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The Veteran Administration's Appointment Scheduling Processes' Effect on the Homeless Women Veteran's Phenomenon

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MA/MS, University of Phoenix, 2015

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Concealed numbers of homeless women veterans could be exposed in the Veterans Administration (VA) appointment scheduling data. The challenges of scheduling healthcare or mental health appointments with the VA could prevent homeless women veterans from gaining access. Studies have shown the problems that male veterans have with scheduling appointments. However, not much research exists on the issues homeless female veterans face in scheduling appointments with the VA. This quantitative study examined the correlation between the number of women and men veterans on the VA's electronic wait list and the percentages of unsheltered women and men veterans at the Continuum of Care (CoC) office level. The theoretical foundation was the psychosocial model for vulnerable populations, such as homeless women veterans. The research questions examined the connection between the appointment scheduling wait times in 30-day increments and the percentage of unsheltered men and women veterans in Florida and Georgia from 2018 to 2020. A multiple linear regression analysis of the independent variables predicted the dependent variable. The key results revealed a relationship between the independent and dependent variables. The analyses identified CoC locations in Florida and Georgia that could provide scalable scheduling models for use at lower-performing CoC facilities. Homeless female veterans could add value and positive social changes to their communities by contributing specific knowledge toward policy and procedural developments to reduce the number of homeless women veterans.

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Dedication

I am dedicating this dissertation to my dad, who has always been my drive and inspiration. Words cannot express how I feel about your love and support during this journey Tina.

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Section 1: Foundation of the Study and Literature Review

The number of homeless women veterans has been a phenomenon for years. Studies have depicted hidden numbers in homeless female veterans and the need for programs to aid in the reduction. The Veteran Administration (VA)'s appointment scheduling processes have had its challenges with maintaining accurate appointment scheduling data. Underestimated wait time data could limit resources that facilitate access to the VA services (as cited in National Academies Press, 2018).

A more detailed evaluation of the VA's electronic wait list (EWL) (see Data Catalog, 2019) data and the continuum of care (CoC) data from Housing and Urban Development (HUD) could determine patterns that indicate a need for changes in the VA's appointment scheduling processes and the homeless women veteran's access to care. This study's potential positive social changes could affect the local, state, and federal levels of government. Communities can use the information to develop programs that reach out to the homeless female veterans with assistance in making appointments. The state and federal governments can frame laws that support local entities in reducing the number of homeless women veterans. Moreover, the homeless female veterans can assist with changes in the community by providing insight into the VA's appointment scheduling processes.

Problem Statement

This study focused on the VA’s appointment scheduling processes and its potential effect on the homeless women veteran’s phenomenon. According to Casura (2018), there may be more homeless female veterans than are documented, while

Richmond (2018a) studied homeless women veterans who were flying under the radar. Researchers presented the possibility of high numbers of homeless female veterans.

The VA's appointment scheduling process could be a challenge for the homeless women veterans due to appointment date availability and their lack of access to resources to make and maintain an appointment. The homeless female veteran's problems mentioned above with scheduling could affect the number of them who are homeless and support the need for innovative research. Gathering specific data from the homeless female veterans could aid in improvements in appointment scheduling and program developments.

Purpose of the Study

In this quantitative study, I focused on comparing values between the CoC and the EWL data. The intent was to determine if significant differences in the data could show an association between the unsheltered homeless female veterans phenomenon on the CoC's office level (dependent variable) and the EWL (independent variables).

Research Questions and Hypotheses

Research Question (RQ)1: Is there an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0$1: There is no association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

H_a1: There is an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

RQ2: Is there an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0 2$: There is no association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

$H_a 2$: There is an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

RQ3: Is there an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0 3$: There is no association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

$H_a 3$: There is an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

Converting the CoC results into a yearly percentage to compare with the EWL had shown an association between the average annual percentages of the dependent and independent variables.

Theoretical and/or Conceptual Framework

This study stemmed from Elberg et al.'s (2000) psychosocial model addressing vulnerable populations. Previous research aligned with the demographics of veterans' status and their social structures (see Elberg et al., 2000). The homeless veterans in this study were a part of the economic and health disadvantaged groups in the United States. The unsheltered homeless women veterans were within vulnerable populations. Elberg et al. (2000) examined the population's community resources and their ability to get around the system.

A homeless female veteran may not have the skills or tools to access the VA's appointment scheduling system. Elberg et al. (2000) also considered the health behaviors, such as individual health behaviors and the outcomes. The status of homelessness could prevent the routine use of health services. Standard personal health practices could be problematic. Therefore, the homeless woman veteran may not provide the outcomes for health status studies.

Examining barriers to scheduling VA appointments, such as mental health issues, access, and locations, could further the VA's cause of reducing the number of homeless veterans' initiatives (see Shinseki, 2016). The VA has had complaints of long wait times for appointments over the years. Data collections and entries have also been

misrepresented (as cited in National Academies Press, 2018), causing issues with developing and implementing better appointment scheduling processes.

Research has identified some barriers to scheduling health and mental health care for female veterans at the VA. Focus group studies were a primary source of information for solving some of the VA's appointment scheduling processes' problems (see Tsai et al., 2015). An extension of focus groups that includes gender-specific homeless veterans could aid in improving access to VA services. Data collection continuums that address homeless women veterans' problems when scheduling VA appointments are vital for developments.

Framing the interviews in the focus groups to resolve specific difficulties would support streamlining future questionnaire. Designing the context of the focus groups to elicit information could lead to additional legislation. Furthermore, the local governments and communities could have the resources to approach homeless female veterans' issues, meet their needs, and reduce the number of homeless women veterans.

Background

The research literature has addressed the scope of information gathered from the VA's appointment scheduling processes and their audit results. Articles depicting research from focus groups about the VA's appointment scheduling processes were considered as were studies about homeless women veterans. The gap was the lack of information from the homeless women veteran's participation in the studies. This study is essential for program development on the local, state, and government levels and could reduce the number of homeless female veterans. Although the continuum of

developments in the VA's appointment scheduling processes has had productive outcomes, the number of homeless women veterans remains problematic.

In this literature review, I analyzed the correlation between the VA's appointment scheduling's EWL, and CoC. Framing VA scheduling strategies to meet the needs of the homeless female veteran could help address the problem. The potential positive social change includes the connection between improved gender-based VA appointment scheduling processes and the reduction in the high numbers of homeless female vets. Homeless women veterans could become active members of society, contributing values through employment, housing, and lifestyles. In this literature, I targeted the VA's scheduling processes and program measurements.

An investigation of the appointment scheduling's EWL date ranges from 31 to 60, 61 to 90, and 91 to 120 days could shed light on the reasons why there is a connection to the homeless female veteran's phenomenon. Researchers have searched demographic statues and social structures to identify gaps and the need for future research (see Miake-Lye et al., 2016). Research techniques have allowed researchers to evaluate the barriers to the utilization of VA services for female veterans. An underexplored area in the focus groups with female veterans are the homeless women veterans.

Modifications to the participatory focus group processes could help lower the high number of homeless women vets. The housing literature has targeted mental health hardships that cause barriers to seeking VA services. The datasets analysis considers the correlation of the variables.

Nature of the Study

During the literature review, an examination of the VA's wait time processes led to the following question: Could there be a connection to the unsheltered women veterans' phenomenon and the VA's EWL? Quantifying the data for statistics that can explain the multitude or the magnitude of variables allows for an observation of a phenomenon.

Measuring the CoC, the dependent variable, against the VA's EWL, the independent variable, could show an association. The data that depict consistencies in a reduction in wait times and the CoC could contradict the high number of homeless female veterans. The appointment scheduling processes wait times and access to services are factors that can discourage homeless women veterans from seeking the VA's health and mental health care services. An evaluation of the VA's appointment scheduling regimen could provide insight into the validity of the process's steps.

Further awareness of how the VA's appointment scheduling system frames its scheme to meet the demands for health and mental health care services could explain the effect the strategy has on the unsheltered women veteran's phenomenon. The VA's transparency initiative provides public access to a dataset catalog that features veterans' pending appointments (see Data.gov, 2020).

The 2018 to 2020 datasets list the veteran's pending appointments on the national, division, and facility levels (see VA.gov, 2020b). A comparison of the wait times data calculated from the veteran's preferred appointment date and the appointments scheduled

between 31 to 60, 61 to 90, 91 to 120 days could provide insight into the VA's scheduling processes' effect on the homeless women veteran's phenomenon.

The EWL's summaries list the data's account of the VA's appointment scheduling processes' outcome. Additional literature examinations may reveal differences in the EWL results. Researchers have found that there were complaints about data collections with variations in information about access to the VA's services, resulting in skewed data (as cited in National Academies Press, 2018). The EWL data presented a high percentage in the VA appointments scheduled between 31 to 60, 61 to 90, 91 to 120 days, meeting the VA's standards (see VA.gov, 2020a).

When comparing the point-in-time (PIT) statistics with the EWL data, there were indications of some challenges to the appointment scheduling process's ability to meet VA standard expectations (see U.S. Department of Veterans Affairs, 2019a). The wait time tracking processes data collections captured the veteran's chosen date from the scheduler's available appointments list instead of the initial appointment request (as cited in National Academies Press, 2018).

The CoC data collections from 2007 to 2019 could support the theory that the VA's scheduling system affects the number of homeless female veterans. The PIT count tool measures the number of homeless veterans every even year, which resulted in 37,878 unsheltered veterans in 2018 (see U.S. Department of Veterans Affairs, 2019b).

Over the years, several modifications of the VA's appointment scheduling system have reduced wait times and have increased the process's quality. New ideas, technology, and outcome analyses have driven the VA's management to broaden their plans of action

and enhance the system. Partnering with community health and mental healthcare facilities has also positively affected reducing the VA's appointment scheduling wait times. New ways to measure the results of partnerships have proven to add value to the scheduling process. Studies and healthcare comparisons of VA to non-VA health care services have driven improvements.

In contrast, an imbalance in timely access to the VA's health and mental health resources prevents adequate results. The Gelberg-Anderson and Leake psychosocial model aligns with the VA administration's challenges with the underestimated appointment schedule's EWL data (see Elberg et al., 2000). A lack of patient information can influence the strategic measures that accommodate patients' volume (structure). The statistical data collection of populations and their mental health needs (demographics) is essential to address those in need of mental health services.

These components support the reasons for the homeless women veterans' mental health problems and their inability to receive timely mental health services, resulting in the increased number of unsheltered female veterans. An analysis of the VA's appointment scheduling processes could show how it affects the unsheltered women veterans. Further research into the veteran's gender-based homelessness could reveal the gap in data collections and the need for innovative focus groups.

The VA's appointment scheduling's EWL was the independent variable that was measured against the dependent variable of the CoC on the office level. The variations in the variables above could indicate skewed data collections visible in the effect sizes. The Women Veteran's Health services were created in 1988 to streamline services providing

cost-effective care, such as medical and psychosocial health care (see U.S. Department of Veteran Affairs, 2017a).

The initial steps in the service provisions were a positive approach to the problems with the unsheltered women veterans' high rates. Researchers Koblinsky et al. (2017) sought to increase women veterans' representation in mental health care improvements.

The study participants recommended tailored approaches to healthcare access and use, and clinical social workers to learn more about the military culture and best practices suited for female veterans (see Koblinsky et al., 2017). Although there has been an overall reduction in veterans' homelessness, the rate of homeless women veterans has increased (see Veterans Administration, 2017). The increase in homeless women veterans' rate from 9% in 2015 to 16% by 2017 augments the persistent demands to innovate the Women Veteran's Health Program's processes (see U. S. Department of Veteran Affairs, 2017b).

Literature Search Strategy

The systematic internet search began with scans of publications in journals in an academic subdivision. Health Services Research and Research Gate were databases essential to the seminal studies. Studies relating to homeless women veterans were found in ProQuest, SAGE, and Google Scholar databases. The NCBI, JAMA Network, VA.gov, and numerous sections of the U.S. Department of Veteran Affairs contributed to veterans' and data collections information.

Homeless women veterans was the main search term. Other related words were *unsheltered, homeless, EWL,* and *scheduling*. Resource scanning covered seminal literature to current studies about the high number of homeless women veterans. The scope included framing the thesis about vulnerable populations to narrow the topic to the homeless female veteran. Information was gathered from journals, articles, and datasets from government websites between 2000 and 2020.

