

# Engaging Providers in Underserved Areas to Adopt Electronic Health Records

Cleo A. Samuel, BS; Jennifer King, PhD; Fadesola Adetosoye, MS;  
Leila Samy, MPH; and Michael F. Furukawa, PhD

**D**espite the potential of electronic health records (EHRs) to improve healthcare quality and efficiency, US healthcare providers historically have been slow to adopt them. In 2009, about 1 in 5 physicians used a basic EHR, and EHR adoption rates lagged even further among physicians in small practices with fewer than 10 physicians, physicians in rural areas, and other providers who disproportionately care for the underserved.<sup>1-5</sup>

To spur more widespread adoption of EHRs, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act of 2009.<sup>6</sup> HITECH included provisions to help ensure that the benefits of increased EHR adoption would accrue equally to all types of healthcare providers and patients. One such provision directed the Office of the National Coordinator for Health Information Technology (ONC) to establish the Regional Extension Center (REC) program to provide community-based education and technical support to healthcare providers as they implement EHRs.<sup>7</sup> Using an on-the-ground outreach approach, RECs were designed to encourage provider “buy-in” and support providers in the EHR product selection and practice integration process.<sup>8,9</sup> In total, \$677 million was allocated to establish and support RECs across the country over 4 years. Today, the REC program consists of 62 heterogeneous, non-profit organizations that have been working to promote equitable patterns of EHR adoption across the entire US geography since 2010.

While RECs are permitted to offer services to all types of healthcare providers, HITECH states that RECs “shall prioritize any direct assistance to a select group of providers” who may otherwise lack the resources to adopt and meaningfully use EHRs.<sup>6</sup> This targeted group of providers consists of primary care providers working in: small group practices of 10 or fewer professionals; public hospitals; Critical Access Hospitals; community health centers; rural health clinics; and other settings that predominantly serve uninsured, underinsured, and medically underserved populations. The *priority* designation is intended to

encourage RECs to support providers treating higher proportions of underserved patients and practices based in medically underserved areas who serve a vital safety-net role. Upon establishing the REC program in 2010, ONC set forth a

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**Objectives:** To assess Regional Extension Centers’ (RECs’) health IT outreach and provider engagement efforts among primary care providers (PCPs) based in underserved areas.

**Study Design:** A retrospective assessment of REC program enrollment.

**Methods:** We computed REC program enrollment rates among PCPs for the entire United States and across census regions and compared enrollment in underserved areas relative to non-underserved areas. Measures of area-level underserved status included rural and health professional shortage area (HPSA) designations.

**Results:** Of the estimated 302,689 ambulatory PCPs practicing in the United States, 120,783 (39.9%) were enrolled in an REC. REC enrollment rates among PCPs were higher in large rural (47.3%) and small rural (56.1%) areas relative to urban (37.9%) areas. REC enrollment rates among PCPs were also higher for single-county HPSAs (51.9%) relative to non-HPSAs (40.0%), geographic HPSAs (41.7%), and population group HPSAs (38.6%). The Northeast region exhibited the highest REC enrollment rates overall and across categories of underserved status relative to all other census regions.

**Conclusions:** The REC program serves as a unique opportunity to address the health information technology needs of PCPs working in underserved areas. Over the course of 2 years, the program has exceeded its goal of enrolling 100,000 priority primary care providers. Provider engagement is the first step in a 3-step process aimed at getting providers to adopt and become meaningful users of electronic health records. Significant work remains for the RECs to meet these objectives, and future research should evaluate the success of the REC program in meeting subsequent milestones.

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**For author information and disclosures,  
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### Take-Away Points

- The Regional Extension Center (REC) program is assisting primary care providers in small practices located in underserved areas with adoption and meaningful use of electronic health records (EHRs).
- RECs have exceeded their goal of enrolling 100,000 primary care providers in programs to receive subsidized technical assistance services in exchange for the provider's commitment to work toward meaningful use of EHRs.
- Provider engagement is the first step in a 3-step approach to assist providers in achieving meaningful use of EHRs. More work remains to assess whether RECs meet their objectives of assisting providers with implementing EHRs and achieving meaningful use.

goal to assist at least 100,000 priority primary care providers with the adoption and meaningful use of EHRs.

The RECs operate under a performance-based reimbursement structure designed to achieve 3 key Milestones with providers in their catchment areas. The Milestones are: (1) engagement and enrollment with the REC, (2) adoption of an EHR, and (3) meaningful use of an EHR (as defined by the Stage 1 Meaningful Use criteria in the Medicare and Medicaid EHR Incentive Programs).

