PRENATAL-TO-3 POLICY CLEARINGHOUSE
EVIDENCE REVIEW

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RESEARCH FOR ACTION AND OUTCOMES

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Evidence-Based Home Visiting

Evidence Review Findings: Effective / Roadmap Strategy

Participation in evidence-based home visiting programs leads to small but positive impacts on parenting skills, but less consistent evidence exists for impacts on other important child and family outcomes. More research is needed to understand which aspects of home visiting contribute most to positive outcomes. As a state strategy, providing evidence-based home visiting programs is effective for improving parenting skills, but current research does not support a specific state policy lever to guide the most effective implementation of programs.

Voluntary parenting programs vary in format, the specificity of their goals, their target populations, and in the extent to which they have demonstrated effectiveness for improving parenting behavior, skills, and knowledge. Home visiting programs, which provide support and education to parents in the home through a trained professional (e.g., nurse or social worker) or paraprofessional, have a growing evidence base and have expanded rapidly over the last decade as a state-based investment in supporting parents and children. Although research has examined the impact of home visiting on a range of outcomes, the scope of this review is intentionally limited to parenting outcomes, the policy goal for which the most evidence on home visiting exists. States differ in how they fund home visiting (i.e., state and/or federal sources), their level of investment, and how they define the scope and goals of home visiting programs.

Decades of research in the field of child development have made clear the conditions necessary for young children and their families to thrive.[1] These conditions are represented by our eight policy goals, shown in Table 1. Because a preliminary review of the evidence on home visiting programs demonstrated inconsistent findings for seven of the eight policy goals, this evidence review is limited to the evaluating the impacts of evidence-based home visiting on nurturing and responsive child-parent relationships.

Table 1: Impacts of Evidence-Based Home Visiting Programs on Policy Goals

Goal Alignment	Policy Goal	Summary of Alignment between Policy and Goal
	Access to Needed Services	*(Policy goal outside the scope of this review)*
	Parents' Ability to Work	*(Policy goal outside the scope of this review)*
	Sufficient Household Resources	*(Policy goal outside the scope of this review)*
	Healthy and Equitable Births	*(Policy goal outside the scope of this review)*
	Parental Health and Emotional Wellbeing	*(Policy goal outside the scope of this review)*
●	Nurturing and Responsive Child-Parent Relationships	Mixed impacts, with beneficial impacts on parenting behaviors and skills
	Nurturing and Responsive Child Care in Safe Settings	*(Policy goal outside the scope of this review)*
	Optimal Child Health and Development	*(Policy goal outside the scope of this review)*

What Are Evidence-Based Home Visiting Programs?

Home visiting programs vary in format and differ in the specificity of their goals and target populations. Some programs target specific changes in parenting or child behaviors, whereas other programs target general improvements in child and family wellbeing. Other programs target high-risk[i] families and others enroll families more universally. The theoretical underpinnings and evidence of effectiveness for home visiting programs also vary widely.[B]

All home visiting programs provide parents with comprehensive in-home support and education through a trained professional (e.g., nurse or social worker) or paraprofessional, but evidence-based home visiting models vary in the exact services offered and populations served.[16] Although home visiting programs are only one model of programmatic support available to parents, they have the most robust evidence as a state-based investment in supporting nurturing relationships between parents and children.

For over 100 years, home visiting programs have existed in varying forms. During the Progressive Era (1870-1920), advocates for charity kindergartens made frequent visits to low income neighborhoods to educate parents on kindergarten education, develop relationships with families and children, and provide instruction on hygiene, health, and discipline.[34] Pediatrician, researcher, and child protection advocate C. Henry Kempe, along with his colleagues, was the first to explicitly identify and research what he termed, "battered child syndrome" in the seminal 1962 paper of the

[i] High-risk is generally defined throughout the evidence review as families with specific risk factors such as parents with low income, teen parents or identified problems such as behavioral problems in children.

same name.[35] In the early 1970s, Kempe advocated for a network of home health visitors as a policy intervention to prevent child abuse.[36,36] In 1975, Hawaii became the first state with a modern home visiting program, the Healthy Start Project, a paraprofessional service model aimed at reducing child abuse. Throughout the 1980s and 1990s, home visiting support grew and several models with varying goals developed. Independent researchers quickly aimed to understand the effectiveness of the various models and programs through randomized control trials (RCTs).

