Policy Adoption and Networked Governance: How Power Arrangements Explain Local Approaches to HIV Testing in County Jails

by

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Abstract

Human Immunodeficiency Virus (HIV) continues to be a pernicious problem in the United States' correctional facilities, despite national prevention efforts for decades. The Center for Disease Control (CDC) has been working to improve HIV screening methods on the local level. A minority of jails in the U.S. follow the CDC's recommendations for HIV testing. The CDC has recommended opt-out HIV testing policies and to use the rapid method. Despite rapid HIV testing has become widely available and affordable to correctional facilities, most jails do not have opt-out testing policies nor do they use the rapid method for screening. This study explores why localities have not adopted an opt-out policy and rapid HIV testing methods in county jails using a power arrangements framework. The findings highlight some organizational arrangements in which power dynamics matter, and point to directions for future research to further explore how power in local networks can encourage or stymie the adoption of new policies. Further, this dissertation presents implications of small administrative arrangements within a larger policy network system, an idea which has not been fully discussed in the networked governance literature.

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List of Abbreviations

Acquired Immune Deficiency Syndrome	AIDS
Bureau of Justice Statistics	BJS
Care and Prevention in the U.S. Demonstration Project	CAPUS
Center for Disease Control	CDC
Community Based Organization	CBO
Food and Drug Administration	FDA
Health Resources and Services Administration	HRSA
Human Immunodeficiency Virus	HIV

<u>Chapter One: Introduction</u>

I.   Introduction

Why do some local jurisdictions adopt policy innovations and others do not? The purpose of this inquiry is to better understand whether power arrangements among local public health administrators effect local decisions about whether to adopt public policies. To explore this question, this dissertation delves into different human immunodeficiency virus (HIV) testing policies in the criminal justice system. Understanding the approach to HIV testing policies is a critical public health issue; HIV causes acquired immune deficiency syndrome (AIDS), which is widely acknowledged to be a life-threatening condition (CDC 2007).

To study this theoretical question, I have chosen to explore HIV testing in county jails. HIV/AIDS testing and prevention policies vary greatly between jurisdictions where decisions are made on a local level. HIV policies have broad significance across public life, with health policy being perhaps the most visible arena. Less visible is the interconnecting consequences of intravenous drug use, incarcerated persons, and the way that HIV testing policy is designed and implemented in the criminal justice system (Fletcher et al. 2007; Harrison et al. 1998). Further, jails are locally controlled and have a degree of independence from the state (Spaulding et al. 2015). This amount of variation is interesting, especially when one considers that there are federal recommendations from the Center for Disease Control (CDC) that apply to health care settings, such as jails.

This study is grounded in the literature that explains the spread of ideas in public service environments today, and reflects the combination of two robust literatures the focus on diffusion

and on understanding interorganizational relationships important to public service. Policy diffusion is defined in the literature as the spread of ideas and innovations (Berry and Berry 1990, 1999; Mooney and Lee 1995; Mossberger and Hale 2002; Gray 1973; Rogers 1962; Shipan and Volden 2012; Walker 1969). An innovation of policy is defined as something new for that jurisdiction (Rogers 1962). The classic method to measure the diffusion of a policy innovation is through policy adoption; e.g., whether and when a jurisdiction adopted a certain policy (Agranoff 2003; Baumgartner 2012; Baumgartner and Jones 1993; Berry and Berry 1990, 1999; Mooney and Lee 1995; Steelman 2010; Sabatier 1987; Sabatier and Jenkins-Smith 1993; Shipan and Volden 2012; McGuire 2006; O'Leary et al. 2006; O'Toole and Meier 2001). In the study of policy diffusion, its mechanisms are understood more broadly than the dichotomous measure of "adoption/no adoption." This study looks at the phenomenon qualitatively.

Across the policy spectrum, command and control mechanisms associated with bureaucratic structures of public service delivery are being replaced with much more complicated collaborative relationships. This phenomenon has occurred in the criminal justice arena as well as in the public health arena. Thus, the diffusion of ideas is broadly understood today to occur in the context of networks of organizational arrangements that encompass government agencies and nonprofit organizations across national, state, and local levels (Agranoff 2003; Hale 2011). Consistent with the literature, the public health network studied here is made up of elected politicians, public administrators, and representatives from non-profit and for-profit organizations, local government officials, and private firms (Agranoff 2003; Hale 2011; Milward and Provan 2000; Sandstrom 2008).

Policy change has been studied many times before and in many ways up until now. For example, scholars have analyzed structural factors that favor or impede policy change (Baumgartner 2012; Baumgartner and Jones 1993; Fisher 2014; Hall 1993; Steelman 2010), the effects of social learning on policy adoption (Bennett and Howlett 1992; Sabatier 1987; Sabatier and Jenkins-Smith 1993), and external shocks in jump-starting policy diffusion (Sabatier and Jenkins-Smith 1993, 1988, 1999). Others have used the Advocacy Coalition Framework to describe national network structures and explain the potential for policy change (Ingold 2011; Nohrstedt 2010; Sabatier 1987) or public management approaches to understand how administrators influence procedure and practices (Agranoff 2003; McGuire 2006; O'Leary et al.2006; Meier and O'Toole 2001). This study takes a different approach from prior work, in that it is not a strictly structural inquisition, and instead measures both structure and interactions between actors in a public health administrative network.

The research expectation for this study is that power arrangements between local administrators can help explain why local policies do or do not change. More specifically, this dissertation uses power arrangements in networks, and particularly a framework advanced by Adam and Kriesi (2007), to explore why certain federal policies do or do not diffuse to sub-national levels. Using mechanisms already identified in the policy diffusion literature, this study seeks to develop an understanding of how interactions between networked actors can encourage or diminish the chance of adoption of a new policy. This study shows that power arrangements and interaction patterns, together with other factors, may influence policy decisions and holds promise as an approach to guide future studies of local networks and policy adoption.

This approach will contribute to our understanding of complex policy decisions made at the local level, where organizational actors are personally affected by overlapping and competing

policy directives and objectives. Theoretically, there are interesting questions about federalism and federal-state-local interactions that should be explored as well. The next section summarizes how federalism in the United States is the backbone of understanding policy diffusion and local administration of public health policies.

II.   The Framework of American Federalism: Reconciling Federal Recommendations and Local Policy Adoption

Federalist systems such as the United States provide an ideal environment for policy diffusion through the states. U.S. federal and state governments frequently pursue overlapping and complementary policies, with federal agencies usually in the dominant role. The federal government can use regulation and financial incentives to induce states to coordinate policy activity with it and accept its authority (Arnold 2015). States very commonly respond to federal initiatives because they are incentivized to do so through the dissemination of research, technical training, and federal grant making (Mossberger and Hale 2002; Yin and Andranovich 1987).

The mechanisms by which states respond to national policy initiatives are varied. The national government can encourage subnational governments to compete for grants or states can learn from one another horizontally (Berry and Berry 1990; Desmarais, Harden, and Boehkme 2015; Gray 1973; Shipan and Volden 2012; Walker 1969). States bear the burden of deciding how to meet federal grant mandates or federal policy recommendations (Arnold 2015). Many scholars have found that grants from the federal government to states and localities often stimulate policy adoptions (Allen, Pettus, and Haider-Markel 2004; Shipan and Volden 2006; Walker 1973). Federal recommendations and available grant money are assumed to stimulate policy diffusion in a policy area implemented on a local level.

Despite the large amount of federal money that goes out to the states to implement federal policies, the local dimension is less well understood. Very little work has sought to explain variation in the pass-through of federal grant funding to the local levels such as counties (Nicholson-Crotty and Nicholson-Crotty 2015). Pass-through grants are awards of federal grants to state governments, and the state governments send the federal money to local governments and nonprofit organizations for implementation (Nicholson-Crotty and Nicholson-Crotty 2015). Pass-through funds are an important intergovernmental policy tool used by states. This delegation of funds to another jurisdiction with its own leaders, characteristics, and prerogatives, introduces the possibility for policies to be adapted by the local leaders and administrators (Nicholson-Crotty and Nicholson-Crotty 2015). The Center for Disease Control (CDC), a federal agency, plays an important policy and funding role in HIV testing policy in the U.S. Federal funding to subnational governments is discussed in greater detail in Chapter Two.

Divergent preferences and goals between the federal recommendations and state practices or desires can explain why federally recommended policies are not adopted (Arnold 2015; Arnold and Fleischman 2013). There is a slow move by county jails to choose opt-out policies and rapid HIV testing methods in county jails. This is relevant to HIV prevention policy, considering the degree of variation found across local HIV testing policies.

In the next section, various dimensions of the problem are presented, including the range in variation of HIV testing policies in states and localities in the United States. To provide context for understanding the policy environment, the role of the CDC, state laws, and the operating grants that fund HIV testing in the counties are presented as well. The literature seems to indicate that federal grant funding of federal recommendations will cause vertical policy

diffusion to the subnational level (see, Mossberger 2000). However, in the case of HIV testing in counties jails, this does not seem to be the case.

III.   The Problem: HIV Testing in County Jails

States and counties across the U.S. have inconsistent testing policies regarding who is required to be tested for HIV and when they are required to be tested. Further complicating the problem, most states do not keep comprehensive and accessible data on the health status of jail inmates (Mears and Cochran 2012). There are practical problems with local variation in testing in jails terms of public health concerns. A lack of consistent testing among state and local correctional facilities makes it difficult to definitively determine the total number of persons infected with HIV in the entirety of the U.S. criminal justice system (Zaller, Thurmond, and Rich 2007).

HIV testing in jails is a public health priority. There is a medical need for HIV testing to keep the staff and other inmates free from contracting HIV, but also a public health opportunity to screen this high-risk population who are involved in the criminal justice system. Additionally, health professionals and the CDC find it important to test people for HIV when they are admitted to jail instead of relying on state and federal prisons to test (Spaulding et al. 2015). Most states test an inmate for HIV only when they are incarcerated into prison instead of when admitted to jail (Sykes and Piquero 2009). A large portion of people filter through local jails and some stay in the jail facility for up to two years (Zaller, Thurmond, and Rich 2007). However, most jails do not have a comprehensive HIV testing policy (Zaller, Thurmond, and Rich 2007).

Jail populations are mostly transient and temporary, making the delivery of HIV testing and results in jail settings difficult. This process is difficult due to the lack of space and staff in jails, the acquisition of consent needed for testing, and the delay in receiving results before the

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inmate is released. Jail inmates are detained only for a short period while they await sentencing, and most states do not require an HIV test for jail inmates detained for less than three months (Zaller, Thurmond, and Rich 2007). It may be the case that more attention should be given to the importance of efficient and consistent HIV testing in jails and the lack of uniformity in adherence to CDC-recommended policies and methods in HIV prevention. Other methods of testing those detained for HIV are interesting practical questions to explore in future research, but are not addressed here.

Most jails take a risk-based approach to screening, meaning only detainees in certain risk categories are tested for HIV while in jail (Beckwith et al. 2009; Beckwith et al. 2005). This is due to the minimal state requirements for HIV testing and the time it takes to receive the results of a traditional HIV test, if the jail relies on someone else to conduct the testing on their behalf. The standard method of testing typically requires a laboratory at a health department and results appear after approximately two weeks (Zaller, Thurmond, and Rich 2007).

There is a faster HIV testing technology called rapid HIV testing, which has been approved for use in criminal justice facilities since 2000 (McGowen et al. 2009). Rapid HIV tests are used as screening tests to detect antibodies to HIV as part of multi-test algorithms to aid in the diagnosis of infection with HIV (CDC 2007). They are single use disposable devices or kits and can provide results in less than 30 minutes with unprocessed oral fluid or a blood drop (CDC 2007). Positive (reactive) rapid HIV test results are preliminary and must be followed up with an approved confirmatory test (CDC 2007).

In 2006, the Center for Disease Control (CDC) released new HIV testing and prevention recommendations to update their previously released 1993 recommendations (amfAR 2007). The CDC recommends rapid HIV testing at admission, following an opt-out policy of consent (CDC

2010). Opt-out policies refer to the practice of allowing an inmate the option to decline HIV testing after they are informed of the risks and benefits of the testing. If the test is not declined, then consent is inferred. However, most jails have opt-in HIV testing policies, and an HIV test is provided only because it is requested or required of certain groups under state law; only a small minority of jails are currently using rapid HIV testing (Solomon et al. 2014).

The biggest change in the CDC's recommendations was routine testing in clinical settings to encourage HIV testing to become a part of everyday health care (amfAR 2007; Institute of Medicine 2011). By making HIV testing part of routine care, the hope of the CDC was that most health insurance plans would cover the test so as not to charge low income populations for an HIV test (amfAR.org). Under the new recommendations, all publicly funded health care insurance plans would cover routine testing. In terms of HIV health care, the three major federally funded health care coverage plans are Medicaid, Medicare, and the Ryan White Program (amfAR 2007). However, in 2006 almost all state Medicaid laws listed routine HIV testing as an optional service, and it was therefore not covered by insurance. Similarly, Medicare recipients only provided coverage for HIV testing when deemed medically necessary and did not cover routine screening (amfAR 2007). To pick up any gaps in coverage of low-income populations, Ryan White Program money was paying for HIV tests on the local level. The Affordable Care Act of 2010 compounded this issue of funding because more people were required to have health insurance, therefore making them ineligible for Ryan White funding for HIV testing (Institute of Medicine 2011). Such concerns are most relevant to low-income and incarcerated persons, who may not know whether they would have to pay for the test after they are released (amfAR 2007).

In 2010, most states and federal agencies were still not in harmony with the CDC recommendations, many federal agencies had conflicting guidelines on who should be screened, and Medicare and Medicaid were still not covering routine HIV testing in most states (Institute of Medicine 2011). By this time, Medicare, Medicaid, and private insurance companies had set a reimbursement rate for states, albeit low, which lee many doctors and clinicians to avoid doing any routine HIV testing (Institute of Medicine 2011). Further, some states still have very restrictive laws that codify who can do the HIV testing and in what settings, as will be discussed in the findings section of this study (and see Institute of Medicine 2011). Most state prisons are now in compliance with CDC recommendations, as found by a 2011 study done by the Journal of American Medical Association (JAMA 2011); however, most jails are not (Spaulding et al. 2015).

