the midpoint survey to the end-point survey; conduct qualitative interviews to better understand the experience of those who were not satisfied with the program or who struggled with the platform to increase accessibility/acceptability; consider a survey and/or interviews with program staff to understand their thoughts on implementation, challenges, barriers, facilitators, and lessons learned. This information will help to understand feasibility, and to better understand acceptability from the program side, in addition to daylighting other ways to improve the program.

4

Coaching: Early data suggest that coaching was acceptable and effective at supporting individual needs.

The participation rate for coaching was promising, especially given that this is an economically stressed group at a stressful time in their lives.

- As of May 2025, 25% of Attane participants participated in coaching (another 3% registered but did not have any coaching sessions), close to the target of 30% participation. Nonparticipants who completed an exit survey (N=25) indicated that their primary barrier was lack of time (58%), followed by being unaware of the service (25%).
- Coaching participation was higher among older participants (36% of those 36+ years old vs. 18% of those 18-25 years old). By race/ethnicity, coaching participation was lowest among individuals who identified as White; 20% of White participants did coaching, compared to 26% of Black participants, and 34% of Hispanic participants.

Tailored 1:1 coaching was useful to participants.

- Data suggest that offering 1:1 tailored coaching was useful to participants across their unique circumstances. Coaches covered a wide range of topics, from foods that encourage breastmilk production, to how to prepare healthy salads, to tips for budget friendly shopping. Coaching notes indicated that coaches offered tailored discussions and resources based on individual needs and wants.
- These are early signs that coaching may be helpful in influencing behaviors, though with only five exit survey responses, these results should not be reported as findings. Of the N=5 exit survey respondents who participated in coaching, 100% indicated at least a little increase in knowledge and at least some change in how they managed their health as a result of coaching.
- At program intake, 90% of the 211 Attane registrants reported moderate or high nutrition knowledge. Even so, there was still interest in nutritional coaching, and early signs that this coaching was helpful to participants.

Implementation suggestions: Attane could increase efforts to encourage coaching, given that 25% of Attane participants who completed an exit survey were unaware of that potential benefit. Consider increasing outreach to younger participants, who were less likely to participate. We do not recommend requiring coaching as a prerequisite for receiving the financial benefit; however, we do recommend increasing outreach to increase participation, given how useful that benefit is independent of coaching and given that barriers to coaching are greater among individuals with higher needs.

Opportunities for further evaluation: Consider conducting qualitative interviews querying barriers to coaching for younger folks, and reasons for not participating for anyone who did not sign up. Consider interviews with coaches or adding a question to their coaching notes to better understand which clients they felt most benefited from coaching and why. We also recommend exploring feasibility from both coach and participant perspectives, which has not yet been evaluated.

5

Wellbeing: Emerging data suggest that participants' experiences with Attane improved nutritional knowledge and self-efficacy, and decreased stress.

Attane participants reported improvements in nutritional knowledge and diet due to Attane.

- Of the 30 Attane participants who completed the exit survey, 40% (N=12) reported their current nutrition knowledge as 'high' or 'very high' compared to only 17% (N=5) at baseline. The percentage of participants reporting 'low' or 'very low' nutrition knowledge decreased from 10% (N=3) at program start, to 3% (N=1) at program end. These within-group changes demonstrate the value of the Attane program in growing nutritional literacy.
- In the exit survey, 73% of respondents (N=22) rated their confidence in how to shop for healthy foods at least a 4 on a 5-point confidence scale; this indicates strong self-efficacy post program participation (without baseline data we cannot attribute their confidence to participation in Attane).
- Attane participants also reported many changes in eating habits because of the Attane program—30% (N=17) reported trying new foods; 19% (N=11) reported eating less unhealthy food; 14% (N=8) said they cook more at home; 12% (N=7) reported they now eat more variety.

Attane participants reported decreased financial stress and maintained food security during a time when household financial status worsened for many families.