To achieve Milestone 1, providers must make a commitment to adopt and meaningfully use an EHR system with the support of their local REC. RECs must obtain signed technical assistance participation agreements from each provider to be reimbursed for Milestone 1 achievement. The participation agreement is a contract that specifies the terms and fees required (if any) to receive specified REC services associated with each Milestone. Qualified providers must commit staff time and resources to work toward meaningful use of EHRs in exchange for receiving subsidized services. Provider engagement services associated with Milestone 1 include education and outreach on EHR options and federal incentive programs as well as planning and needs assessments. These provider engagement services assist providers with the early stages of the technology adoption decision process by increasing knowledge of EHR benefits and networking with opinion leaders who have already adopted EHRs.<sup>10</sup>

Since early 2010, the REC program has been working to promote equitable patterns of adoption and meaningful use of EHRs throughout the United States. Evaluating whether the REC program successfully helps providers achieve the 3 program Milestones will provide insight into the value of the program investments and how the REC model may be useful in supporting future delivery system modernization efforts. The REC program is the subject of an ongoing national evaluation that will provide summative feedback across all 3 Milestones when the HITECH funding period concludes. However, monitoring progress on an interim basis is also important.

Now is an opportune time to examine the progress of RECs toward Milestone 1. In the early phases of the program, RECs focused on engaging and enrolling providers before

shifting their focus to assisting those providers through the next Milestones of EHR implementation and meaningful use. However, the progress of RECs toward their goal of engaging 100,000 providers, especially penetration in underserved areas, has not been systematically documented to date. This analysis examined REC enrollment (Milestone 1) among primary care providers (PCPs)

with a focus on 2 types of priority settings: rural areas and health professional shortage areas. In addition, the analysis sought to highlight geographic variations in provider engagement, to identify existing gaps, and to offer recommendations for promoting increased provider engagement in underserved areas.

## METHODS

### Data Sources

Data on PCPs enrolled with an REC came from the REC program's proprietary customer relationship management (CRM) database. As part of their funding agreement, RECs are required to report data into the CRM on individual provider credentials, provider specialty, Milestone achievements, and the practice location (address) at which the Milestone is achieved. If an individual provider practices in more than 1 location, the REC must select 1 location for the Milestone achievement (ie, RECs can receive credit for achieving Milestone 1 once per provider; RECs cannot receive additional credit for enrolling the same provider in multiple locations). Data collection began in January 2010 and data are collected on a rolling basis.

Data on the total number of PCPs in each REC's geographic catchment area were obtained from the 2011 SK&A Office-based Providers Database, a product of SK&A Information Services, Irvine, California. The database is designed to comprise a census of all providers in an ambulatory health-care site with at least 1 provider with prescribing authority in the 50 states and the District of Columbia. The database includes information on each provider including practice location, provider credentials, and provider specialty. Data are collected and verified through a rolling telephone survey (all sites are contacted twice a year).

### Definitions

**REC-Enrolled PCPs.** As of February 2012, a total of 134,463 providers were enrolled with an REC (Milestone 1). To ensure comparability with SK&A, we limited our analyses to REC-enrolled physicians, physician assistants, and nurse

practitioners with specialties of Family Practice, General Practice, Internal Medicine, Geriatrics, Obstetrics and Gynecology, Pediatrics, and Adolescent Medicine. We excluded providers located in the US territories (ie, American Samoa, Guam, Northern Mariana Islands, Marshall Islands, Palau, Puerto Rico, and US Virgin Islands). The final data set included 120,783 PCPs, which comprised 89.8% of all providers enrolled with an REC.

**Total Number of PCPs.** To ensure comparability with REC data, we limited the SK&A data to physicians, physician assistants, and nurse practitioners located in the 50 states and DC with the primary care specialties listed above. In 2011, there were 302,689 such PCPs in the SK&A database.

**Rural and Health Professional Shortage Area Designation.** We explored REC penetration across 2 types of areas: rural areas and health professional shortage areas (HPSAs). County-level rural status was based on the Core Based Statistical Area (CBSA) designations obtained from the 2010 Area Resource File. Under this designation, counties belong to 1 of 3 categories: metropolitan (urban); micropolitan (large rural); and non-CBSA (small rural). Among these categories, non-CBSA indicates the greatest degree of rurality.

