

# Veterans as physician assistants

Douglas Brock, PhD; Timothy Evans, MD, PhD; Drew Garcia, MPAS, PA-C; Vanessa Bester, MPAS, PA-C; F.J. Gianola, MA, PA

## ABSTRACT

The physician assistant (PA) profession emerged nearly 50 years ago to leverage the healthcare experience of Vietnam-era military trained medics and corpsmen to fill workforce shortages in medical care. In 2009, the American Recovery and Reinvestment Act Primary Care Training and Enhancement program was established to improve access to primary care. Training military veterans as PAs was again identified as a strategy to meet provider access shortages. However, fewer than 4% of veterans with military healthcare training are likely to apply to PA school and little is known regarding the factors that predict acceptance to training. In 2012, we surveyed all veteran applicants and a stratified random sample of nonveterans applying to PA training. We compare the similarities and differences between veteran and nonveteran applicants, application barriers, and the factors predicting acceptance. We conclude with a discussion of the link between modern veterans and the PA profession.

**Keywords:** physician assistants, military, workforce shortages, primary care, veterans, training

As the physician assistant (PA) profession approaches its half-century mark, the scope of modern PA practice has increasingly expanded beyond those roles filled by returning Vietnam-era medics and corpsmen who first pioneered this innovative healthcare solution, seeking to fill generalist and rural physician shortages of the time.<sup>1-3</sup> How has the military veteran applicant to PA education changed across this time? In this article, we describe the modern veteran applicant to PA training and address the implications of a current graduating cohort as a snapshot indicator of the future for veterans in the profession. Throughout this article, we refer to medics and corpsmen. These terms have not been consistently applied in military or civilian literature. We use this

term to refer generally to those service personnel receiving training in emergency medicine, limited primary care, and inpatient care. Variation occurs in what additional training is received and how this training is applied.

In general, today's graduates clearly differ from early veteran graduates in significant ways. Current graduates tend to practice in a medical or surgical specialty and will likely never fill primary care roles.<sup>4</sup> Today's PA students are younger, more likely to be women, report fewer prerequisite clinical hours of patient contact before entering training, and are more likely to have completed a 4-year college education.<sup>5</sup>

In 2014, 187 accredited PA programs competed for top applicants and more than 7,000 students were graduated in 2014. The profession is expected to grow an additional 72% by 2025.<sup>6,7</sup> Despite this surge of program development, the number of veteran applicants has declined and fewer than 4% of newly graduating PA students report having military experience.<sup>5</sup> Veterans have established roots in the profession and provide care in a wide range of settings but also have faced challenges as the profession has evolved.<sup>8</sup> Declining bachelor's and certificate options, coupled with increasingly rigorous academic requirements, limit veteran access. PA programs also continue to struggle when seeking to equate military experience and training to civilian coursework.<sup>9,10</sup>

The United States is experiencing a shortage of primary care providers as physicians and PAs increasingly seek specialty positions. This shortage coincides with an increasing demand for primary care practitioners in rural and underserved communities, an increase of required primary care services defined through the Affordable Care Act, and an aging population.<sup>11-14</sup> Veterans trained as medics and corpsmen may again offer a solution to these primary care shortages.<sup>15,16</sup> In the past, medics and corpsmen were considered exceedingly able candidates for primary care work and as rural providers; their broad training was considered an untapped reservoir of needed attributes and clinical skills.<sup>1,2</sup> Just as new opportunities arise for veterans to fill emerging healthcare workforce gaps, an increasingly larger number of military personnel are separating from service each year. Before the current drawdown, about 52,000 Army, Navy, and Air Force enlisted personnel with military healthcare experience left military service between 2006 and 2010; about 56.3% were medics and corpsmen.<sup>17,18</sup> Unfortunately, no estimates exist of the percentage of these service personnel who will seek training as healthcare providers.

**Douglas Brock** is an associate professor at MEDEX Northwest at the University of Washington in Seattle, Wash. **Timothy Evans** is medical director of MEDEX Northwest. **Drew Garcia**, **Vanessa Bester**, and **F.J. Gianola** are lecturers at MEDEX Northwest in Tacoma, Wash. The authors have disclosed no potential conflicts of interest, financial or otherwise.

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For this article, we examined the modern veteran PA applicant through the lens of the 2012 applicant cohort. MEDEX Northwest and the Physician Assistant Education Association collaborated to collect these data. The majority of the accepted applicants matriculated into a PA training program, successfully completed their training, were graduated, and moved into practice in 2014. This study was conducted to explore three questions:

- What academic and experiential factors predict acceptance to PA training for veteran applicants?
- Are modern veteran applicants the equivalent of their nonveteran counterparts with regard to demographics, academics, and previous healthcare experience?
- How do veterans and nonveterans accepted to PA school differ with regard to self-reported preparedness for PA school and desired characteristics of future practice following graduation?