It is unclear what policies county jails are operating under. With so much incongruity in insurance requirements and state requirements for HIV testing, it is not shocking that most county jails did not test for HIV before 2006 (Zaller, Thurmond, and Rich 2007). Of what is known, not has much changed since then either (Spaulding et al. 2015). In 2008, only 18.5 percent of jail inmates reported being tested for HIV at admission to jail (Beckwith et al. 2009; Mayer et al. 2002; Spaulding 2002). Capacity and technological barriers may be barriers to adopting or adapting the CDC's testing recommendations on a local level, regardless of the grant money the CDC sends to improve testing capacity. This is not particularly surprising in some ways, given other research on whether and how states follow voluntary federal initiatives (see, e.g., Hale 2011 for local drug court policies; Hale and Brown 2013 for voting system certification guidelines; Mossberger 2000 for enterprise zones).

Grant funding for HIV testing in correctional settings is prevalent and abundant, and the CDC's opt-out testing policy using a rapid testing method has been the CDC's preferred approach to states and localities since 2006. Yet states, counties, prisons, and jails all have very disparate approaches to HIV testing. Jails, being the correctional setting most frequented by the public, have a unique opportunity, and potentially a normative responsibility, to efficiently and consistently test for HIV. The next two sections provide the purpose and significance of this dissertation and how it fits into the current literature.

IV.   The Purpose of this Study

The aim of this study is to explore power arrangements among local administrative network actors in order to identify reasons why network actors may choose to maintain or change policies. This study measures repeated interactions between stakeholders through interviews with local administrators. The question is grounded in the literature in the conception of diffusion mechanisms (Hale 2011; Mooney and Lee 1995; Mossberger and Hale 2002; Shipan and Volden 2008), classic conceptions and questions of power (Lasswell 1936; Schattschneider 1960), and more modern ideas of discretion to act with resources (Baumgartner and Jones 1993; Moe 2005). This question is worth exploring because the CDC recommends an opt-out testing policy using rapid HIV testing methods, yet a minority of jails do not have this policy. Further, rapid testing not only makes it possible for jails to utilize opt-out policies, but it is a cheaper, faster, more efficient method of testing that could have a huge impact on public health,

The findings of this study can begin to illuminate whether and how local power arrangements matter in policy diffusion, and to policy adoption decisions. Unique characteristics of a locality will influence whether and how a policy change occurs. Administrators must interact frequently, and power arrangements exist and affect the process of policy change.

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Although other authors have found cooperation among administrators leads to more efficient implementation and execution (e.g., Mooney and Lee 2000) this study's purpose is to better understand whether different power arrangements are linked to status quo policies or whether these power arrangements are linked to policy change through the diffusion of innovation. In the next section, the research design for studying power relationships through interactions is described.

V.   The Research Design

This study employs a comparative case study method to explore the policy landscape of HIV testing in jails and to identify the relationship, if any, between power relationships and policy change through diffusion. I use interview data to capture interactions between local network actors and the predictors of policy adoption. The interview instrument takes a transactional approach to measuring power. This approach is based on measuring interactions between actors on several dimensions including how they use resources, how the group makes decisions when collaborating, and the priorities that are shared. These variables are based on the theoretical constructions of resources and power distribution explained by Adam and Kriesi (2007), Huxham and Vangen (2004), and Kalu (2012).

This project uses a local, county network as the level of analysis to delve into the workings of HIV testing policy in county jails. Secondary data is used to create variables that reflect internal and external characteristics at the county level. Primary data through interviews were collected from each case in a snowball sample of administrators and political actors engaged in HIV testing in the county jail. The jail was contacted first, and provided the names of other actors involved in the activity. Interview questions elicit information about interactions between network actors regarding how they conduct HIV testing in the county jail. Questions

measure priorities, resources shared, and decision-making processes between actors in the network. Priorities are the things most important to the actor and her organization, and questions ask how much of those goals are shared between stakeholders in the network. Resource sharing includes such things as who applies for the grant money and who administers the grants, who controls access to the jail or needed technology, and information expertise. Decision-making includes who decides how grant funding is used, who sets meeting times, or who gets the final say on policy changes. These three concepts and how I manifested them into questions are explained in Chapter Three.

The case selection process, interview instrument, secondary data collected, and the qualitative analysis are described in detail in Chapter Three. Counties are selected based on internal and external mechanisms identified on the policy diffusion literature. The definitions of these mechanisms are presented in the literature review in Chapter Two and the case selection criteria is described in detail in Chapter Three.

VI.   The Research Question and Expectations

The research question in this study explores a new combination of factors that may influence the relationship between federal recommendations, federal funding, and local policy adoption. Much research has already been done exploring the structural or circumstantial factors of a network that can influence policy adoption (Agranoff 2003; Baumgartner 2012; Baumgartner and Jones 1993; Bennett and Howlett 1992; Hale 2011; Hall 1993; Ingold 2011; Nohrstedt 2010; McGuire 2006; O'Leary et al. 2006; O'Toole and Meier 200; Steelman 2010; Sabatier 1987; Sabatier and Jenkins-Smith 1993). This study seeks to extend the literature by diving deeply into local administrative interactions about policy choices. These interactions can unveil how certain arrangements in a network effect policy adoption.

This study asks the question: in comparing counties, do power arrangements predict the likelihood a county jail will have a certain HIV testing policy? The general research expectation of the study is that *county networks that illustrate cooperation and concentrated power arrangements are the most likely to keep status quo policies in place.* In other words, those in a cooperative and concentrated power arrangement are the least likely to change their HIV testing policy and testing method away from an opt-in and non-rapid testing at admission. Power arrangements are measured by the pattern of interactions in decision making between actors in the network as based on the work of Adam and Kriesi (2007).

Status quo policies are those that were in place before the CDC's 2006 recommendations. A policy change is measured as the nominal difference between the county's pre-2006 policy to a new testing policy (opt-in to opt-out, voluntary to opt-in, voluntary to opt-out, or voluntary or mandatory). Incremental changes are defined as policies that are mostly like the county jail's pre-2006 policy, with a few updates. A rapid serial shift is a whole-sale policy change from one nominal category to another. These conceptualizations of status quo, incremental, and rapid serial shift in policies follow Adam and Kriesi (2007). This conceptualization of policy categories assumes that most jails did not have opt-out and rapid HIV screening in jails before 2006. This assumption comes from the review of the literature and secondary data from the CDC, BJS, and HRSA; most jails did not, and still do not, have opt-out policies and rapid HIV testing.

I expected to find that power concentrated in one or few stakeholders in a network would result in a maintenance of status quo HIV testing policies in county jails. Data that may support this expectation are collected through the designed interview instrument that will be discussed in Chapter Three. Adam and Kriesi's (2007) power dynamics matrix is used to frame the analysis

of the interview data. These concepts are defined briefly in the next section and deeply explained in Chapter Three.

VII.   Definitions of Terms: Power and Interactions

This section goes through the most important concepts used in this study that need definition. The conceptualization of this study will be explained further in Chapter Three. This section is a brief overview of concepts and terms used throughout this paper.

This dissertation uses policy diffusion as a theoretical framework to understand policy adoption. Policy adoption can take place and the policy spreads horizontally, or it can spread vertically down the federal levels of government, such as policies created by the CDC, a federal agency, down to subnational levels. Horizontal policy diffusion is defined as the process by which an innovation is communicated through certain channels over time among the members of a social system (Rogers 1962). In the contemporary understanding of the networked environment in which public administrators and policy makers operate, policy diffusion can also occur because of specialized information that is created by, and disseminated through, networked arrangements (Hale 2011). Information is a resource when it comes to considering new policies or new ways to implement policies. Synthesized information generated within and shared by organizations and actors in a network is a special type of communication, in that the messages are concerned with new ideas and packaged in a way that provides meaning to network participants (Hale 2011).

Other mechanisms identified in the literature explain policy adoption. There are two sets of mechanisms that influence policy adoption: a set of internal factors and a set of external factors. Berry and Berry (1990) extended the understanding of policy diffusion in their work to

predict the likelihood of policy adoption among jurisdictions based on internal and external environmental characteristics and motivations.

County-level networks are the level of analysis. Networks are structures of independence involving multiple organizations not arranged in a hierarchical structure of management (O'Toole 1997). Networks are stable patterns of social relations between interdependent actors which take shape around policy problems or programs (Kickert, Klijn, and Koppenjan 1997). Conceptually, networks are informal or formal arrangements based on a common goal, legal structure, such as a grant or contract, or another organizing principal (Hale 2011). The local network is defined by its structural and compositional traits. Networks consist of two elements: a set of actors and the relationships between these actors. Accordingly, networks should be characterized by two types of variables, composition variables (characteristics of the actors) and structural variables (specific types of ties between actors) (Westermann and Faust 1999).

This dissertation considers interactions between actors according to a power dynamics framework based on power differentials (Adam and Kriesi 2007). The type of interaction determines the distribution of power: the group is either in conflict, bargaining, or cooperation. Within those three larger categories are more specific indicators. Conflict may be caused by the dominance of one actor, or competition between actors. Cooperation may be between many actors or many actors are in cooperation with one dominant actor. Cooperation can be either horizontal or hierarchical. The interactions between actors may resemble bargaining in that many actors are using their own leverage within the group. This bargaining can be asymmetric, in that one or a few organizations hold the leverage, or symmetric between many actors.

Through interview and qualitative coding, I catalogue and analyze the power arrangements of networks and explore whether this is connected to the kind of HIV testing

policy the jail uses. Adam and Kriesi (2007) describe two categories of power arrangements in networks: concentrated and fragmented power. Such categories are based on the predominate interaction patterns of conflict, cooperation, and bargaining. The predominant interaction pattern is determined by my coding of the priorities, resources-shared, and decision-making practices of the actors in the network to implement HIV testing in the county jail. Such coding schema are presented in Chapter Three, and used to analyze the data in Chapter Four.

Resources are any factors that enhance the ability of advocates or opponents of a policy to promote or quash new policy adoption (Mooney and Lee 1995). Resources can include technical knowledge, technical skill, organization skill, and leadership, money, and information exchange capabilities (Agranoff 2007; Hale 2011). Other resources include access or knowledge of funding opportunities, access to programs, new technologies, and educational opportunities, can enter the transactional mix to create further dependencies (Adams and Kriesi 2007; Agranoff 2007). For the purposes of answering the research question and measuring the Expectations, resource categories are defined as: money, capacity (facility staff and space), reputation, and information expertise.

The county network arrangements are coded as in conflict, cooperation, or bargaining to determine whether the power arrangement is concentrated or fragmented. The presence of conflict can be seen through two types of interactions: dominance or competition. Dominance is where a coalition of actors with critical resources is challenged by a minority coalition who also have resources. Competition is where the power differential between the challengers and the dominant coalitions is less pronounced. Cooperation can be horizontal or hierarchical. Horizontal cooperation is on equal terms between actors. Hierarchical cooperation is a type of tiered cooperation, and actors do not have equal resources to leverage. Bargaining can be asymmetric

or symmetric. Asymmetric bargaining is unbalanced, disproportionate bargaining of resources and symmetric bargaining is more equal, proportionate bargaining of resources (Adam and Kriesi 2007). These codes are explained in Chapter Three and used in analysis in Chapter Four.

State HIV testing policies are also catalogued as either in compliance with the CDC's recommendations or not. Each state requires certain HIV testing policies for detention facilities, whether these policies be in the state code, in county government procedure documents, or in health department procedures. Voluntary testing is defined by informed consent and is required to be given before a person is tested for HIV (Pope 2009). Voluntary testing refers to performing an HIV test only after receiving informed consent. Most correctional facilities that require informed consent prior to performing an HIV test will only test upon inmate request (Pope 2009).

The county jail's HIV testing policy and method is the dependent variable. The two predominantly implemented methods of testing are "opt-in" testing and "opt-out" testing. There are opt-in policies and opt-out policies in county jails. Opt-in policies are when the person requests to be tested and usually includes mandatory testing in certain circumstances such as sex-workers, drug use, and other instances of exposure to blood. Opt-out policies have everyone tested unless the person wishes to not be tested. These policies are usually implemented at admission to jail or prison and who is not to be tested is based on an informed consent process, in which someone will not consent to testing. Under the "opt-in" approach, inmates are provided with pre-test counseling and will receive an HIV test only after they have provided specific consent to an HIV test. Under the "opt-out" approach, also referred to as routine screening, inmates are provided with pre-test counseling and are informed that an HIV test will be performed unless they refuse (Pope 2009).

Rapid HIV testing is a method of testing for HIV and many brands of testing kits have been approved by the Food and Drug Administration (FDA) in health care settings, such as a jail. The kits include an oral swab or oral fluid sample. Traditional blood samples for HIV tests require more blood and need to be tested in a lab. These blood samples are still required to confirm positive results from a rapid test in all states (McGowen et al. 2009).

The next section reviews the expected findings and the relevance of this study. The expected findings of this study have great potential to add knowledge of how policy adoption in local networks. Further, this study adds to the understanding of policy diffusion between the federal government and subnational levels.

VIII.   Relevance for Policy and Practice

It is expected this study will confirm that networked relationships do generally promote policy change through the exchange of information and resources (Agranoff 2003; 2007; Hale 2011). However, the new addition to the literature will be that the power arrangements in local networked relationships are important to understanding how and why certain policies diffuse or do not diffuse.

I expected to find that power relationships among network actors make a difference in actor's consideration of policy innovations and ultimately what policies are adopted on a local level (Adam and Kriesi 2007). These findings distinguish the work of others in the public administration realm in that there is a different analysis between policy change and successful policy implementation. Although a clear principal- agent relationship among actors may lead to better public administration outcomes (see Bushouse 2011; Milward and Provan 2000; Moe 2005) a concentrated power arrangement between one or few dominate actors may delay or

discourage policy change and innovation (Adam and Kriesi 2007; Fischer 2014; Sandstrom 2008; Hall 1993).