County-level HPSA designations were derived from the Health Resources and Services Administration's (HRSA's) November 2011 Primary Care HPSA data file. We characterized counties in 4 categories: non-HPSA (no shortage); geographic area HPSA (shortages in specific geographic areas within the county but not the entire county); population group HPSA (shortages for specific population groups that may be present in a specific geographic area within the county or across the entire county); and single-county HPSA (shortages spanning entire county area and population). Among these categories, single-county HPSA indicates the greatest degree of health professional shortage for a given area.

## METHODS

We calculated REC enrollment rates among PCPs using a numerator of REC-enrolled PCPs and a denominator of total PCPs. We calculated enrollment rates for the nation overall, for each of the 4 Census regions (Northeast, Midwest, South, and West), and by county. We then calculated enrollment rates within each category of underserved area designation at the national and regional levels. Finally, we mapped enrollment rates for each county in the nation to visually assess geographic variation in enrollment rates.

Of the denominator of 302,689 PCPs, 14% ( $n = 43,453$ ) were observed in multiple practice sites; 9% ( $n = 27,729$ ) were

in multiple sites in the same county; and 5% ( $n = 15,724$ ) were in sites in more than 1 county. When calculating enrollment rates by county and underserved area designation, we divided these PCPs evenly across their practice locations. For example, if a PCP was observed in 2 practice locations each in a different county, we counted the PCP as 0.5 providers in each county.

A small number of counties ( $n = 7$ ) reported positive REC enrollment (eg, 1-5 PCPs) but zero PCPs in the SK&A data. We included these enrollment numbers in the nationwide and region estimates of county-level enrollment rates.

## RESULTS

Of the total office-based PCPs in the United States, 120,783 (39.9%) were participating in an REC as of February 2012 (Table). However, we found variation in overall enrollment rates across Census regions, ranging from 34.7% in the South region to 45.7% in the Northeast region. This geographic variation was evident when visually examining county-level REC enrollment rates as well (Figure).

REC enrollment rates were highest in the most rural areas. Relative to metropolitan areas, REC enrollment rates were higher for small rural (non-CBSA, 56.1%) and micropolitan areas (47.3%). This pattern was present in the nation overall and within all Census regions.

REC enrollment rates were also highest in counties with the highest degree of health professional shortages. We found that REC participation was highest for single-county HPSAs (51.9%) relative to non-HPSAs (40.0%), geographic HPSAs (41.7%), and population-group HPSAs (38.6%). In all regions, REC enrollment rates were highest in single-county HPSAs.

The data also indicate regional variations in REC enrollment across categories of rural and HPSA designations. Although relatively low overall, the West reported the highest REC enrollment rates for PCPs located in small rural areas (non-CBSA, 77.7%), micropolitan areas (58.9%), and single-county HPSAs (74.5%). Compared with other regions, the South had the lowest REC enrollment rates overall and across all categories of rural and underserved areas.

Our findings indicate that RECs have targeted enrollment to providers in priority settings. Across all types of geographic areas, nearly all REC-enrolled PCPs (99.5%) were in one of the priority settings targeted by HITECH (see eAppendix, available at [www.ajmc.com](http://www.ajmc.com)). Moreover, the majority of REC-enrolled PCPs (65.5%) were in counties with some type of HPSA designation, including the majority of REC-enrolled PCPs in metropolitan (65.5%), micropolitan (61.2%), and non-CBSA (70.9%) areas.

■ TRENDS FROM THE FIELD ■

■ **Table.** Regional Extension Center (REC) Enrollment Rates Among Primary Care Providers (PCPs): Nationwide, by Census Region, and by Rural and Provider Shortage Area Designation