- Stress, including financial stress, can significantly impact health outcomes.² 61% (N=20) of Attane participants reported that the Attane program reduced their financial stress; 13% (N=4) reported that the program had no effect on their financial stress. The ability of the Attane program to reduce financial stress may be one avenue for influencing participant wellness and health outcomes.
- 93% (N=28) of exit survey respondents reported some improvement in access to high quality food, with 40% (N=12) rating this improvement as significant. These data suggest the program is meeting its goal of increasing access to quality foods for individuals with high needs.
- In the exit survey, participants indicated if (and how) their household’s overall financial situation has changed since starting the Attane program. 37% (N=11) reported their financial situation worsened, 40% (N=12) indicated no change, and 23% (N=7) reported their financial situation improved. Attane households are experiencing significant financial stress; pregnancy and a new baby often increase financial stress. Maintaining food security levels among participants should be considered a positive outcome; Attane may be moderating food insecurity as financial situations worsen.
- Among the 30 participants who completed the exit survey, 83% were food insecure at the program start, and 83% were still food insecure at the program end. However, within food insecurity questions responses shifted: there was a 10-percentage point *decrease* among individuals who ‘often’ worried about running out of food by the end of the program, but a 3-percentage point *increase* in individuals who ran out of food and didn’t have money to buy more. This could possibly be due to changes in household budgets to accommodate a newborn and missed work post-birth. Interviews with Attane participants may help further understand these shifts and Attane’s role.

Implementation suggestions: Attane participants reported that the Attane program helped them improve their diets and nutritional knowledge and reduced household financial stress. Outreach to Attane participants to encourage use of the full benefit could increase the health and social wellness benefit to individuals and increase the overall program effect.

Opportunities for further evaluation: We recommend developing the evaluation in two keys ways. First, the Attane program potentially affected health levers upstream of the health outcomes measured in this evaluation (described below in key finding 6, also see Appendix A). Given how the program is delivered (e.g., timing of orders in pregnancy) and what participants are ordering (e.g., fresh fruits and vegetables vs. snacks and drinks), program partners should consider what types of health and wellness indicators Attane participation could feasibly influence. Measuring nutritional literacy, diet, household resiliency, food helpfulness, etc., may better capture where the Attane program is affecting change for participants. The Food and Nutrition Security Related Measures developed by the Center for Nutrition & Impact are a good place to begin searching for intermediate outcome measures.³ Second, participant interviews would elucidate more fully where and how the program builds health and wellness and help identify additional measures for capturing any effects of program participation.

²Hasriantirisna, H., Nanda, K. R., & Munawwarah. M, S. (2024). Effects of Stress During Pregnancy on Maternal and Fetal Health: A Systematic Review. *Advances in Healthcare Research*, 2(2), 103–115. <https://doi.org/10.60079/ahr.v2i2.339>

³Center for Nutrition & Health Impact. Food and Nutrition Security Related Measures. <https://www.centerfornutrition.org/food-security-measures>

6

Health Outcomes: Preliminary data do not show Attane participation having a measurable effect on maternal and child birth outcomes.

At the program outset, Attane wanted to measure the effect of program participation on maternal and child birth outcomes (See Appendix A). Using anonymized HC patient medical records, CCHE examined cesarean section rates, NICU rates, gestational age at birth and child birth weight for Attane participants compared to a control group of non-Attane participants:

- Average gestational age was 37.26 weeks in the Attane participant group (N=76), and 37.67 in the control group (N=351). Average birth weight in grams was 3,134 in the Attane participant group (N=38), and 3,135 in the control group (N=125). These measures were similar across the two groups, noting that there was substantial missing birth weight data in both groups.
- 42% of Attane participants had a cesarian section (N=89), compared to 35% of individuals in the control group (n=382).
- 19% of babies among Attane participants were in the NICU (N=89), as compared to 14% of babies in the control group (N=382).