The study relies on an in-depth case study design to dig into local administrators' reasoning and relationships when making decisions and implementing HIV testing policies. The research design and qualitative analysis do have limitations in getting to the causal nature of why local networks make the policy decisions they do, and these limits will be discussed briefly in the next section and deeply evaluated in Chapter Three.

IX.   General Limitations and Assumptions of this Study

Certain limitations arise in all research. One limitation is the possible reliability of certain public data. Most states produce criminal justice statistics to compete for federal and state grants and may use these same data to report HIV statistics to the CDC. This limitation will not apply to the data collected by the Annual Survey of Jails, the Census Bureau, and CJ-DATS, for these sources of data are collected independently from the state and counties.

At the outset of this study, I assumed the existence of a robust network of service providers in each county and state to observe. I expected to find great variation in networks and this variation would provide a large amount of data to analyze. Further, this study depended on practitioners responding to my requests for interview. I assumed I could get access to administrators in this way.

Researchers always come into a project with personal assumptions, as well. Bias can and should be minimized in empirical study. Bias in research can occur when one uses her own and prior research to show evidence of a held assumption (Yin 2009). The validity of a study can be enhanced when I can identify preconceived positions first, before beginning my research (Yin 2009). I bring some assumptions to this dissertation that should be stated here. First, I believe

HIV is a public health problem that should be addressed in every way possible to eradicate the disease. Second, I believe correctional facilities can and should test and treat many inmates for HIV. Third, I believe jails should use the most efficient technology available for HIV testing, which is the rapid method.

These biases are managed through the course of this study in that I truly want to know why jails are or are not testing for HIV and not using rapid testing. This personal desire is a benefit to this study because I care deeply about understanding HIV testing in jails. This study's goal is to understand more deeply so policy recommendations can be made, and not to reinforce assumptions or bias. Such recommendations will be discussed in Chapter Five.

X.   The Significance of the Study

The importance of this study is to add to our understanding of the factors that influence policy diffusion and the adoption of new ideas. This study produces an in-depth understanding of how local policy adoption works and potentially why policy diffusion, either horizontal or vertical, does not occur on the local level. O'Toole (2014) says we know that managerial networking can improve outcomes (Meier and O'Toole 2001, 2003), not simply in a linear, additive fashion but also in a nonlinear way with respect to selected resources. What we do not know yet is what characteristics of the network lead to policy change or why some stakeholders benefit from certain arrangements. Other than Milward et al. (2010), who did an intensive examination of a small number of cases to detail network characteristics, not many others have done an in-depth study of network power dynamics. Further, local networks are an understudied level of analysis when it comes to policy adoption and policy change, and this study seeks to add to the literature in that way. Considering the amount of policy interpretation and implementation that occurs within or through local networks, this level of analysis is crucial to understanding the

policy diffusion process. It is also important to understand the choices that states make when the federal government suggests, but does not require, a particular course of action. This idea will be discussed in Chapter Five. Perhaps it is the case that power arrangements within a network effect policy consideration, adoption, and ultimately diffusion. This implication can have a tangible impact on important public policy topics such as public health and HIV. Further, these findings can be generalized to many different policy arenas, beyond criminal justice policies.

The next chapter reviews what is already known in the literature and the theoretical basis for the study. Relevant theoretical literature pertaining to policy diffusion, networks, and power arrangements is presented. Particular studies that reflect these strains of literature are also discussed.

Chapter Two: Review of the Literature

I.   Introduction

      This dissertation takes the approach that networks, either formal or informal in structure, are a distinct governing structure that facilitate policy diffusion (Hale 2011; Shipan and Volden 2008). In practice, this means public administrator involvement in public service network, nongovernment organizations and professional organizations increases the exchange of information between jurisdictions which, in turn, increases the likelihood of a new policy being adopted (Hale 2011; Shipan and Volden 2008). The unique contribution of this study is the introduction of how power relationship between actors in local networks affect policy decisions, an approach that shares a limited amount of research in the field.

      Publicly funded health and human services at the local level is the integration and coordination of public and private organizations and government administrators (Provan and Milward 2001). There are two types of local networks explored here. They are either formally created with a memorandum of understanding or informally operating under the organizing purpose of HIV testing in the county jail. Such networks are comprised of actors who interact across traditional and hierarchical forms of government (Agranoff 2007; Agranoff and McGuire 2003; Coleman and Perl 1999; Hale 2011; Ingram and Smith 2011; O'Toole 1997).

      This chapter will first present HIV testing in correctional settings, which includes state prisons and local jails. Further, this section presents what is known about the current state of HIV testing policies in the states and counties. Next, I present the status of federal grant funding from the CDC to states and localities for HIV prevention efforts. A literature review follows covering networks and power arrangements. This literature review includes whether and why state and

localities adopt federal guidelines, the actors in public health care networks, and why power relationships can help explain local dynamics of policy adoption.

II.   HIV Testing in Correctional Settings

This section presents HIV testing policy terminology and an overview of HIV testing policies in prisons and jail as written in state laws. The testing policies and testing methods in correctional settings can be broken down into two major categories. One reflects different degrees of decision freedom for the test subject. The other reflects the technology involved and how quickly test results are known. Testing policies and methods are either voluntary or mandatory, and either a rapid or a traditional method of testing. There are variations of each policy, based on when the testing takes place. This includes testing the person at intake to jail, during detainment, or at release. Other variations include the circumstances under which an inmate must be tested, for example, whether the person was arrested for sex crimes, prostitution, or illicit drug use. This section reviews the different policies in place for HIV testing in correctional settings. First, the variations of testing policies and methods will be covered. Then, current state policies that effect county jail HIV testing policies are presented.

a.   Methods of HIV Testing

This dissertation uses the terms traditional and rapid testing as two broad categories of testing methods. Traditional tests include all tests that use a blood sample to look for markers of HIV and require a laboratory for analysis. Rapid tests are disposable kits that use reactive technology and can give a simplistic reading of whether the blood or fluid contains a high level of antibodies, indicating the possibility of HIV. There are three types of HIV tests: antibody; combination of antibody and antigen; and nucleic acid tests (AIDS.gov 2014).

Most rapid tests are antibody tests which test the level of antibodies in the blood or mucus from one's mouth. When there is an elevated level of antibodies, there is a good chance the person has HIV. Combination tests detect both antibodies and HIV antigens in the blood and these tests are most likely to be performed in a laboratory. Nucleic acid tests detect the HIV infection in the blood. These are expensive and the least used of all three tests (AIDS.gov 2014).

The first rapid HIV testing method was available in clinical settings in 1992. In 2012, HIV testing techniques became available following FDA approval for use of these tests in nonclinical settings (Kaiser Family Foundation 2015). Rapid HIV testing approved for nonclinical settings made it possible to conduct HIV testing in county jails and to obtain test results within 30 minutes (Tartaro and Levy 2013; Mayer et al. 2002). Federal grant support has been available since 1999 from the Center for Disease Control (CDC), the U.S. Department of Health and Human Services, and the Health Resources and Services Administration (HRSA) to increase screening in correctional settings. The CDC recommends correctional facilities use rapid HIV testing at admission, and if the rapid test is positive, conduct a required confirmatory laboratory test (CDC 2006; CDC 2009). The CDC also recommends the use of voluntary, opt-out policies discussed in the next section.

b.   Opt-in, Opt-out, Voluntary, and Mandatory Testing Policies

Most states test an inmate for HIV only when they are incarcerated into prison instead of when admitted to jail (Sykes and Piquero 2009). Each state has different testing requirements, in terms of who is to be tested, variation in frequency and timing for testing, and whether HIV testing is routine in county jails and state prisons (Zaller, Thurmond, and Rich 2007). Most state prisons and jails take a "risk-based" approach to screening; only detainees in certain risk based categories are tested for HIV (Beckwith et al. 2009; Beckwith et al. 2005). However, these

policies do not always cover groups that would be typically thought of as at-risk for HIV

infection such as offenders with a history of injection drug use: If the crime for which they are

incarcerated is not a drug crime, such as theft, they may go unidentified as drug-users and not be

tested for HIV (Mayer et al. 2002; Spaulding 2002). In a study conducted by Spaulding (2014),

half of those that tested positive for HIV in a jail setting reported either no risk factors or

reported only heterosexual sex (Spaulding et al. 2014).

State testing policies are considered mandatory, optional, discretionary, or non-specific in

nature (Aguilar 2012; Pope 2009). Mandatory testing is a policy that requires an incarcerated

person to be tested for HIV regardless of history of risk behaviors or whether there are symptoms

that clinically indicate HIV. Optional testing policies dictate when an entering or existing

incarcerated person is offered HIV testing during a medical exam and he or she can decide

whether to consent to HIV testing. Discretionary testing occurs when medical practitioners can

decide whether an incoming or exiting inmate needs to be tested for HIV. Non-specific testing

laws are those state laws that do not say if, how, and when HIV testing takes place during a

medical screening (Aguilar 2012). Thirteen states have nonspecific HIV testing requirements for

inmates coming into state prisons (Pope 2009).

U.S. prison and jails perform either voluntary or mandatory HIV tests upon entry and/or

prior to release from state correctional facilities. Many correctional facilities perform HIV tests

upon inmate request, upon physician request, or under other circumstances, such as when an

inmate has a high risk of HIV infection or has been involved in an incident where there may have

been possible exposure to HIV. Mandatory testing refers to an HIV test that is performed

regardless of inmate consent. Voluntary testing refers to performing an HIV test only after

receiving informed consent (Pope 2009).

Most correctional facilities that require informed consent prior to performing an HIV test will only test upon inmate request. However, for correctional facilities that do provide voluntary testing upon entry, the two predominantly implemented methods of testing are opt-in and opt-out testing. Under the opt-in approach, inmates will receive an HIV test only after they have provided consent to an HIV test. Under the opt-out approach, which is also referred to as routine screening, inmates are informed that an HIV test will be performed unless they refuse (Pope 2009). The next subsection explains the different methods of HIV testing.

c.   State HIV Testing Laws

Although this study focuses on the policies of county jails, these jails may be bound by state policies in place. Further, there is a dearth of county-level data, and this study seeks to explore HIV testing policies on the local level. For the sake of a fuller understanding of HIV policy over time and federal efforts to influence state HIV prevention efforts, current state HIV policies in the criminal justice system are presented here. State policy is an independent variable in this study, as later explained in Chapter Three.

The very first HIV testing recommendations were published by the CDC in 1986. They called for voluntary HIV testing for all persons in clinical settings (CDC 2010). Most prisons have HIV testing policies created through the legislative process. Most states have statutes, codes, or other legislative regulations that govern HIV testing within the state correctional system. In some states, the legislature has delegated the prison HIV testing issue to a state or local administrative agency, such as the department of corrections or department of health, and administrative regulations promulgated by those agencies typically will govern the method of testing in the state correctional system (Pope 2009).

HIV testing laws are unique to each state and vary greatly among states. There are states where the legislature has not directly dealt with the issue or has merely delegated the decision to a state administrative agency, such as the department of corrections or department of health. In states where the legislature or general assembly has responded to the issue of HIV testing in the correctional system, a statute or code section will typically require or authorize some form of voluntary or mandatory HIV testing. For example, in both California and Illinois, an entire chapter of the state code has been devoted specifically to how and when inmates will be tested for HIV. However, in other states, inmate testing is mentioned only briefly within the provisions of another interrelated statute (Pope 2009).

Eleven states have state law that required mandatory testing at intake to state prison. Only one state has an "optional testing" state law, and it is for the release of inmates from state prison. Sixteen states have state laws that allow for discretionary testing at intake to a state prison. In the table below, all 50 states have been categorized by HIV testing laws found in their state codes. This state level data comes from a variety of secondary sources: Pope's (2009) review of state laws, The National HIV/AIDS Clinical Consultation Center (NCCC) of the University of California review of state HIV testing laws published in 2011 and 2015 state codes.

Table 2.1 shows state HIV testing laws in prison for states and indicates the type(s) of HIV policies in place. Policy categories include: "Test when Admit to Prison"; "State Requires Jails Test for HIV"; and "Rapid HIV Testing Law." Only one state, Florida, has a written law that requires local jails to test for HIV, and this policy is only mandatory for those jailed for sex offenses. Seventeen states had some mention of how and when rapid HIV testing is allowed. This table shows that while most states require HIV testing in prisons, requirements of jails are

not codified in almost all states. Rapid HIV testing laws are present in some states, but not in the majority.

[Table 2.1 about here]

I used Pope's (2009) review of HIV testing laws and my own document analysis of all 50 states and the District of Columbia's state codes. When I did a word search of a state code section, I was looking to see if the words "rapid," "HIV," and "testing" appear together. Table 2.2 shows when certain states adopted any mention of rapid HIV testing, based on the state legislative data. The table lists the states with rapid HIV testing regulations and the year in which they were first reflected in state code. Most states began to adopt rapid HIV testing laws after the year 2000, and even more so after 2005. New Hampshire codified rapid HIV testing procedures in 1987, one year after the CDC published its first recommendations on HIV testing. However, most states began to adopt rapid HIV testing laws after the year 2000, when the FDA approved a few brands of testing for clinical use. This table is interesting in that we can see the shift in the year 2000, when the CDC began to fund testing efforts through grant money (CDC 2010).

[Table 2.2 about here]

An interesting finding of this search was that some states regulate who legally can test for HIV. For example, Maryland requires all clinicians that perform rapid HIV tests to have a public health testing license (COMAR 10.10.12.04). In Missouri, the testing site must meet state requirements, apply for a certificate and be certified by the state in order to perform HIV testing (19 CSR 25-33.010). These written laws within state code do not necessarily represent what is done in practice on the local level, however, for many localities have their own policies and practices (Pope 2009).

In this policy arena, the Center for Disease Control (CDC) sends trillions of dollars to state health departments, counties, cities, and community-based organizations (CBOs) to develop, design, and implement HIV prevention strategies (CDC 2012). The CDC uses money allocated by Congress through the Domestic HIV/AIDS Prevention program (CDC 2010). This funding source allocates funds for HIV testing activities which include opt-in testing targeted to priority populations, such as inmates, and allocates funds to routine, opt-out testing/screening in non-health care and health care settings (CDC 2010). The background of the CDC's involvement in this policy area is discussed in the following section.

