



New Mexico Sponsors Identify Time and Money as Factors Affecting Home-Based Provider *Child and Adult Care Food Program* Engagement

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ABSTRACT

Objective: Describe *Child and Adult Care Food Program* (CACFP) sponsor perspectives on barriers and facilitators to home-based provider CACFP eligibility, enrollment, and participation and ways to improve provider support.

Methods: Semistructured interviews were conducted with 11 New Mexico CACFP sponsor staff representing 9 out of 13 agencies (69% response rate) from August to September, 2020. Interviews were analyzed using thematic analysis with an essentialist/realist epistemological approach.

Results: Sponsor-perceived barriers to provider CACFP: eligibility (costs, background checks, fear/stigma, and delays in becoming state-approved providers); enrollment (lack of translated/low-literacy materials and cumulative systems requirements); and participation (challenges maintaining qualifying menus and documentation and accessing qualifying food, inadequate reimbursements, and unannounced visits). Sponsors suggested systems changes to improve provider support (eg, more assistance with becoming state-approved and for start-up costs and accessible, progressive nutrition training opportunities).

Conclusions and Implications: Sponsors noted CACFP barriers for home-based providers and identified corresponding systems changes that could be tested.

Key Words: child care, nutrition policy, nutrient intake, preschool child, infants (*J Nutr Educ Behav.* 2022;54:947–956.)

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INTRODUCTION

The child care sector is an important avenue for addressing child nutrition, as about 60% of young children in the US are regularly cared for by someone other than their parents.¹ The *Child and Adult*

Care Food Program (CACFP) is a federal program that reimburses providers in child care (homes and centers), *Head Start*, prekindergarten, afterschool programs, and adult care settings for serving meals and snacks designed to support the nutritional needs of children during critical periods for growth

and development.^{2,3} The CACFP nutrition standards were updated in 2017 to better align with the Dietary Guidelines for Americans, with an emphasis on reducing added sugars and saturated fat and exposing children to a wide variety of fruits and vegetables, whole grains, lean meats or meat alternates, and low-fat and fat-free dairy products (for children aged > 2 years).³ Through CACFP, an estimated 2 billion meals were served in 2019.⁴

As navigating CACFP enrollment and participation can be complex, sponsor agencies are available to support child care providers through the process. Sponsors are organizations that serve as intermediaries between some child care centers and all home-based child care providers, and the state agencies that administer CACFP. Sponsors train providers on nutrition and the CACFP rules and regulations, classify home-based providers into a reimbursement tier, conduct home visits and collect and

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review documentation (ie, menus, attendance documentation, and meal counts) to monitor compliance with program standards, submit paperwork for reimbursement, and distribute meal reimbursements.^{5,6}

Despite the availability of sponsor support, the number of home-based providers enrolled in CACFP has been steadily declining, from a high of close to 200,000 providers nationwide in 1996 to slightly < 100,000 providers in 2018.⁷ This decline may be due in part to the shift back to a tiered reimbursement system for home-based providers in 1997.^{5,8} Under the tiered system, providers who are low-income or live in low-income areas (tier 1) receive reimbursements that are roughly double those for providers that do not meet these criteria (tier 2).^{8,9} However, the decline in home-based providers enrolled in CACFP also parallels a nationwide drop in the number of small (1 sole caregiver) home-based providers engaging with state child care regulatory systems.¹⁰ Home-based providers are only eligible to participate in CACFP if they are licensed or approved by their state and are sponsored.⁵

Given their pivotal role as intermediaries, sponsor perspectives are valuable; however, they are largely absent from current CACFP research, although sponsors are sometimes included as secondary informants.¹¹ Our objectives for this qualitative study were to describe New Mexico sponsor perceptions of barriers and facilitators to home-based provider CACFP eligibility, enrollment, and participation and ways to improve system capacity to support providers.