Since 2010, MIECHV has funded states, territories, and tribal entities to develop and implement evidence-based, voluntary home visiting programs. The populations served differ by state, however MIECHV identifies priority criteria[ii] as a guideline for states aiming to reach families with characteristics associated with adverse developmental outcomes.[31] State investments in home visiting programs predate MIECHV (47 states[iii] funded home visiting programs prior to MIECHV), but data and tracking of states' home visiting programs were poor.[3] In Fiscal Year 2010, states made approximately $1.4 billion available for home visiting programs, but they could not account for the use of more than 40 percent of funds that were appropriated to broad-based early childhood initiatives rather than exclusively to home visiting programs. States also failed to provide adequate oversight to ensure quality or require the use of program models with documented effectiveness.[3]

The designation "evidence-based" among home visiting programs has been defined and determined through the federally funded HomVEE review.[16] Currently, HomVEE has identified 27 home visiting models as "meeting HHS criteria for evidence-based models," meaning the models have either at least one study demonstrating at least two favorable impacts or at least two studies demonstrating at least one overlapping favorable impact (i.e., the findings for the impact were replicated). Findings must also be from RCTs or in studies with quasi-experimental designs (QEDs) rated to be of either high or moderate quality across measures of child and family wellbeing. If findings are from an RCT, the favorable impact must be sustained for at least one year after program enrollment and at least one favorable impact must be in a peer-reviewed journal.[B,27,33]

Many home visiting programs have been evaluated with RCTs, an evaluation method that is recognized by the National Academies of Sciences, Engineering and Medicine as providing "the highest level of confidence" in program efficacy or failure (p. 2).[4] Findings from an internally valid RCT indicate what could be expected from a program if the program were replicated exactly like the RCT, but neither the random assignment of participants into treatment and control groups nor the careful control of the research design required in an RCT are likely to occur when programs are replicated during scale-up. Thus, the extent to which findings from an RCT can be generalized to a larger and often different population and context at a later time is limited—an "evidence-based" designation shows promise, but it does not guarantee program effectiveness when implemented on a large scale.[23]

[ii] The targeting criteria for "high-priority" include: (a) Low-income families, (b) Families in priority communities, (c) Pregnant women under age 21, (d) Families with a history of child abuse or neglect, (e) Families with a history of substance misuse or with members who need substance misuse treatment, (f) Families with users of tobacco in the home, (g) Families with children who have low student achievement, (h) Families with children who have developmental delays or disabilities, (i) Families with individuals who are serving or have served in the Armed Forces, including those with multiple deployments.
[iii] State counts include the District of Columbia.

Who Is Affected by Evidence-Based Home Visiting Programs?

In 2024, evidence-based home visiting programs were implemented in all 50 states and the District of Columbia, the five major territories, 32 Indigenous communities, and 52 percent of US counties, serving more than 284,000 families through more than 3 million home visits with approximately 14 percent of visits provided virtually.[6] However, of the approximately 16.9 million pregnant parents and families in the US who meet criteria to benefit from home visiting, only 1.7 percent, approximately 284,000 families, received services in 2024, indicating that home visiting programs reach a small fraction of the families who could benefit from participation.[6]

No national dataset provides a demographic overview of access to evidence-based home visiting programs specific to the prenatal-to-3 period. However, the National Home Visiting Resource Center provides a yearly snapshot of the recipients of 17 HomVEE-recognized models broken out by demographic characteristics. In their sample, adult home visiting recipients were 56 percent White, 34 percent Hispanic (of all races), 24 percent Black, and approximately 14 percent multiracial or from other racial groups.[6,iv] Families that are American Indian/Alaska Native, Asian, or Native Hawaiian/Pacific Islander represent less than 3 percent of home visiting recipients. This sample suggests that the receipt of home visiting services is proportional to the demographic distribution of the US population with slight over- or under-representation of some groups. More information is needed to understand the demographic distribution of access, beyond just receipt of services.