III.   CDC Grant Funding of HIV Prevention to Localities

Beginning in 1999, the CDC has provided grant funds to sixty-five state and local health departments, to serve HIV positive people, including at least one health department in every state. These funds are marked as HIV prevention funds, and recipient jurisdictions can choose their priorities for using the money. Beginning in 2001, the CDC created strategic plans to curb the spread of HIV in the states and municipalities. These strategic plans included increasing HIV services to people in correctional settings due to the concentration of people with HIV that traverse these facilities (Rapposelli et al. 2002). When the CDC surveyed grantees about their priorities for the grant money, a minority of jurisdictions ranked HIV testing and care in jails and prisons as a top priority (Rapposelli et al. 2002).

Jails are the most frequented facilities within the criminal justice system, and over 28 percent of HIV positive people go undiagnosed in jail (Spaulding et al. 2014). The CDC links the high rates of HIV in state prisons and jails in large part to injection drug use (IDU) (CDC 1999; Harrison et al. 1998). Illicit drug use is a prevalent habit of those incarcerated; 69 percent of state inmates report using illicit drugs a month prior to being incarcerated (Fletcher et al. 2007).

To better target incarcerated populations with HIV, the CDC funded states starting in 2000 through demonstration projects in prisons and jails. In 2000, the CDC teamed up with the Health Resources and Services Administration (HRSA) to fund the Continuity of Care Demonstration Project for Incarcerated Individuals within Correctional Settings. This special grant program funded six states, California, Florida, Georgia, Massachusetts, New Jersey, and New York, and one city, Chicago, Illinois. These jurisdictions were given around one million dollars a year to conduct HIV related service activities in jails, prisons, juvenile detention centers, and community correctional settings. Some jurisdictions used the funding for their existing efforts to prevent HIV, although other activities were made possible by the funding. Most states focused on discharge HIV planning and continuity of care; other states used the money to increase HIV testing in jails. For example, Georgia was successful in using some of this money to implement rapid HIV testing at admission to the Fulton County Jail with help from Emory University (Robillard et al. 2003).

In 2007, the CDC began the Expanded Testing Initiative (ETI) under which three separate grant programs were launched. PS07-768 is called the "Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African American." It was followed by PS10-10138: "Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations" which in turn was incorporated into PS12-1201: "Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments." This study uses data from PS12-1201, in which the funding ended in 2016.

Between 2007 and 2010, the CDC funded 25 jurisdictions with high levels of AIDS diagnosis and where a large proportion of the population were populations disproportionately

affected by HIV, including African Americans (CDC 2010). It is unclear the extent to which this money was used in correctional settings.

PS12-1201 ran from 2012 to 2016. All funding was sent to a state or municipal health department and is discretionary, meaning the state chooses to use the money for HIV prevention activities. For the first time, health departments were required to direct at least 75 percent of CDC funds received to four areas of prevention in Category A: 1) HIV testing; 2) prevention services for HIV positive individuals and their partners; 3) condom distribution; and 4) efforts to align policies to optimize HIV prevention, care, and treatment, such as "efforts to eliminate external barriers to routine opt-out testing" (CDC 2012). Category A of the funding is provided to at least one jurisdiction is every state plus the District of Columbia and Puerto Rico. Category B funds 24 states and eight cities that have populations disproportionately affected by HIV and AIDS, African Americans and Latinos, to improve access to HIV testing and health care.

An additional $20 million was granted to Category C recipients in March 2012 to support the Care and Prevention in the U.S. Demonstration Project (CAPUS) of innovative HIV prevention programs. Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia are part of CAPUS and was funded up until 2015. The required uses of the funding include: increased HIV testing; improve surveillance and data systems; enhance navigation services; and address social and structural factors that contribute to the spread of HIV (CDC 2012).

Table 2.3 shows the distribution of funds under the Comprehensive HIV Prevention Programs for Health Departments grant in 2012 to health departments according to categories A, B, and C. PS 12-1201 funded all state health departments in the U.S. for HIV prevention programs in category A, 34 health department jurisdictions for expanded HIV testing services for

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disproportionately affected populations in category B, and 30 health department jurisdictions for demonstration projects to implement and evaluate innovative, high-impact HIV prevention interventions and strategies in category C.

Table 2.3 shows CDC grant funding through PS12-1201 to state health departments for HIV prevention according to categories A, B, and C. Grants were awarded based on need. Category A has no variation, in that all 50 states were funded. Category B is a five-year grant and Category C is a four-year grant. Most states were awarded one or the other, with a few being awarded both (Arizona, Colorado, Maryland, New Jersey, Pennsylvania, and Texas). PS12-1210 funded 8 state health departments to conduct HIV testing and continuum of care services among racial and ethnic minorities (CAPUS). This is a three-year grant. The CAPUS grant is an important line of funding for health departments who are expected to increase their testing and access to care after an HIV diagnosis. Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia are the 8 state departments that received the CAPUS grant. Three states received all three sections (A, B, and C) of PS12-1201: Georgia; Illinois; and Louisiana. One of these grants currently funds health departments that were interviewed in this study. Counties in two of these states, Georgia and Illinois, were selected for interview in this study.

[Table 2.3 about here]

Seven counties and cities were directly funded by the CDC in category B of PS12-1201. These municipalities were selected by the CDC for special grant funding due to a disproportionate effect of HIV on African American and Latino communities (CDC 2012). Each state health department in which these municipalities are located also received CDC funding for HIV testing and prevention through one for the PS12-1201 grants presented in the above table

2.3). In Table 2.4 below, the selected cities and counties and the amount awarded are presented alongside the amount the state health department received. Category A is not listed because all states received an award. The amount is the total initial amount awarded through PS12-1201 in 2012. The information presented in this table is used as one of the selection criteria for counties selected for interview in this study.

[Table 2.4 about here]

Such funding from the CDC should increase HIV testing in correctional settings, and encourage more advance screening methods. When surveillance and evaluation of the grant recipients was conducted by the CDC in 2013, the CDC found that the funding was influencing local behavior. Within the states funded by these grants, more HIV testing was conducted in health care and correctional facilities (70.8%) than in non-health care facilities (29.2%). More than half of the HIV tests in correctional settings were rapid tests (CDC 2014). However, where this federal funding is directed has varied; where the money goes is dependent on state mandates, state decision making, and local decision-making. In the next section, relevant literature is presented concerning why states and localities adopt or do not adopt federal guidelines.

IV.   State Reponses to Voluntary Federal Guidelines

This section discusses how states respond to voluntary federal guidelines. Inadequate screening in correctional settings persists despite the CDC funding state and local correctional systems. Federalism may explain part of this, in that state and local laws vary, and may be a barrier to policy implementation. Studies of policy diffusion often focus on the horizontal spread of enactments from one state to another, paying little or no attention to the effects of local laws. Local characteristics may temper or block a policy from diffusing from locality to locality (Shipan and Volden 2008).

States have at least three options when a federal agency puts forth voluntary federal policy recommendations: states can choose to adopt federal requirements, adapt the federal guidelines to their own unique conditions, or opt-out altogether (Hale and Brown 2013). On a local level, there might be network-specific characteristics that cause a county to opt-out, adapt, or adopt a federal recommendation. Hale and Brown (2013) found that a state's choice to opt-out appears to be a function of low performance in information technology, racial and ethnic homogeneity, political contention, and lower levels of administration professionalism. They also found that states that adopt or adapt a federal guideline have one key difference, which is the technological capability needed to implement the policy. States with higher information technology capability can more readily adopt or adapt the federal guidelines than states with less technological capacity (Hale and Brown 2013). This study extends the concept of adapting, adopting, and opting-out to a county-level comparison. Counties may be faced with three similar options after federal guidelines are published and can choose to adopt the recommendations wholesale, adapt the guidelines to fit any state or local limitations, or opt-out of the policy completely.

There are other examples of voluntary federal guidelines that have not been adopted by localities that shed light on the topic of this study. Arnold (2015) explored the failure of states to integrate rapid wetland assessment (RWAT) tools into their regulatory programs. The Environmental Protection Agency (EPA) has been encouraging state wetland agencies to use RWATs for years, and has employed funding to advance this goal. Rapid wetland assessment is considered a best practice and is frequently used by scientists and resource professionals in the private and public sectors (Arnold 2015). Yet none of the states in Arnold's (2015) study had adopted the policy two years after the EPA recommendations were published (Arnold 2015).

Arnold (2015) found that adoption failure was a consequence of the U.S. Army Corps of Engineers' rejection of RWATs generally and of condition-focused tools specifically. Cooperative federalism makes the Corps the dominant player in wetland regulation; at the state level, the Corps directly regulates in some wetland scenarios and sets parameters for state action in others. Although the power the EPA holds over state wetland programs explains why the agency can get state officials to develop RWATs, the EPA's leverage over states' funding is constrained so that it cannot support tool deployment (Arnold 2015). In the case of HIV prevention and testing, the CDC sends copious amounts of money to states and localities, however, they have little to no discretion on how the money is actually used in the design of policies that the CDC considers to be high-impact.

Within the HIV testing and prevention realm specifically, two studies indicate the complexity of factors that may influence policy decisions at the local level. Two experimental studies have been conducted specifically on the implementation of rapid HIV testing in jails. First, Beckwith et al. (2011) conducted a rapid HIV testing pilot program with the Rhode Island Department of Corrections in the state's only jail between 2008 and 2009. Second, Mitchell et al. (2015) conducted interviews with practitioners involved in a pilot program study commissioned as part of the Criminal Justice of Drug Abuse Treatment Studies (CJ-DATS) (Friedmann et al.2012). Each of these studies will be looked at in turn.

In the first study, Beckwith et al. (2011) conducted a pilot program in the Rhode Island jail to conduct a trial implementation of an opt-out rapid HIV testing policy for all detainees at reception to the jail. The goal of the pilot program was to introduce rapid HIV testing as an alternative to traditional testing during the initial medical evaluation of all inmates coming into the jail. During the 12-month program, 1,364 detainees were offered rapid HIV testing and 98

percent of them were tested. The Rhode Island jail had been conducting opt-out HIV testing at intake, within 24 hours of reception, since 1990. This pilot program had correctional staff replace the traditional finger prick needed for a Western Blot test with an oral swab needed for rapid HIV testing. The oral swabs were self-collected by the detainees and collected by staff for testing. Swabs were tested in the jail instead of sending all blood samples off to the state health department's lab. All detainees with reactive tests (potentially positive indication of the HIV virus) were sent to the state health department for confirmation of results. Two brands of rapid HIV tests—Ora Quick Advanced and ClearView HIV ½ Stat Paks—were sent to the state health lab for confirmation of results due to an advisory from the CDC of potentially inaccurate results from these two brands (Beckwith et al.2011).

After the pilot program concluded, staff interviewed were overwhelmingly in support of implementing rapid HIV testing at intake. Inmate cooperation and attitudes about the process were said to be improved. Staff felt that inmates swabbing themselves and then the staff collecting the specimens provided a vast improvement in efficiency and safety from blood-born risk as compared to the staff collecting blood samples needed for conventional tests. When staff was asked about the challenges they would face if the jail were to implement rapid HIV testing into the intake process, staff reported that more personnel were needed. Additional personnel would be needed to deliver test results to ensure confidentiality of results, conduct quality assurance of test results, and keep records of the tests collected and sent to the health department. Space limitations in the jail also made delivering test results in a confidential way very difficult. There was also great doubt that the Rhode Island Department of Corrections would provide the money needed to implement the change in policy (Beckwith et al. 2011).

In the second study, Mitchell et al. (2015) interviewed participants in an experimental implementation strategy program conducted by HIV Services and Treatment (HIV-STIC) as part of the CJ-DATS series. HIV-STIC was testing an implementation strategy for promoting evidence-based practices in nine correctional facilities. A "change team" was created by pairing a research center staff member (principal investigator), a criminal justice agency member (executive sponsor), a member of the correctional facility staff (facility sponsor), and a "change coach" from the HIV-STIC research team as an external consultant trained in the implementation strategy to help the team implement new policies. Each "nexus" of actors constituted an experimental site in which opt-out and rapid HIV testing methods were implemented. There were some control sites that did not use the implementation strategy but still attempted to implement new polices. New policies to be implemented included prevention and testing strategies. The executive sponsor, or the member from the corrections agency, selected the particular strategy they wanted to develop and implement (Mitchell et al. 2015).

The strategy itself was not found to be a significant factor in successful implementation of new policies within the facilities (Pearson et al. 2014). However, staff reported that the change coach and the strategy given to them made change seem more feasible. Although quantitative results indicated that facility and site characteristics could predict successful implementation, such as staffing, funding, and inter-organizational linkages, Mitchell et al. (2015) found interesting qualitative results. Members of change teams reported that getting all the key players together to speak about improving correctional HIV testing and prevention was novel, refreshing, and incredibly productive. It made correctional facility staff feel inspired and encouraged to change practices to better serve inmates. Some staff reported that finding out who to call about certain problems made them feel more productive. It appeared that many correctional staff felt

isolated from key players within state agencies, research centers, and community organizations that were all part of the broader picture of HIV testing and prevention.

In Mitchell et al.'s (2015) study, the greatest struggle reported from staff in both experimental and control sites was the reluctance of key stakeholders to cooperate in designing change and implementing new policy. Further, staff reported the over-involvement of certain actors clashing with each other and leading to unproductive strategy development and implementation. One staff member interviewed reported that they failed to recruit the cooperation of the state department of corrections as well as two large urban CBOs, and this led to almost nothing being accomplished in terms of strategy development. This site did not even make it to the implementation phase, for they could not produce a coherent strategy to implement. Overall, the experimental sites were more successful in implementing something new in the correctional facilities due to reports of increased communication between key stake-holders and cooperation of powerful players in the network. There was an overall complaint from participants who said they were resistant to change because a perceived conflicting cultural paradigm within the work place to new strategy, lack of faith in powerful players to support change, and a perceived lack of money to implement anything new (Mitchell et al. 2015).