METHODS

The study protocol was approved via a minimal risk review of non-federally funded research by the University of New Mexico Institutional Review Board. All participants were adults who provided verbal consent and received a \$20 gift card. The consolidated criteria for reporting qualitative research checklist was used to guide reporting.¹²

Study Context

New Mexico is a border state with rural and frontier (ie, most remote rural¹³) areas with high concentrations of home-based care use.¹⁴ Approximately 13 million total CACFP meals were provided across settings in New Mexico in fiscal year 2021.¹⁵ In New Mexico, both licensed and registered (license exempt) home-based providers are eligible to enroll in CACFP, with CACFP enrollment required for all providers who care for nonresident children during meal times. This is not the case in all states; many states only allow licensed providers to enroll in CACFP.¹⁶ Detailed information about the requirements for becoming a licensed or registered home-based provider and enrolling and participating in the CACFP in New Mexico is provided in [Table 1](#).^{3,6,9,17–25} As of July, 2020, the New Mexico Early Childhood Education and Care Department oversees enrolling as a licensed or registered home-based provider and administration of CACFP.

Despite the more liberal criteria allowing (and mostly requiring) both licensed and registered providers to enroll in CACFP in New Mexico, from 1998 to 2018, the number of home-based providers enrolled in the CACFP declined from 6,759 to 1,833 homes, a 72.9% decrease that was among the most drastic in the country (rank, 46).⁷ This decrease largely reflects a drop in the overall supply of regulated, home-based child care,¹⁰ and has occurred although CACFP is designed to serve low-income children,⁵ and New Mexico ranks 48th in the country on measures of child economic well-being.²⁶ New Mexico's home-based providers are overwhelmingly low-income themselves or live in low-income areas, with approximately 99% of home-based providers in New Mexico designated as tier 1 (see [Table](#); highest reimbursement rate) in fiscal year 2021.²⁷

Study Design

We conducted semistructured interviews with CACFP sponsor staff in New Mexico for this qualitative

study. The study was designed using thematic analysis as defined by Braun and Clarke^{28,29} and a cost-benefit conceptual framework, as there is evidence that individuals often weigh perceived costs vs benefits in making decisions about participation in social programs.³⁰ We conceptualized the benefits and burdens of the program holistically, with burdens including food costs, the provider's labor and cognitive burden, and increased government surveillance. For this, we used Moynihan and co-authors³¹ components of administrative burden, defined as learning costs, psychological costs, and compliance costs. Benefits explored included financial reimbursement for food, nutrition knowledge, and psychic and business benefits of serving healthy food to children.

Participants and Recruitment

We initially recruited sponsor staff via email, with a follow-up phone call made after 1 week. A purposive sampling strategy was used to enroll at least 1 staff member from New Mexico's 13 CACFP sponsors serving different state regions. Our recruitment efforts targeted sponsor staff with direct knowledge of and experience with CACFP. Their job titles varied across programs.

Instruments

Team members with early childhood education and nutrition expertise developed and refined the interview guide ([Supplemental Material](#)). Our questions asked sponsors to discuss their role, the types of child care providers they serve, and their perceptions of child care provider barriers to CACFP eligibility, enrollment, and participation (encompassing decisions to enroll and/or continue with the program), policies and sponsor practices that facilitate or could facilitate CACFP enrollment and participation and disruptions that have occurred because of the coronavirus disease 2019 (COVID-19) pandemic. The interview guide was not pilot-tested.

Table 1. Requirements to Become a Licensed¹⁷ or Registered^{18,19} Home-Based Provider and Enroll and Participate in CACFP^{6,20–22} in New Mexico

Requirements	Licensed Home-Based Provider	Registered Home-Based Provider (Full)	Registered Home-Based Provider (CACFP Only)	Registered Home-Based Provider (Exempt)
	CACFP eligibility (becoming a licensed or registered home-based provider)			
Key features of provider types: Providers must be approved by their state to participate in CACFP; New Mexico has 4 levels of approval	Licensed; up to 12 children; can receive child care subsidy and tiered quality subsidy reimbursement May participate in CACFP	License exempt; up to 4 non-resident children; can receive child care subsidy Must participate in CACFP	License exempt; up to 4 nonresident children; cannot receive child care subsidy; cares for children during meal or snack times Must participate in CACFP	License exempt; up to 4 nonresident children; can receive child care subsidy; does not care for children during meal or snack times (such as overnight) Not required to participate in CACFP
Requirements: all provider types	Scheduled home inspection; initial training in first aid, CPR, and other safety topics; 6 annual hours of child development and safety training; fire extinguisher; safety renovations, and application fee			
Requirements: specific provider types	Local zoning and fire approvals; curricular/quality requirements (eg, a parent handbook, differentiated areas for different types of play); Fingerprint background check for all household adults; 6 additional annual training hours	Fingerprint background check for all household adults	Fingerprint background check for caregiver only; child abuse and neglect screen for other household adults	Fingerprint background check for all household adults; CACFP not required/allowed
	CACFP enrollment			
All provider types	Must be licensed or registered (full or CACFP only); must be sponsored; documentation of eligibility ^a for reimbursement tier 1 or 2 ¹² ; initial training from a sponsor on CACFP processes and requirements; sponsor home inspection during first 4 wk of operation			
	CACFP participation			
All provider types	Menus reflecting age-specific quantities and types of food specified in the CACFP meal patterns ^b were served; daily attendance logs; daily meal count records; annual training from sponsors on meal patterns and CACFP processes; 3 annual sponsor home visits (at least 2 must be unannounced)			