What Are the Funding Options for Evidence-Based Home Visiting Programs?

The Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 reauthorized MIECHV, the largest source of federal funding in home visiting and increased federal investment for the first time since Fiscal Year 2013. Between Fiscal Year 2024 and Fiscal Year 2027, funding will increase from $500 million to $800 million.[2] MIECHV funding requires state maintenance of effort (MOE), which means that states must maintain existing levels of state spending on home visiting as a condition of receiving federal MIECHV funds. According to the US Government Accountability Office, from Fiscal Years 2016 through 2018, state-reported MOE spending varied from $0 (28 states) to more than $25 million.[7] States can report $0 in MOE spending if "a state's only home visiting spending was on programs that did not meet MIECHV criteria. State-reported MOE spending does not necessarily reflect all state spending on all home visiting services" (p. 9).[7]

According to the National Conference of State Legislatures (NCSL), states use a wide variety of funding sources to support home visiting programs. In Fiscal Year 2019, these sources included federal MIECHV grants, the Title V Maternal and Child Health (MCH) Block Grant, Temporary Assistance for Needy Families (TANF), Medicaid, federal child welfare funds (e.g., through the Family First Prevention Services Act of 2018), the federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), state general funds, tobacco settlements and taxes, and private philanthropic funds.[9] It is not clear from the research what the optimal funding mechanism or level is, and the data available on how states are using funds often come from surveys, many of which do not include responses from all states. For example, only 21 states responded to the most recent NCSL survey.[10]

[iv] This sample incorporates some of the largest evidence-based home visiting programs but it is not representative of home visiting receipt in the US as a whole.

Since the 1990s, states have used Medicaid to fund home visiting services through service provider reimbursement, often combining Medicaid with other sources of funding.[11,28] In 2016, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) provided guidance to states permitting them to use Medicaid funding to pay for home visiting when provided to Medicaid beneficiaries.[12] Although Medicaid funding is an option, the coverage and payment rates often fail to cover the full cost of services and a more streamlined approach by the states and the federal government is necessary to initiate broader access.[28] As of 2022, at least 28 states use Medicaid through a variety of mechanisms (e.g., managed care, waivers) to fund evidence-based home visiting programs□□ The most common mechanism is using a Medicaid State Plan Amendment.

As of September 2026, 19 states use Medicaid to specifically fund evidence-based home visiting programs with demonstrated positive impacts on parenting, and two additional states (the District of Columbia and Nebraska) are taking steps to implement Medicaid coverage for these programs.

Why Should Evidence-Based Home Visiting Programs Be Expected to Impact the Prenatal-to-3 Period?

Parents play a critical role in shaping children's early development, and supporting families in the early years has the potential to produce long-term benefits for families and for society.[13,D] Programs designed to support parents, and thus produce positive outcomes for children, are founded on decades of empirical evidence demonstrating the association between parenting and child wellbeing.[14,15,17] Improving parents' knowledge, social support, and coping and problem-solving skills, as well as connecting families to community and health resources during the prenatal and early childhood periods, promotes positive long-term developmental trajectories in children.[18] Teaching parents the skills to provide warm and responsive caregiving can buffer the long-term negative effects of childhood stress and adversity.[19]

Home visiting may be a particularly effective model of parenting education, and parenting skills are the outcome of focus for this review. The convenience of home-based service delivery may maximize the likelihood that families will participate by eliminating or reducing barriers such as transportation costs and child care needs.[D] Additionally, by providing support to families in their homes, it may be easier for the entire family, including fathers, to participate and may facilitate more personalized, individual attention, potentially increasing families' engagement in the programs.[18]

What Impact Does Evidence-Based Home Visiting Have, and for Whom?