There may be other reasons for a county to not to adopt rapid HIV testing policies, as found by other studies. Many practitioners expressed concern about the cost of an opt-out HIV testing policy in the studies explained in this section. Correctional institutions' efforts to test and treat HIV could be hampered by underfunding, a lack of personnel, and limited availability due to the cost of testing (Oser et al. 2007). Spaulding et al. (2015) explored the total costs of implementing a policy of opt-out HIV screening in a hospital emergency room and a county jail in Fulton County, Georgia. In 2011 for ten and a half months the county jail used employed

nurses to implement rapid HIV tests through an opt-out policy. In this trial period, 41 new cases of HIV were diagnosed and cost an average amount of $6,688 per new diagnosis. Costs in this figure include cost of rapid HIV test kits ($12.50 per kit), cost of confirmatory HIV tests, medical supplies, and labor costs. Labor includes hourly wages to staff, salaries and fringe benefits to employees, and fees paid to medical services provided by a contractor that serves the jail. Costs related to time, facility space, or any durable office equipment, such as internet connect or printer ink, were not included in this cost analysis. Total cost of implementing the opt-out testing policy in the jail was $113,132 for personnel and labor costs and $5,356 for confirmatory Western Blot tests. The average cost of $6,688 per new diagnosis in the Fulton County Jail, as implemented by jail personnel, was lower compared to the national average of $15,018 per new diagnosis. The only limitation to this comparison is that many jails do not have 24-hour a day staff to implement an opt-out policy at reception to the jail (Spaulding et al. 2015).

There are also costs associated with medical care required after a person is newly diagnosed with HIV in a correctional setting. A decision maker may consider the cost of care for inmates more important than the cost of implementing an opt-out policy and/or rapid HIV testing. It is also possible that jails and prisons avoid opt-out testing because they fear having to pay for those with HIV while they are in state custody. State correctional and detainment institutions are constitutionally required to give inmates appropriate care for serious medical conditions, including HIV and AIDS (Belenko et al. 2013; *Estelle v. Gamble* (1976).

The following section details the relevant literature as to why studying local networks and local actor decisions matter in understanding the diffusion of policy innovation. The local, county-level public health network explored in this study is defined. Additional discussion of aspects relevant to the research design will be addressed in greater detail in Chapter Three.

V.   Local Public Health Administrative Networks

In the current understanding of public administration and public policy, networks have emerged as the standard institutional arrangement to address the disparate problems and the realities of political decision making in the American federal system (O'Toole 1997). Intergovernmental relations between jurisdictions and nonprofit organizations developed over time to solve social problems that traditional conceptions of separation of powers and hierarchy of government could not adequately address. Networks emerged as self-organizing, autonomous, and self-governing institutions, apart from the state's steering (Rhodes 1997).

Collaboration and partnerships refer to formalized, joint-working arrangements between organizations that remain legally autonomous. However, these collaborations are actors engaging in ongoing, coordinated collective action to achieve outcomes that none of them could achieve on their own (Cornforth, Hayes, and Vangen 2015). In the literature, these arrangements are often conceptualized as networks (Agranoff and McGuire, 2001; O'Toole, 1997; Provan and Milward, 2001; Van Bortel, Mullins, and Rhodes 2009). Networks are viewed as unique institutional structures because they are working relationships between public, private, and nonprofit entities, making the collaboration a separate operation from the government or private spheres of actors (Agranoff 2007; Agranoff and McGuire 2003; Hale 2011, O'Toole 1997). This dissertation studies public-service networks created to prevent and test for HIV in county jails.

Networks can be studied as service-delivery vehicles. Public health networks form to provide some health and human service to a defined population (Provan and Milward 2001). These networks are composed of independent organizations, and are created by a mandate of law or out of administrative practice (Agranoff 2007; Hale 2011). The network approach considers public policy making and governance as a joint venture between various actors, none of whom

possess the legal power to determine the strategies of the other actors (Agranoff 2003; Provan and Milward 2001).

Networks, as the unit of analysis used in this study, can be defined as the persistent patterns of relationships and interactions between administrators, courts, legislatures, administrative agencies, and nongovernmental organizations (Ostrom 2005; Schneider and Ingram 1997). O'Toole (1997), in his seminal work on why networks matter to policy research, defines networks as units of interdependence, and involve multiple organizations that are not organized in a hierarchical structure of management as found in formal structures of government.

This dissertation explores both formal and informal networks operating on the county level. Formal networks are characterized by the predominance of formal, legally binding contracts (Hale 2011). Informal networks can be horizontal relationships built through habitual interaction and can be based on shared resources, trust, or commitment (Adam and Kriesi 2007; Kalu 2012; Provan and Milward 2001). For the purposes of this study, the concept of a county network is based on a central organizing principle (whether formal or informal), following Hale (2011) in defining networks of actors engaged in drug court design and implementation as a matter of policy innovation. In this study, the central organizing principle is HIV testing in county jails.

The modern public administrator operates in an environment filled with networks (Hale 2011). Without networked relationships between different sectors of society, government would be stretched thin to accomplish all the things citizens expect it to do (O'Toole 1997). Administrators recruit and maintain other actors within and outside their organizations to help effectively achieve government goals. Public administrators can perform many functions such as: building support for a policy, negotiating with others in an agency's external environment,

contributing to the management of multi-organizational efforts, exploiting opportunities, protecting the core organization from challenges or threats, and sometimes helping move a set of organizations toward an objective (O'Toole 2014).

Networks typically do not replace bureaucratic organization and instead add more layers of structural complexity (O'Toole 2014). Individuals as actors can be seen simultaneously as occupants of positions within a public administrative organization and as components of one or more multi-organizational webs of action built in one way or another around functions or public problems (O'Toole 2014). In formally constructed taxpayer funded public sector networks, network growth and operations usually are coordinated by a public administrator (Provan and Milward 2001). Provan and Milward (2001) refer to this network structure as a network administrative organization, in which a public administrator distributed funds, administrates the implementation of policies, and coordinates most activities of the network. Other networks can take many different forms; some are less centralized, and in some, the primary administrator is not a government employee (Agranoff 2003).

Networks are thought to be the vanguard of policy change, either because of the utility of shared resources under collective action principles (Lejano et al. 2013) or the collective results of a process of generating and synthesized specialized information through multiple channels and layers of organizational arrangements (Hale 2011; Mossberger 2000). Networks thus become important platforms for bringing together individuals who have potential resources and a stake in certain problems, deepening and broadening knowledge of technical information, and adapting to immediate situations (Agranoff 2007). Multiple actors representing different mandates can overcome information and resource asymmetries and also create learning and problem solving (Agranoff 2007; Agranoff and McGuire 2003). The next section discusses the connection

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between networks and policy diffusion and why this form of organizational arrangement promotes the spread of policy ideas.

VI.   Networks and Policy Diffusion

Although scholars are often able to observe the flow of information itself, it is more difficult to empirically identify the underlying network of connections, which is usually the concept of chief theoretical interest (Desmarais, Harden, and Boehkme 2015; Hale 2011). Desmarais, Harden, and Boehkme (2015) find that a researcher can infer information moves between policy networks, and these collaborations connect political actors based on observable information about the repeated interactions and choices the actors make.

Networks are structural arrangements that promote policy diffusion (Agranoff 2012; Hale 2011; Kettl 2002; Meek and Thurmaier 2012; O'Toole and Christensen 2012). Desmarais et al. (2015) argue that policy diffusion research must rely on the inference of networks as a vehicle of social learning. Diffusion is defined as the process by which an innovation is communicated through certain channels over time among the members of a social system (Walker 1969). It is a special type of communication, in that the messages are concerned with new ideas. Communication is a process of convergence (or divergence) as two or more individuals exchange information to move toward each other (or apart) in the meanings that they ascribe to certain events. The exchange of information in network structures is what connects actors to new ideas and allows policies to diffuse (Graham, Shipan and Volden 2013; Mossberger and Hale 2002; Shipan and Volden 2008; Rogers 1962).

Well established research indicates that a state becomes more likely to adopt a policy when its neighboring states have previously done so (Rogers 1962; Walker 1969). Following this logic, a jurisdiction should be more likely to adopt a policy when any state to which it is

connected through a network of actors in the same policy network has already done so (Desmarais, Harden, and Boehkme 2015). Policy networks that span jurisdictional boundaries are crucial to understanding the diffusion process (Desmarais, Harden, and Boehkme 2015). Hale (2011) found that the development of spread of specialized information among actors in a network increases the probability a policy idea will be diffused as well as increasing the chances a jurisdiction will have enough information to successfully implement the policy. Through information exchange between professional and nonprofit organizations localities were motivated to implement a policy innovation. Hale (2011) conceptualized synthesized information such as research, best practices, templates, and model programs as a resource and found that the increase of synthesized information shared through communication between actors in policy subsystem that is intergovernmental, cross-sectoral and multi-jurisdictional increases the likelihood of local adoption of innovation.

Poly-diffusion combines vertical diffusion, which emanates from the federal government down to the subnational governments (states, counties, cities) with horizontal diffusion at the subnational level (Mossberger 2000; Mossberger and Hale 2002). Federal promotion of innovations, such as the CDC's recommendation of opt-out and rapid HIV testing polices in the criminal justice system, includes specialized information dispersed through intergovernmental channels and through funding of non-government organizations. Federal agencies disseminate technical assistance information, recommendations about best practices, and funding requirements to encourage states to adopt certain activities (Kincaid 1998; Mossberger and Hale 2002; Yin and Andranovich 1987). In this study, the Center for Disease Control (CDC) supports state and local efforts to prevent HIV in every state in the United States. The CDC funds, disseminates research, and offers technical assistance to local actors to accomplish HIV

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prevention policies. This type of federal involvement is advisory to jurisdictions. Advisory federal policy initiatives are considered in various ways by subnational jurisdictions, and can be voluntarily adopted, adapted, or ignored by states (Hale and Brown 2013). The result is varying state and local responses to the CDC's recommendations and varying uses for of federal grant money for HIV prevention and testing.

Rogers (1962) published a seminal work on policy diffusion that created one of the first typologies of policy innovation adoption. Diffusion itself is simply the spread of an idea. Rogers (1962) divided states into early adopters, the early and late majority, and laggards. Rogers (1962) explored the regional patterns of policy diffusion among states and connected this trend to social learning of policy makers. Rogers (1962) found the existence of policy peer groups and evidence of bounded rationality of state decision makers to emulate policy leaders (early adopters) within a regional peer group. Jurisdictions may look to each other for policy cues, and engage in learning from, competition with, or imitation of other jurisdictions. Walker (1969) produced one of the first works concerning state and regional policy diffusion. Walker (1969) suggested that policy makers take mental shortcuts to rational decision making, in that it is easier to copy policies from peer states than to make up a new policy. Thus, jurisdictions may look to each other for policy cues, and engage in learning from, competition with, or imitation of other jurisdictions.

Berry and Berry (1990) further developed this line of thinking by identifying two sets of mechanisms that influence policy adoption: a set of internal factors and a set of external factors. Berry and Berry (1990) observed the diffusion of legalization of state lotteries. They extended the understanding of policy diffusion in their work to predict the likelihood of policy adoption among jurisdictions based on internal and external motivations. Like Walker (1969), they used

an event history analysis to observe whether there was temporal evidence of innovation adoption that influenced other jurisdictions to do the same. They found that there are internal determinants, such as social, political, or economic factors, that can encourage or stifle the adoption of a new policy. They also found that there are external elements are at work, in that the decisions/actions of other jurisdictions do influence whether a new policy will be adopted.

One can look to the rapid diffusion of drug courts across the U.S. in a relatively short amount of time as explored by Hale (2011) and see that networks are crucial to policies diffusing from the federal government or between states. This idea has significance because, as here, the concept is an innovation in criminal justice policy. The idea and adoption of drug court polices quickly spread from state to state because of a national network of professional organizations, administrators, and nonprofit practitioners from multiple jurisdictions across the country. The diffusion of drug court policy adoption across the U.S. was linked to the communication between actors in extensive networks of interested persons, including administrators, medical service providers, and nonprofits, and the production and dissemination of synthesized information among them. Hale's (2011) study furthers the understanding that social learning requires an exchange of ideas, and networks are an institutional arrangement that facilitates the adoption of policy innovation locally.

Shipan and Volden (2008) produced the first comprehensive analysis of vertical policy diffusion from city governments to state governments, simultaneously examining the influence of state-to-state and national-to-state diffusion. Focusing on three different types of antismoking laws, the authors found evidence that policies do bubble up from city governments to state governments. State politics are crucial to this relationship, however, as local-to-state diffusion is

contingent on state-level factors including legislative professionalism and the strength of health advocates in the state.

Local policy adoption provides an excellent opportunity to test potential mechanisms of policy diffusion. By examining three types of antismoking policy choices by the 675 largest U.S. cities between 1975 and 2000, Shipan and Volden (2008) uncovered robust patterns of policy diffusion, yielding three key findings. First, they found evidence for four mechanisms of policy diffusion: 1) learning from earlier adopters; 2) economic competition among proximate cities; 3) imitation of larger cities; and 4) coercion by state governments. Second, they found a temporal component to these effects, with imitation being only used temporarily and then discarded in policy or practice. Third, they show that these mechanisms are conditional, with larger cities being better able to learn from others, less fearful of economic spillovers, and less likely to rely on imitation (Shipan and Volden 2008).

Shipan and Volden (2008) identify additional variation in the concept of social learning and distinguish two additional mechanisms that are very similar to one another (competition and imitation), which were previously lumped into the term social learning by other authors. Notably, what may appear to be a jurisdiction engaging in social learning may be imitation or competition (Shipan and Volden 2008). Innovation leaders are usually larger, wealthier, and more cosmopolitan jurisdictions (Shipan and Volden 2008). Imitation occurs when a jurisdiction copies the actions of another jurisdiction to look like them. Imitation is different from social learning in that the jurisdiction focuses on the actions of another ("how can we look like them?") instead of focusing on the policy itself and seeking to replicate the policy (Shipan and Volden 2008). Smaller communities copy the actions of these leading cities so to appear more like the leader instead of a "laggard" (Rogers 1962; Walker 1969). Jurisdictions also tend to compete

with each other, in the sense that once a policy is adopted in a peer-jurisdiction, others will adopt similar or the same policies to attract or maintain resources (Shipan and Volden 2008).