The statistical literature covered wait times for VA services, comparisons, and appointment scheduling barriers for homeless female veterans. The supporting research addressed women veterans' health care, the high number of homeless female veterans, and the VA program measurements. There were very few studies regarding homeless women veterans in focus group settings. The evidence mapping studies were sufficient to present findings of the homeless female veteran's barriers to the VA's healthcare services. The research rendered information about patterns, progressions, and study volumes but did not include gender-specific focus groups.

Literature Review

There were 19,209,704 veterans in the United States, Puerto Rico, and Foreign Territories in 2019 (see U.S. Department of Veteran Affairs, 2019a). The female veterans' population consisted of 1,920,965 (see U.S. Department of Veteran Affairs, 2019a) . The top five states most populated by women veterans were Texas, Florida, California, Virginia, and Georgia (see U.S. Department of Veteran Affairs, 2019a). According to Hud Exchange, (2020) the PIT count data showed the overall number of U.S. homeless veterans in 2019 was 37,085. The number of homeless female veterans was 3,292 (see

Annual Homeless Assessment Report; Hud Exchange, 2018). History has shown that more women tend to live in poverty than men (see Bleiwels et al., 2020). Therefore, in theory, there may be more homelessness among female veterans.

Research has revealed that women have a lower percentage of military participation. The information in some ways helps explain the data depicting a decrease in homeless women veterans each year but not those who are not counted. Carusa (2018) discussed hidden numbers of homeless female veterans and supported research pointing out the need for modifications and new women veterans' programs.

The VA's appointment scheduling processes could affect the high number of homeless women veterans. Evidence mapping a broad field of literature about women veterans' barriers to accessing and utilizing the VA's health services was used to determine if the skewed data theory was why the VA's appointment scheduling processes had contributed to the increased number of homeless women veterans.

Researchers have considered the reasons why women veterans were not scheduling and or maintaining appointments with the VA. The studies were performed and analyzed through focus groups (see Cheney et al., 2006 - 2022). However, though broad, many systematic searches have not included research that focused solely on the homeless female veteran. The number of homeless women veterans could be decreased if more programs targeted the problems homeless female veterans have with scheduling appointments with VA facilities.

The use of the EWL datasets and the unsheltered homeless veteran's datasets was the concept for comparison. If the datasets show a downward direction with the

dependent (EWL) and independent (unsheltered homeless veterans) variables, there could be a connection. The information could support the need for new programs targeting the homeless female veteran's problems with scheduling appointments or prove that the VA's scheduling system does not need changes.

VA's Appointment Scheduling Process

The first step toward reducing the number of homeless women veterans would be scheduling VA healthcare or mental health care evaluations. After the initial assessment, a veteran could receive treatment and assistance with housing. However, VA network barriers have caused an imbalance in veterans receiving equal health and mental health care benefits (see Department of Veterans Affairs Office, 2002).

Primary sources indicated that nonsystem veterans and new enrollees were not getting the same assistance as vets who were already in the system (see Department of Veterans Affairs Office, 2002). The homeless female veteran might not be in the VA's system if she had not decided to seek health and or mental health services. Not receiving the same assistance as those veterans in the system could factor into the number of homelessness among women vets.

In February of 2002, the VA's Operations Management Deputy of Health Laura Miller saw the need to monitor veteran's demands for services (see Department of Veterans Affairs Office, 2002). Further monitoring of the appointment scheduling system was essential to combat the problems with long wait times for VA services. Developing a venue through technical means could serve the practical purpose of time management. The EWL was the solution to problems with long wait times for the vet's requests for

services within the VA's system (see Department of Veterans Affairs Office, 2002). An outpatient veteran's care team could access a Primary Care Management Module (PCMM) (see Department of Veterans Affairs Office, 2002.

The PCMM software generated a process that identified veterans who could not obtain an immediate VA appointment, placing the vet on an EWL for assignment (see Department of Veterans Affairs Office, 2002). Additional monitoring of the appointment scheduling system would require the VA's healthcare provisions in areas of the homeless female veteran's demographics. The EWL's format could assist community clinics and VA medical centers in managing veterans' access to care as outpatients.

The system housed information about veterans waiting for appointments or PCMM assignments for service, specialty, or a specific clinic (see Department of Veterans Affairs Office, 2002). The wait list placement was contingent upon the veteran's primary care team's initial assignment and if the primary care team had maximized its capacity.

After the initial entry of patient information, the system would evaluate the veteran for a 50% or more service connection (see Department of Veterans Affairs Office, 2002). In 2014, the VA's Office of Inspector General (OIG) report indicated issues with the Phoenix VA's scheduling system. Patients wait times were insufficient and possibly the cause of veterans' deaths (see U.S. Department of Veteran Affairs, 2014).

The review addressed service delays, omitted patient names from the EWL, followed scheduling protocols, and addressed insufficient systematic scheduling (see U.S.

Department of Veteran Affairs, 2014). The multidisciplinary team found that there were nationwide systematic issues in the VA's appointment scheduling processes. The team's recommendations for improvement measures included the Phoenix VA Health Care System and nationwide reviews of veterans on VA waitlists (see U.S. Department of Veteran Affairs, 2014).

The scheduling process began and had a persistent problem with following protocols across the VA's system. The new enrollees and the vets who were not in the system were affected by the VA's lack of organization (see U.S. Department of Veteran Affairs, 2014). The EWL became another issue with scheduling veterans for services because it also was lacking in structure (see U.S. Department of Veteran Affairs, 2014). The report would prompt a system-wide strategy to decrease the number of vets on the EWL and increase timely access (see U.S. Department of Veteran Affairs, 2014).

The VA needs an ongoing system analysis to modify, update, and innovate the scheduling processes. The homeless women veteran's phenomenon needs to be included in the VA's scheduling system's improvement measures to reduce their high number of homelessness.

Evaluating the VA's Appointment Scheduling System

Research outcomes over time supported the need for a continuum of monitoring and evaluations for change after the implementation of the EWL to improve veteran's wait times for health and mental health services at the VA. The Northern Virginia Technology Council (see NVTC, 2014) was enlisted by the VA to evaluate the VA's scheduling processes for improvement measures in 2014.

They examined the scheduling, communication, confirmation, and systems results and found deficiencies in the VA's appointment scheduling system (see NVTC, 2014). The goal was to pinpoint strategies that would improve the VA's scheduling processes. Identifying the initial causes of the VA's appointment scheduling problems could aid in the NVTC's recommendations for improvements (see NVTC, 2014).

The NVTC's (2014) final report identified insufficient technology for the VA's scheduling processes and inconsistent standard operating procedures requiring substantial updating. The 2014 Veteran's Choice Act expanded the criteria for veterans. Veterans could seek services from civilian providers to combat long wait times for VA health and mental health care services. The act called for independent evaluations of the VA's health care system (see Choice Act Summary, 2014).

The NVTC's assessment included the VA's health care services and its contractors (see Choice Act Summary, 2014). At this point in the VA's appointment scheduling system's evaluation, researchers did not use strategic measures to include demographics that would place more focus on patient-centered efforts. The emphasis was on analyzing the scheduling processes and technology.

The recommended system changes for the appointment scheduling processes could positively affect the problems with missed or canceled mental health appointments. The complaints about the VA's appointment scheduling system continued into 2016, prompting a different direction for assessing the VA's system. Using the patient-centered approach, targeting the veteran's population demands, and enlisting independent

evaluations could render information for updating the VA's appointment scheduling system.

Independent Assessments

Outsourced assessments of the VA's appointment scheduling system will eventually include the veteran's demographics data. The use of research information every few years has been sufficient for pointing out the ongoing complaints with the VA's appointment scheduling processes. Some research has indicated improvements while stressing the need for modifications within the VA appointments scheduling system. The VA enlisted Rand in 2016, an independent research and analysis corporation, to evaluate the veteran population's demands and VA competencies (see Farmer et al., 2016). The independent analysis of the VA's appointments scheduling system addressed demographics but did not include homeless veteran's data (see Rand Corporation, 1994 – 2020). The researchers found that the younger veterans in rural areas were more dependent on VA services due to a lack of healthcare resources (see Farmer et al., 2019).

Clearly defined research would identify the needs for innovative programs. Age and gender findings from this research require an in-depth analysis to determine the who, what, where, and why elements. Older males were more prone to use VA services because they were less healthy, and 52% were over 65 years old (Farmer et al., 2016). Specific data collections could lead to the need to include the homeless women veteran's population when analyzing the demographics for the VA's appointments scheduling system.

Additional data could provide information about the ability to access resources to make and maintain an appointment. Recommendations could include provisions that address the homeless veteran's barriers to obtaining access to VA health and mental health services. According to Farmer et al. (2016), most veterans lived near a VA healthcare facility or within 40 miles of driving distance. Moreover, measuring the VA's capacity to meet the veteran's need for services was contingent upon their distance from the facility and the type of health services required. If the homeless veterans were living near a VA health care facility, that would be a decisive factor.

Veterans would experience long wait times for appointments, dispelling their hopes for timely access. Some veterans waited up to 60 days after their preferred date for an appointment (see Farmer et al., 2016). However, homeless veterans may not have had the option of waiting 60 days for an appointment at the VA. The homeless veteran could need VA services before further health or mental health complications occur.

Even though the NVTC evaluated the VA's scheduling processes and communication systems for improvements in 2014, the inconsistencies in their operating procedures were still an issue in 2019 (see NVTC, 2014). A closer look at the scheduling policies and training schedulers using an independent investigation is another approach to resolve the wait time problems. The U.S. Government Accountability Office (GAO, 2019) released findings of a study about the challenges of the VA's appointment scheduling procedures and processes.

The VA's goal was to improve wait time measurements, and as a result, they revised scheduling policies. Management redefined wait time measurements, retrained

appointment schedulers, and modified these changes using audits (GAO, 2019). In July of 2019, the GAO's report findings rendered the VA's approach to the appointment scheduling problems to be sufficient. The GAO recommended consistency in the new scheduling policy and training. Although the VA made changes to the appointment scheduling wait time measurements and the VA's system, the homeless women veteran's phenomenon remained an issue, requiring ongoing research and robust VA appointment scheduling procedures and processes.

Additional suggestions were to evaluate and improve the 3-month wait time for the initial enrollment for VA benefits (see GAO, 2019). The analysis of the VA's appointment scheduling process from 2014 to 2019 did not include measures for homeless women veterans. Instead, the GAO's focus was on new enrollees and vets who were not in the VA's database.

The GAO researchers could have addressed the omission of gender-based preparations for the appointment scheduling process. Further insight into the homeless veteran's population from the homeless female veteran's point of view could enhance the VA's appointment scheduling processes. The use of gender-related homeless veterans' focus group sessions could positively affect the VA's wait time problems. These focus groups could aid in identifying variations in scheduling across the VA's systems.

Variations in Timely Access to Mental Health Services

Homeless female veterans in various locations could add valuable data to appointment scheduling wait times across systems developments. The aftermath of addressing mental issues among homeless women veterans could lower the homelessness

number substantially. The Board on Health Care Services Committee noted that timely access to the VA's mental healthcare services varied across the facilities (as cited in National Academies Press, 2018).

The initial mental health appointments should occur within 24 hours after the patient's request, while diagnostics and treatment assessments should follow approximately 30 days later (see GAO, 2019). All consecutive follow-up appointments must be 30 days apart (see GAO, 2019). The mental health appointment scheduling process could be successful in providing the care and in identifying and treating the homeless female veterans' issues, resulting in permanent solutions. Additionally, keeping the VA's mental health care appointments could lead to housing and employment. Nevertheless, strategies should be in line with the demands of homeless women veterans.

Wait time data was underestimated because times were tracked using preferred dates information instead of the initial request for mental health services date. Instead of the data indicating the patient's initial day contacting the VA for an appointment, the data would reflect the days in between the preferred date and the actual appointment date (as cited in National Academies Press, 2018). Therefore, the data collection did not accurately calculate the wait time for an appointment for mental health services (as cited in National Academies Press, 2018). The miscalculated wait time could affect clinical services framework and the homeless female's barriers to access.

The scheduling process could be a challenge for homeless women veterans who may not have consistent telephone or internet access. Waiting for a VA scheduler to contact her for an appointment, and not having the resources to go on the VA's available

date affects the outcome. She could then become discouraged and give up on seeking the help that is available because of missing the assigned appointment.