## METHODS

From May through July 2012, we surveyed all veterans ( $n=700$ ) and a stratified random sample of 1,052 nonveterans applying to PA training through the Central Application Service for Physician Assistants (CASPA). In 2012, CASPA applicants could apply to 165 (96% of 172 programs) accredited PA training programs. Most programs (80%,  $n=137$ ) accepted applicants only through the CASPA system.

The veteran and the parallel nonveteran online surveys assessed applicant demographics, academics, clinical training and experience, reasons for seeking to become a PA, perceived barriers to this goal, and plans for practice. Veteran applicants were questioned further on their military experience, including combat experience, deployments, and use of support tools designed specifically to assist veterans in making educational and vocational choices. For some variables (such as grade point average [GPA] and hours of clinical experience), CASPA data were available for all prospective study participants and could be assessed without consideration of response rate.

Our survey was designed to compare veteran applicants to nonveterans who were generally comparable in terms of sex and age; both variables hold important associations with the profession. Veterans are more likely to be men, have completed time in college, and have worked outside of the military following their discharge. The net result is they tend to be older and have more experience in healthcare and nonhealthcare-related work.<sup>8</sup> We compared all veteran applicants to a randomly selected nonveteran subgroup stratified by sex and age (under age 30 years, ages 30 to 40 years, and over age 40 years). Key demographic variables were compared between respondents and nonrespondents based on the nationally available CASPA data. This step provided a check on the representativeness of the response samples.

Means, standard deviations, and percentages were calculated for demographic and other variables used to describe

veteran and nonveteran applicants to PA training. Chi-square nonparametric tests were used to examine differences between categorical variables. Independent group *t*-tests were conducted to make aggregate comparisons between groups. In all analyses, a  $P<0.05$  was required to demonstrate significance. SPSS version 19 was used to conduct all analyses. The University of Washington internal review board approved all aspects of this study.

## RESULTS

Seven hundred veterans applied through the CASPA system for entrance to PA training in 2012 and 334 (47.7%) completed online surveys. Of the 1,052 stratified random sample of nonveterans, 384 (36.5%) completed the online survey. Veteran and nonveteran survey respondents did not differ significantly from nonrespondents when compared on age, sex, percentage who were white, overall GPA, overall hours of previous healthcare experience, and acceptance to PA training (each  $P>0.05$ ). Of the 700 veteran applicants, 222 (31.7%) were accepted to training; 247 (23.5%) of the 1,052 nonveterans were accepted. Veterans were significantly more likely to be accepted than were their age- and sex-matched nonveteran peers ( $\chi^2=14.54$ ,  $P<0.001$ ). Seventy-five percent ( $n=525/700$ ) of all veteran applicants had completed at least a bachelor's degree at time of application; 74.8% ( $n=166/222$ ) of accepted veteran applicants had completed at least a bachelor's degree. Inspection of veteran surveys revealed that 28.1% of respondents were still in the service (active duty military or reserves) at the time they applied to training. Applicants who had been discharged from the service had been out of the military for an average of 7 years. The time since leaving the military and applicant age were not significantly correlated with acceptance to a training program.

Figure 1 illustrates that 35.6% of veteran survey respondents received all of their healthcare training outside of the military. Acceptance to PA training was not significantly

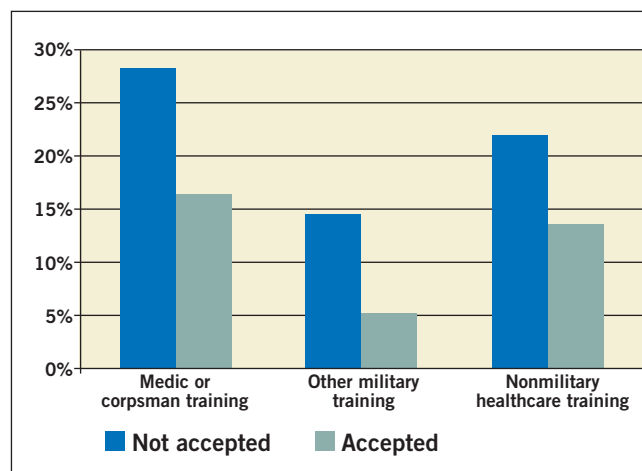


FIGURE 1. Veteran healthcare training

( $P>0.05$ ) related to the source of the veteran applicant's healthcare training.