Recent research has explored how policy characteristics shape diffusion, but this work has focused on attributes related to the ease of policy implementation, and analyzing how the cost, complexity, and salience of innovations shape the speed of policy diffusion (Boushey 2010; Makse and Volden 2011; Nicholson-Crotty 2009). Although important, this research often overlooks the tendency of policy entrepreneurs and policy-makers to distill complex information about policy information into a simple policy image (Baumgartner and Jones 1993). This over-simplified image usually has a moral connotation, and becomes "embedded in policy as messages that are absorbed by citizens and affect their orientations and participation patterns" (Schneider and Ingram 1993, 993).

Framing of policy characteristics may include the moral salience of the policy to state decision makers and citizens. The decision to adopt a neighbor's policy innovation is often influenced by policy image, or the moral salience of the policy, just as much as by the details or benefits of the policy itself (Mooney and Lee 1995; Mossberger 2000). Mooney and Lee (1995) researched whether the moral policies diffuse differently than policies that do not evoke a moral reaction, and found the influence of moral valence, or the political environment in which other internal factors interact.

Mooney and Lee (1995) found that certain conditions must be present for social learning to occur. Without an environment in which a jurisdiction could take cues and learn from the experiences of other jurisdictions, what other peers are doing may not have an effect. Mooney and Lee (1995) introduced three categories of internal factors that might influence diffusion as potential mechanisms to predict the probability of policy adoption: 1) demand; 2) resources; and

3) politics, Demand includes factors that increase need or want for new policy. This can include economic, demographic, or social need. Resources are any factors that enhance the ability of advocates or opponents of a policy to promote or quash new policy adoption. Politics is the ideology of citizens and/or policy makers in a state on a liberal conservative, or left-right, continuum (Mooney and Lee 1995).

Allen, Pettus, and Haider-Markel (2004) examine how and under what conditions actions of the national government influence the diffusion of policy across the states. They posit that the national government can force or entice state governments to act on policy through a variety of actions, including providing monetary incentives and sanctions. They test their expectations on the cases of the diffusion of partial birth abortion laws, truth-in-sentencing laws, and hate crime laws using event history analysis on pooled cross-sectional data from the 50 states. Their results suggest that, in addition to fiscal incentives, the national government can influence state policymaking when it sends strong, clear signals to the states concerning its preferences and the potential for future action.

Yet, even national-level signals that are weak and ambiguous may influence state policymaking indirectly (Allen, Pettus, and Haider-Markel 2004). Furthermore, much work has been done that relies on the inference that peer governments are connected to one another by their reliance on others to make policy decisions. Desmarais et al. (2015) show that a pattern of repeated interactions among actors in a network can be seen in many different policy arenas. Desmarais et al. (2015) found that capacity, political homogeneity between states, and geographic proximity predicted whether a state would adopt a similar policy to its peer. The results for capacity are the most striking, with more populous and wealthier states as more likely to engage in a diffusion process: these bigger, wealthier states are more likely to be named by

other states as sources of policy information as well as identify more states as sources for policies. Secondly, political similarities between states indicate which states are more likely to be seen as sources for new policies. Ideologically liberal states looked to a lesser number of states for policy ideas. These liberal states were also less likely to be named as a source of policy ideas by other states. Ideologically conservative states appeared to networked with other conservative states for policies, as compared to liberal states. These conservative states were more likely to name and be named as policy idea sources by other Republican states. Demarais et al. (2015) offer three important conclusions: 1) the overwhelming majority of policy diffusion is not based on geographic proximity; 2) there are policy diffusion networks that connect states allowing decision makers to learn from actions of other governments; and 3) internal factors such as capacity, money, demographics, and politics effect the probability a state will adopt a policy being used by other states.

Knight (1992) argues that institutional actions are not explained by uncovering collective goals or benefits to individual actors, but instead these decisions are a byproduct of conflicts over distributional gains. A theory of institutions can be rooted in bargaining relationships and the power asymmetries that shape their outcomes. Rational individuals struggle to distribute gains, with no one losing, rather than an analysis of redistribution or coercion in which some individuals gain, and others lose.

Steelman's book, *Implementing Innovation* (2010), also uses an institutional approach and poses a question similar to that of this study, but explores it in a very different way. Steelman asks, "why were some … innovations implemented [and] others were not?" (2010, 1). Steelman uses institutional theories to show that formal and informal structural parameters shape an organization's actions, and this can constrain or facilitate innovations. This is very similar to

Elinor Ostrom's Institutional Analysis and Development framework, which points to structural

boundaries as explanatory variables when considering whether and when policy change can

occur (Ostrom 2005). These approaches focus solely on institutional constraints as explanations,

including forced and voluntary regulation of actions. This study takes a different approach that

incorporates institutional barriers into the analysis but also focuses in on the informal network

relationships based on the exercise of power between actors in a network.

The types of actors in a network may influence the chances of local policy innovation, as

well. Sandstrom and Carlsson (2008) did a comparative case study of four networks within the

higher education policy sector to explore whether the diversity of actors in a network are related

to the effectiveness and innovativeness of the network; diversity is considered in terms of how

different the missions and identifies are between the actors. They defined heterogeneous

networks as composed of actors from dissimilar backgrounds and representing different

organizations. They found the more heterogeneous networks had higher levels of resource

mobilization in the process of policymaking. The actors within the more heterogeneous networks

reported active and successful resource mobilization processes, in which new actors possessing

the proper resources and qualities were easily engaged in the work to establish the specific

knowledge areas. Innovation, understood in that study as the ability to promote new lines of

thinking and develop new concepts, is seemingly promoted by heterogeneity of organizations in

a network. Variations in innovation and the ability to perform a successful resource mobilization

process might indeed be related to variations in network heterogeneity (Sandstrom and Carlsson

2008).

Other studies have drilled down to the local level to explore policy adoption, yet are still

focused on governing structures instead of more fluid diffusion of information through

networked actors (Hawkins 2011). Hawkins (2011) uses the concept of resource dependency as influential in whether local redevelopment and smart growth policies are implemented locally. This perspective underscores the importance of local governing relationships on policy choice and the preferences of local interests for growth and development. Hawkins' study was conducted on the local level, and uses resource-dependency to understand policy choice. Hawkins' study uses governing structures and this study uses networked arrangements to answer similar policy adoption questions.

Structural features of the network are also relevant to this study. In a 1997 HIV Wellness Collaborative study in Orange County, California, done by Takahashi and Smutny (2002), they found that structures do emerge from repeated collaboration, and if the governance structure cannot adapt to changing conditions, then relationships would slowly die. They also found that non-hierarchical, fragmented power arrangements precluded rapid responses to changes in the collaboration. Although this study does not focus on governance structures of collaborative arrangements, it does borrow from this line of research in that there are structural variables that create power differences between actors, such as size-power differentials, trust, information asymmetry, institutional identity and decision-making power shared between actors, one can better study the transactional nature between actors (Kalu 2012).

VII.   Power in Networks

Power relationships between local actors may be considered as an over-arching structure that can encourage or discourage policy adoption. The way in which collaborating actors interact with each other, based on power balances and imbalances, may affect the likelihood of new policies being considered and adopted by a county jail. By studying local actors' roles in a county network and their interactions with each other, one can see how power differences effect

decision-making. These power relationships may explain why some jurisdictions adopt new polices and others do not.

Power as a theoretical underpinning can already be found in theories of policy diffusion including consideration of internal and external environmental constraints, communication relationships, and the pressures of political forces, resource constraints, and public demands (Graham, Shipan and Volden 2013; Hale 2011; Mooney and Lee 1995; Provan and Milward 2001; Shipan and Volden 2008). This study uses power relationships as an additional explanation for why policies do or do not change, and goes beyond considering some measure of power simply as an independent variable.

Collaboration is not only about making public service delivery more efficient, but it also transcends the constant struggle for advantage between actors either in specific policy domains or in the control over resources (Kalu 2012). Most public-sector agencies may continually seek influence, attention, and dominance over other agencies within their policy domain and this may lead to collective action problems (Kalu 2012). Public administration problems are reflected in the process of interactions or transactions between actors over goals, priorities, and power over the group (Adam and Kriesi 2007; Kalu 2012). The transaction cost of collaboration involves the information, bargaining, and decision costs of actors seeking to find levels of agreement (Adams and Kriesi 2007; Kalu 2012; Fry and Jos 2008).

Fellow collaborators will jockey for authority and positions of decision making power within a network. Resources are shared in this group to promote its maintenance and sustainability. Because collaborations lead to the creating of a new governing structure, certain arrangements are built over time, based on the repeated interactions of the actors, to organize the behaviors of the participants (Adam and Kriesi 2007; Kalu 2012). Depending on the types of

interactions within a collaboration, certain structural patterns emerge in the group. This is primarily due to the nature of the functional relationships between participants and the different capabilities, or resources, each brings to the table. In the public sector, most agencies perform specific functions mandated within the requisite expertise of their legislative mandate. Expertise may be possessed by relatively few people in any given dimension of a policy question or substantive policy area; these experts then make their knowledge available to the rest of the group via collaboration. In the case of medical issues and HIV testing, only a few people in a county network are likely to have specialized knowledge to share with the group.

Power has long been part of the way political scientists think about politics and most have tried to fit power into a rational choice framework. Long (1949) says that the lifeblood of administration is power, yet it is often taken for granted, put aside as periphery matter, and simply not fully developed in theory. "Who is the Boss?" Long (1949) asked this as a central question of public administration. Durant (2015) follows up on Long's call for theory building and not much has changed since 1949. Margaret Levi (1997) has been a proponent of power-based theory arguing that political institutions are shaped by power asymmetries and that they protect and promote interests of the powerful. Only rarely have researchers employed longitudinal and comparative research designs necessary for truly studying the processes involved in the building of power relationships (Durant 2015).

Cooperation and power are two sides of the same coin: cooperation makes the exercise of power possible and the exercise of power often motivates cooperation. To focus on cooperation alone misses the essence of what is going on. Cooperation is essential, but it is bound up in the exercise of power (Moe 2005). Foucault said power is the ability to influence, encourage, or constrain in a complex strategic situation in each social setting (O'Leary 2006). Power can also

be defined as one actor intentionally shaping the choice set of another (Moe 2005). Power is essential in understanding how actors interact to make decisions. Even basic claims of cooperation, mutual benefit, and stability become unclear once power balances are questioned.

Power dynamics must be a consideration and included in the bargaining framework instead of viewing power as something static (Saz-Carranza, Iborra, and Albareda 2016). Power dynamics may shape collaborative endeavors such as the decisions of actors in a network (Saz-Carranza, Iborra, and Albareda 2016). Power resides in the one's dependence on another (Emerson 1962; Malatesta and Smith 2014). Power-based explanations of decision making are plausible, considering each actor in a network has different interests, aims, and resources that dynamically shape the relationship and its outcomes to their advantage by holding or controlling key resources (Saz-Carranza, Iborra, and Albareda 2016). Following, power within a network is conceptualized in this study as resource dependency. Resources are defined as capacity, money, reputation, and political influence. The conceptualization of resources is explained in detail in Chapter Three.

Through the lens of the network approach and using the policy diffusion mechanisms already identified in the literature, this dissertation explores the nature and extent, if any, of the role that power arrangements play in the diffusion of innovation at the local level. Power is conceptualized as being built by repeated interactions and exchanges of resources between actors. This conceptualization is an important contribution of this study because it better explains policy adoption and implementation in the face of federalism barriers.

Power relationships emerge from repeated interaction among actors in a network (Adam and Kriesi 2007). Delegated or centralized authority within the network can affect the response time to new information, and the way the network processes information (May, Workman, and

Jones 2008). Adams and Kriesi (2007) put forth a framework for understanding interactions among participants in a network. Adams and Kriesi (2007) posit that network relationships consist of two elements: a set of actors and the relationships between these actors. As described in detail in later sections, Adam and Kriesi's power dynamics framework guides the research design of this dissertation.

Milward and Provan (2000) illuminate the role of a strong central actor in a network composed of state and local actors. Their study involved the relationship between funding, network structure, and client outcomes in the mental health services arena. Institutional design was conceptualized as a four-category variable that captured the method of delivery of mental health services to the public: 1) quasi-market; 2) private; 3) public; and 4) monopoly. One mental health network was dominated by a powerful organization that functioned like a monopoly and had much higher levels of client and family satisfaction than other network structures. The structure of this network closely conformed to principal-agent theory and was characterized by the centralized integration among providers as controlled by one powerful entity. The findings contradict conventional wisdom of competition as a good thing in public service delivery (Milward and Provan 1998; 2000). However, these findings do fall into line with how grant-makers select who to give the high dollar amounts, which are organizations and agencies that have the capacity to administer large grants.

Fischer (2014) explores coalition structures influencing policy change. Fischer uses Qualitative Comparative Analysis to compare 11 important policy processes in Switzerland between 2001 and 2006. Fischer (2014) assumes that policy change happens because of negotiations and coordination among coalitions. The study analyzes how conflict, collaboration, and power relations among coalitions of actors' influence policy change in an institutional

context of a consensus democracy. Fischer finds that major policy change is facilitated by coalition structures with low conflict and strong collaboration among the coalitions, and by coalition structures with dominant coalitions and weak collaboration. Competing coalitions that are separated by strong conflict but still collaborate strongly produce policy outputs that are close to the status quo. Fischer (2014) found support for the Adam and Kriesi's (2007) framework on a national level with through the study of national coalitions. Fischer found that weak conflict with strong collaboration among coalitions facilitates major policy change. In situations of strong conflict, policy change is still possible if a dominant coalition defends a solution of major policy change and then does not collaborate with minority coalitions. Although strong collaboration among coalitions facilitates major policy change in the absence of conflict, it favors a policy output close to the status quo (Fischer 2014).