This review focuses on the evidence supporting home visiting programs' impact on parenting outcomes among families with children under age 3. The review does not focus on a particular program model, but rather examines the effectiveness of a variety of program models as demonstrated in rigorous meta-analyses. Program models in the studies reviewed include, but are not limited to, Early Head Start (EHS) Home Visiting, Healthy Families America (HFA), Healthy Start, Home Instruction for Parents of Preschool Youngsters (HIPPY)[v], the Nurse-Family Partnership (NFP), Parents as Teachers (PAT), Play and Learning Strategies (PALS) Infant, and SafeCare. The effects of individual program models have been presented independently in other reviews.[B,E]

[v] HIPPY program evaluations include samples with children older than ages 0 to 3.

The research discussed here meets our standards of evidence for being methodologically strong and allowing for causal inference, unless otherwise noted. Each meta-analysis reviewed has been assigned a letter, and a complete list of causal studies can be found at the end of this review, along with more details about our standards of evidence and review method.

The findings from each strong causal study reviewed align with one of our eight policy goals from Table 1. The Evidence of Effectiveness table displays the findings associated with evidence-based home visiting programs (beneficial, null,[vi] or detrimental) for each of the strong studies (A through G) in the causal studies reference list. For each indicator, a study is categorized based on findings for the overall study population; subgroup findings are discussed in the narrative. The Evidence of Effectiveness table also includes our conclusions about the overall impact on each studied policy goal. The assessment of the overall impact for each studied policy goal weighs the timing of publication and relative strength of each study, as well as the size and direction of all measured indicators.

Of the seven meta-analyses included in this review, only one examined how outcomes differed by race or ethnicity (beyond simply presenting summary statistics or controlling for race/ethnicity).[E] Where available, this review presents the analyses' causal findings for subgroups. A rigorous evaluation of a policy's effectiveness should consider whether the policy has equitable impacts and should assess the extent to which a policy reduces or exacerbates pre-existing disparities in economic and social wellbeing.

Table 2: Evidence of Effectiveness for Evidence-Based Home Visiting Programs by Policy Goal

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Nurturing and Responsive Child-Parent Relationships	Parenting Knowledge and Attitudes	A			Mixed+
	Positive Parenting	A	B*, E, F		
	Parent-Child Interactions		G		
	Quality of Family Relationships		A		
	Quality of the Home Environment	E			
	Parenting Behaviors and Skills	A, C, D, G			
	Family Conflict	G			

** The HomVEE study found positive impacts on parenting in most of the 21 home visiting models included in the study, but because the study examined a very large set of outcomes, null effects outnumbered significant effects.*

+ Mixed impacts, with beneficial impacts for parenting behaviors and skills.

[vi] An impact is considered statistically significant if p≤0.05. Results with p-values above this threshold are considered null or nonsignificant.

Nurturing and Responsive Child-Parent Relationships

The outcomes of home visiting programs for children and families have been extensively studied, likely in part because of MIECHV and the emphasis on implementing evidence-based programs. Parenting has been conceptualized and measured in a variety of ways as an outcome across studies of home visiting, including: "positive parenting,"[vii,A] "parenting behavior and parenting attitudes,"[18] "parenting skills,"[viii,E] "positive parenting practices,"[ix,B] and "maternal parenting behavior."[x,D] Studies have consistently shown small but significant effects for improving parenting behaviors (overall effect sizes on parenting outcomes from meta-analyses range from 0.09 to 0.37),[A,18,C,D,E,G] but studies have failed to consistently demonstrate significant impacts for other outcomes (e.g., birth outcomes,[A,20] child maltreatment,[C,18] child health,[A,C,G] etc.) therefore our review is restricted to focus on nurturing and responsive child-parent relationships. Importantly, across outcomes, including parenting, the significant effects that emerge do so within the context of many more null findings.[B,E,G] Further, studies have done little to clarify which components of home visiting are particularly effective for outcomes (e.g., targeted population, frequency of visits).