The homeless female vet's opportunity to gain assistance with her mental health issues could be lost, resulting in a continuous homelessness status. Also noted were limited resources to facilitate access to VA mental health care, such as the required data to maximize clinical planning (as cited in National Academies Press, US, 2018b).

Framing care management is essential for reducing the number of homeless women veterans. Many components encompass the VA's mental health services. Therefore, having an in-depth understanding of a specific patient population's needs allows the clinician to provide the patient-centered approach to care. The process of ending homelessness among female veterans would require different tactics that could bring about change.

Addressing the barriers to appointment scheduling would also require VA system analytics. Expanding the VA's appointment scheduling system for a long wait time reductions requires data analysis for improvements, updates, and innovative efforts where applicable. Health care comparisons of the VA and private sector are vital to the resolution of long wait times for appointments and model execution.

Health Care Comparisons

Researchers have gathered data for evaluation to determine the changes, updates, and new procedures for the VA's use for reducing the number of homeless women veterans. Another strategy for examining barriers to appointment scheduling, affecting

the high numbers of homeless female veterans in the research, was non-VA to VA quality healthcare comparisons (see O'Hanlon et al., 2017).

The systematic review targeted articles about the quality of health care services at the VA and non-VA organizations. The research found similarities in safety and effectiveness outcomes but noted the need for additional information about the quality of care (see O'Hanlon et al., 2017). Homeless female veterans could benefit from having various accesses to mental and health care services within the communities where they live.

Therefore, non-VA health care facilities could have a positive effect on their homelessness phenomenon. Another advantage was the Veterans Choice Program (VCP), a new measure to combat the timely access to healthcare issues. The temporary solution would allow veterans waiting for health care services beyond 30 days to go through the private sector for three years (see US Department of Veteran Affairs, 2014). The program was also accommodating to veterans 40 miles or more away from the closest VA facility (see US Department of Veteran Affairs, 2014).

The VA Mission Act of 2018 would further solidify the internal VA system's integrations with non-VA networks. The VCP and the VA Mission Act could address the problems of timely access to veterans' health and mental care services (see US Senate Committee on Veteran’s Affairs, 2018). Researchers did note the need for ongoing studies that could identify innovative strategies for improving the process and implementing procedures for better service (see O'Hanlon et al., 2017).

The repetitive mention of patient-centered approaches in study results encouraged the need for continuous efforts of collecting input and feedback through participatory measures. The homeless women veterans who can attend a focus group session and explain their individual experiences with barriers to health care access could provide substantial information.

The researcher could analyze the data to frame future focus group studies that are patient-centered. Evaluating the data for the development of policies and procedures for local VA facilities to customize the appointment scheduling process could aid in resolving the wait time issues. Outcomes of the research note the inconsistencies in the same standards of operations across the VA's system as one of the reasons for the wait time challenges (see GAO, 2019).

However, the efforts to develop and implement system-wide standards could cause additional problems because of the need for patient-centered services. Also, each VA entity does not offer the same health or mental health services, as veterans may require a significant treatment regimen. Consistent evaluations of the VA scheduling systems are essential to modifications that render positive results. Measuring VA wait times with non-VA wait times could aid in defining accessibility.

Measuring the VA's Appointment Scheduling Process

The vast amount of VA appointments scheduled daily would advocate care coordination. Measuring wait times could be problematic as there must be a starting point for measurements to be reliable. The VCP became a solution for the VA's wait time issues. The program was slow in implementation but allowed veterans to choose a non-

VA healthcare facility in their community (see Kelley et al., 2019). The VCP was not the most cost-effective program as the approximate cost was $21 billion, prompting additional streamlining (see Kelley et al., 2019).

The veteran's access to care was modified upon consolidation of the VCP and the Veterans Community Care Program (VCCP) through the VA's Mission Act (see Kelley et al., 2019). The intention was to streamline non-VA care by separating the VA's standard patient qualifications from the program's requirements (see Kelley et al., 2019). The VCP and VCCP implementations further challenged the VA's ability to measure the appointment scheduling system.

The streamlining process that had shift responsibilities was confusing to where the quality measurements would start (see Kelley et al., 2019). The change in responsibilities created problems for the veterans seeking to schedule appointments for VA services as well (see Kelley et al., 2019). The issue for the homeless female vet was the additional pressures stemming from the VCCP. The problem was with the new eligibility standards. When the homeless woman veteran's preferred appointment date would not be available, she had to decide whether or not to use the VCCP (see Kelley et al., 2019).

The VA's shift in appointment scheduling requirements could negatively affect the homeless women veterans' phenomenon. How the VA's appointment scheduling processes affected the high number of homeless female veterans was apparent in the problems with wait times and the processes across its systems. In the past, the VA's publicly reported wait time measurements made them the leader.

When the VA partnered with community health facilities, the variations in data collections of wait times for appointments became difficult to measure (see Kelley et al., 2019). A solution to the confusion was to begin mystery shopping using veterans as patients for data collections. The mystery shopping initiative could have been objective; however, it also became an issue when measuring VCP with VCCP. The VCCP was not measured and, therefore, did not provide data for comparisons (see Kelley et al., 2019).

The exception to the measurement initiatives was comparing the VA to non-VA new patient wait times. The measurements from 2014 to 2019 rendered improved VA outcomes. There were stagnant non-VA wait time reports (see Kelley et al., 2019). The 2018 VA Mission Act prompted measurements of non-VA wait times using public data for comparisons to the VA. Standardized wait time criteria could help optimize networks in the future (see Kelley et al., 2019).

The VA's ability to measure wait times for the appointment scheduling process is an ongoing issue. The problems with data collections stem from a lack of wait time information from the non-VA entities to the shift in responsibilities from the implementation of new programs. Nonetheless, the enactment of veteran patients as mystery shoppers could enhance the appointment scheduling process.

The data from the mystery shopping experience could solidify modifications to the process to include the homeless female vet population. The issue with additional responsibilities for the homeless women veterans could be the lack of accommodating resources. The lack of support could cause barriers to accessing health and mental health services from the VCP or the VCCP.

Homeless Women Veterans

The National Coalition for Homeless Veterans (2017) defined homelessness as individuals without an adequate living residence. Barriers to the prevention of homelessness among veterans have been examined since the initial goal to end the homelessness phenomenon in 1987 (see Us Department of Veteran Affairs, 2019a). The amount of homeless female veterans continues to increase against efforts to end homelessness among veterans.

Between 2018 and 2019, homelessness among male vets was reduced by 3%, whereas homelessness among female vets increased by 2% (see Montgomery, E., 2019). Women make up 10% of the veteran's population and are twice as likely to become homeless within 12 months while living in poverty (see Montgomery, E., 2019). Obstacles, such as mental health challenges, can prevent homeless veterans from seeking help from the VA's mental health program to resolve the unsheltered situation. A myriad of issues from a female veteran's childhood to military enrollment could drive reasons for housing instabilities after discharge (see Montgomery, E., 2019).

Moreover, she may be accompanied by dependents fueling the desire to remain unnoticed to maintain the supporter role (see Montgomery, E., 2019). Some female veterans may elect to stay with friends or family members, which can skew homelessness data collections. Their homeless status could be difficult to identify (see Montgomery, E., 2019).

A homeless woman vet is more likely to seek help from VA resources that accommodate family housing needs and lifestyle. The objective would be to prevent

family separation (see Montgomery, E., 2019). Creating and customizing service programs for women veterans is essential to addressing problems with scheduling and maintaining appointments with the VA and reducing the number of homeless female vets.

Kaboli and Fihn (2019) studied the issues with VA appointment scheduling wait time measurements. They noted the difficulties in obtaining accurate wait times due to the measurement processes. Patient's wait times were calculated using the intervals between the time that the patient made the appointment request to when the appointment occurred (see Kaboli & Fihn, 2019).

The recorded wait times in the scheduling system were shorter than the patient's actual appointment date. Private sector secret shopper measurements were another strategy for measuring, but the data may have been skewed because of the low number of physicians contacted for appointments (see Kaboli & Fihn, 2019). The authors suggested that additional measures of access to VA healthcare services could alleviate wait time issues.

The Rural Health Information Hub (RHI) (2021) stated that veterans in rural areas may have problems with access to health care. There were issues, such as homelessness, poverty, and substance abuse. Some veterans were not aware that there were VA resources or facilities for assistance (see RHI, 2021).

On December 1, 2020, a Management and Oversight of the EWL for Healthcare Services report was submitted by the OIG (see VA.gov, 2020a). An audit report addressed concerns about the EWL. Allegations were made that the waitlist entries had

management issues (VA.gov, 2020a). The OIG's findings were insufficient oversight on community and federal levels of the EWL's management (see VA.gov, 2020a).

Mismanagement of the EWL could mean that patients did not receive health care in a timely manner. Patients could have been overlooked for appointments or transfers to preferred facilities. These types of mistakes could also cause repetitive waitlist entries. Improvements were implemented for new patient tracking. The process included eliminating the EWL and implementing the consult toolbox (see VA.gov, 2020a). The new strategy would identify new patients, track patients, and use standard operating procedures (see VA.gov, 2020a).

Studies of Barriers to Healthcare

The WH enlisted the Altarum Institute to study barriers to healthcare for women veterans in 2015 (see Altarum Institute, 2015). The institute's research consisted of a telephone interview of 64,509 female veterans (Altarum Institute, 2015). The research on women veteran's mental health stigmas rendered 24% of the number of female vets hesitant to seek help from the VA for mental health problems (Altarum Institute, 2015).

The participants in the study were concerned with medication use (62%), the effect on their employment (54%), other's opinions of them (47%), and family or spousal reactions to their mental health treatment (31%) (Altarum Institute, 2015). Some participants (40%) preferred religious counseling instead of the VA's mental health services (see Altarum Institute, 2015).

The research results on the female veteran's mental health stigmas support the theory of the need for more tailored focus groups for homeless women vets. Future focus

group procedures can be designed to gather information from homeless female veterans to create the motivation to make and maintain VA mental health appointments.

Women Veteran's Health Services

The VA created the Women's Health (WH) Services in 1988 to streamline health and psychosocial services (see US Department of Veterans Affairs, 2017b). The WH program was elevated to the Strategic Health Care Group in 2007 to broaden services for female veterans (see US Department of Veterans Affairs, 2017b). Between 2010 and 2015, the number of homeless women veterans was 36,443; however, The National Center on Homelessness Among Veterans expects the number to increase to 40,000 by 2025 (see Richman, 2018b).

The Women Veteran's Health services is a resource that should help the homeless female vet gain control of her homeless status and continue toward a sheltered outcome. Therefore, more evaluations of the homeless women veteran's phenomenon are essential to the reduction goal. Addressing mental health barriers to the VA's appointment scheduling processes can provide ancillary insight for improvements of the VA's appointment scheduling procedures.

Researchers Koblinsky, et al. (2017) sought to increase the women veteran's representation in mental health care improvements. The researchers recommended tailored approaches to access, use, and clinical social workers to learn more about the military culture and best practices for female veterans (see Koblinsky et al., 2017).

Studies should involve a closer look at the woman vets who are homeless to reduce the amount of homeless female veterans and add to research about how to lower

the number. O'Toole (2015) studied innovative measures for addressing homeless veterans and discussed the disproportionate number of female veterans who experienced poverty in the four subpopulations requiring increased attention. The author suggested a tailored focus, proactive planning, and program models that can identify the programs' problems, intervene, prevent, and provide support to the homeless female veterans.

A strategy of participatory focus groups targeting the homelessness of the women veterans could enhance the understanding of issues with mental health appointment scheduling at the VA. The improvement of the processes to include the homeless female veteran's input can help the VA and their clinicians develop more vigorous policies and procedures to reduce the number of homeless women veterans. There has been limited research on homeless women veteran's focus groups for the VA's appointment scheduling processes. Most studies were systematic and derive from descriptions of specific health and disease factors.

Byrne, et al. (2013) reported dominating and descriptive studies that did not include focus group studies on homeless female veterans' appointment scheduling procedures and processes for the VA's mental health services. Reviews targeted epidemiology inquiries but excluded characteristics, such as gender-specific, clinical, and demographics (see Byrne, et al., 2013). Modifying the types of focus groups' research to increase studies on homelessness and barriers to the VA's mental health services for homeless female veterans could be a vital resource for reducing the number of homeless women veterans.

Over the years, there have been numerous strategies for studying evidence about the barriers to the use of the VA's health and mental health services. There should be further research about tailoring focus groups for gender-specific interventions to access and utilize the VA's health services.