CACFP indicates *Child and Adult Care Food Program*; CPR, cardiopulmonary resuscitation.

^aReimbursement rates are based on a 2-tiered system.^{9,23} To qualify for tier 1 reimbursement rates, providers must have a household income < 185% of the federal poverty level or be located in a geographic area in which at least 50% of children are members of households with incomes < 185% of the federal poverty level.⁹ Providers that do not meet these criteria receive tier 2 rates unless they demonstrate that individual families they serve have incomes < 185% of the federal poverty level.⁹ Reimbursement rates are adjusted every July based on the Consumer Price Index for food at home.⁹ The 2021–2022 per meal payment rate for tier 1/tier 2 home-based providers in the contiguous states is \$1.40/\$0.51 for breakfast, \$2.63/\$1.59 for lunch and supper, and \$0.78/\$0.21 for snack²³; ^bMeal pattern requirements are defined for different child age groups (birth–5 months, 6–11 mo, 1–2 y, 3–5 y, 6–12 y, and 13–18 y) and meal types (breakfast, lunch, supper, snack).³ For example, breakfast for a child aged 3–5 years must include 6 fl oz of unflavored low-fat or fat-free milk, 0.5 cups of vegetables and/or fruits, and 0.5 oz Eq of grains (or up to 3 times/wk, 0.5 oz of meat/meat alternates) to be reimbursable.²⁴ At lunch or supper, meals must include 5 components (age-specific amounts of fluid milk meeting age-specific fat content requirements, meat/meat alternates, vegetables, fruits, and grains) to be reimbursable.²⁵

Data Collection

Study staff conducted semistructured interviews with CACFP sponsor staff August–September, 2020 using Zoom teleconferencing software (Zoom Video Communications, Inc., version 5.2.1). All interviews were conducted by a woman with a Master's degree in health education (J.M.) that included qualitative research training on the basis of recommendations from McGrath et al³² and Bradley et al.³³ She had no previous relationship with any of the interviewees. Interviews were audio-recorded with permission and professionally transcribed nonverbatim (removing ums and false starts). The interviewer also took detailed notes on the process and content of each interview, recording insights, questions, and reflections.

Data Analysis

Interviews were analyzed using thematic analysis, with a primarily essentialist/realist epistemological approach. We assumed a simple, largely unidirectional relationship between what our informants said and what they meant.²⁸ We did not apply more constructivist methods that explicitly interpreted informants' words in their sociocultural context because sponsors speak as professionals and use a policy vernacular shared by the interviewer. A coding manual was generated by the interviewer and team members with early childhood education and nutrition expertise in advance of the coding process, with deductive codes on the basis of the scholarly literature about barriers to CACFP access for home-based providers³⁰ and interviewer impressions of themes from the interviews. These codes were broadly organized around the cost-benefit conceptual framework described above, with codes for challenges and burdens, the rewards and values of participation, and policies and/or sponsor activities that lessen or increase benefits and burdens.

Interviews were then independently coded line-by-line for themes by the interviewer and a woman who is a registered nurse with a Master's degree in public health that included training in qualitative research methods. The coders were trained and oriented to the codebook by a project

co-principal investigator, and coding procedures were completed in Microsoft Word (Microsoft Inc., version 1808). Coding differences were reconciled through discussion during regular meetings between these 2 individuals, with advisement from a third individual as needed. Interrater reliability was not quantitatively assessed. During the subsequent iterative coding processes, the coders made additions and modifications to the coding manual to refine themes and capture emergent findings. Analysis followed Braun and Clarke's²⁸ 6 phases of thematic analysis, and continued until coding saturation (ie, no new codes or themes emerged from additional analysis). Although some sponsors discussed child care centers, this paper is focused on findings regarding home-based providers.