A 2010 meta-analysis of 29 RCT and QED studies of home visiting programs targeting at-risk families found a weighted mean effect size for home visiting that was significant and positive for maternal behavior (0.37 effect size).[D] A 2013 meta-analysis of 51 studies (both experimental and nonexperimental, but with comparison groups) of home visiting programs targeting pregnant women and families with young children (between birth and age 3) found a significant average effect size of 0.23 (small effects) on parent behaviors and skills.[C] A 2016 meta-analysis of 156 studies (both experimental and nonexperimental, but with comparison groups) of nine evidence-based home visiting programs focusing on children under age 5 found slightly larger, yet still small, significant effects for positive parenting (0.26 effect size) and parenting knowledge (0.21 effect size) compared to other null outcomes, including birth outcomes, child health, and child behavior.[A]

The federally funded HomVEE review of home visiting programs reviewed over 550 RCT or QED studies of 70 home visiting programs and identified 27 home visiting models as "meeting HHS criteria for evidence-based models," and most have demonstrated favorable impacts on positive parenting practices.[B,32] However, the favorable impacts on positive parenting practices emerged in the context of many more null findings.[B,E,F]

The authors of the federally funded RCT evaluation of MIECHV (the Mother and Infant Home Visiting Program Evaluation—MIHOPE) provided a summary of the evidence from past studies of the four program models in MIHOPE (HFA, EHS, NFP, and PAT) and noted that "the quality of the home environment during early childhood is one of the most examined outcomes in the home

[vii] Positive parenting referred to positive observed parent-child interactions; positive self-reported quality of relationships (supportive, accepting); positive behaviors (nonviolent discipline, praise, provision of play materials, reading to child); and parent involvement.
[viii] Parenting skills encompassed the quality of the home environment and parental supportiveness.
[ix] Positive parenting practices included observational measures of parent-child interactions or of the home environment and parent self-reports of parenting attitudes and practices.
[x] Improvements in maternal behavior were measured using observational scales, including the Home Observation for Measurement of the Environment (HOME) Scale, the Nursing Child Assessment Satellite Training (NCAST) scale, the CARE-Index of adult-child interaction, and the Maternal Interactive Behavior Scale.

visiting literature" yet "most estimated effects from studies have not been statistically significant" (pp. 48–49).[E] The authors went on to quantify the number of significant impacts relative to null impacts across outcomes in past studies and concluded that only "125 of the 1,104 estimated effects–or 11 percent–are statistically significant and indicate improved outcomes for families" (p. 20).[E] In addition to the review of past studies, the MIHOPE report also presented a current analysis of findings from 88 home visiting programs in 12 states across the four key program models. The analysis found a small but significant effect (0.09 effect size) for improving the quality of the home environment, but no significant effect on parental supportiveness.[E]

A 2004 meta-analysis of research articles and reports (both experimental and nonexperimental, including pre-post designs) of 60 home visiting programs[18] serving families prenatally through age 5 that were included in a larger 2001 meta-analysis of family support programs[21] found small but significant effects on parenting behavior and parenting attitudes (weighted mean standardized effect sizes were 0.14 and 0.11, respectively). The 2004 study is not included in the Evidence of Effectiveness table (Table 2) because it included pre-post analyses; our review is limited to meta-analyses that only review QEDs and RCTs.[18]

In 2017 and 2019, the MIHOPE team asked families for updated contact information when children were 2.5 and 3.5 years of age and, although the primary purpose of surveys was to obtain contact information, surveys also asked information about families' current circumstances and found many null results.[F] Authors found the home visiting programs did not impact the use of yelling or any physical discipline. The home visits also did not impact the number of days or time spent reading to children, or time spent on in-home learning activities or frequency of telling stories or nursery rhymes to children.[F]

Finally, a subsequent follow-up of the MIHOPE cohort conducted approximately 5 to 7 years after enrollment in home visiting programs found that several benefits of home visiting persisted into children's kindergarten and early elementary school years.[G] Using composite (omnibus) analyses across multiple parenting and family domains, the study found significant improvements in maternal coping strategies and parenting behaviors, as well as significant reductions in family conflict, intimate partner violence, aggression toward children, and child maltreatment.[G] The study also found a near statistically significant improvement in parent-child interactions ($p = 0.065$). These findings suggest that benefits of home visiting for parenting behaviors and broader family functioning may persist into the early elementary years.