Homeless female veterans can better define the reasons why they do not seek assistance from the VA and the circumstances that prevent them from making and maintaining mental healthcare appointments at the VA. Increasing data collection from homeless women veterans can help create new ideas and methods toward an unsheltered to a secure housing status, lowering the number of homeless female veterans.

Research Methods

A method of data analysis was researching systematically using evidence mapping through the Patient-Centered Outcomes Research Institute (PCORI) (PCORI, 2011-2019). This research method continued Elberg, et al. (2000) psychosocial model about vulnerable populations. Danan et al. (2008 - 2015) used the evidence mapping strategy to study women veterans' barriers to accessing and utilizing the VA's health services, focusing on women veterans' access to mental health care, finances, and delays in health services and homelessness.

The system's search of 208 articles presented patterns and progress, noting an increase in studies about healthcare delivery, access, and utilization (see Danan et al., 2017). However, the researchers did not find accessory reviews about gender-specific interventional research (see Danan et al., 2017). Focus groups are a source of information for VA health service improvements, modifications, and creative proposals.

Although research shows theories, and themes from VA mental health care focus groups, the need to improve female veteran's focus group processes remains. Cheney et al. (2018), found that focus groups for the VA's appointment scheduling for the mental health services process rendered communication barriers. Examining the focus group's procedures could effect change and reduce the number of homeless female veterans.

Due to the emotional, behavioral patterns of self-sufficiency and self-confidence, homeless women veterans were resistant to seeking help (see Absher, 2018). A comprehensive approach to lowering the rate of homelessness among women veterans should include extensive feedback from them.

Supplementary information from their participation in tailored focus groups can aid in policy changes and innovative measures for scheduling appointments at the VA favorably. Reframing the methodology of the focus groups can prevent miscommunication, increase data accuracy, and help reduce female veterans' homelessness.

Participatory Focus Groups

Concentration on a psychosocial model's approach required a look at an individual's influences. Conducting healthcare focus groups allows the researcher to study a person's physical, mental, and wellness functions. Focus groups are a participatory approach that can collect in-depth knowledge of the VA's healthcare system's homeless female veterans' perception.

The group discussions could target how the homeless women veterans gain access to tools and resources to schedule an appointment with a VA facility. The information

could allow researchers to acquire an understanding of any social issues. The data is obtained from selecting specific participants instead of a broad population (see Nyumba et al., 2018). Cheney et al. (2018) continued the evidence maps studies of healthcare barriers in 2015, with a mixed-methods approach, analyzing cultural domains, gaining further insight.

The studies' participants voiced concerns about a lack of confidence in the VA health care system (see Cheney et al., 2018). The veterans mentioned personal obstacles, such as understanding VA benefits and how to obtain healthcare services (see Cheney et al., 2018). New patient-centered focus groups can add valuable information for modifications in the VA's mental health appointment scheduling processes to ensure attendance. Attaining data for framing focus group procedures for homeless women vets should include female veterans from specific demographics.

Linking women veteran populations with homelessness and their tour locations could be a great source of information. Homeless female vets' participation in these types of focus groups could present a more detailed description of needs from the VA's mental health services. Koblinsky et al., (2017) reported research findings consistent with O'Hanlon et al. (2017) and Cheney et al. (2018) studies. Issues such as patient-centered access and stigmas were barriers that hindered successful appointment scheduling for the VA's mental health services. The qualitative research performed by Koblinsky et al., (2017) was instrumental in collecting more information from women veterans who served in Iraq and Afghanistan.

The Koblinsky et al., (2017) study targeted data for advising mental health professionals and improving female vets' care with mental health issues. The researchers considered the focus groups as the best approach to collecting data from female veterans with mental health service needs (see Koblinsky et al., 2017). The research was on demographics covering women veterans but not homeless women veterans seeking to make and maintain appointments with the VA's mental health department (Koblinsky et al., 2017). The VA's appointment scheduling processes' effect on the homeless women veteran's phenomenon is apparent in the author's research.

The homeless female veteran's personal, financial, and mental barriers should be addressed for them to make and maintain their VA mental health appointments. New in-depth methods for focus group procedures and processes would help improve the VA's appointment scheduling processes and reduce the number of homeless female veterans.

There was a challenge to the forecast in the increase in homeless women vets by 2025 as the VA's combined efforts and the Department of Housing, and Urban Development (HUD) would result in a decrease in homeless female veterans in 2018 (see Shane III, 2019).

Housing for Homeless Veterans

The female veteran who is homeless may not be able to access telephone services daily. She could experience limitations in resources allowing her to receive callbacks from VA staffers for appointment scheduling. There could be other hardships related to mental pressures, which averted her from pursuing the VA's resources. These factors link

the VA's appointment scheduling processes' issues to the high number of homeless women vets.

Stumbling blocks hinder access to health and mental health services at the VA. Nevertheless, appointments at the VA for the homeless female veteran can lead to treatment, housing, and employment. From 2010 to 2016, the VA reduced homelessness among veterans; however, from 2016 to 2017, the number of homeless veterans was on the rise again (see Shane III, 2019). The increase, reduction, and increase again sparked a strategic measure of using a holistic approach to the unsheltered veteran's phenomenon. In 2018, the VA and HUD departments gave vouchers to charities in local communities for housing for homeless veterans (see Shane III, 2019).

The new measure outcome was an overall 5% drop in homeless veterans and a 10% reduction in the homeless female veteran's subpopulation in 2018 (see Shane III, 2019). If the result of housing vouchers continues toward a reduction in the number of homeless veterans, the number of homeless women vets in 2025 could be considerably less than the forecast of 40,000 (see Richman, 2018b). However, housing vouchers cannot be the only solution for reducing the number of homeless women veterans. The approach to issues with the unsheltered women veterans should include gender-specific strategies. Male veterans have had a dominant presence in military services. Since the increase in female enrollments, the demand for resources has heightened for women veterans.

Authors Kim et al., (2020) found that 53% of homeless women veterans had a history of military sexual trauma, 74% had positive screenings for PTSD, and 33% were

suffering from depression. Recommendations from the "Safer Housing for Homeless Women Veterans" study stemmed from the need for VA services framed with an understanding of the homeless female's traumas (see Kim et al., 2020).

The VA housing services should include separate housing, rooms with accessible exits, safety mechanisms and plans, security, reporting policies, and open communications. The aforementioned strategic measures could address homeless women veteran's vulnerabilities (see Kim et al., 2019). Other factors should be inclusive in solving the homelessness problem to combat the future forecast of 40,000 homeless female vets (see Richman, 2018b). Focus groups that target homeless female veterans for participation should gather information about gender-specific issues. How and where women veterans use VA systems is vital for focus groups and program developments in specific areas.

Data Collection for Research

According to Richman (2018a), capturing partial data is one of the causes of the increases in homelessness among women veterans. When female veterans use the VA system, their information is in the database for research (see Richman, 2018a). In contrast, the homeless women veterans who use the non-VA programs in their community are not in the VA's system. The missing data from homeless female veterans using community programs prevent accurate data for consideration in program and service development (see Richman, 2018a).

Although the government has been addressing barriers to preventing the homeless women's phenomenon since 1987, there is much more to accomplish. There is a need for

increased attention to the multiple problems that homeless female veterans face in accessing care.

A substantial reduction in the number of homeless female vets is possible with in-depth knowledge of the obstacles that discourage them from seeking assistance from the VA's health care and mental health services. Focus groups with processes that include extensive input from participatory agents can aid in decreasing the number of homeless female veterans.

Variables Definitions

Continuum of Care

Monitoring unsheltered veterans provide information for program developments. HUD PIT data collections occur every year, gathering information about veterans who stay in emergency shelters and transitional housing. The datasets define populations and groups such as age and gender (see US Department of Veteran Affairs, 2019b). The CoC tools collect data on the sheltered and unsheltered who live on the streets or in non-human habitation areas every odd year. HUD is responsible for managing PIT data from their CoC facilities to coordinate services for the homeless (see US Department of Veteran Affairs, 2019b).

The VA's appointments scheduling processes could affect the homeless women veterans in several ways. If the homeless female vet is unable to schedule an appointment for services at the VA or its affiliates, she will not be counted. The accurate number of unsheltered women veterans could be skewed by those who are not identified. The analysis of the data could render an inaccurate lower number of homeless female

veterans. The imprecise information could also affect policies, procedures, resources, and planning.

Electronic Wait List

According to the national public datasets, the VA appointments scheduled as of April 1, 2020, was 9,849,963 (see VA.gov., 2020a). Approximately 8.10% of veteran's appointments were scheduled beyond 30 days. The primary care average wait time was 4.15, and specialty care appointment wait times were 12.64, while mental health wait times were 6.19 (see VA.gov, 2020b). Although the data lists appointments scheduled in day ranges, it does not show the veteran's preferred date for an appointment.

Preferred date data would add accuracy to the wait times for an appointment. Listing days that reflect wait times on the EWL between the days those vets wait for VA available dates reduces wait time inaccurately. Adopting innovative measures to include the veteran's preferred appointment date tracking to the actual appointment date could improve the process. The connection between the EWL and the high numbers of homeless women veterans could be in their ability to maintain their preferred appointment date.

Initial access to VA services could augment the desire to get assistance and solidify confidence in relieving the homeless status. Not having to rearrange travel resources could result in resolutions to treatments, housing, and employment. Improving the VA's appointment scheduling processes can also aid in reducing the high number of homeless female veterans.

Assumptions

The number of unsheltered women vets is the aspect of this study that would be difficult to prove. According to Casura (2018), there are hidden numbers of women veterans who might be homeless. One can consider homeless statistics about homeless female veterans from the VA and HUD data but could not demonstrate the accuracy of the findings.

Homeless women veterans who stay wherever possible at any given time, such as in their vehicles, on someone's couch, or in an unsafe relationship, may not be counted (Casura, 2018). Hence, the assumption of the high number of homeless female vets, absent of the correct total. The aspect of the high rate of homeless women veterans necessitates the theory of the VA's appointment scheduling processes' effect on the homeless women veteran's phenomenon.

The homeless female veteran's phenomenon have been a problem for numerous years. Streamlining the VA's women's health services and distributing vouchers for housing has not resolved the issue. Additional focus on the high number of homeless female veterans could drive the demand for an increase in research for legislation, policies, and programs. Some homeless women suffer from mental health problems and may not think they are worthy of the VA's services.

Local facilities may be able to develop activities that compel the homeless female to participate and accept assistance from VA service offers. Developing a rapport with homeless women veterans could increase focus group participation. Framed community

events attract the homeless female veterans leading to programs that resolve access to health care problems.

Scope and Delimitations

The focus of this study is the VA's EWL and the CoC data. Participants are the veterans making appointments with the VA for health and mental health services. Specific sites of the scope are at the CoC office level, where veterans schedule their appointments. The delimitations of this study are the female veterans who are homeless as they have the most potential of being concealed from the documentation. The generalization of this study could be applied to the broader group of homeless in other environments. Information collected in future studies could aid in creating programs for homelessness prevention.

Limitations

Quantitative research is descriptive and therefore has its limitations. Although the research can be an in-depth view of the thesis, the reasons why the number of homeless women veterans have issues with scheduling appointments cannot be completely identified. There is a lack of studies about how a homeless female veteran schedules an appointment at the VA. Moreover, the difficulties in going through the processes without the resources to do so. In addition, there can be challenges with the VA's appointment scheduling data due to complaints about variations in collecting information about access to VA services (as cited in National Academies Press, US, 2018).

Undocumented data about homeless women veteran's attempts to make an appointment with the VA could distort the data. The data collection issues also include

the CoC local office levels of VA services. The study design will focus on monthly and yearly bases comparing the percentages of women on the VA's EWL in ranges of 31 – 60, 61 – 90, 91 – 120 days to combat limitations.

Significance

Homeless female veterans have the highest rate of homelessness compared to their counter parts (see U.S. Department of Veteran Affairs, 2017b). The supposition is that the high number of homeless women vets is caused by a lack of research from their input. The information obtained from homeless female veterans can lead to policies, programs, and services to reduce the high number of homeless women veterans. Furthermore, the solutions for reducing the number of homeless female vets will support the VA's goal to end homelessness among veterans.