The Adam and Kreisi (2007) framework conceptualizes and suggests analyzing power relationships among actors through the interactions types based on exchanges of resources. Power dynamics are the undergirding motivation of actors instead of traditional conceptions of voluntary cooperation leading to collective action.

Figure 2.1 demonstrates the connection between all the different mechanisms mentioned thus far within the existing literature. This figure presents how power relationships fits into the current literature. Morality valence and power arrangements are at the top of this figure to show both concepts' overarching importance in understanding the other mechanisms of policy adoption. Morality valence overarches all other mechanisms because it reflects the general public perception of a particular policy and policy goals. This valence will influence the power arrangements of a network. Power arrangements are on the same level as morality valence because other mechanisms explained in this chapter and found in the literature all depend on the

power dynamics of the administrative network. The network uses politics, demand, and resources in accordance to their relationships with each other. These mechanisms are politics, demand, and resources, as listed vertically in this figure. Following are special information (Hale 2011) and federal funding. These two specific resources are listed in the figure because this study relies on these concepts to create some of the explanatory variables, such as information and expertise, and federal grant funding to the local network.

[Figure 2.1 about here]

This conceptualization of the mechanisms at work, as described in the figure and in this section, can explain where the independent variables of politics, demand, and resources fit into the overall picture of factors that influence policy adoption and the diffusion of innovation across jurisdictions or networks. How actors interact reflects and creates power relationships and perhaps more lasting arrangements.

There are a range of interactions between government agencies and organizations within a network. These relationships might come from legal or statutory authority, chartered or unchartered coalitions, or based on grants procurement (Agranoff 2007). Public agencies share their authority to provide public services with organizations in a network of mutual dependence. Joint activity is dependent on seeking an adequate supply of resources. Organizations that have resources on which others are dependent can influence the actions of those others that grant them even greater advantage (Kalu 2012). Resource differentials and dependencies would suggest power differentials (Rhodes 1981). Hoarding of any of these would result in power asymmetries, and could prevent policy change.

Organizations differ in resources; thus, different resource dependencies and power differences will exist within networks (Rhodes 1997). There is a need to observe and study

power balances and disparities based on knowledge, technical skill, organization skill, and leadership (Agranoff 2007). The literature suggests that actors in a network are in some form of interactive resource dependency, usually based on resources and information exchange (Agranoff 2007; Hale 2011). Mutual dependency, particularly oriented based on the availability of resources, provides an explanation for actors in a network to work together in the first place. Dependencies between actors can be based on knowledge, technical skill, organization skill, and leadership. Mechanisms of such dependencies include size-power differentials, trust, information asymmetry, institutional identity or reputation, and decision-making ability (Kalu 2012). Potential resources, such as funding opportunities, access to programs, new technologies, and educational opportunities, can enter the transactional mix to create further dependencies (Adams and Kriesi 2007; Agranoff 2007).

Actors in a network may want to assert influence over a collaborating group to achieve certain policy ends. Most public-sector agencies and Community Based Organizations (CBOs) seek influence, attention, and dominance over others within a contested policy domain. On the local level, it is expected that similar collective action problems exist (Ostrom 1998). These problems are reflected in an evolving process of continuous transactions over the instrumental objective of power, mission, and identity (Kalu 2012). These concepts are elusive and hard to measure, yet can be observed in a local network through actors' repeated interactions with each other (Adam and Kriesi 2007).

There are costs associated with network actors working together, as well as working alone. Some actors cannot accomplish what is legally required or desired without the resources of another. Actors involved in public service delivery must face the costs of collaboration that include the exercise of organizational power or the withdrawal of it, resource "hoarding" within

agencies, and policy barriers that frustrate collaboration (Agranoff 2003). Although the literature

suggests that local administrators complain about money and personnel as barriers to

implementing rapid HIV testing in jails, staff also report that lack of communication between

actors in a network, resistance to change from key players, and difficult dynamics among

important actors within a county and state, can limit or kill the success of even the most

promising implementation strategies (Beckwith et al. 2011; Mitchell et al. 2015).

Money, whether it be state or federal funding, is crucial to the perception of public

administrators that policy change as possible (Mitchell et al.2015). However, it is not the only

type of resource shared in local networks. Different partners in public service delivery may play

different roles in the network and exert power over certain necessary roles: advocacy,

communication, technical assistance, facilitator, or funder (Thomson and Perry 2006). Power

could be related to size of an organization or the possession of key resources deemed

instrumental to the success of a collaborative effort. Information is a resource among public

administrators and the sharing of such can help a policy innovation diffuse (Hale 2011).

Information sharing may be as essential an interaction within the network to drive policy change

(Agranoff 2003).

Table 2.5 below shows how Adams and Kriesi (2007) conceptualize the distribution of

power in a network based on interactions between actors. Networks in this study are described

through two ways categories of variables: Composition variables (characteristics of the actors)

and structural variables (specific types of ties between actors) (Adams and Kriesi 2007).

Compositional variables and structural power arrangements constitute the key explanatory

variable in this study. The structural nature of the network is measured by specific ties between

actors and measure through interactions, and determines the power arrangement of the network.

[Table 2.5 about here]

In Table 2.5, the left column lists the type of variable as compositional or structural, the middle column lists the concept measured, which is either interaction patterns or power arrangements, and the right-side column lists the variables used to measure the concepts. Interaction patterns are measured as conflict, bargaining, or cooperation, and the power arrangements are measured as either concentrated or fragmented.

Chapter Three explains in greater detail the research design and methodology of this study. The research question and expectations are operationalized, and data collection and methods of analysis are presented. The chapter also identifies the strengths and weaknesses of the design and the study.

<center>Chapter Three: Methods</center>

I. Introduction

This dissertation uses a framework of power arrangements within networks as the overarching explanation for policy diffusion decisions in county networks that administer HIV testing in jails. The research design is exploratory and qualitative, and utilizes both secondary and original data. The analysis controls for competing explanations by considering competing explanations for policy diffusion advanced in the literature and discussed in previous chapters. The case study method is used to understand the relationships between local actors in a network. Interviews of selected counties are conducted over the course of a few months, mostly through phone interviews. A qualitative analysis is used to understand the interview data. In the next section, the research design is explained.

II. The Research Design: A Comparative Case Study

A good research design is anchored by validity and reliability in every stage of the design. Validity of measurement refers to measuring what we think we are measuring, and with a concept such as culture, in any emanation, this is acutely important. Reliability means that if future researchers were to apply the same design in the same way, they would produce the same or similar inferences from the analysis (King, Keohane, and Verba 1994).

Data collection for this case study followed the three principles suggested by Yin (2009) to improve the construct validity and reliability of the case study method. These principles are: using multiple sources of evidence, constructing a case study database, and maintaining a chain of evidence. Using multiple sources of evidence collected by various methods allows for the triangulation of data. Constructing a case study database allows for the easy retrieval of raw evidence for independent inspection. Maintaining a chain of evidence provides a pathway for the

readers of the case study to link the research question to the conclusions (Yin 2009). This study uses many different sources of secondary data to triangulate the primary data; uses electronic and physical file folders for each selected case to store data; and the research question is addressed in the case study's data collection instruments, as well as connected to the data presented in Chapter Four.

The case study design is very valuable for uncovering phenomena in which there is limited quantitative data or a very striking human element to be measured. Case studies can provide great depth into unknown spaces. HIV testing in jails is one of those spaces in that there is limited reliable data of HIV testing policies and methods and no systematic collection of HIV testing methods of county jails. The downside to this qualitative research design is the limited scope in which this study's findings apply. Only six cases were able to be selected and getting administrators to respond to a study inquiry is difficult, resulting in less than complete data for each network selected. However, the data that was collected is rich with information and will lead to better research in the future of this understudied area of criminal justice and HIV policy. The next sections explain how this case study was conducted.

III. Collection of Data

Secondary data was first collected to create variables for case selection. Counties are selected based on internal and external mechanisms identified on the policy diffusion literature: demand, resources, and politics. The data sources for each mechanism are presented later in a table in the Case Selection section of this chapter. These concepts are based on the work of Berry and Berry (1990), Mooney and Lee (1995), and Shipan and Volden (2008).

Demand is operationalized as how much a jail is likely to need the benefits of rapid HIV testing, such as high turnover in jails. Here, this is conceptualized per capita, using "most

inmates held within 30 days" from the Annual Survey of Jails in 2014, and normalized per county population. This indicator measures whether there is a high demand for HIV testing in a heavily transient jail environment and a need for a quick turnaround for HIV test results.

Resources are any factors that enhance the ability of advocates or opponents of a policy to promote or quash new policy adoption, such as CDC grant funding for HIV testing. Here, resources are conceptualized as whether the jurisdiction was directly funded by the CDC for HIV prevention and testing efforts through grant PS12-1201.

Political decisions are reflected through state laws. State law can explain why a county jail has certain policies. State law has the power to coerce counties to compel or limit their actions (Shipan and Volden 2008). Many counties may not consider new HIV testing policies in jails if the state has laws in place limit a jail's actions (Shipan and Volden 2008). Political factors are conceptualized as: whether a state's law is in accordance with CDC HIV testing recommendations (and this is used for case selection); majority vote for president, as either Trump or Clinton, in the 2016 election; state HIV testing requirements; and state rapid HIV testing laws.

Lastly, morality valence of HIV policy in the county is conceptualized as whether the county has a needle exchange program. Mooney and Lee (1995; 1999) bring the idea of morality valence as a factor to consider. Mooney and Lee (1995) found that certain conditions must be present for social learning to occur, such as a politically friendly environment for certain policy solutions to even be considered. The cases are discussed in further detail later in this chapter, in the Case Selection section.

After the cases were selected, I contacted a jail administrator from the selected county. After informed consent was given, I administered a preliminary survey to see who else works

with them to make HIV testing possible in the jail. This survey also asks about shared priorities between all the named actors. After they completed the survey, I went through the interview questions with them. Once I got in contact with another actor in the network, and I received informed consent, I then gave them the preliminary survey and administered the interview. This process is detailed later in this chapter, in the Instruments and Procedures section.

IV. Research Expectations

This study expects to find relationships between different types of power arrangements and policy diffusion at the local level. A systematic analysis of the impact of administrative networks can begin with interaction patterns and how concentrated power is in the networks. This can help uncover why networks have different HIV testing policies.

This study engages one general expectation: In comparing networks, those in a cooperative and concentrated power arrangement are the least likely to change their policy away from the status quo. Put in specific terms of this study, networks in cooperation and with concentrated power arrangements are the least likely to change their HIV testing policy and testing method away from an opt-in and non-rapid testing at admission.

The existing literature refers to the relative share of power of different types of actors. The actors in the selected networks interact often to make HIV testing in jails possible. This aspect is part of the distribution of power in a network. The distribution of power can be operationalized by reputational, positional, or participation-based indicators; these have been developed in community power studies on local political elites (Laumann and Pappi 1976). The operationalization of interactions between actors involved based on interview data is inspired by earlier work on political elites and their involvement in specific policy areas (Laumann and Pappi 1976; Knoke 1996; Kriesi 1990; Kriesi and Jegen 2001; Kriesi, Adam, and Jochum 2006).

Power relationships are conceptualized as concentrated and fragmented. Concentrated power is when one dominant actor or a coalition of actors are bigger, have more staff, money, reputation, or information expertise. Fragmentation of power is operationalized as many actors being on equal footing in terms of resources. These relationships in turn effect whether policy change will occur away from the status quo (Adam and Kriesi 2007; Carpenter 2001; 2010; Carpenter and Krause 2012; Kalu 2012; Moynihan 2008). Table 3.1 shows the possibility of change based on these different conceptualizations of power.

[Table 3.1 about here]

The distribution of power is divided into Hierarchical and Horizontal. The types of interaction between actors are listed at the top of the table: Conflict, Bargaining, and Cooperation. Within the table, the distribution of power variables line-up with the interaction patterns. Hierarchical Conflict is the asymmetric delineation of priorities by one or few actors. Horizontal Conflict is the competition of priorities between actors in a network. Hierarchical Bargaining is the asymmetric possession of resources in one or few actors in the network, while Horizontal Bargaining is when resources are more symmetrical. Hierarchical Cooperation is when there are leaders of the group, but this authority is accepted by the network. Horizontal Cooperation is when actors share in decision making.

In conflictual circumstances, it is expected that rapid serial shift will occur whereas incremental changes are more likely in bargaining situations. Cooperative environments are likely to maintain the status quo. The degree of concentration of power is expected to determine the potential for change. It is assumed that the potential for each type of change is greater when power is fragmented, as based on Adam and Kriesi's (2007) work. If the power is fragmented, then the scales are more easily tipped in the favor of challengers instead of champions promoting

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the status quo. When power is concentrated, challengers lack the resources to break the status quo (Adam and Kriesi 2007).

Status quo policies are those that were in place before the CDC's 2006 HIV testing recommendations. A policy change is measured as the nominal difference between the county's pre-2006 policy and their current policies (opt-in to opt-out, voluntary to opt-in, voluntary to opt-out, or voluntary or mandatory). Incremental changes will be policies that are mostly like the county jail's pre-2006 policy, with a few updates. A rapid serial shift is a whole-sale policy change from one nominal category to another. These conceptualizations of status quo, incremental, and rapid serial shift in policies are based on the definitions used by Adam and Kriesi (2007). This conceptualization of policy categories assumes that most jails did not have opt-out and rapid HIV screening in jails before 2006. This assumption comes from the review of the literature and secondary data from the CDC, BJS, and HRSA; most jails did not, and still do not, have opt-out policies and rapid HIV testing.

IV.   The Dependent Variable

The dependent variable is the HIV testing policy and HIV testing method of the county jail. There is a general delineation between jails who test everyone unless they do not want to be tested (opt-out) and jails who only test people who are required to be tested or request to be tested (opt-in). The method of which the jail uses falls into two categories as well, either the traditional blood sample is drawn and tested off site, or the initial test is a rapid method which is done on-site, and positive tests are confirmed with traditional blood samples.