**Table 1** compares veterans accepted to training with those not accepted, using all available CASPA data. Accepted veterans were similar to veterans who were not accepted in terms of patient contact experience, other healthcare experience, and community service hours. Accepted applicants had higher overall, science, and nonscience GPAs, higher graduate record examination (GRE) quantitative and verbal scores. Accepted veterans were also significantly more likely to be white.

**Table 2** compares all accepted veterans with the sample of stratified nonveteran applicants who were accepted. Veterans were generally similar to their nonveteran counterparts in terms of GPAs but veterans had lower GRE quantitative scores than did nonveterans. However, accepted veterans averaged over 3,000 more hours of direct patient care, more hours of other healthcare experience, and more other nonhealthcare-related work than did the accepted nonveterans.

**Table 3** compares veteran survey respondents' preparedness with the preparedness reported by their nonveteran counterparts. Veterans and nonveterans accepted to training did not differ significantly in perceived preparedness with regards to family support for their decision to enter training, ability to relocate for training, educational background, motivation, being physically able to complete training, and reported psychologic readiness for training. However, accepted veterans were significantly more likely to report being financially able and having the necessary healthcare experience to enter training than were accepted nonveterans.

**Table 4** outlines differences between survey respondents regarding the desirability of different aspects of PA practice. Accepted nonveterans were significantly more likely to express interest in medicine specialties and practice based

in suburban or urban settings. The two groups were not significantly different with regards to interest in practice within a rural setting, primary care, emergency care, or in surgery or surgical subspecialties.

## DISCUSSION

Veterans continue to compete successfully for PA training positions and some reported hurdles facing veteran applicants have begun to ease.<sup>9</sup> However, the emblematic link between the PA profession and the image of medics and corpsmen moving from service to civilian practice may be weakening. These early iconic images have begun to fade as an increasingly smaller percentage of veterans constitute the profession, and most have not trained in a traditional medic or corpsman role or have no military healthcare training. This article describes the modern veteran training applicant from the perspective of the PA entering class of 2012. The key findings, which emerged from this work, are discussed below.

The PA profession continues to attract and select veterans with a broad base of healthcare training and experience, generally more extensive than their nonveteran counterparts. This experience is both individually focused and team-based. Much of this team focus pertains to how the military trains and uses healthcare providers, but the team aspect of service extends past the vocational into all aspects of military life. Veterans have also been trained to know when and how to lead. They have successfully navigated working within hierarchical environments and are comfortable responding to a range of leadership styles. They commonly have experience with state-of-the-art information technologies such as telemedicine years before their civilian healthcare contemporaries. Veterans often have healthcare experiences that are uncommon in civilian healthcare environments, including addressing incipient epidemics, rapid risk assessment, and providing care under conditions of heightened

**TABLE 1. Comparison of veterans not accepted to training with veterans accepted to training**

Variable	Not accepted			Accepted			P value
	n	Mean	SD	n	Mean	SD	
Female	478	34%	47%	222	29%	45%	>0.05
Age (years)	478	34.4	7.9	222	33.3	7.2	>0.05
White	478	71%	46%	222	83%	38%	<0.001
GRE verbal	138	463.5	114.3	83	508.7	117.1	0.002
GRE quantitative	138	537.8	146.4	84	580.8	128.8	0.028
Overall GPA	466	3.03	0.40	219	3.33	0.38	<0.001
Science GPA	462	2.91	0.54	218	3.30	0.50	<0.001
Nonscience GPA	466	3.11	0.43	219	3.35	0.41	<0.001
Patient contact (hrs)	411	10,169.2	11,110.6	198	9,051.9	10,010.1	>0.05
Other healthcare (hrs)	214	11,224.6	12,956.7	126	11,238.6	11,699.2	>0.05
Other work (hrs)	209	5,062.2	7,881.2	105	3,766.7	7,011.1	>0.05
Community service (hrs)	243	847.2	1,724.3	140	601.5	997.6	>0.05

TABLE 2. Comparison of nonveterans accepted to training with veterans accepted to training\*