The gender-based focus group's relation to current studies is that it is a continuum of the research. Only the homeless woman veteran can explain why she does not seek help from the VA services. Consequently, an examination of the literature and datasets could show an issue with skewed data collections that prevent program development and reduce the rates of homelessness among female veterans. Descriptive research can provide insight into what is happening in the homeless female veteran population.

A non-analytic approach could explain the homeless women veteran's experience and result in a sufficient resolution. Their specific input from research questions could be the catalyst to VA services, treatments, housing, and employment.

New policies and procedures for legislation derived from gender-specific focus groups could result in positive social change in communities. The Grant and Per Diem

(GPD) Program is an example of community-based agencies that obtain VA grants to purchase vans for outreach services (see VA.gov, 2020c). The homeless female veterans could provide input for program developments to frame in-depth outreach programs. The focus group participants could give information about homeless women veterans' locations for assistance from the VA.

A sheltered women veteran could participate in community events that she helped frame, adding her particular value to the knowledge of a personal homelessness plight. That individual's input could help reduce the high number of homeless female veterans while helping to create a community within a community of survivors.

A social change example would be Jas Boothe who experienced homelessness in 2005 as a single parent. Hurricane Katrina and a health challenge rendered her inability to deploy (see Final Salute Inc., 2018). A decision to relocate in 2006 resulted in an opportunity of full-time employment with the National Guard. The experience with homelessness led Boothe to open Final Salute Inc. in 2010 (see Final Salute Inc., 2018). She has provided services for approximately 7,000 homeless women veterans and their children in more than 30 states and territories (see Final Salute Inc., 2018).

Summary and Conclusions

The VA's appointment scheduling processes effect on the homeless women veterans' phenomenon could be the problems with the wait times for appointments. Consistency in its program updates, innovations, and measurements could add to the resolutions for lowering the high number of homeless female vets. Research inclusive of

gender-specific participation is essential for legislation, programs, policies, and procedure developments.

There may be groups of homeless women veterans in certain areas of a community who live too far from the resources needed to make an appointment with the VA or its partners. A program developed to identify these groups and reach out to help could frame strategies that are successful in problem-solving. The homeless women veteran's input could clarify problems with seeking help from the VA. Mental health issues, such as PTSD and feelings of unworthiness behavioral patterns could lead to gender-specific programs that identify interpersonal issues in individual communities.

Planning specialized transportation for that homeless female veteran who is fearful of male interactions is an example of policy development. This study focuses on the gap in research that examines the homeless women veteran's issues with scheduling appointments with the VA. The information can extend knowledge in developing programs and legislation on the local, state, and federal levels.

Studies have identified the need for more VA programs addressing homeless women veterans' necessities. However, there is a need for an ongoing regimen of homeless female veteran's studies for researchers to gather the unknown information that can help the VA with its goal to end homelessness among veterans.

An examination of the correlation between the percentages of the women veterans on the VA's EWL and the number of unsheltered women veterans who schedule appointments at the CoC office-level could show a common denominator.

Section 2: Research Design and Data Collection

This quantitative study focused on comparing values between the CoC and the EWL data. My intent was to determine if significant differences in the data could show an association between the EWL and the unsheltered homeless female veteran's phenomenon on the CoC's office level (dependent variable) and the VA's EWL (independent variable). In this section, I describe the research and design rationale and the methodology for analyzing the VA's scheduling processes at the EWL and CoC office levels.

Research Design and Rationale

Research Design

The study variables were the CoC (dependent) and the EWL (independent). The multiple regression analysis was used to predict the value of a variable based on the value of two or more other variables (see Laerd Statistics, 2018). The components of this study were the CoC data from the office level by cities from the states of Georgia and Florida. Data collections consisted of the number of homeless veterans by gender who had scheduled appointments at the CoC office levels. The EWL data's components derived from appointments scheduled from 31 to 60, 61 to 90, and 91 to 120 days. The CoC and EWL datasets were extracted from the years 2018 to 2020.

The multiple regression analysis helped provide an understanding of the VA's appointment scheduling performance. Values, such as the number of appointments scheduled per month, CoC office level scheduled appointments, and gender helped explain the variances in the datasets (see Laerd Statistics, 2018). The outcome of the

analysis helped establish an association between the VA's EWL dates and the CoC at the office levels to support the theory that the VA's appointment scheduling processes could have an effect on the homeless women veterans' phenomenon.

Rationale

The purpose of the study was to analyze the CoC's office levels (dependent variable) with the VA's EWL (independent variables from 31 to 60, 61 to 90, and 91to 120 days) datasets to determine if there was a common denominator. The EWL and CoC datasets should not show a common outcome if there is a high number of homeless women veterans. The homeless women veteran's inability to access an appointment at the VA for various reasons would affect the VA's datasets outcome.

The results could reflect variations in appointments scheduled, indicating the need for further evaluations. Moreover, the EWL (31 to 60, 61 to 90, 91 to 120) appointments scheduled could show a significant pattern. However, the CoC's datasets may not show a constant decline as years progress. The data analysis helped determine if the VA's appointment scheduling processes may affect the homeless women veterans' phenomenon. Skewed data could prevent innovative measures for lowering the number of homeless female veterans.

Methodology

Population

The target population was the unsheltered homeless veterans. They actively served in the armed forces and were discharged but did not have adequate housing. According to the PIT count in 2019, the homeless veteran’s population was 37,085. There

were approximately 14,345 documented unsheltered homeless veterans (see U.S. Department of Veteran Affairs, 2019b).

Sampling and Sampling Procedures

The sampling strategy consisted of obtaining data from two VA departments. The Department of Housing and Development (CoC) and the Office of Health Informatics (EWL). The sampling inclusion was the appointment scheduling data for the previously mentioned VA departments for the states of Georgia and Florida. The sampling exclusions were the remaining U.S. states' data.

Acquiring the data required an electronic request submitted to the Freedom of Information Act departments for each previously mentioned department within the VA (see U.S. Department of Veteran Affairs, 2021). There was no letter of permission for accessing the data requirements because it was a part of the VA's healthcare performance transparency policy (see U.S. Department of Veteran Affairs, 2018).

A power analysis determined the sample size to test the hypotheses that there is no correlation between the VA's appointments scheduling EWL and the unsheltered homeless veterans. A study using G*Power software (see Apponic, 2021) determined the sample size for research (see Faul et al., 2009).

The allocation ratio was *N*1 for the same number in each group (see Faul et al., 2009). After choosing a medium effect size (0.5) with an alpha of 0.05, a high-powered study (0.95), and the same number of participants in each group (*N*1), the sample size required was 210 participants. The power analysis justified the sample size needed to reject the hypothesis that there is no correlation between the VA's EWLs and the CoC.

The differences could support modifying the scheduling processes to include information about the veteran's desired appointment date (as cited in National Academies Press, 2018). Adding this information of days in between making the appointment and the appointment's actual date could prevent possible skewed data. Furthermore, gender-specific modifications to the VA's scheduling system could reduce the number of homeless female veterans.

Data Analysis Plan

Analyzing the datasets required software that conducts hypothesis testing showing patterns and models. The Statistical Program for Social Sciences (SPSS) software is suitable for generating predictions (see IBM, 2020). Data cleaning and screening for multiple linear regression were essential to data analysis. Consulting with the Walden statistics staff was a crucial step before data cleansing. Creating a checklist for cleaning the data ensured the omission of errors. The cleaning and screening process checked for consistencies in columns, values, duplications, and features (see Tao, 2020). Data analysis supported the hypotheses.

Research Questions

RQ1: Is there an association between the number of women and men veterans on the VA’s EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0$1: There is no association between the number of women and men veterans on the VA’s EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

H_a1: There is an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

RQ2: Is there an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0 2$: There is no association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

$H_a 2$: There is an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

RQ3: Is there an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

$H_0 3$: There is no association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

$H_a 3$: There is an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

Statistical Testing

The data for the variables derived from monthly (EWL) and yearly (CoC) intervals to test the hypotheses. The multiple linear regression analysis could explain the independent variables EWL (31to 60, 61to 90, 91to120 days) to predict the results of the CoC office-level dependent variable across time. The method was building a model through SPSS using the multiple linear regression beginning with stepwise.

The stepwise process identified predictors in sequence. The statistics included the estimates and model. The regression coefficients were confidence intervals, descriptive, part, partial correlations, and collinearity diagnostics. The Durban-Watson test predicted the residuals. The y = ZRESD and the z = ZPRED plots tested for the assumption of the heteroscedasticity and balance and strength across the board. There was a histogram and a normal probability plot for analysis (see IBM, 2019).

The independent variables (EWL: 30-60, 61-90, 91-120 days) were potential covariates because they are measurable and had a statistical relationship to the dependent variable (CoC office level). The CoC office-level data and the EWL data are in relation to appointments scheduled at the VA for services. The CoC offices are locations for VA services and could be a subsidiary providing VA services within the veteran's community.

The plots were examined for a linear relationship between the dependent and independent variables. To interpret the results, scattered plots indicated if there was a good relationship. The 1-sample K-S test predicted the hypotheses while checking for a normal multivariate. The stepwise criteria used the probability of *F* with an entry .05 and

removal of .10. The constant equation was included, and the missing values excluded cases listwise (see IBM, 2019).

Threats to Validity

There could have been threats to external validity due to generalization. Determining if this study could benefit a broader population of homeless veterans could approximate the truth of the thesis or the conclusion. The external validity could be threatened by the population's location or times of the sampling. Focusing on homeless veterans and narrowing it to homeless women veterans in Georgia and Florida could be considered bias. The locations for data extractions could be considered limited or disproportionate as homeless veterans can be located throughout the United States.

An analyst could consider the outcome of the study to derive from an unusual type of sampling. Addressing the issues with external validity would require random data extractions that include all data regarding VA appointment scheduling in Georgia and Florida. The threats to internal validity could be the history of complaints of the VA's data collection processes. Maturation of the data in which some homeless veterans received the VA's healthcare and mental health services could result in a homeless status change.

There was the threat of repetitive testing and the outcome of the testing. If the appointment scheduling instruments were to change or there were additional problems with data entries, internal validity could be threatened. If data extractions were limited to locations with the most homeless veterans, this could cause statistical regression. Bias

selection of subjects, such as gender specifics, could affect experimental mortality. Limiting data extractions to homeless female veterans could threaten validity.

Moreover, comparing old CoC and EWL data to current data could cause confusion or incorrect interpretation of the results. Threats to the construct or statistical conclusion could be the error of assumption. The inability to interpret the results of a possible association between the variables could threaten validity.

Ethical Procedures

An electronic application was emailed to the VA's Office of Health Informatics and the Department of Housing and Urban Development. Both previously mentioned entities have a Freedom of Information Act (FOIA) section within (see US Department of Veterans Affairs, 2021). Neither department required an IRB to process FOIA requests; therefore, institutional permission processes were omitted.

The secondary data did not include the identity of the participants as they showed numeric outcomes and locations. The FOIA staff from each VA department either mailed or emailed the data to me, depending on the ability to transmit. The information was privately stored and shared with Walden University's statistics staff.

Summary

The unsheltered homeless veterans were the target population for this study. Data collections derived from the CoC and the Office of Health Informatics within the VA. A power analysis determined the required sample size of 210 participants. The SPSS software showed patterns and models from the hypothesis testing. Data cleansing and screening prepared the datasets for the multiple regression analysis (see IBM.com, 2021).

The multiple linear regression analysis explained the EWL data to predict the CoC office level data across time.

The stepwise process identified predictors in sequence. The visual outcomes were formed in a histogram and a probability plot. The potential covariates are the EWL date ranges in measure and possible relationship to the CoC. External threats included population, location, or times of sampling. The internal threats were the history, maturation, testing, and instruments. Ethical procedures were addressed through the VA's FOIA department's request for data process. There were no IRB requirements. The secondary data were free of participant identities, emailed or mailed according to the file's size. The data were privately stored and shared with Walden University's staff.

Section 3: Presentation of Results and Findings

In this study, I examined the correlation between the women and men veterans on the VA's EWL and the percentages of unsheltered women and men veterans at the CoC levels. The research questions addressed a possible connection to the EWL's wait times and the phenomena of homeless women veterans.

RQ1: Is there an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020?

$H_0$1: There is no association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

H_a1: There is an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

RQ2: Is there an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020?

$H_0$2: There is no association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

H_a2: There is an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

RQ3: Is there an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020?

$H_0 3$: There is no association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

$H_a 3$: There is an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level from 2018 to 2020.