	Overall	Rural Designation			Provider Shortage Area Designation			
		Metropolitan	Micropolitan	Non-CBSA	Non-HPSA	Geographic HPSA	Population Group HPSA	Single-County HPSA
<b>Nationwide</b>								
REC-enrolled PCPs	120,783	96,964	13,928	9891	37,876	20,622	57,902	4383
Total PCPs	302,689	255,602	29,443	17,644	94,732	49,475	150,032	8450
% enrolled with REC	39.9%	37.9%	47.3%	56.1%	40.0%	41.7%	38.6%	51.9%
<b>Census Region</b>								
Northeast								
REC-enrolled PCPs	28,600	25,365	2243	992	11,745	3862	12,869	124
Total PCPs	62,531	56,902	4051	1578	24,312	7947	30,074	198
% enrolled with REC	45.7%	44.6%	55.4%	62.9%	48.3%	48.6%	42.8%	62.5%
Midwest								
REC-enrolled PCPs	27,803	20,843	3806	3154	8434	6570	11,851	948
Total PCPs	64,533	50,934	8052	5547	18,545	15,164	29,010	1814
% enrolled with REC	43.1%	40.9%	47.3%	56.9%	45.5%	43.3%	40.9%	52.3%
South								
REC-enrolled PCPs	37,005	28,834	4676	3495	11,688	6191	16,937	2189
Total PCPs	106,621	87,099	11,897	7625	35,587	17,355	48,747	4932
% enrolled with REC	34.7%	33.1%	39.3%	45.8%	32.8%	35.7%	34.7%	44.4%
West								
REC-enrolled PCPs	27,375	21,922	3203	2250	6,009	3999	16,245	1122
Total PCPs	69,005	60,667	5443	2895	16,288	9010	42,201	1506
% enrolled with REC	39.7%	36.1%	58.9%	77.7%	36.9%	44.4%	38.5%	74.5%

CBSA indicates Core Based Statistical Area; HPSA, Health Professional Shortage Area; PCP, primary care provider; REC, regional extension center. Nationwide: 50 states, DC; Northeast: CT, MA, ME, NH, NJ, NY, PA, RI, VT; Midwest: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI; South: AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV; West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY. Data sources: REC-enrolled PCPs from ONC Customer Relationship Management (CRM) Database; Total PCPs from SK&A Office-based Providers Database.

## DISCUSSION

Nearly 40% of all PCPs in the United States have made a commitment to adopt and meaningfully use an EHR with the support of their REC. REC-enrolled providers comprise over half of PCPs located in small rural areas as well as over half of providers located in single-county HPSAs. These findings indicate that the REC program has exceeded its Milestone 1 goal of enrolling at least 100,000 priority primary care providers in less than 2 years. This Milestone achievement is one indication that the REC program has been successful in obtaining commitment from providers in underserved areas to work toward health system modernization.

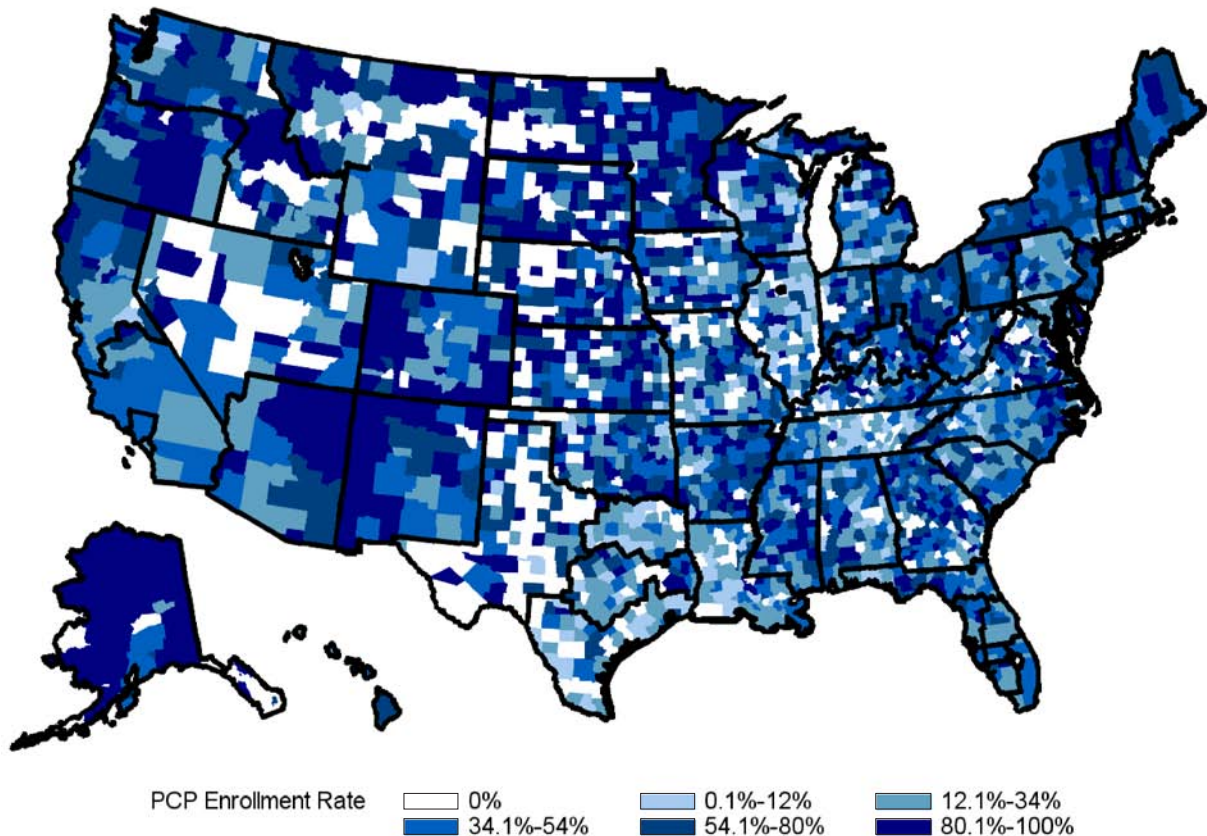
Despite significant progress nationwide, substantial geographic variation in REC enrollment rates exists across the country. The Northeast had some of the highest REC enroll-