Variable	Nonveterans accepted to training			Veterans accepted to training			P value
	n	Mean	SD	n	Mean	SD	
Female	247	36%	48%	222	29%	45%	>0.05
Age (years)	247	30.7	8.1	222	33.3	7.2	<0.001
White	247	81%	39%	222	83%	38%	>0.05
GRE verbal	136	506.8	95.9	83	508.6	117.1	>0.05
GRE quantitative	137	626.6	92.2	84	580.8	128.8	0.005
Overall GPA	243	3.34	0.38	219	3.33	0.38	>0.05
Science GPA	243	3.24	0.49	218	3.30	0.50	>0.05
Nonscience GPA	243	3.41	0.42	219	3.35	0.41	>0.05
Patient contact (hrs)	245	4,139.3	5,819.3	198	9,051.9	10,010.1	<0.001
Other healthcare (hrs)	247	1,475.8	3,955.9	105	3,766.7	7,011.1	0.002
Other work (hrs)	245	3,530.7	6,965.5	126	11,238.6	11,699.2	<0.001
Community service (hrs)	247	648.7	1,791.0	140	601.5	997.6	>0.05

\* All veterans and all nonveteran stratified sample

stress such as combat. In short, veterans continue to enter PA training with experiences and training that aligns well with current healthcare team practice models and fits well in environments requiring a nuanced mix of independence and supervision. Veterans also have the flexibility to confront the challenges of the modern healthcare environment.

Is today's veteran PA applicant pool shifting to better align with modern civilian PA selection priorities? As the PA profession becomes increasingly younger, more female, and more academic, the prototypical veteran (typically older, male, and with less formal education than nonveteran counterparts), may face challenges unfamiliar to earlier veteran applicants. One shift is demonstrated by the finding that more than 33% of veteran applicants and those accepted to PA training had no military healthcare training. Most veteran applicants have completed bachelor's level training and spent considerable time between leaving the service and being accepted to PA training. These veterans are significantly more likely to be selected for training than are their civilian counterparts, but are similar in their expectations of training and self-reported preparedness to enter training. Early publications suggested veterans showed special promise and interest in primary care and rural practice.<sup>2,3</sup> Whether today's veterans constitute a prescriptive for filling primary care and rural workforce shortages is debatable. This cohort of veterans did not express greater interest in these pathways than their nonveteran peers.

Originally and for some years after the first PA training classes, most applicants to PA training were highly trained military medics and corpsmen. Leveraging the significant training provided to these veterans was a guiding philosophy early in the PA profession.<sup>2,3</sup> Today, a minority of all veteran applicants and veteran matriculants report this training.

Modern medics and corpsmen continue to receive extensive training, and the argument for enhanced recruitment efforts to civilian practice remains a relevant question. Economically, the added value of medic and corpsman training to civilian practice is calculable, but unknown. Unfortunately, medics and corpsmen have few opportunities to use their training as civilian healthcare providers directly after separating from the service. Paramedic work and licensed practical nursing constitute two of the few practice areas military veterans with healthcare training can enter that don't require significant additional academic or vocational training. Some medics and corpsmen will enter nursing training or medical school. Many will choose to never use their medical training vocationally in a civilian world. The net effect is likely a poor, but largely unknown, efficiency in capitalizing on military healthcare training.

We believe society and the healthcare professions benefit from continuing support of veterans.<sup>20</sup> The PA profession was founded in a time of very different attitudes and beliefs about military service. The vehement disputes of the 1960s and 1970s have waned and veterans are perhaps now more generally understood and respected. This cultural shift does not, unfortunately, resolve the effects of service, especially in wartime. Homelessness, unemployment, risk of suicide, and service-related injury continue to beleague veterans. Social justice arguments, including reciprocity, support society honoring the promises made to many entering the service that they could translate military service training into civilian workforce opportunities.<sup>19</sup> Reciprocity argues that the sacrifices of veterans, including financial, social and medical, at least warrant consideration from the PA profession. Addressing these arguments constitutes a social good, one that benefits both veterans and society in general.

Federal and state legislation guaranteeing increasing levels and quality of healthcare suggest that all attempts should be made to optimize veteran training. We believe that veterans' skill sets may prove beneficial to resolving complex healthcare questions. These opportunities include, but are not limited to, addressing primary care shortages in all areas and improving access to care in rural and other underserved communities. Some recent trends are encouraging. In large part as a response to the Obama Administration's efforts in support of the Health Resources and Services Administration (HRSA) Helping Veterans Become Physician Assistants initiative, the percentage of PA programs reporting active recruitment of military veterans has increased from an estimated 16% to 31.2% over 2 years.<sup>9,20,21</sup>

### LIMITATIONS

We acknowledge that we describe data from a single cohort that include only those veterans who applied through the CASPA system. This cohort may not fully reflect emerging trends. We also have provided only preliminary evidence that veterans have the skills and experience that are more likely to ensure their value as practicing civilian clinicians. The extent that nursing, medicine, and other areas of healthcare provide attractive opportunities to military veterans with healthcare experience also remains relatively unknown. The Interservice Physician Assistant Program (IPAP) offers PA training for enlisted service personnel, an option that may draw many of those interested in PA training but whose experiences are not represented in this study. We elected to compare veteran applicants with stratified sample of nonveterans having equivalent age and sex distribution. This decision was made in order to make for a more meaningful comparison of a veteran applicant with a peer applicant. However, we acknowledge that these statistics would likely prove different if comparing veterans with the typical non-

veteran applicants, who are significantly more likely to be women and younger.