Several of the meta-analyses conducted in the last decade have examined studies across home visiting program models to identify the specific characteristics or components of home visiting programs that are associated with positive impacts, but a consistent pattern has failed to emerge.[C,18] Targeting programs to families with one or more risk factors produced larger effect sizes overall compared to universal programs in one meta-analysis (0.20 versus 0.18),[A] but not in the MIHOPE evaluation of four program models.[E] And, in another meta-analysis, targeting higher-risk families[xi] was associated with smaller effect sizes for some outcomes, including parenting behavior,

[xi] Higher-risk families is defined in this study as families with single and/or teenage mothers, families dependent on public assistance, or families at risk for child abuse or neglect..[18]

compared to universal approaches.[18] Dosage demonstrates a similarly inconsistent trend—one meta-analysis[D] found that programs with more frequent visits were more likely to demonstrate improvements in maternal behaviors, but in the MIHOPE study, estimated effects were not larger among families who received more visits compared to families who received fewer visits.[E]

Is There Evidence That Evidence-Based Home Visiting Programs Reduce Disparities?

Recent meta-analyses of home visiting programs have attempted to identify which factors or components, including targeting high-risk families versus taking a more universal approach to enrollment, are associated with program impacts on outcomes. No consistent pattern has emerged from these analyses—program impacts for high-risk families have been larger,[A] smaller,[18] and null[E] compared to the effects of programs for families of lower risk or more universal approaches.

The MIHOPE study examined differences in effects across subgroups based on race and ethnicity, but no parenting differences emerged.[E] The only significant difference found was in the number of Medicaid-paid well-child visits: Non-Hispanic White mothers showed no increase in the number of Medicaid-paid well-child visits as a result of home visiting, whereas all other subgroups, including families of Mexican origin, other Hispanic origin, non-Hispanic Black, multiracial, and other ethnicities, showed positive impacts on this outcome.

The 2025 MIHOPE kindergarten follow-up found little evidence that the long-term effects of home visiting differed by maternal race or ethnicity. Across 60 outcomes, only a small number of subgroup differences were identified, and the authors concluded that the overall pattern did not suggest that home visiting was consistently more or less effective for any racial or ethnic group.[G]

The HomVEE study, however, was not able to examine effects by race/ethnicity, and the authors noted that sample size was a limitation: "Overall, the studies included in the HomVEE review had fairly diverse study samples in terms of race/ethnicity and socioeconomic status. However, sample sizes in these studies are not typically large enough to allow for analysis of findings separately by subgroup" (p. 21).[B]

A third study found that home visiting programs that matched clients and home visitors on race and/or ethnicity had better effects on birth outcomes, but this finding did not hold for parenting outcomes.[C] The final two studies in the review did not examine impacts by race or ethnicity.[A,D]

Has the Return on Investment for Evidence-Based Home Visiting Programs Been Studied?

A 2017 report, as part of the Mother and Infant Home Visiting Program Evaluation (MIHOPE), examined the lifetime return on investment for Healthy Families America (HFA), the Nurse-Family Partnership (NFP), and Parents as Teachers (PAT).[24] The study projected that long-term benefits are 25 percent greater than costs in HFA, 88 percent greater than costs in NFP, and 244 percent greater than costs in PAT. Benefits of the NFP program were greatest for single mothers with low incomes, with each $1 spent producing over $5 in benefits for this group, compared to $1.10 in benefits for other families. The authors explained that lifetime benefits typically accrue in the form of increased

earnings for both mothers and their children through reduced child maltreatment, better academic achievement among children, and better high school graduation rates among mothers.