Content Organization

This section addresses the data collection's time frame, response rates, and discrepancies, inclusive of the baseline descriptive, sample demographic characteristics, and external validity. A univariate analysis, detailed statistics with a table, and a summarized answer to the research questions follow.

Data Collection of Secondary Data Set

Time Frame and Recruitment

The EWL and unsheltered veterans' data were extracted from 2018, 2019, and 2020. The EWL data derived from VA wait times for a scheduled appointment from 30 to 60, 61 to 90, 90 to 120 days were maintained by the VA's informatics division (see

VA.gov, 2020b). The VA's HUD division derived the unsheltered women and men veterans' data. The data were collected from the CoC levels yearly (see HUD User, 2020).

The recruitment and response date methods did not apply to this study because the data collection was standardized through government monitoring of VA appointment scheduling processes and HUD's record-keeping of the homeless population.

Discrepancies in Secondary Data

Secondary data sets of homeless veterans from 2018 to 2020 had some discrepancies in data entry. Data were missing for female veterans' appointments more than for male veterans (see VA.gov, 2020b). This discrepancy aligned with the history of complaints about the VA's data collections process (as cited in National Academies Press, 2018).

Another cause for data discrepancies could have been the 2020 COVID-19 pandemic affecting scheduled office appointments (see CDC, 2020). The COVID pandemic could have caused interruptions in appointment scheduling data collections. The stay-at-home orders reduced the community-level population movements. The stay-at-home strategy implemented lowered the number of cases of COVID-19 in participating states and territories (see Moreland et al., 2020). Changes in staffing and medical services at the VA could have affected patient volume and data collection.

Baseline and Demographic Characteristics

The homeless veterans and wait times were the baseline measures for a continuous outcome. The demographic characteristics were gender and location. The female and male data were extracted from the states of Georgia and Florida.

Sample Representation of Population

The data collections were derived from the Office of Government Information Services National Archives and Records Administration (EWL) and the U.S. Department of Housing and Urban Development (CoC). There were two master data files. The EWL file (Master EWL by Gender 20210112) had 727 records. The CoC file (Master 2007-2020 PIT-Estimates-by-CoC) had 1,178 records.

The G*Power analysis required a sample size of 210 participants (see Apponic, 2021). The sample size collected was 1,905, indicating there were significant data (see VA.gov, 2020b). The homeless veterans in Georgia and Florida were a representative subset of the homeless veterans in the United States population.

A random sampling of the homeless women and men veterans in Georgia and Florida represented states with a balance of high and median rates of homeless veterans. In 2020, Georgia and Florida were among the top 13 states of estimates of homeless veterans. Florida was the second-highest state, while Georgia was listed as number 13 (see Statista, 2020).

Statistical Fidelity and Categorization of Variables

To analyze the data, I used the SPSS software Version 28 (see IBM.com, 2020). I filtered the 1,905 data set from the EWL and the CoC to include only data from Florida

and Georgia for 2018, 2019, and 2020. Each year rendered nine CoC locations for female veterans and nine locations for male veterans. The final sample size was $N = 324$.

After filtering the data, I renamed the file EWL CoC Final.sav. I used multiple linear regression to analyze the data and the three research questions. The multiple regression analyses could show the strength of the relationship between the dependent variable and the independent variables. The variable labels, definitions, and measures are listed in Table 1.

Table 1

Variables and Definition

Variable label	Definition	Measure
Report date	Year	Nominal
Facility	Location	Nominal
Gender	Female / Male	Nominal
Wait time	< 14 days from preferred appointment date	Scale
Wait time	15-30 days from preferred appointment date	Scale
Wait time	31-60 days from preferred appointment date	Scale
Wait time	61-90 days from preferred appointment date	Scale
Wait time	91-120 days from preferred appointment date	Scale
Wait time	>than 120 days from preferred appointment date	Scale
PctLT15	Unsheltered homeless veterans	Scale
Pct30	Unsheltered homeless veterans	Scale
Pct60	Unsheltered homeless veterans	Scale
Pct90	Unsheltered homeless veterans	Scale

Pct120	Unsheltered homeless veterans	Scale
PctGT120	Unsheltered homeless veterans	Scale

Table 2 shows the recoded variables.

Table 2

Recoded Variables

Variable labels	New code	Measure
Wait times		Nominal
<14	1	Nominal
15 – 30	2	Nominal
31 – 60	3	Nominal
61 – 90	4	Nominal
91 – 120	5	Nominal
>120	6	Nominal
Gender		
Female	0	Nominal
Male	1	Nominal
Homeless vets	Pct	Scale

Note. These variables were recoded to reassign their values for analyses.

Results

Multiple Regression Analyses

In this study, I examined the association between the number of women and men veterans on the EWL and the percentage of homeless veterans on the CoC levels in Florida and Georgia for the years 2018, 2019, and 2020. The hypothesis was that there may be a connection between the homeless women veterans phenomenon and the VA's appointment scheduling processes. An examination of the wait times for appointments at the VA in 30-day increments could determine a significant correlation with the percentage of homeless veterans. I used multiple linear regression to predict the outcome of the dependent variable (unsheltered homeless veterans) while comparing multiple independent variables (EWL).

Frequency Tables

Table 3 gives the statistics.

Table 3

Statistics

		Wait Time	Gender	Facility
N	Valid	324	324	324
	Missing	0	0	0

Note. The sample size of this study was (N = 324). The wait times were for female and male veterans' appointments at the VA in Florida and Georgia.

Table 4 illustrates the wait time.

Table 4

Wait Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<14	54	16.7	16.7	16.7
	>120	54	16.7	16.7	33.3
	15-30	54	16.7	16.7	50.0
	31-60	54	16.7	16.7	66.7
	61-90	54	16.7	16.7	83.3
	91-120	54	16.7	16.7	100.0
	Total	324	100.0	100.0	

Note. The wait times were analyzed from < 14 (constant) to >120 days in 30-day increments. There were six data entries for each of the nine CoC facilities in Florida and Georgia.

Table 5 shows the gender.

Table 5

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	F	162	50.0	50.0	50.0
	M	162	50.0	50.0	100.0
	Total	324	100.0	100.0	

Note. $N = 324$ ($n = 162$ for each wait time). There were 50% female and 50% male data extractions from the Florida and Georgia facilities.

Table 6 shows the facility.

Table 6

Facility

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Atlanta	36	11.1	11.1	11.1
	Augusta	36	11.1	11.1	22.2
	Bay Pines	36	11.1	11.1	33.3
	Dublin	36	11.1	11.1	44.4
	Gainesville	36	11.1	11.1	55.6
	Miami	36	11.1	11.1	66.7
	Orlando	36	11.1	11.1	77.8
	Tampa	36	11.1	11.1	88.9
	West Palm Beach	36	11.1	11.1	100.0
	Total	324	100.0	100.0	

Note. *N* = 324 (n = 36 wait time increments). The data were evaluated from nine VA facilities.

Regression Analysis Results

Table 7 shows the descriptive statistics.

Table 7

Descriptive Statistics

	Mean	Std. Deviation	N
PCT	.1777	.21823	324
Wait_Time=15-30	.1667	.37325	324
Wait_Time=31-60	.1667	.37325	324
Wait_Time=61-90	.1667	.37325	324
Wait_Time=91-120	.1667	.37325	324
Wait_Time=>120	.1667	.37325	324
Gender_Recode	.5000	.50077	324

Note. The PCT (homeless veterans), wait time increments, and gender were evaluated for value in data distribution.

Table 8 shows the residual statistics.

Table 8

Residuals Statistics

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	.0800	.2983	.1777	.06708	324
Residual	-.29833	.82000	.00000	.20766	324
Std. Predicted Value	-1.456	1.799	.000	1.000	324
Std. Residual	-1.425	3.918	.000	.992	324

Note. The EWL and the percentage of homeless veterans were evaluated for distribution.

Figure 1 shows the scatter plot of PCT by *N*

Figure 1

Scatter Plot of PCT by N

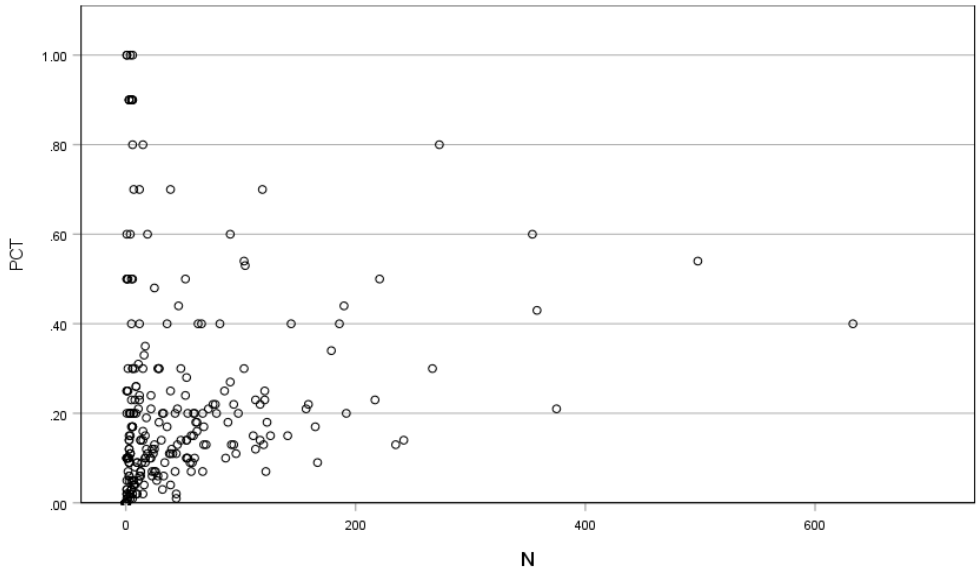


Table 9 shows the correlations.

Table 9

Correlations

			PCT	N	Gender_Recode
Spearman's rho	PCT	Correlation Coefficient	1.000	.634**	.121*
		Sig. (2-tailed)	.	<.001	.029
		N	324	324	324
	N	Correlation Coefficient	.634**	1.000	.583**
		Sig. (2-tailed)	<.001	.	<.001
		N	324	324	324
	Gender_Recode	Correlation Coefficient	.121*	.583**	1.000
		Sig. (2-tailed)	.029	<.001	.
		N	324	324	324

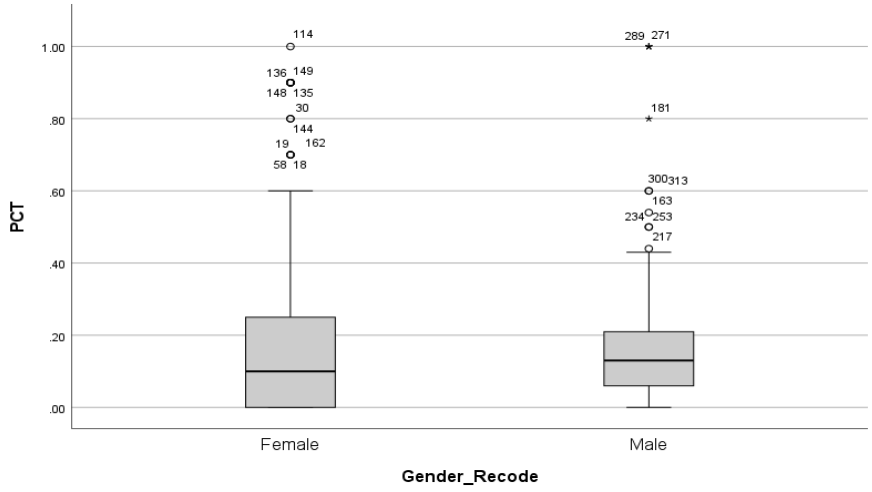
Note. The results show the correlation between the PCT of homeless veterans at the CoC level *n* = .634**. The gender data were at .121* with a *p*-value of .029. The wait times were correlated as *n* =.583**, with a *p*-value of 1.0.