RESULTS

Sponsor Characteristics

Eleven sponsor staff were interviewed, representing 9 out of the 13 CACFP sponsor organizations serving New Mexico. Sponsors ranged from smaller, regional entities to larger nonprofits with statewide reach and collectively supported home-based providers in every region of New Mexico, including providers located in urban and rural settings, the US-Mexico border region, military bases, and sovereign Tribal nations.

Provider Populations Served

Sponsors served a mix of registered and licensed home-based child care providers and said the majority of the providers they serve are Hispanic, with many speaking only or primarily Spanish. About half of the sample described their provider population as mostly older, consisting largely of grandparents caring for their grandchildren, sometimes alongside non-relative children.

Sponsor Perceptions of Provider Barriers to Becoming Eligible for CACFP (Licensed/Registered)

Increased upfront costs related to becoming a registered home

provider in New Mexico (eg, fingerprint background checks, safety equipment, renovations, and first aid/cardiopulmonary resuscitation [CPR] class) can be a barrier to CACFP eligibility. One sponsor (Program H) said the costs can quickly become overwhelming: "...[I]f you're living paycheck to paycheck and you're on a very limited income, that money that you shell out upfront is—that's very difficult for home providers."

Background checks also pose a barrier. Sponsors said in most cases, the care providers are not concerned about passing the background check but are hesitant to subject the rest of their household to the process. One sponsor (Program B) described:

[I]n the past year and a half, we probably have had, maybe, 40 providers...or more who...didn't pass background checks, or they have decided...this process is just way too stringent and costly for them upfront.

Sponsors said prospective providers often have concerns about unwanted government attention, especially for providers who are undocumented immigrants or whose families have mixed immigration statuses. One sponsor (Program D) said some providers do not want state employees in their homes "looking down on them," and multiple sponsors said providers were hesitant to have any dealings with the New Mexico Children, Youth and Families Department, which previously oversaw the licensing/registration process in New Mexico, as it is also the agency that investigates child abuse allegations.

Several sponsors also described specific delays in the process, mainly around the home inspections required to become a registered provider, which is conducted by the state. One sponsor (Program I) said: "I know we have probably 30 clients now who are just waiting for the state to approve them so they can start getting reimbursement."

Sponsor Perceptions of Provider Barriers to CACFP Enrollment

Several sponsors said low general literacy (in any language) makes it difficult for some providers to read and complete the required paperwork. One sponsor (Program H) said most of the paperwork needed for CACFP is available in Spanish, but some regulations exist only in English. Some sponsors said their organizations could provide services in Spanish or Indigenous languages, whereas others said they were limited in this regard. One sponsor (Program A) said their organization serves “a lot of Spanish-speaking” providers but is limited in its capacity to provide training in Spanish.

Sponsors described a cumulative system in which each requirement for becoming registered/licensed and enrolling in CACFP might be manageable, but taken together, they become overwhelming. One sponsor (Program B) described it this way:

I think it's just getting everything all at once, they just get a little bit of that scare moment, that they're like, 'No, it's too much for me'... 'I think I'm already regretting this.'

Sponsor Perceptions of Provider Barriers to On-Going CACFP Participation

Sponsors said a key hurdle for new providers is learning to plan and maintain a qualifying menu.

...They need to know what qualifies, what doesn't qualify. At the beginning, their first menus are going to be a little bit challenging, because, really, they probably never had to keep a menu before. That's different, and probably serving all components was not something that they would do.

one sponsor (Program G) said. Sponsors said some longtime providers still struggle to adapt to the 2017 updates to the CACFP nutrition standards, either because of established habits or difficulty purchasing qualifying foods. Multiple sponsors noted that menu planning is complicated by the limited types of food available in rural areas; in particular, limited

low-fat milk options were mentioned multiple times, as children aged ≥ 2 years must be served 1% or skim milk or the whole meal cannot be reimbursed. One sponsor (Program I) said,

[W]e have to work with our providers, to understand the necessity and how to navigate around it... those are real barriers that I see some of the people dinged on for un-reimbursable milk.