ment rates overall, while the South exhibited lower enrollment rates relative to all other regions. The West demonstrated particularly high enrollment rates in underserved areas. The source of these regional differences remains unclear, although they may reflect preexisting regional variations in access to information technology (IT) services and health system organization. Dissemination of best practices from RECs in the Northeast and West to other regions may help address some of these gaps, though region-specific challenges and barriers should also be considered.

While RECs have made notable progress in engaging providers to adopt EHRs—a critical step in the early stages of new technology adoption—evaluation of the program’s overall success will depend on progress with the second and third Milestones over the final 2 years of the program. At the time of this study, February 2012, more than half (55%) of the



■ **Figure.** Geographic Variation in REC Enrollment Rates Among PCPs Across US Counties



PCP indicates primary care provider; REC, regional extension center. Black boundaries reflect individual REC service areas.

120,783 REC-enrolled PCPs had implemented an EHR system (Milestone 2) and 7% were capable of attesting to meaningful use (Milestone 3). It is premature to evaluate progress to Milestones 2 and 3, but these results indicate that much work remains for the RECs to meet their objectives of assisting engaged providers with implementing EHRs and with achieving meaningful use.

Recommendations for effective strategies to advance EHR adoption among providers in underserved communities can be gleaned from the innovation diffusion literature and the experiences of prior extension initiatives.<sup>10-13</sup> Several of these strategies were built into the REC program, including subsidizing costs for technical assistance services, use of a customer relationship management tool for coordinating outreach efforts, and leveraging relationships with community and physician leaders.

Among the REC strategies to promote EHR adoption in underserved settings, partnerships among public and private stakeholders are particularly noteworthy. For example, RECs are collaborating with State Offices of Rural Health and HRSA to identify and disseminate best practices across

a variety of underserved and under-resourced settings, including safety-net providers. In addition, other community-based organizations and local entities that support providers serving vulnerable populations should be included in outreach and education efforts in order to gain broader support for EHR adoption in these communities. Partnering with the EHR vendor community to facilitate access to EHR software and services could also alleviate some barriers faced by practices in underserved areas. HHS's Office of Minority Health has already made progress in formulating these types of partnerships with EHR vendors.

While the full impact of health IT in underserved communities has yet to be realized, existing research indicates that health IT can be associated with greater efficiency, improvements in access to care, and enhanced quality of care and patient outcomes in disadvantaged populations.<sup>14,15</sup> RECs working with providers in underserved areas can help facilitate the development of a level playing field for improving health-care delivery through EHR adoption and meaningful use.

This study has some important limitations. First, we examined REC enrollment across 2 types of underserved geogra-

phic areas: rural areas and health professional shortage areas. However, this is not an exhaustive definition of underservice; future analysis should explore REC enrollment patterns across other types of geographic areas as well as enrollment patterns among facilities known to care for traditionally underserved populations.

Second, our enrollment rate calculations may contain some measurement error. The SK&A database used for the denominator is designed to contain information on the universe of PCPs eligible to be counted in the numerator: physicians, nurse practitioners, and physician assistants providing outpatient care. Estimates of primary care provider supply derived from the SK&A database compare favorably with estimates from other sources. For example, estimates of the number of office-based primary care physicians in 2010 based on the American Medical Association Masterfile ranged from 205,000<sup>16</sup> to 208,800.<sup>17</sup> These estimates include physicians with specialties of general or family practice, pediatrics, internal medicine, and geriatrics. The SK&A database contained 202,900 physicians with these specialties in 2011 (99% of the 205,000 estimate and 97% of the 208,800 estimate). However, it is possible that enrollment rates are slightly over- or underestimated in certain local areas. For example, if a PCP is observed in 2 practice locations in the SK&A data—1 rural and 1 urban—and if RECs are more likely to enroll the PCP at the rural practice location, the rural enrollment rate would be slightly overestimated.