**p* < .05, two-tailed. ***p* < 0.1, two-tailed.

Figure 2 shows the PCT, and gender recode boxplot

Figure 2

PCT and Gender Recode Boxplot

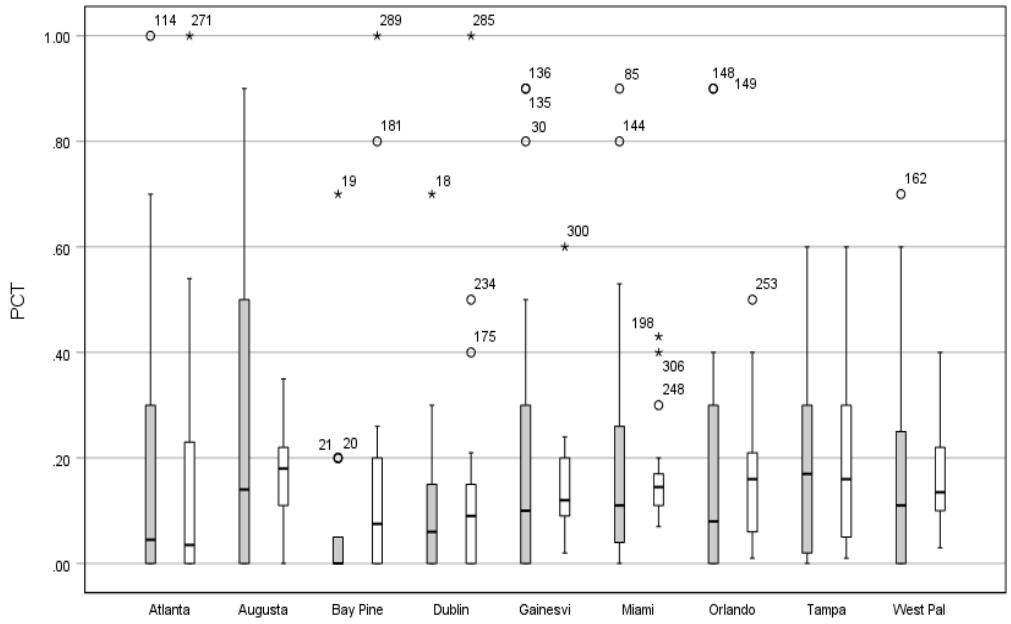


Note. The male and female CoC appointment placements.

Figure 3 shows the VA facilities in Florida and Georgia.

Figure 3

VA Facilities in Florida and Georgia



Note. The nine VA facilities show the PCT appointment placements. The gray represents the female veterans, and the white represents the male veterans.

Table 10 shows the model summary.

Table 10

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.307	.094	.080	.20928	.094	6.637	5	318	<.001

Note. The percentage of variance (R^2 = .080) with a significance of < .001 indicates the model's status.

Table 11 shows the ANOVA.

Table 11

ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.454	5	.291	6.637	<.001
	Residual	13.928	318	.044		
	Total	15.382	323			

Note. The *p*-value (6.637) shows the correlation between the wait times and the PCT.

Table 12 shows the coefficients.

Table 12

Coefficients

		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
Model		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
1	(Constant)	.298	.028		10.475	<.001	.242	.354
	Wait_Time=15-30	-.133	.040	-.227	-3.301	.001	-.212	-.054
	Wait_Time=31-60	-.102	.040	-.175	-2.543	.011	-.182	-.023
	Wait_Time=61-90	-.166	.040	-.284	-4.124	<.001	-.245	-.087
	Wait_Time=91-120	-.218	.040	-.373	-5.421	<.001	-.298	-.139
	Wait_Time=>120	-.104	.040	-.178	-2.589	.010	-.184	-.025

Note. The (constant) < 14 days was used as a reference for comparison to the wait times variables.

[a]Approximately 30% of veterans waited < 14 days for an appointment at the VA. Ten percent waited 31 to 60 and >120 days. While approximately 17% waited 61 to 90 days, and 22% waited 91 to 120 days.

[b]Values reflect 30-day increments across three years of data.

Statistical Assumptions Evaluation

The assumption was that the data would show a connection between appointment wait times and the percentage of homeless veterans. The number of wait times would result in standard deviations of the mean, and the residual values would equal zero. The homogeneity data samples were derived from homeless veterans seeking to make appointments at the VA. They were on the wait list in 30-day increments in 2018, 2019, and 2020. The scatter plot would present a linear relationship between wait times and the number of homeless veterans, excluding distinct horizontal patterns in the total number of samples. Sample sizes equaled the total number of group subjects, resulting in independent samples.

Statistical Analysis

The multiple linear regression model was used to determine if there was an association between this study's variables addressing the three research questions.

RQ1: Is there an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

H_o1: There is no association between the between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

H_a1: There is an association between the number of women and men veterans on the VA's EWL from 31 to 60 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

The 31 to 60 days wait time was associated with the PCT. The sample size was (N = 324). The terms were well fitted to the horizontal line in the scatter plot (see figure 1). The *p-value* was (6.637), the significance was (<.001) the 95% CI [18.2, 02.3], showing a difference in the wait times and PCT. The 31 to 60 days showed that for every unit increase in wait times, compared to the < 14 days constant (29.8%), there was a 13.3% decrease in lower appointment placements. Therefore, the null hypothesis was rejected.

*RQ*2: Is there an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020?

H_o2: There is no association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

H_a2: There is an association between the number of women and men veterans on the VA's EWL from 61 to 90 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

The 61 to 90 days wait time was associated with the PCT. The sample size was (N = 324). The terms were well fitted to the horizontal line in the scatter plot (see figure 1). The *p-value* was (6.637), and the significance was (<.001), the 95% CI [24.5, 08.7], showing a difference in the wait times and PCT. The 61 to 90 days showed that for every

unit increase in wait times, compared to the < 14 days constant (29.8%), there was a 16.6% decrease in lower appointment placements. Therefore, the null hypothesis was rejected.

*RQ*3: Is there an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC level in Florida and Georgia from 2018 to 2020?

H_o3: There is no association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

H_a3: There is an association between the number of women and men veterans on the VA's EWL from 91 to 120 days and the percentage of unsheltered homeless women and men veterans at the CoC office level in Florida and Georgia from 2018 to 2020.

The 91 to 120 days wait time was associated with the PCT. The sample size was (N = 324). The terms were well fitted to the horizontal line in the scatter plot (see figure 1). The *p-value* was (6.637), and the significance was (<.001) the 95% CI [29.8, 13.9], showing a difference in the wait times and PCT. The 91 to 120 days showed that for every unit increase in wait times, compared to the < 14 days constant (29.8%), there was a 21.8% decrease in lower appointment placements. Therefore, the null hypothesis was rejected.

Results and Findings Summary

The research questions examined the association between the number of women and men veterans on the VA's EWL from 31 to 120 days and the PCT of unsheltered

homeless women and men veterans at the CoC office levels in Florida and Georgia from 2018 to 2020. A multiple linear regressions test evaluated the 31 to 60, 61 to 90, and 91 to 120 day wait times to measure the PCT for each increment. The constant of < 14 days was used to compare with each 30-day increment group. There was a 13.3% decrease in the VA's appointment placements at 31 to 60 days compared to the < 14 days constant, a 16.6% decrease in appointment placements at 61 to 90 days compared to the < 14 days constant, and a 21.8% decrease in appointment placements at 91 to 120 compared to the < 14 days constant. The association between the dependent variable and the independent variables rendered a statistically significant difference as the mean was (6.637) and the significance were (< .001), and the 95% CI was [18.2, 02.3]. Therefore, the null hypothesis was rejected. The VA's appointment scheduling processes have been the subject of modifications, change, and innovation for years. This study identified Augusta Georgia, Tampa, and West Palm Beach in Florida as facilities with the most appointment placements. These CoCs could aid in the innovative professional development of programs that support social change for homeless veterans.

Section 4: Application to Professional Practice and Implications for Social Change

In this study, I aimed to examine the VA's appointment scheduling wait times to determine an association with PCT. The research stemmed from the homeless women veterans' phenomenon and the connection to scheduling an appointment at the VA. There was an association between the wait times and PCT as the data analysis rendered a statistically significant correlation. Professional developments and social change could derive from the facilities in Florida and Georgia, where most appointment placements occurred.

Key Findings

The multiple linear regression results were statistically significant. There was an association between the VA's wait times and the PCT. The wait times were analyzed in 30-day increments (31to 60, 61 to 90, 91 to 120) using < 14 days as the constant. The veterans had to wait the least time in < 14 days (29.8%) and 91 to 120 days (21.8%). Veteran's wait time increased between 61 to 90 days (16.6%), while the most wait time for an appointment was between 31 to 60 days (10.2%). The VA facilities in Augusta Georgia, Tampa, and West Palm Beach, in Florida, showed the most appointment placements from 2018 to 2020 for female and male veterans.

Interpretations of the Findings

In this study, I aimed to determine if the EWL and CoC data sets of women and men veterans from Florida and Georgia would depict a common denominator or a difference in direction. The analysis addressed the association between the number of veterans of women and men on the VA's EWL in 30-day increments and the percentage

of homeless women veterans in 2018, 2019, and 2020. The multiple linear regression analysis of the dependent and independent variables showed common traits in the data. The data had shown that the placement for male veterans was slightly higher than for female veterans in Figure 2 of the PCT and gender boxplot. Moreover, the data showed the wait times for appointment placements were statistically significant in the variable's association. Wait times decreased more for < 14 days and 91 to 120 days. The longer wait times were between 31 to 60 days and 61 to 90 days.

Theoretical and/or Conceptual Framework Analysis

Elberg et al. (2000) began the study of psychosocial models examining vulnerable populations. Homeless veterans are a health disadvantaged group, and the homeless women veterans are within the vulnerable population. Elberg et al. (2000) reviewed community resources, prompting more in-depth analysis. Barriers to scheduling appointments at the VA drove the investigation of data collection and entries issues by the National Academies Press (2018). Carusa (2018) discussed the possibilities of hidden numbers of homeless female veterans. Other authors studied focus group data to determine why the women veterans were not scheduling or maintaining appointments at the VA (Carusa, 2018). In this study, I questioned the connection between the homeless women veteran's phenomenon and the VA's appointment scheduling processes. The focus was on wait times for appointments to determine if there was an effect on the number of homeless women veterans. The findings were able to reject the null hypotheses.

Limitations of the Study

The limitation to generalizability in this study was the inability to study the entire homeless veteran population. Narrowing down the secondary data to two states could have affected the data's trustworthiness to explain the effect of the VA's appointment scheduling processes on other states. The validity of the data had limitations because it was collected by the VA's departmental staff and not the primary users. Reliability could have also been challenged because it was initially collected by appointment scheduling staff, questioning data accuracy. There was a lack of previous research on studies regarding the effect of scheduling appointments at the VA on homeless women veterans. Previous studies addressed hidden numbers of homeless female veterans, their challenges with mental issues that hindered scheduling appointments, or general research on only women veterans who scheduled appointments at the VA. The processes used to collect the data were not consistent by each facility, causing problems with correct data entry within the VA's system. Time constraints in retrieving the data sets also affected the limitations of this study as data availability was interrupted by the methodology collection processes.

Recommendations

The results of this study revealed a relationship between the dependent variable and the independent variables. However, the rank-order results indicated that the Augusta Georgia, Tampa, and West Palm Beach in Florida, facilities had the highest appointment placements for veterans during test ranges. Further research into appointment scheduling methods at the Augusta Georgia, Tampa, and West Palm Beach in Florida, locations

could be used to improve appointment scheduling processes at other CoC locations. A broader approach to the VA's appointment scheduling processes could include fact-finding focus groups with homeless women veteran participants in the communities. The homeless women veterans could provide information during the focus groups that lead to creating and implementing innovative measures toward housing and employment for homeless women veterans.

Implications for Professional Practice and Social Change

Professional Practice

The homeless female veteran is a part of the vulnerable population with health, mental health, and economic disadvantages. Considering former research suggesting that there could be hidden numbers of homeless women veterans, studies leading to increased professional practices should continue. Researchers must continue to find and help the homeless female veterans. Focus group enhancements could collect data from local, state, and government levels. Professional practice should begin with local discovery, identifying where most homeless women survive and starting the process with discussions. Developing a rapport through assistance could lead to trust and lifestyle management. The data collected from the close encounters could aid in the development of customized policies and procedures that address health, mental health, and the economic issues causing homelessness. Creating homeless women veterans' focus groups on the local level could enhance knowledge about which prevention methods are the right fit for professional practice supporting positive change in the community.