Even when qualifying food is served, providers face record-keeping challenges. Sponsors said it is disappointing for providers who plan and serve qualifying meals but have not written them down to discover they cannot be reimbursed. One sponsor (Program D) said:

There's been times when we've gone to the person's home, and they don't have their menus up to date, which is really sad because they have fed the kids [but] they don't receive a reimbursement for all the meals that were not recorded.

Unannounced home visits can be a barrier as well. Multiple sponsors used words such as nervous or nerve-racking to describe the way providers feel at first about unannounced visits. One sponsor (Program H) said unannounced visits could create unwelcome constraints on providers:

Meeting that requirement of having to be home at certain times or notifying the sponsor if you're not going to be home, a lot of people find that somewhat intrusive and are not really pleased about that. It's easier for them to just not be on the food program...

Finally, numerous sponsors reported that CACFP reimbursement could seem inadequate relative to the effort required to participate.

Sponsor Perceptions of Supportive Policies and Practices

Some sponsors reported using non-CACFP-funded staff time or resources to support providers with tasks and expenses required to become a

registered home provider. One sponsor (Program D) described these additional efforts:

We'll help them with fingerprinting registration. We'll scan their forms to the background check unit, so they don't have to worry about having to mail them out and have that wait time. We also help them fill out their background check application, and then...we offer assistance every step that they need to do to get their home inspected.

Another sponsor (Program I) said their organization sometimes provides funding from other sources to help providers with the upfront costs of becoming registered. “It wouldn't be out of the norms for us to help them pay for their fire extinguisher, their first aid kits, their CPR classes, and training and such,” this sponsor said. Funding for such additional supports was reported to be largely informal and nonsystemic.

A number of sponsors also said they value having bilingual staff who can help providers navigate the system and understand any untranslated documents. One sponsor said providers use their organization as a resource for understanding any communications they get from the state or elsewhere that are not provided in their preferred language.

Providing training and technical assistance is a key sponsor role, and most sponsors said the CACFP supports they offer to providers are meaningful and help them succeed. One sponsor (Program G) said: “[In-person] [t]raining is a biggie, because that's when they...can network. They can see how another person does things. How it works for them, the challenges they have.” Sponsors noted that by regularly visiting providers in their homes, they build relationships and can deliver individualized guidance and support.

Numerous sponsors felt CACFP has evident child benefits that can motivate providers to continue with the program. Sponsors also described positive impacts on providers, who learn skills through the program that help them shop for better produce, prepare healthier meals, and stretch limited funds.

Sponsors also perceived that the program helps address food insecurity in New Mexico. They said the reimbursements help ensure providers can afford reliable meals for the children in their care. However, a few sponsors voiced concern that providers in areas with a great need for food support sometimes do not participate in the program. The number of registered home providers has decreased markedly in recent years.

Barriers Related to the COVID-19 Pandemic

Several sponsors noted that providers struggled more than usual to purchase qualifying foods early in the pandemic. Virtual home inspections were challenging for some providers because of limited digital literacy and internet and/or device access.

Innovations During the COVID-19 Pandemic

With public health restrictions in place, providers were asked to learn new systems for signing and submitting documents, attending training, and being virtually visited by their sponsors. Sponsors said delivering nutrition training over the phone was common, as many providers had difficulty accessing virtual video training. One sponsor described using conference calling and said their agency is developing a paper-and-pencil training to allow providers to read materials, answer questions and submit their answers on paper. Some sponsors maintained limited physical office hours for providers to drop off their paperwork.

Sponsors also described how they simulated the unannounced visit during the public health emergency. One said her agency called providers during mealtimes and asked them to take pictures on the spot of their menus, the children in attendance, and the food they are serving, and then to send these pictures to their sponsor by text message.

Sponsors also highlighted helpful government policies and waivers, such as a meal pattern flexibility waiver issued by the US Department of Agriculture to address challenges due to COVID-19.³⁴

Sponsor Recommendations for Improving CACFP Policies and Practices

Several sponsors suggested that more providers might go through the registration process if certain requirements, such as fingerprinting and CPR classes, were offered free. Sponsoring organizations are permitted to provide some support and resources for getting registered but are not funded specifically to do so.