Response rates were not optimal. However, the ability to assess both groups in their entirety and demonstrate no significant differences between respondents and nonrespondents supports our interpretations of these data.

### RECOMMENDATIONS

How can the PA profession and its educational institutions best ensure that veterans have reasonable access to training as PAs? Increasing PA programs' attentiveness to veterans constitutes one road. Support for veteran faculty in educational hiring, and creating more flexibility in admission processes to ensure appropriate valuation of military education, training, and experience may increase the appeal of and access to the profession to a greater number of veterans. Institutional participation in the Yellow Ribbon Program (a post-9/11 GI bill) is another important step. Dispelling common misconceptions such as that veterans are less flexible as students, may have significant physical or emotional concerns associated with combat that are difficult to accommodate, and that veterans are academically inferior to their nonveteran peers, must and can be confronted with evidence. If evidence existed that veterans were entering other areas of healthcare provision, the concerns we have voiced would be mediated. However, this is not the case, and for the most part military-trained healthcare providers are likely underused in the civilian world. Outreach opportunities may reach active duty service personnel and recently discharged veterans who might be unaware of healthcare training opportunities or who may have exaggerated beliefs about the hurdles to attaining these training opportunities. Efforts should focus on informing medics and corpsmen early in their military training about how best to leverage the military benefits and academic opportunities provided during service to support later civilian training.

**TABLE 3. Self-reported preparedness of accepted nonveterans and veterans to PA practice**

Data are for veteran survey respondents and nonveteran stratified sample survey respondents. The scale was from 1 = not at all prepared to 6 = highly prepared.

Variable	Nonveterans accepted for training			Veterans accepted for training			P value
	n	Mean	SD	n	Mean	SD	
Financially able	98	4.06	1.54	109	4.56	1.49	0.019
Family supports my decision	98	5.5	1.11	109	5.51	1.20	>0.05
Able to relocate without disruption	97	3.74	1.87	109	3.61	1.92	>0.05
Necessary educational background	97	5.41	0.83	108	5.55	0.75	>0.05
Necessary healthcare experience	98	5.13	1.04	109	5.44	0.93	0.026
Necessary motivation	98	5.76	0.66	109	5.8	0.52	>0.05
I am physically able	98	5.76	0.66	109	5.71	0.72	>0.05
I am psychologically able	98	5.63	0.76	109	5.64	0.70	>0.05

**TABLE 4. Self-reported desirability of practice areas for accepted nonveterans and veterans to PA practice**

Data are for veteran survey respondents and nonveteran stratified sample survey respondents. The scale was from 1 = not at all desirable to 6 = highly desirable.

Variable	Nonveterans accepted for training			Veterans accepted for training			P value
	n	Mean	SD	n	Mean	SD	
Medically underserved	98	4.61	1.21	108	4.51	1.47	>0.05
Rural	98	3.9	1.48	108	4.12	1.64	>0.05
Suburban	97	4.21	1.38	108	3.58	1.48	0.002
Urban	96	3.99	1.51	108	3.44	1.57	0.013
Primary care (family medicine, general internal medicine or general pediatrics)	98	4.59	1.34	108	4.48	1.49	>0.05
Surgery and surgical subspecialties	98	4.15	1.46	108	3.76	1.503	>0.05
Medicine specialties (other nonsurgical, nonprimary care specialties)	98	4.42	1.19	108	3.69	1.29	<0.001
Emergency medicine or urgent care	98	4.22	1.52	107	4.42	1.55	>0.05

Many critical questions have not been adequately addressed in this study. Little research exists to support to what extent veterans across a wide range of healthcare training experiences are able to leverage these skills directly in civilian healthcare. Almost no work has been conducted that explores veterans' understanding, awareness, and preparedness for transitioning military training and experience to the civilian world. Unfortunately, this poor understanding of veteran needs as they reenter the civilian world is not unique to healthcare. By further evaluating the real and perceived barriers to matriculation into a PA education program, initiating active outreach programs, and coming to a consensus about the valuation of military experience, the PA profession and society can potentially benefit from this pool of well-qualified applicants. **JAAPA**

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