These data show no measurable effect of Attane on cesarian section nor baby NICU rates. The results presented above highlight two reasons why any potential Attane program effect on maternal and child birth outcomes may be muted:

- 1) Individuals received food late in pregnancy or after birth, and
- 2) Many individuals used the benefit for foods and items that likely do not directly affect the pregnant person's health (e.g., child snacks, beverages).

It is also possible that individuals at higher risk of pregnancy complications and with more significant social needs are more likely to participate in Attane, though this is not knowable given our current data.

Implementation suggestions: As designed, most individuals received their Attane benefit either very late in pregnancy, or after birth. The benefit may have more effect on maternal and child birth outcomes if participants received it earlier in pregnancy—we recommend exploring when in pregnancy nutrition and improved food access is most consequential and timing the benefit for that period. Specifically targeting people with a certain condition (e.g., gestational diabetes) may have a greater influence on health outcomes.

Opportunities for further evaluation: There are likely many benefits of the Attane program this evaluation did not capture. Consider exploring wellness and health outcomes such as the nutrition measures linked above.

Appendix A: Program Logic Model

Developed by CCHE, on conjunction with Attane and their healthcare (HC) partner

In 2024, CCHE facilitated a process with program partners (including Attane Health, HC, Health Forward) to identify and document anticipated outcomes for participants in the Attane Health Demonstration Project. It included a document review of Attane programs, literature review to understand outcomes, and several discussion sessions to ensure that input was fully captured and buy-in for the final model was maximized. Our team then used this logic model to frame our evaluation questions and subsequently develop the participant surveys and identify medical record data of interest. A logic model is a living document, and this Demonstration Project logic model can continue to be updated to capture actual (vs. planned) activities, and revise outcomes/metrics over time.

Inputs	Outputs		Outcomes		
	Activities	Participation	Short-term	Intermediate	Long-term
			<i>During the 6 months receiving benefits</i>	<i>Post Partum, after benefit ends</i>	<i>Within 5 years</i>
Attane Health food ordering platform Attane Health coaching services Healthcare Partner case management Grant support for Attane Medicaid reimbursement for program	Enroll Healthcare Org members in case management services & Attane Health support: Attane support • Provide tailored food deliveries • Offer nutrition coaching Healthcare Org case management • Provide links to community resources • Support WIC/SNAP enrollment • Conduct home visits and monthly follow-up check-ins • Provide doula support	500-600 pregnant people will participate in Attane Health program; ideally people on Medicaid identified through UHC algorithm as having a high-risk pregnancy (hypertension and diabetes, preeclampsia, other conditions).	Engagement and utilization • Healthcare org enrolls ≥70% of high-risk patients in case management • Healthcare org connects ≥80% of identified high-risk patients into case management to Attane • ≥90% of patients connected to and enrolled with Attane make food orders • ≥ 30% of patients connected to and enrolled with Attane get coaching Maternal experience • Improved (decreased) maternal stress • Improved food security • Improved nutritional literacy, self-efficacy, self-management skills • Increased fruit & vegetable consumption • Increased number of patients report eating food at home • Patients are satisfied with the program • Patients are comfortable with virtual services	Engagement and utilization • ≥80% post-partum engagement maintained in UHC case management Maternal Experience • Increased peace of mind/hope/resilience • Patients feel positively towards UHC Maternal Outcomes • Increased fruit and vegetable consumption • Reduced A1C, blood pressure levels Baby Outcomes • Reduced # of babies with low birth weight • Reduced # of babies with NICU stays • Increased infant feeding, weight gain, well child visits 3 months post-partum • Decreased number emergency department/hospital stays	Sustainability • Attane Health services are eligible for Medicaid reimbursement (in lieu of services) Maternal Outcomes • Improved long-term physical and mental well-being • Lower health care utilization/costs Baby Outcomes • Decreased morbidity and mortality • Lower health care utilization/costs

Program will be equitably delivered and strive to improve equity (by race, ethnicity, geography) in health outcomes for patients with high-risk pregnancies.