Background checks are a complex topic for sponsors. Although sponsors said they understood the importance of child safety, several said they would alter or remove the requirement if they were in charge of policy, as they felt background checks do little to keep children out of unsafe care situations and instead push the most vulnerable families out of the formal child care and child nutrition systems. One sponsor (Program I) described it this way:

...[T]he grandmother needs to provide services to her grandkids or the neighbor's kids, but because her son parks his travel trailer in her yard and he's a felon, her [home] doesn't qualify. She doesn't stop seeing those kids. It's just we stopped engaging in services, right, because they weren't under a [registered] entity.

Sponsors also said CACFP used to work better for home-based providers when sponsors were a 1-stop shop and could approve homes for registration. This changed after the US Department of Agriculture issued guidance in 2013³⁵ that CACFP sponsor funds could not be used to monitor providers' compliance with state requirements separate from CACFP. Around this time, New Mexico state officials took on the role of monitoring homes for compliance with state regulations.³⁶ Sponsors said this had detrimental effects. It created a second, separate agency providers had to navigate and interact with, making the process more confusing and overwhelming. Secondly, they said the state lacks sufficient staff to register homes in a timely way.

Financial support for upfront and ongoing costs was another recommendation. Several sponsors said program enrollment and retention could improve if start-up funds for providers and reimbursement rates escalated with food price inflation and accounted for the time involved in creating and tracking menus. One sponsor said sponsor reimbursement rates do not adequately cover operational costs, especially in rural areas in which sponsors may drive hundreds of miles round-trip to make an unannounced home visit.

Finally, several sponsors said training content and access could be improved. Sponsors noted that most providers care for children during the day and sometimes on evenings and weekends and cannot close or bring in a substitute caregiver to attend the in-person training. Sponsors also noted difficulties rural providers face in traveling long distances for in-person training and language access issues if training is only offered in English. Although they urged increased attention to access and flexibility, sponsors also noted that the video and phone training employed during the COVID-19 pandemic had access challenges. They said in-person group training creates valuable professional connections among providers and is preferred by many sponsors and providers. One sponsor said training content could be improved with more hands-on opportunities to learn and prepare new recipes and by advancing training content over time, as longtime providers are trained in the same basics every year.

DISCUSSION

Little is known about sponsor perceptions of barriers and facilitators to child care provider engagement with the CACFP, particularly for providers that serve rural, border, and home-based providers. In this qualitative study, sponsors identified several barriers to CACFP: eligibility (costs, household background checks, fear/stigma, and delays associated with becoming a state-approved home provider), enrollment (lack of translated and low-literacy materials and cumulative requirements across systems),

and participation (developing and maintaining qualifying menus and required documentation, limited access to qualifying foods, inadequate reimbursement rates, and unannounced visits) for home-based providers. Sponsors also described practices they employ to support eligibility (eg, providing modest financial and technical assistance related to becoming a registered home) and enrollment and participation (eg, hiring bilingual staff and building relationships that allow them to provide individualized support). Sponsors suggested changing the system to better support provider eligibility (eg, offering financial support for the costs of becoming a registered home, modifying household background check requirements, allowing sponsors to approve homes for registration) and enrollment and participation (eg, covering start-up costs, higher reimbursement rates for providers and sponsors, and providing accessible, linguistically appropriate, hands-on, and progressive training opportunities). Our findings broadly align with those from a recent Urban Institute brief focused on expanding CACFP participation among home-based providers, which recommended examining the adequacy of reimbursement rates, reducing paperwork burden, and exploring virtual tools for some monitoring and compliance activities, especially in rural areas.¹⁶

Food costs and inadequate reimbursements were perceived by sponsors as barriers to provider participation in the CACFP. This is consistent with findings from survey studies with child care providers examining challenges in implementing CACFP nutrition standards before and after 2017 updates.³ The cost of healthy foods was a commonly reported challenge for center directors and home-based child care providers.^{37–39} Similarly, healthy food costs were reported as a barrier in focus groups with Hispanic family child care providers in Massachusetts.⁴⁰ In contrast, a recent nationally representative study conducted before the 2017 changes found that CACFP reimbursements fully covered food costs but only covered between 18% and 51% of the full cost of food service, including labor.⁴¹ These findings are consistent with