Third, although Milestone 1 achievement requires providers to enroll with an REC and commit to engage with the REC to adopt and meaningfully use an EHR, we could not observe the level or intensity of actual engagement among providers in working toward meaningful use.

Finally, our study only assesses REC enrollment and engagement (Milestone 1). Provider engagement is the first step in a 3-step approach geared toward assisting providers to achieve meaningful use. As the REC program evolves, future research will examine overall progress and geographic patterns in EHR adoption (Milestone 2) and Meaningful Use (Milestone 3) among REC-enrolled providers in rural and other underserved areas.

**Author Affiliations:** From Office of the National Coordinator for Health IT (MF, JAK, FA, LS), Office of Economic Analysis, Evaluation, and Modeling, Washington, DC; Harvard PhD Program in Health Policy (CAS); Cambridge, MA.

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**Address correspondence to:** Michael F. Furukawa, PhD, Office of the National Coordinator for Health IT, Office of Economic Analysis, Evaluation, and Modeling, 200 Independence Ave, SW, Washington, DC 20201. E-mail: Michael.Furukawa@hhs.gov.

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## Engaging Providers in Underserved Areas

### ■ eAppendix. Characteristics of REC-Enrolled Primary Care Providers

	Overall	Metropolitan Status			HPSA Status	
	Total	Metropolitan	Micropolitan	Non-CBSA	Non-HPSA	HPSA
<b>Total REC-enrolled Primary Care Providers</b>	120,783	96,964	13,928	9,891	41,701	79,082
<b>Priority Primary Care Provider Designation</b>						
Yes	99.5%	99.5%	99.9%	99.9%	99.5%	99.5%
No/Unknown	0.5%	0.5%	0.1%	0.1%	0.5%	0.5%
<b>HPSA Status</b>						
Non-HPSA	34.5%	34.5%	38.8%	29.1%	100.0%	0.0%
HPSA	65.5%	65.5%	61.2%	70.9%	0.0%	100.0%
<b>Metropolitan Status</b>						
Metropolitan	80.3%	100.0%	0.0%	0.0%	80.1%	80.3%
Micropolitan	11.5%	0.0%	100.0%	0.0%	13.0%	10.8%
Non-CBSA	8.2%	0.0%	0.0%	100.0%	6.9%	8.9%
<b>Provider Credentials</b>						
Physician	76.0%	78.5%	68.8%	61.1%	78.2%	74.8%
Nurse Practitioner	16.1%	14.6%	20.8%	24.1%	14.7%	16.8%
Physician Assistant	7.9%	6.8%	10.3%	14.8%	7.0%	8.3%
<b>Practice Type</b>						
Priority Primary Care Providers						
Small private practice or practice consortium	49.9%	52.8%	45.1%	27.9%	53.1%	48.2%
Community health center or rural health clinic	18.9%	17.5%	19.6%	31.7%	13.2%	21.9%
Priority hospital ambulatory care setting	18.0%	16.5%	19.9%	29.6%	21.0%	16.4%
Other underserved setting	12.8%	12.6%	15.3%	10.7%	12.3%	13.0%
Non-Priority Primary Care Providers						
	0.5%	0.5%	0.1%	0.1%	0.5%	0.5%

HPSA includes providers in counties that had any type of HPSA designation, including single county, geographic, and population group HPSA designations. Practice Type is based on the practice type reported by the REC at the time of provider enrollment. Small private practices have 10 or fewer professionals. Priority hospitals include public hospitals, Critical Access Hospitals, and other rural hospitals. Other underserved setting is a designation defined by each REC and includes providers caring for underserved populations in settings other than those listed above.

CBSA indicates Core Based Statistical Area. A non-CBSA area is defined as an area with no core town of at least 10,000 people and is the equivalent of a small rural area designation. A micropolitan area is defined as an area with a core town of 10,000 to 49,999 people and is the equivalent of a large rural area designation. A metropolitan area is defined as an area with a core city or town of at least 50,000 people and is the equivalent of an urban area designation. HPSA indicates Health Professional Shortage Area.