According to a review by the National Conference of State Legislatures, high-quality home visiting programs have been found to produce between $1.75 and $5.70 of cost savings for every dollar spent on the program; savings attributed to home visiting programs have been identified in areas including child welfare, special education, and criminal justice.[22] However, these cost savings are not necessarily attributable to home visiting's impact on parenting outcomes.

What Do We Know, and What Do We Not Know?

Home visiting programs have clearly defined parameters to determine whether a program is "evidence-based" and have a long history as a statewide investment to support families with young children. Studies have consistently found small but positive impacts on measures of parenting, but there is far less consistent evidence for impacts on other important child and family outcomes and for which aspects of home visiting drive impacts. Additionally, more recent evidence from the long-term MIHOPE follow-up suggests that benefits of home visiting may become more apparent when examined across related domains of parenting and family functioning using omnibus measures rather than through individual outcomes alone, although effects remain modest.[G]

This review was limited in scope to examining parenting outcomes, but future reviews may examine home visiting's impact on other policy goals as well. Additionally, when examining findings outlined in home visiting meta-analyses, null impacts continue to outnumber the positive impacts for all outcomes, including parenting.

Future research should continue to address the gaps in evidence for which aspects of home visiting are associated with impacts on outcomes. Studies should be designed to identify the components of home visiting programs that matter most for families, rather than relying on meta-analyses to assimilate findings across studies that were largely not designed to identify those components. Research should evaluate whether aligning program models with the specific identified needs of client families produces larger effects. Further research on differential impacts by race, ethnicity, and socioeconomic status is also needed.

Are Evidence-Based Home Visiting Programs an Effective Policy for Improving Prenatal-to-3 Outcomes?

Evidence from seven rigorous meta-analyses suggests that families who participate in evidence-based home visiting programs see small but positive impacts on parenting skills. More research is needed to understand which aspects of home visiting most contribute to positive outcomes and whether home visiting has consistent impacts on other policy goals beyond nurturing and responsive parenting. As a state strategy, providing evidence-based home visiting programs is effective for improving parenting skills, but current research does not support a specific state policy lever to guide the most effective implementation of home visiting programs. Funding sources and level of investment vary widely by state.

How Did We Reach Our Conclusions?

Method of Review

This evidence review began with a broad search of all literature related to the policy and its impacts on child and family wellbeing during the prenatal-to-3 period. First, we identified and collected relevant peer-reviewed academic studies as well as research briefs, government reports, and working papers, using predefined search parameters, keywords, and trusted search engines. From this large body of work, we then singled out for more careful review meta-analyses that reviewed causal studies (either QEDs or RCTS) with a specific focus on parenting outcomes. We then subjected this literature to an in-depth critique and chose only the most methodologically rigorous research to inform our conclusions about policy effectiveness. All studies considered to date for this review were released on or before February 29, 2026.

Standards of Strong Causal Evidence

When conducting a policy review, we consider only the strongest studies to be part of the evidence base for accurately assessing policy effectiveness. A strong study has a sufficiently large, representative sample, has been subjected to methodologically rigorous analyses, and has a well-executed research design allowing for causal inference—in other words, it demonstrates that changes in the outcome of interest were likely caused by the policy being studied.

The study design considered most reliable for establishing causality is a randomized controlled trial (RCT), an approach in which an intervention is applied to a randomly assigned subset of people. This approach is rare in policy evaluation because policies typically affect entire populations; application of a policy only to a subset of people is ethically and logistically prohibitive under most circumstances. However, when available, RCTs are an integral part of a policy's evidence base and an invaluable resource for understanding policy effectiveness.

The strongest designs typically used for studying policy impacts are quasi-experimental designs (QEDs) and longitudinal studies with adequate controls for internal validity (for example, using statistical methods to ensure that the policy, rather than some other variable, is the most likely cause of any changes in the outcomes of interest). Our conclusions are informed largely by these types of studies, which employ sophisticated techniques to identify causal relationships between policies and outcomes. Rigorous meta-analyses with sufficient numbers of studies, when available, also inform our conclusions.

Studies That Meet Standards of Strong Causal Evidence

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