Social Change

One's self-actualization can be a powerful force in lifestyle management. At times, people need assistance with realization and actions toward positive social change. The cycle begins with the individual and continues with sharing the knowledge. Some homeless female veterans may have offspring who can learn from their journey because of sharing. When the homeless women veteran reaches the level of gaining healthcare, mental healthcare, and housing, she can become the value a community and organization seeks. Further studies can provide insight into how data collections from homeless women veterans during VA appointments can support policies and society. Identifying and lowering the possible hidden number of homeless female veterans could add value to a community's operations.

Conclusion

The results of this study allowed for the rejection of the null hypothesis. There was an association between the number of homeless women and men veterans on the VA's EWL from 30 to 60 to 90-day increments and the percentage of unsheltered women and men veterans. The rank correlation showed a statistical significance in data association. Wait times for VA appointments were decreasing for each 30-day increment whereas veterans waited more for the 31 to 60 day and 61 to 90 day appointments. Further studies should include additional research into appointment scheduling methods fact-finding using homeless female veteran's focus groups. The Augusta Georgia, Tampa, and West Palm Beach in Florida facilities could provide the foundation for researching appointment scheduling methods. This study identified the Augusta Georgia

Tampa, and West Palm Beach in Florida facilities as an example of positive change in reducing veteran homelessness through scheduling processes. Knowledge gained through this study supports continuous measures for in-depth research. Examination of local CoC facilities with high numbers of VA appointments and lower numbers of homeless veterans could increase knowledge and policy and procedure developments with scalable professional practices. Finally, reducing the number of homeless veterans could add value to local communities and a positive social change.

References

Absher, J. (2018). Female Veterans Are Fastest Growing Segment of Homeless Veteran Population. *Military.com.* https://https://www.military.com/militaryadvantage/2018/03/28/female-veterans-are-fastest-growing-segment-homeless-veterans.html

Annual Homelessness Assessment Report. (2018). *Part 1 – PIT estimates of homelessness in the U.S. – HUD exchange. Hudexchange.info*. https://www.huduser.gov/portal/sites/default/files/pdf/2018-AHAR-Part-2.pdf

Altarum Institute. (2015). *Study of barriers for women veterans to VA health care*. https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf

Apponic. (2022). *G*Power software*. https://www.statista.com/statistics/727819/number-of-homeless-veterans-in-the-us-by-state/

Bleiwels, R., Boesch, D., & Cawthorne Gaines, A. (2020). The basic facts about women in poverty. https://www.americanprogress.org/article/basic-facts-women-poverty/

Byrne, T., Montgomery, A. E., & Dichter, M. E. (2013). Homelessness among female veterans: A systematic review of literature. *Women & Health, 53*(6), 572-596. https://doi.org/10.1080/03630242.2013.817504

Casura, L. (2018, July 9). Hidden numbers: *Why far more women veterans may be homeless than you realize. Medium*. https://medium.com/@lilygc/hidden-numbers-more-women-veterans-may-be-homeless-than-you-realize-21c00f42179d

Centers for Disease Control and Prevention. (2020). *Timing of state and territorial covid-19 stay-at-home orders and changes in population movement-United States, March 1-May 31, 2020*. https://www.cdc.gov/mmwr/volumes/69/wr/mm6935a2.htm

Cheney, A. M. (2006 - 2022) https://www.meta-analysis.com/pages/why_do.php?cart=

Choice Act Summary. (2014). Veterans access, choice and accountability act of 2014. US Department of Veteran Affairs. https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf

Danan E, Ensrud K, Krebs E, et al. An Evidence Map of the Women Veterans' Health Research Literature (2008 – 2015) [Internet]. Washington (DC): Department of Veterans Affairs (US); 2017 Jul. https://www.ncbi.nlm.nih.gov/books/NBK487713/

Data.gov(2020). Data catalog. https://catalog.data.gov/dataset?publisher=Department%20of%20Veterans%20Affairs

Data Catalog. (2019*). VHA support service center electronic wait list (EWL)*. https://catalog.data.gov/dataset/vha-support-service-center-electronic-wait-list-ewl

Department of Veterans Affairs Office. (2002). Scheduling and primary care management module (PCMM). *Enterprise Development Management, Enrollment, Financial Systems.* https://www.va.gov/vdl/documents/Clinical/Electronic_Wait_List/ewl_um.pdf

Department of Veteran Affairs. (2014). Veterans health administration review of alleged patient deaths, patient wait times, and scheduling practices at the Phoenix VA health care system. *VA Office of Inspector General.* https://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf

Elberg, L., Andersen, R. D., & Leake, B. (2000). The behavioral model for vulnerable populations: Application to medical care use and outcomes for homeless people. *Health Services Research, 34,* 1273-1302.

Farmer, C. M., Hosek, S. D., & Adamson, D. M. (2016). Balancing demand and supply for veterans' health care: A summary of three RAND assessments conducted under the Veterans Choice Act. *Rand Health Quarterly*, 20; *6*(1):12.

Farmer, C. M., & Tanielian, T. (2019). Ensuring access to timely, high quality health care for veterans. *Rand Corporations*. https://www.rand.org/content/dam/rand/pubs/testimonies/CT500/CT508/RANDCT508.pdf

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41,* 1149-1160. https://doi.org/10.3758/brm.41.4.1149

Final Salute Inc. (2018). *To provide homeless women veterans with safe and suitable housing*. https://www.finalsaluteinc.org/Founder.html#

HUD Exchange. (2020). 2020 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. https://www.hudexchange.info/resource/6291/2020-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

HUD User. (2020). Office of policy development and research. https://www.huduser.gov/portal/home.html

IBM. (2019). IBM SPSS statistical software. Retrieved from, https://www.ibm.com/products/spss

IBM.com. (2020). SPSS software analytics. https://ibm.com/analytics

IBM.com. (2021). Cleaning data. https://www.ibm.com/docs/sv/spss-modeler/SaaS?topic=preparation-cleaning-data

Kaboli, P., J., Fihn, S., D. (2019). Waiting for care in Veterans Affairs health care facilities and elsewhere. JAMA Network. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720912

Kelley, A. T., Greenstone, C. L., & Kirsh, S. R. (2019). Defining access and the role of community care in the Veterans Health Administration. *Society of General Internal Medicine*. https://link.springer.com/content/pdf/10.1007/s11606-019-05358-z.pdf. doi: 10.1007/s11606-019-05358-z

Kim, J. C., Matto, M, & Kristen, E. (2020). Safer housing for homeless women veterans. American academy of psychiatry and the law. http://jaapl.org/content/early/2019/06/11/JAAPL.003854-19

Koblinsky, S. A., Schroeder, A. L., & Leslie, L. A. (2017) "Give us respect, support and understanding": Women veterans of Iraq and Afghanistan recommend strategies for improving their mental health care, Social Work in Mental Health, 15:2, 121-

Koenig, C. J., Miller, C. J., Zamora, K., Wright, P., Stanley, R., Pyne,J. M. (2018). Veteran-centered barriers to VA mental healthcare services use. *BMC health*

services research, 18(1), 591. https://doi:10.1186/s12913-018-3346-9

Laerd Statistics. (2018). Multiple regression analysis using SPSS statistics. https://statistics.laerd.com/spss-tutorials/multiple-regression-using-spss-statistics.php

Miake-Lye et al. (2016). What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. Systematic Reviews. https://doi: 10.1186/s13643-016-0204-x

Montgomery, E. (2019). VA Research reveals circumstances that can lead to Homelessness among women Veterans. VAntage Point. https://www.blogs.va.gov/VAntage/73113/va-research-reveals-circumstances-can-lead-homelessness-women-veterans/

Moreland, A, Herlihy, C., Tynan, MA, et al. (2020). Timing of state and territorial covid-19 stay-at-home orders and changes in population movement-United States, March 1-May 31, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1198-1203. doi:http://dx.doi.org/10.15585/mmwr.mm6935a2external icon

National Academies Press (US). (2018). Washington (DC): Timely Access to Mental Health Care. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. Evaluation of the Department of Veterans Affairs Mental Health Services. https://www.nap.edu/read/24915/chapter/11

National coalition for homeless veterans. (2017). Background and statistics.

http://nchv.org/index.php/news/media/background_and_statistics/#facts

NVTC report. (2014). An opportunity to improve the scheduling of medical exams for American veterans. https://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf

Nyumba, T.O., Wilson, K., Derrick, C.J., & Mukherjee, N. (2018). The use of focus group discussion methodology: Insights from two decades of application in conversation. *British Ecological Society*. https://besjournals.onlinelibrary.wiley.com/doi/full/10.1111/2041-210X.12860

O'Hanlon, C., Huang, C., Sloss, E., Anhang Price, R., Hussey, P., Farmer, C., & Gidengil, C. (2017). Comparing VA and Non-VA Quality of Care: A Systematic Review. *Journal of general internal medicine*, *32*(1), 105–121. https://doi:10.1007/s11606-016-3775-2

O'Toole, T. P. (2015, November - December). Innovative efforts to address Homelessness Among veterans. *North Carolina Medical Journal*, *76*(5), 311-314. https://doi: 10.18043/ncm.76.5.311

PCORI. (2011-2019). Evidence Maps and Evidence Visualizations. https://www.pcori.org/research-results/evidence-synthesis/evidence-maps-and-evidence-visualizations

Rand Corporation. (1994-2020). About the Rand Corporation. https://www.rand.org/about.html

Richman, M. (2018a). US Department of Veteran Affairs. Homeless women vets 'flying

under the radar.' https://www.research.va.gov/currents/0318-Female-Veterans-comprise-fastest-growing-segment-of-homeless-Veteran-population.cfm

Richman, M. (2018b). US Department of Veteran Affairs. Female Veterans comprise fastest-growing segment of homeless Veteran population. https://www.research.va.gov/currents/0318-Female-Veterans-comprise-fastest-growing-segment-of-homeless-Veteran-population.cfm

Rural Health Information HUB (RHI). (2021). Rural veterans and access to healthcare. https://www.ruralhealthinfo.org/topics/returning-soldier-and-veteran-health

Shinseki, E. K. (2016). *U.S. Department of Veterans Affairs*. National Summit on Homeless Veterans. https://www.va.gov/opa/speeches/2009/09_1103.asp

Shane III, L. (2018). *Militarytimes*. Fewer veterans were homeless in 2018, after a worrisome rise last year. https://www.militarytimes.com/news/2018/11/01/after-a-worrisome-rise-last-year-the-number-of-homeless-veterans-dropped-in-2018/

Statista. (2020). Estimated number of homeless veterans in the United States in 2020, by state. https://www.statista.com/statistics/727819/number-of-homeless-veterans-in-the-us-by-state/

Tao, (2020). Data cleansing – where to start? Towards Data Science. https://towardsdatascience.com/data-cleansing-where-to-start-90802e95cc5d

Tsai, J., Mota, N. P., & Pietrzak, R. H. (2015). Psychiatric Services. U.S. Female Veterans Who Do and Do Not Rely on VA Health Care: Needs and Barriers to Mental Health Treatment. American access Psychiatric Association. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400550

US Department of Veteran Affairs. (2014). Choice act summary. Office of Public Affairs. https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf

US Department of Veteran Affairs. (2021). Freedom of information act FOIA. https://va.gov/foia/request.asp

US Department of Veteran Affairs. (2017a). Women veterans healthcare. https://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/about.asp

US Department of Veteran Affairs. (2017b). Women veterans health care. https://www.womenshealth.va.gov/WOMENSHEALTH/programoverview/about.asp

US Department of Veteran Affairs. (2019a). Background on VHA's National Center on Homelessness Among Veterans (the Center). https://www.va.gov/homeless/nchav/about-us/background.asp

US Department of Veteran Affairs (2019b). Point-in-Time count. https://www.va.gov/HOMELESS/pit_count.asp

US Department of veteran affairs. (2018). VA transparency. https://www.va.gov/transparency/

US Government Accountability Office *(GAO).* (2019). Veterans health care. https://www.gao.gov/assets/710/700431.pdf

US Senate Committee on Veteran's Affairs. (2018). The VA Mission Act of 2018. https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf

VA.gov. (2020a). Management and oversight of the electronic wait list for health care services. VA, OIG. https://www.va.gov/oig/pubs/VAOIG-19-09161-02.pdf

Va.gov. (2020b). Public data pending appointments. https://www.va.gov/HEALTH/docs/DR139_042020_PublicData_PendingAppointments.pdf

VA.gov. (2020c). Grant and Per Diem (GPD) Program. https://www.va.gov/homeless/for_women_veterans.asp

Veterans Administration. (2017). Women veterans report. https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf