

Ryan White Title I Needs Assessment 2001

Survey of the Unconnected



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Survey of the Unconnected

Background

As Ryan White programs mature and increase efforts to adapt to the changing nature of the epidemic, concerns have expanded from providing services to those who present for them, to moving out into communities in search of HIV positive people not receiving medical care. While increasing emphasis is placed on getting those people into care, efforts to identify, describe, and connect this group to care are just beginning.

Finding the unconnected is a challenge. People are unconnected for many reasons, including lack of access to services, lack of knowledge of services, the inability to connect and remain connected in any meaningful way, and by choice (some simply do not want to use the medical care system). Barriers to connectedness also include substance abuse and mental illness. In communities such as Miami-Dade County, free medical care for HIV is widely available. While the medical care system for HIV possesses many of the virtues and vices of the entire medical care community, the care is there. The community is now challenged to find and serve those not receiving HIV care, the most difficult group.

There have been few formal efforts to find, enumerate and describe the unconnected. The earliest one identified by the Miami-Dade HIV/AIDS Partnership was conducted in New York City by the Columbia University School of Public Health. The results of the first study were published in a technical report in 1996. A follow-up study was reported in 1999. A recent assessment of those not in care in Seattle found that people remained outside the service system because they wanted to, not because they lacked access to care.¹

In 2001, the Miami-Dade County HIV/AIDS Partnership, as part of its annual needs assessment, undertook a project to identify who and where the unconnected are, and barriers to entering into care. The study was very much an experiment in finding people, asking them questions and making sense of the results. Efforts will continue during the coming year. This report describes what is known about the “unconnected,” discusses the methodology used, and presents findings and suggestions for further studies.

What is being studied?

A recent report of a conference call held by HRSA defined the unconnected as those who are not currently receiving HIV-related medical care. A Columbia University study² suggested a somewhat broader definition, being outside or marginal to the service delivery system. They further defined the population as aware of their HIV status, having no regular source of medical care for HIV, and not receiving case management services. They could have received sporadic or urgent care, or been treated for mental health or substance abuse issues. Some unconnected people may have been connected at some point but are now unconnected. Others may use medical care in acute care emergencies but not for HIV.

Such people are considered “hidden” and “hard to reach,” often living marginalized existences, with unstable living arrangements and other problems. As by definition this population is hidden, it is difficult to count how many there are or to describe them. The Centers for Disease Control suggests a breakdown of people with HIV/AIDS that can provide a hint as to numbers. One-third of the HIV/AIDS population has AIDS, one-third is positive but undiagnosed and therefore not seeking care, and one-third are HIV-positive and know it. It is among this latter group, those who know they are positive, as well as those with AIDS, that one would look for the unconnected. Numbers can then be estimated using the same methodology as Miami-Dade County uses to measure unmet need. The number in care is estimated, and this number is subtracted from the number with AIDS and those who know they are HIV-positive; the difference is the unmet need. If one is sure there are few to no access barriers in the community, then estimates of the unconnected can be developed. They will by necessity be rough ones.

What is known about why people are unconnected?

Insurance Status, Poverty and Immigration

People remain outside the health care system, or unconnected from it, for a variety of reasons. These include lack of means to pay for care, suspicion of the system, personal inability to comply with medical care, and a belief that medical care is not needed except in an emergency.

Lack of health insurance is a major obstacle to becoming and remaining connected to health services. Nationally, 18 percent of the population under age 65 lacks health insurance.³ Of the uninsured, the Kaiser study found, 74 percent said they could not afford insurance, and 19 percent reported they didn't need insurance. The uninsured are less likely than others to seek care, including prenatal and preventive care, as well as treatment for chronic conditions. The majority of the uninsured are the working poor and their children.

A statewide survey of Floridians in 1999 showed that 16.8 percent lacked health insurance.⁴ However, in Miami-Dade County the rate of uninsured climbed to 25 percent of the under-65 population. The Health Insurance Study reported uninsurance rates by zipcode. In those marked by extreme poverty and high rates of HIV/AIDS, the rates of uninsured reached nearly 40 percent; the rate went as high as 43 percent in one area of South Miami-Dade County.⁵

Income concerns are compounded by the high number of undocumented immigrants living in the County. Miami-Dade County has 2.25 million people, 45 percent of whom are foreign born. An estimated 18 percent are non-citizens (about 400,000), according to the Kaiser Commission on Medicaid and the Uninsured.⁶ A significant but unknown number of these are undocumented, meaning they are in the U.S. illegally. Non-citizens are more likely to be poor than citizens, with 34 percent below the Federal poverty level compared with 20 percent of the total county population. Further, 42 percent of non-elderly non-citizens lack health insurance. For the undocumented, the figures are even worse.

Immigrants were found by the Kaiser report to be likely to delay care, avoid treatment altogether, and use

alternative, “underground” forms of treatment. At times, the publicly funded medical care facility in Miami-Dade has declined to treat undocumented immigrants, leaving them completely without a safety net of care. Language and illiteracy are barriers in many instances, although most publicly funded medical care providers have at least Spanish-language capability, if not the accent of the patient’s own country. The Haitian population suffers the most from language barriers.

Race and ethnicity also bear on whether people seek medical care. Issues such as cultural competence, alienation from medical professionals and the system, and racial and ethnic disparities also present barriers to medical care. A Kaiser Family Foundation study of attitudes among various racial and ethnic groups identified some barriers to access as perceived by these groups.⁷ They included the perceptions that people with money and insurance have better access, that health care providers lack concern and empathy, that they hold negative stereotypes of minority patients, and that they had been discriminated against because of health insurance coverage, age, gender and where they lived.

The Unconnected in the HIV/AIDS Population

It can be expected that people with HIV/AIDS face some of the same barriers as those without the disease, at least in terms of attitudes toward the medical profession and the medical profession’s attitudes toward them. Major societal barriers to care have been removed from large segments of the population with HIV. Lack of insurance has ceased to be a major barrier for most of the population with HIV/AIDS in Miami-Dade County due to the Ryan White CARE Act program, which pays for medical care, prescription drugs, and other services for people below 300 percent of the Federal Poverty Level. This program can serve those who are in the country illegally as well as others who lack other sources of health care coverage. Concerns remain over attitudes and cultural sensitivity of professionals.

What remains for this population is largely a set of internal barriers (in addition to the elements of discrimination described above). One of the few studies of people with HIV who are “unconnected” is a two-phase project by the Columbia University School of Public Health. They attempted to identify and interview HIV positive individuals in New York City who know their status and are outside or marginally integrated into the service delivery system. The study defined unconnected as those who had been aware of their status for at least three months, had no source of regular medical care for HIV and no HIV case management services.⁸

The first study was reported in 1996, and the second in 1998.⁹ The researchers recruited participants for the first study through acquaintance sampling (asking participants if they knew of anyone who was HIV positive) and street outreach. They screened about 150 individuals, and only 46 met their requirement for unconnectedness.

In comparing the unconnected to a larger population receiving medical care, the study documented several things. Among the unconnected sample the majority were extremely poor, with a median household income of \$6,875. Many had unstable living arrangements and lived in hotels or the streets. Also, the unconnected population are more likely than the connected to be drug users and to be at an earlier stage of HIV

infection. The unconnected showed higher rates of heroin, cocaine and alcohol use, and often engage in risky sexual behaviors. Most had never been in drug treatment. They showed a higher rate of engaging in risky sexual behaviors. Finally, the unconnected were more likely to have serious mental health problems.

The first study relied on the relationship approach, while the second study relied on an “ethnographic” approach of going to locales where high-risk populations were known to congregate, such as soup kitchens, shooting galleries and sex worker areas. After intensive efforts involving several researchers and interviewers, small numbers of people were identified and interviewed.

The conclusion drawn from the Columbia University study was that fewer people remain outside of the system of care once they knew their status. However, there remains a group of unconnected who are extremely hard to reach even with aggressive street outreach. The 1998 unconnected individuals were more likely than the earlier group to report their first experience with the system of care in prison and drug treatment centers. It also appeared that it was even harder to reach the currently unconnected because of client characteristics and barriers such as homelessness, chemically addicted and seriously mentally ill among the unconnected.

The first study identified 46 eligible people, while the second wave identified 24 unconnected individuals following months of work by several researchers. These small numbers indicate the enormous difficulty of identifying and reaching people who are HIV positive, know their status, and are truly unconnected to medical care and case management services. The report suggests that it is important for agencies to operate mobile clinic operations that seek out clients, provide clients with a safe place and sustain a relationship with the client as well as provide confidential and culturally competent health care services.

Needs Assessment 2001 Methodology

The Miami-Dade team decided on an ethnographic approach for its first effort to identify and interview the unconnected. First, a meeting with providers funded under Ryan White Title I to perform outreach services; the supervisors were asked to participate in the study by permitting their outreach workers to administer the surveys, either while on their appointed rounds or after work hours. The team stressed the importance of reaching people at all times of day and in varied locales.

Eleven organizations helped with the survey, including eight Ryan White providers. Outreach workers from the following agencies went to the places they thought we would find unconnected people: Christ Crusaders, CHI, Center for Haitian Studies, Help from the Heart, America Helping America, MOVERS, Family Health Center, University of Miami. In addition, Camillus Health Concern’s Project SafeStreet, was asked to help. Project SafeStreet is a CDC-funded HIV prevention program whose staff has extensive experience doing outreach work among homeless populations throughout the community. All People at Risk and the Haitian Methodist Church also participated. Finally, several individuals were recruited for their special knowledge of certain populations (such as sex workers) or areas.

In all, at least 25 outreach workers and others worked on the study. To the extent the survey relied on

outreach service providers and their outreach workers, the survey was conducted in places they said they conducted their own outreach activities. Other volunteers relied on acquaintance sampling at certain high-risk areas to identify potentially unconnected people. These special recruits were indigenous to the HIV/AIDS population, knew people who were unconnected to care, and knew where to find some of them.

The workers distributed surveys at more than 40 locations. We focused primarily on areas known to be gathering places for people who might be at high risk of being HIV positive or unconnected to medical care, and which may not have been surveyed previously. These included the Camillus House soup kitchen, high crime and drug sales areas in Opa Lock, Liberty City and Coconut grove, and other areas of Miami-Dade County considered at high risk. In addition, one Haitian church and an inner city high school was visited to attempt to gain some baseline information on those thought to be unconnected, whether or not they are HIV positive.

A brief survey was created to elicit information on whether people get medical care, use alternative medicine or religious support, whether the respondent had HIV positive acquaintances, and perceived barriers to care. Questions on HIV testing and serostatus were left to the end in order to achieve the best possible returns.

The volunteer outreach workers were trained at their own locations by staff from WSA. All surveyors signed confidentiality statements at the training. They were instructed on how to give and get back the surveys, to check for completeness, and other elements. The volunteers and WSA worked out approximate locales where the questionnaires would be given out in an effort to avoid duplication of effort. Finally, they were given small denomination food coupons as incentives for the respondents. During the process, several individuals were given referrals and connected to services.

A total of 911 surveys were completed. As was expected, the majority of respondents said they were not HIV positive. These breakdowns will be described in the section on findings.

The methodology did not work perfectly, and the lessons learned will guide our efforts in the coming year. The survey forms were completed by the respondents themselves, and some misunderstanding of questions occurred. Some of the interviews were completed by the interviewers during conversations. In these instances, some interviewers believe they obtained more frank responses. For example a person who checked no for HIV status subsequently admitted to being positive in reality. Although most of the workers worked hard to identify high-risk areas, a few did not take the study seriously, and went to easy places. In two instances where they went to clinics, resulting in all their respondents being connected, they were asked to go out to high-risk areas and collect new surveys.

It must be emphasized that this study did not produce a representative sample of the county, or of any particular group. There was no intent to try to create a random sample. Rather, the study gathers some information about and perceptions of people who frequent certain areas, street corners, or other locations. Even considering the sensitivity of the issue and the reluctance of people to admit they are HIV positive,

the study results demonstrate once again how difficult it is to find the “unconnected” population. If outreach workers aren’t finding them, it is likely that they do not want to be found.

Survey Findings

Demographic Characteristics of Respondents

Of the 911 respondents completing a questionnaire, 54 percent were male, 45 percent were female, and just over one percent (11 people) self-identified as transgender. This breakdown is more similar to the general population than to people with HIV or AIDS, as females represent a smaller percent of these groups.

The average age of respondents was 36 years. They ranged from 14 years old to 85 years old. Table 1 shows the age groups of respondents.

	Number	Percent
Under 19	64	8%
20 - 29	217	27%
30 - 39	233	29%
40 - 49	193	24%
50 - 59	84	10%
60 and over	25	3%

The majority of respondents were African American or other Blacks. Clearly this is a result of the locations chosen for the survey, which were primarily areas thought to be places where the unconnected gathered, and where we might find people who are HIV positive. The outreach workers thought these areas would be the best places to gather information. Indeed, the literature on the unconnected, and on health disparities across population groups, support such choices. Table 2 below provides the breakdown of respondent race and ethnicity.

	Number	Percent
Black	561	65%
Hispanic	133	15%
Haitian	118	14%
White	39	5%
Other	6	1%

Most of the people completing the survey said they had no health insurance of any type. Lack of insurance, of course, is likely to affect access to care among the entire group. However, those who are HIV positive may be able to access services under Ryan White. Table 3 provides details.

	Number	Percent
No Insurance	506	56%
Medicaid	197	22%
Private Insurance	128	14%
Medicare	57	6%
VA	50	5%

Respondents were asked at some point in the questionnaire to reveal their HIV status. While it is suspected that the number who are positive is higher than the number who admitted it, we accept the self-identified categories. Only 14 percent said they were HIV positive. It must be kept in mind that the venues were often rather public places, and although they were completing the surveys themselves and did not have to speak, many appeared to be sensitive about the information they shared. This was supported by the personal exchanges that did take place. Another important piece of information to consider is that, as Table 4 shows, 12 percent said they did not know their status. And fully one-quarter of respondents said they had never been tested, and therefore could not know for sure whether they are HIV positive.

	Number	Percent
Positive	127	14%
Negative	444	49%
Unknown	111	12%
Never Tested	229	25%

Connectedness to Medical Care

This section describes the level of connectedness to medical care of the respondents. The categories were created by combining and analyzing two questions: one on whether the person receives medical care, and one on whether the person had seen a doctor in the past year. The categories, as described in Table 5, are Connected, Marginal 1, Marginal 2, and Unconnected. Fully 47 percent of the respondents were unconnected to medical care by this categorization, and an additional 17 percent had not seen a doctor in the past year.

		Number	Percent
Connected	Receives medical care from a doctor or clinic, and saw a doctor in last year.	296	33%
Marginal 1	Receives medical care, but has not seen a doctor in the last year.	159	17%
Marginal 2	Does not receive medical care, but has seen a doctor in the last year.	28	3%
Unconnected	Does not receive medical care and has not seen a doctor in the last year.	428	47%

We examined these categories to identify whether there were demographic differences among the categories.

- C Females are more likely to be connected: say they receive medical care and saw a doctor in the last year, or say they receive medical care even if not in the last year. They are less likely than males to be completely unconnected.
- C There were no age or race/ethnicity differences in connectedness.
- C There was no difference in connectedness to medical care between those who are HIV positive or negative, but those who are unconnected are less likely to know or report their HIV status.
- C Those who had some sort of health insurance, regardless of their HIV status, were twice as likely to be connected to medical care, three times more likely to be marginally connected, and three times less likely to be unconnected to medical care than those without insurance.
- C Blacks were more likely to have some sort of health insurance (51%) than whites, Haitians or Hispanics (30%). Medicaid may account for some of this difference.
- C For those who are connected to medical care, there was a significant difference by HIV status in the number of times that they saw a doctor during the last year. Those who were positive saw a doctor an average of ten times during the year (median = 6) and those who were HIV negative or whose HIV status was unknown saw a doctor five times during the year (median = 3).

Connectedness to Medical Care: HIV Positive Respondents

Only 127 respondents self-identified as HIV positive (many more did not know their status). We analyzed these respondents to see how connected to services they are. Fully 45 percent were found to be unconnected, meaning they did not receive medical care and have not seen a doctor in the past year. Another 15 percent appear to be only marginally connected, as they said they receive medical care but have not seen a doctor in the last year. The degrees of connectedness of those self-identified as HIV positive are shown in Table 6.

Table 6: Connectedness to Medical Care: HIV Positive Respondents			
		Number	Percent
Connected:	Receives medical care from a doctor or clinic, and saw doctor in last year.	48	38%
Marginal 1	Receives medical care, but has not seen doctor in last year.	19	15%

Marginal 2	Does not receive medical care, but has seen a doctor in the last year.	3	2%
Unconnected	Does not receive medical care and has not seen a doctor in the last year.	57	45%

Reasons for Not Receiving Medical Care

The two main reasons listed as to why respondents were not receiving medical care were “can’t afford it” (27%) and “do not need” (17%). No other response was selected by more than six percent of the respondents. More than one response could be selected. Table 7 presents the reasons why people said that they were not receiving medical care from a doctor.

	Number	Percent
Can’t afford it	244	27%
Do not need medical care	154	17%
Can’t get transportation	56	6%
Do not know where to go	44	5%
Do not trust doctors	31	3%
I am depressed	26	3%
Do not like the way I am treated	25	3%
Confidentiality (fear of disclosure)	25	3%
Do not believe in medications	18	2%
Can’t get childcare	17	2%
Do not believe in doctors	15	2%
Do not believe in Western Medicine	10	1%

Reasons for not receiving medical care were largely unrelated to HIV status, but were more likely to describe what makes a person unconnected to the medical system. There were few differences by gender or ethnicity and none by age. The following significant differences were found.

- C The unconnected were almost four times as likely to say that they could not afford medical care as those who said they received care from a doctor, even if they had not seen a doctor in the last year.
- C Males were more likely than females to say that they could not afford medical care.
- C The unconnected, regardless of their HIV status, were twice as likely to say that they did not receive medical care because they did not need it than the connected or marginally connected. But virtually no connected or marginally connected HIV positive person said they did not need medical care.
- C Males were twice as likely as females to say they did not need medical care, and Hispanic

males were twice as likely as non-Hispanic white, black, or Haitian males to say that they did not need medical care.

The following demographic differences in reasons for not receiving medical care were observed, but they need to be interpreted with caution due to the low percent of respondents who gave a reason. For example, even though differences were observed in who does not know where to go receive care, it must be remembered that only 5 percent of respondents said that they did know where to go to get medical care.

- C The unconnected were eight times more likely to say they did not know where to go to receive medical care than those who said they received care from a doctor, even if they had not seen a doctor in the last year.
- C Males were three times more likely than females to say that they did not know where to go to get medical care.
- C Five percent of the unconnected or marginally connected said they did not trust doctors; none of the connected said that they did not trust doctors.
- C Hispanics and non-Hispanic whites were nearly five times more likely than Blacks and Haitians to say that they did not like the way they were treated.
- C Individuals who are HIV positive or status unknown are three times more likely to say that confidentiality is a reason for not receiving medical care.

Free Services for HIV Positive Individuals

Sixty percent of all respondents said they knew there were free services available for HIV positive people. Looking at all HIV positive respondents, 64 percent knew there were free services, while 50 percent of HIV positive respondents who were unconnected to medical care knew. However, a significant minority said they did not know such services were available.

What The Unconnected Said About Medical Care

For this analysis, we looked only at people who are unconnected. They were asked what would get them to go to a doctor. As Table 8 shows, the most common answer was transportation. The next largest number said they would have to be acutely ill. Several commented on the quality of care, and others wanted more advice and information. Other responses were given, but only by one or two respondents. Eleven percent of the unconnected specifically stated that nothing would get them to go to a doctor.

Table 8: Things the Unconnected Said Would Get Them to Go to the Doctor		
	Number	Percent
Transportation	73	16%
Acute illness	69	15%
Cost of medical care	35	8%
Incentives	18	4%
Insurance cost	15	3%
Better quality services	9	2%
Referrals and advice	8	2%
More information about services	5	1%
Better trained health care professionals	4	1%
Employment opportunities	4	1%
Substance abuse treatment	4	1%
Outreach services	4	1%
More government services	3	1%

HIV positive respondents were also asked what could be done to link them with medical care. Just over half of this group answered the question. As Table 9 shows, most respondents wanted more information, referrals and advice.

Table 9: Things the HIV Positive Unconnected Said Could Be Done to Link Them to Medical Care		
	Number	Percent
Referrals and advice	21	35%
More information about services	6	10%
Outreach	3	5%
Respondent education	1	2%
Cost of medical care	1	2%
Housing	1	2%
Transportation	1	2%
Substance abuse treatment	1	2%

Respondents Were Asked about People They Know

Just over half (51 %) of the respondents said they knew someone who was HIV positive. There were no differences in responses by HIV status, race/ethnicity, or gender. In other words, all groups answered in similar ways. They were also asked if these people were receiving medical care. According to their responses, almost half of those who are HIV positive are thought to be receiving medical care, and an additional 36 percent are thought to be receiving at least some. In other words, the great majority of the HIV positive people known to the respondents are receiving at least some medical care. The responses are listed in Table 10.

Table 10: Are The HIV Positive People You Know Receiving Medical Care?		
	Number	Percent
Yes	223	49%
Some	164	36%
No	57	12%
Unknown	16	3%

Respondents were asked why others they know are not receiving medical care. The primary answers were fear of disclosure, the first two categories in Table 11. Other reasons accounted for only small percentages.

Table 11: Why Don't People Receive Medical Care?	
	Percent
Worried that people will find out	14%
Confidentiality (fear of disclosure)	9%
Healthy	8%
Cannot afford	7%
Do not know where to go	5%
Do not have transportation	5%
Could not get an appointment	3%
Drugs	2%

Alternative Medical Care Used

Overall, there was little use of alternative medical care by those who answered the survey, but when it was used, it was more likely to be used by Haitians or Hispanics, and about a fourth of Haitians said that they had used herbal medicine. People who were HIV positive or status unknown were more likely to use herbal medicines, including leaf doctors and root workers.

Table 12: Use of Alternative Medical Care		
	Number	Percent
Herbal (leaves or bush medicine)	77	8%
Acupuncture	12	1%
Chinese medicine	11	1%
Homeopathic medicine	6	1%

Religious/Spiritual Practices Used to Treat Illnesses

Overall, there was little use of religious/spiritual practices other than church to treat illnesses, but when it was used, it was more likely to be used by Haitians or Hispanics. Fifteen percent of Hispanics said that they relied on Santeria and nine percent of Haitians said that they relied on Voodoo.

The use of religious/spiritual practices used to treat illnesses was not related to connectedness to medical care.

Table 13: Use of religious/spiritual practices used to treat illnesses		
	Number	Percent
Church	244	27%
Spiritualist/Spiritist	31	3%
Leaf doctor/Root worker	26	3%
Santeria	24	3%
Voodoo	12	1%
Curandero	5	1%

Things Respondents Felt Would Improve Health Care

The respondents to the survey were asked about what they thought would improve health services. This was an open-ended question, meaning the respondent could write whatever they wanted to. There were too many categories of response to present them all. The most frequent are presented in Table 14; those that are not show were given by less than ten respondents. Collapsing the first two categories results in 17 percent saying more funding is needed.

Table 14: What Would Improve Health Care?		
	Number	Percent
More government services	99	11%
Cost of medical care	57	6%
Outreach	49	5%
More information about services	44	5%
Better quality services	40	4%
Closer services	38	4%
Transportation	37	4%
Better trained health care professionals	35	4%
Patient education	34	4%
Community health mobile vans	16	2%
Cultural sensitivity	14	1%
Incentives	12	1%
Referrals and advice	11	1%

Conclusions

Reaching and interviewing the unconnected is a major challenge. This study was a start for the community, and forms the basis for further work. Lessons learned in this study will be applied to efforts in the coming year. It is the sense of the team that many people in the survey are HIV positive but will not self-declare. In addition, though personal interviewing is challenging in the street, is more costly, and results in fewer interviews, WSA will use this methodology next time. Some informal interviews in the street resulted in people admitting their status after initial denial. Not all of the outreach workers appeared to make sufficient

efforts to find people, sometimes choosing the easier targets. Other workers went out of their way to find the unfindable. Some changes in the methodology will be needed in the future. Some of these points will be added as choices in the next version of the survey instrument.

In spite of these difficulties, the study team obtained a great deal of valuable information. A total of 911 interviews identified 127 HIV positive individuals, and a large number who did not know their status. Almost half of the respondents said they were negative, but were found in areas characterized by high-risk activities.

There were no questions aimed at obtaining information on substance abuse or mental illness, found in the Columbia University study to be major factors in unconnectedness. However, focus groups and key informant interviews conducted in conjunction with this survey identified these as factors. In addition, in the study depression was listed by unconnected respondents as a major reason for not seeking care.

Some major findings were:

- C The unconnected are cohesive as a group. That is, they have characteristics, beliefs and practices that are different from the connected. HIV positive and HIV negative people who are unconnected are more similar to each other than to either group in the connected. In other words, the unconnected are simply different from the connected.
- C The unconnected were far more likely to report they do not know where to go to get care than the connected.
- C The unconnected are more likely to say they can't afford medical care. This likely means they do not know they are unaware of free care.
- C The unconnected, including the HIV positive unconnected, are more likely to say they don't need medical care.
- C There is less trust in medicine and doctors among the unconnected.
- C The unconnected are more concerned about confidentiality issues.

The information from this survey, coupled with information from extensive focus groups and key informant interviews regarding traditionally under-served and less well-understood groups highlights the lack of knowledge about what services are available, where, and how they can be paid for. While many unconnected people will wish to remain unknown to the system, many others might be willing to use services under certain conditions.

HRSA restricts the use of federal funds to publicize services, yet the lack of just such publicity is a recurring

theme in Miami-Dade County needs assessments. Outreach services, designed as a one-on-one intervention, might better be supplemented by expenditures to inform people by radio and TV about the availability of free medical care.

Notes

1. HRSA Title I Conference Call Minutes, Tuesday, April 10, 2001.
2. Columbia University School of Public Health, Community Health Advisory Information Network, 1996. The “Unconnected”: Service Needs Of HIV-Positive Persons Who Are Outside or Marginal to the Service Delivery System. Technical Report # 9. March 22, 1996.
3. The Kaiser Commission on Medicaid and the Uninsured. A Chart Book. May 2000.
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7. Henry J. Kaiser Family Foundation. Perceptions of How Race and Ethnic Background Affect Medical Care: Highlights from Focus Groups. October, 1999.
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9. Columbia University, School of Public Health. The Unconnected Revisited: A CHAIN Briefing Paper. May 6, 1999.