sponsor perceptions that current reimbursements are not adequate to incentivize program participation because they do not cover all costs associated with participating. In addition, rural providers may experience disproportionate costs for obtaining foods that meet CACFP nutrition standards (eg, needing to travel long distances to procure foods at full-service grocery stores).^{42,43} Similar to our study, 1 recent mixed-methods study with licensed family child care providers in Illinois found that rural providers were more likely than urban providers to report difficulty purchasing foods that met program requirements and to identify reimbursement rates as too low to justify CACFP administrative burdens.³⁰ Although New Mexico's overall food costs are slightly below the national average,⁴⁴ food costs can be much higher in rural areas. For example, a New Mexico nonprofit found that the cost of the same food basket was \$30 higher in a small-scale rural store compared with an urban store.⁴² More unique to our study was sponsor identification of costs and procedures related to becoming eligible for CACFP (ie, becoming a registered home) as barriers for home-based providers. Although some sponsoring agencies offer financial and technical assistance support for becoming a registered home, these sponsor activities are often funded by non-CACFP dollars.³⁵

Similar to Speirs et al,³⁰ sponsors in this study identified that rural providers appreciate networking opportunities via in-person training.³⁰ This study also identified some unique training-related challenges. Sponsors raised concerns about the limited translation of regulations into Spanish and limited materials for participants speaking other languages. They also described challenges related to providing virtual video training. Although there is evidence from some recent studies of the emerging promise of online professional development to improve training accessibility for child care providers,^{45,46} this promise is potentially challenged by the limited provider digital literacy and internet and device access noted by sponsors in this study. This is consistent with recent studies finding that poor internet infrastructure,

broadband or cell phone internet costs, and limited digital device access and troubleshooting skills inhibited access to education and telehealth care for vulnerable populations during the COVID-19 pandemic.^{47–50} However, sponsors also raised concerns about transportation costs and the complicated logistics of providing in-person provider training and conducting home visits in rural areas.

This study has several strengths in that it begins to address gaps in the literature related to the perspectives of sponsors serving home-based providers, particularly rural and Spanish-speaking providers. It also has some limitations. We were not able to interview sponsor staff from all of the agencies in New Mexico, and thus these results may not be generalizable to all sponsors in New Mexico. In addition, policymakers in other states can consider whether unique aspects of New Mexico's regulatory framework or provider population may influence the implications of our findings. Finally, our findings reflect only the perceptions of sponsors. Although sponsors work with many providers and can thus comment on commonly observed barriers and facilitators and potential systems changes, their perceptions may not fully align with barriers, facilitators, and solutions from the New Mexico child care provider perspective. Sponsors also have limited perspective on why some providers choose not to have any contact with the child care regulation or CACFP systems.

IMPLICATIONS FOR RESEARCH AND PRACTICE

Our findings contain opportunities for research and systems change in 3 areas: eligibility of home-based providers for CACFP, provision of meaningful and accessible training and compliance monitoring, and support for sustained provider CACFP participation.

Following our study findings, researchers could investigate whether different processes for approving home-based providers for CACFP eligibility result in different levels of participation. Because states have

considerable discretion in setting these processes, cross-state variation could be examined to study differences in program uptake.

Policy implications center on the role of sponsors, who are regionally well-positioned to approve providers as registered homes and have done so effectively in the past in New Mexico. To return to this model, state leaders could appropriate stable, separate funds for CACFP sponsor organizations to have this role.

Implementation research studies with sponsors and providers could help identify the best ways to make training and home visits more accessible and flexible for home-based child care providers. For example, studies could examine whether paying a share of broadband costs for home-based providers improves the viability of online contacts with sponsors or whether provider language barriers are lessened by supplying sponsors with translated materials, access to phone interpretation services, and/or incentive pay for bilingual staff.

Implementation research studies with sponsors and providers could test strategies for accessing better food prices. For example, pilot studies could examine whether sponsors could connect home-based providers with local schools or centers in a cooperative model to access products at bulk-purchase prices.

Policymakers could consider increasing reimbursement rates for sponsors to more fully cover the actual costs of quality nutrition supports. This could especially be considered for sponsors traveling extensively for training and compliance activities or serving providers who may need more assistance navigating program requirements.

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SUPPLEMENTARY DATA

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