The dependent variable is presented in Figure 3.1. It is based on categories of policy types of *opt-in* or *opt-out* and testing method as *traditional* or *rapid*. This variable is expected to encompass the practices of all selected cases because of what is already known from the survey

of the literature. These categories are somewhat discrete and can describe the majority of jail HIV testing policies in the United States. The jail could have no formal HIV testing policy in the jail or no HIV testing. However, most jails have either opt-in, high-risk populations only, or out-out policies. These policies are paired with a method of testing, which is traditional blood sample testing in a laboratory, or rapid testing in which all positive results are confirmed with a traditional test. These categories make sense as the dependent variable because all county jail policies and methods of testing will fall into one of these groups.

[Figure 3.1 about here]

I expect to find variation in HIV testing policies and HIV methods of testing. Most jails will have a formalized testing policy. This variable represents HIV testing policy at admission or shortly after admission of all inmates. This variable will be used to determine whether the jail maintains the status quo, is experiencing or has recently experienced a slow incremental change, or a rapid serial shift to a new policy and method. This conceptualization of status quo, incremental change, or rapid serial shift, comes from Adam and Kriesi's (2007) framework. How I analyze the independent and dependent variables is discussed later in this chapter. Next, the method for selecting cases for study is explained.

V. Independent Variables

Interaction patterns will determine the power arrangements and their alignment with three general interaction categories of cooperation, bargaining, and conflict (Adam and Kriesi 2007) These interactions are the predominant patterns of interaction among stakeholders in a local network. Such patterns can be observed through measuring priorities shared, resource asymmetries, and how decisions are made within the working administrative group.

Cooperation is operationalized as how often an organization goes along with the consensus of the group or goes along with the ideas of a leader, or champion, in the network (Adam and Kriesi 2007). Resources exchanged in cooperative interaction patterns can include state and federal grant monies, agenda setting, and trust. Cooperation can be either horizontal or hierarchical. Horizontal Cooperation is cooperation on equal terms of resources. Hierarchical Cooperation is tiered cooperation, and actors are not on equal terms.

Bargaining is when actors attempt to seek out areas of agreement. Bargaining is operationalized as how often organizations attempt to convince the others of their ideas, goals, and priorities. Resources included here can be capacity, money, information exchange, and reputation. This bargaining feature of policy making is emphasized by Coleman (1990), who considers social action to be a negotiating process in which actors, constrained by their existing resources and driven by their pursuit to maximize their interests, interact. It is a matter of giving and taking, and the success of individuals depends upon the resources they possess as well as the recourses held by others and the strategic and social context constraining their opportunities (Sandstrom 2008). Bargaining can be asymmetrical or symmetrical based on resources controlled by the actors involved. Asymmetric bargaining is unbalanced, disproportionate bargaining and symmetric bargaining is equal, proportionate bargaining (Adam and Kriesi 2007). Bargaining based on exchange of political resources, rather than cooperation based on trust, can be the main way of interacting between stakeholders to reach well-defined goals. Consequently, the actors' mode of participation and interaction in decision making is central to understand how conflict is managed to produce desirable outcomes (Dupuis and Knoepfel 2015).

Conflict can take the shape of a dominate actor being challenged by another actor or many actors in competition with each other. Conflict in priorities can elucidate who is dominant

or whether priorities are in competition (Fischer 2014). Indicators of conflict are the number of actors involved, the complexity of interests represented in the network, established rules of order or proceedings, and cost of cooperation involved in being part of that network. Conflict is the result of an actor's ambition to maximize their advantage and utilize the desirable resources to fulfill their preferences and priorities (Sandstrom 2008; Fischer 2014). Conflict over priorities can be either dominating or competitive conflict between actors. If a dominant actor is being challenged by others in the network, then this is a different set of interactions than whether actors on more equal footing in terms of resources are in competition (Adam and Kriesi 2007).

VI. Case Selection

Six counties were selected for study: Clark County, Nevada; Cook County, Illinois; Fulton County, Georgia; Harris County, Texas; Miami-Dade County, Florida; and Los Angeles County, California. Each case was selected based on the variables of demand, resources, and politics. Below is Table 3.2, which presents data sources in the left column, the purpose for which the data are used in the middle column, and the mechanism the data measures in the right column. These secondary sources were used to compile data on each mechanism used for case selection.

[Table 3.2 around here]

Not all data was used to select cases. Politics, as measured by who the county voted for president in the 2016 election, had no variation, for all voted a majority for Hillary Clinton, and was not used in case selection. State laws as in compliance with the CDC recommendations was instead used to represent politics. It should be noted that morality valence, while similar to politics, is a different concept and was measured by two different kinds of data. As seen in Table 3.2, data was collected for both.

This study selects cases by considering the independent factors above, which have been shown to have an impact on policy diffusion. Table 3.3 shows the six counties selected for study. The selection criteria are: jail population per 100,000 people; state law alignment with the CDC recommendations; direct grant funding from the CDC to the county; and if the county has a needle exchange program. The jail population number is based on the Bureau of Justice Statistics for the average number of inmates in a 30-day period in 2014. This average jail population is weighted by county population, and then transformed into a per capita number as presented in this table.

The first cut at selection of counties was based on a most similar comparison, and based on demand. I calculated the per capita number for the top 20 counties presented in the BJS data of the county jail's highest population in a 30-day window in 2014. Ten counties with the highest per capita number were selected as most similar for the per capita calculation. Once this demand variable was created, the variables of resources, politics, and morality valence, were used to select: Clark, Cook, Fulton, Harris, Miami-Dade, and Los Angeles County. The six counties reflect a diversity of "yes" and "no" across the other independent factors used in this comparative case study. State law alignment with CDC testing recommendations is the politics variable. The direct grant funding from the CDC to the county is the resources variable. The needle exchange is a measure of morality valence, in that a county that can get a needle exchange up and running probably views HIV morally differently than a county without a needle exchange.

[Table 3.3 about here]

As shown in the Table 3.3, Harris County, Texas does not have state law alignment, direct funding to the county, nor a needle exchange program. Los Angeles County, California,

has all three. Cook County, Illinois has state law alignment, no direct funding, and a needle exchange. Clark County, Nevada, has state law alignment, no direct funding, and no needle exchange. Fulton County, Georgia, does not have state law alignment, has direct funding, but does not have a needle exchange. Miami-Dade County, Florida, does not have state law alignment, does not have direct funding, but has a needle exchange program.

VII. Instruments and Procedures

Interview data was collected on three types of independent variables: priorities, resources, and decision-making. To drill down into interactions between administrators in county networks, I use interview data to paint a full picture of interactions between local network actors in the network, and between local actors and predictors of policy adoption. The interview instrument utilizes a transactional approach to measuring power. This is based on measuring how a group makes decisions when collaborating, and coding for points of power as noted by Huxham and Vangen (2004) and Kalu (2012). Interview questions encompassed several major areas of inquiry, including interactions between actors invested in HIV testing in the county jail, testing polices in the jail, the reasons these policies were adopted, and the others with whom the actor works in other government and nongovernmental arenas to make HIV testing in the jail possible. This section goes through all the different procedures and instruments used to collect data. Procedures include the Institutional Review Board protocol process, in which a solicitation email was submitted and approved, and an informed consent form was submitted and approved for use. Instruments include an interview, and within the interview I uses a list of actors to best organize those involved in the local network. The interview itself is forty (40) questions long and was administered either by email or phone.

a.   Solicitation Email and the Informed Consent Form

In investigating the selected networks, I first contacted the sheriff's office with an approved solicitation email. The email introduced me, the purpose of the study, and how the person was asked to participate. What that participation entailed was also specified, including the general nature of the interview questions and approximately how long the process would take. The informed consent form was mentioned in, and attached to, the email.

Prospective participants were instructed to read, print, sign, scan, and send it back to me. The informed consent form was approved by the Auburn University Institutional Review Board. Each participant was sent this form to review and sign before any data was collected. If the form was emailed, then the participant printed it out, signed it, scanned it, and sent it back electronically. If the form was received physically through the mail, then the participant signed it and sent it back in a sealed and pre-stamped envelope provided.

The form introduced me and the committee chair, providing contact information for both, and briefly detailed the details of the study and the interview used to collect data. This form is a two-page form. The participant is asked to initial on the first side, and sign and date on the back. When forms were received, I signed and dated the form on the second page. I kept electronic and physical informed consent forms in an encrypted file and in a locked filing cabinet. If the form was emailed, I saved the electronic copy and then printed a physical copy to file.

b.   The Preliminary Survey

A preliminary, one-page survey was administered in conjunction with the interview. This short survey provided me with a list of network actors and facilitated my ability to personalize questions specific to the network and the participant during the interview. Priorities shared were collected through the preliminary survey, and the actor was asked whether he or she completely

shared, somewhat shared, somewhat did not share, or do not share, goals with other actors in the network. In the interview, the respondent was asked why she chose what she did on the survey.

In this survey, I ask the participant to list who she works with on one side and how much her organization or agency shares priorities with that actor. The description says: "Please list people and their organizations that you work with the most to conduct jail policy design and HIV testing in the jail. For all listed, please circle whether you "completely share," somewhat share," "somewhat do not share," or "completely do not share," priorities and goals." All participants completed this short survey by themselves and not over the phone. Once this short survey was received, I set up an interview time convenient for the participant.

This survey provided a central listing of network actors. I attempted to contact everyone listed by the jail administrator for interview. Once another actor was contacted, and a new actor was listed, I contacted them as well. This process continued until I interviewed everyone identified or I received no response after three tries and two weeks had passed after the last attempt to contact the actor.

c.   The Interview

The comparative case study method is used here to explore and explain why county jails adopt certain HIV testing policies regarding the federal recommendations for HIV testing in a health care setting, in which jails are included. Interview questions include questions about interactions between invested actors in HIV testing in the county jail, testing polices in the jail, the reasons these policies were adopted, and who the actor works with other government and nongovernment actors to make HIV testing in the jail possible. The interview is 35 questions long.

The first two questions ask the participant to identify her role at her organization and identify her employer. There are six questions that capture data about the type of HIV testing policy and method the jail uses. Questions measure priorities, resources, or decision-making. There are eight (8) questions that measure priorities, eight (8) questions that measure resources, and four (4) questions that measure decision-making. There are two questions at the end of the questionnaire that ask whether any question was unclear or whether the participant thinks I missed something important. These two questions measure internal and external validity, respectively.

A few questions ask how aware the administrator is of the surrounding area's policies and what their own professional organizations are saying about HIV testing in jails. Questions were asked about the policy environment include various aspects of proximity and social learning as identified in the literature and discussed previously in Chapter 2. To measure both proximity factors and social learning I asked actors in the network whether they relied on the actions of any other jurisdictions to design and adopt their own HIV testing polices.

Interview questions also attempt to elicit responses tied to three categories of variables: Priorities; decision-making; and resource asymmetries. These questions measured if actors have mainly convergent or divergent priorities (Fischer 2014; Sandstrom 2008). Data on decision-making processes are catalogued through many interview questions. The interview questions explore decision making between the jail administrator and other actors in a network. Questions include who the jail administrator works with to achieve HIV testing in jails, how the group of stakeholders came to their decision on what HIV testing policy they use, what kind of federal grant funding they receive for HIV testing, and the distribution of resources between actors needed for implementation.

Data on resource asymmetries are collected through interview questions. Indicators of specific resource asymmetries between actors include an actor's capacity, money, reputation, trustworthiness, and information expertise in comparison to other actors in a network. Using resources, actors will either press their priorities, comply with the group, or bargain with others to get some or all of what they want. Networks will be in cooperation, bargaining, or conflict, and this will influence how they make policy decisions.

The first asymmetry, capacity, includes jail staff and jail facility space for HIV testing. This is an important characteristic of the jail and other actors to discern whether the jail can practically and confidentially test for HIV in the jail. Whether the jail does or does not have that facility space or staff, it may rely on another organization or private company to test for HIV.

The second asymmetry, money, is operationalized as budgeted money for the jail and federal and state grant money awarded. What is budgeted for the operation of the jail may or may not cover HIV testing procedures, and CDC grant funding is most likely used to cover this financial shortfall. This asymmetry is relevant because more money going to the jail could be used to development and implement new policies.

The third category of resource asymmetry is reputation and influence. Some actors will have more sway in the policy process because of how other perceive them as reliable and trustworthy. Fischer (2014) measured conflict in a network by reputational power. Based on a list comprising all actors participating in each process, interview partners were asked to indicate those actors that, in their view, had been very influential. Based on these answers, Fischer (2014) calculated the score of reputational power of each actor, which corresponded to the mean of all the judgments of the interview partners. The power of each coalition was calculated by aggregating the reputation of each actor in a coalition.

The fourth asymmetry is dependability. Repeated interactions can give certain actors a resource of trust and reliance. This creates a resource depending on who promises to do what, based on reciprocity and trust between actors in a network (Thomson and Perry 2006). Certain actors provide consistent and continuous policy information, which may also align with a particular direction, and are relied upon the most to provide help to the state in making policy decisions (Hale 2011). An actor can speak very clearly on how much they rely on another organization or agency and speak to their trustworthiness. Indicators of such are tested through targeted interview questions.

The fifth asymmetry is information, technology, and expertise. Those that have a better handle on technology or have access to more technical information will have the upper hand in negotiating with the other actors in the network. Actors may rely on others for their expertise when discussion and developing new polices.

Table 3.4 below shows specific questions asked in the interview that directly test these concepts of decision-making, priorities, and resource asymmetries. Not all the interview questions are presented in this table. These are only those questions that specifically test the concepts discussed in this section. In the table, resources are subcategorized as capacity, money, reputation, trust, and money. These concepts are listed to the far-left side of the table. The question number the concept corresponds to is in the middle of the table, and the question asked is on the far-right. Some concepts are measured with multiple questions.

[Table 3.4 about here]

VIII. Limitations of Methods

In this section, I detail the limitations of using interview data and the case study method. In general, data collection was difficult considering the reliance on local administrators to sit

down with me for a phone interview. Further, the unwillingness of certain people to divulge sensitive information prevented some from participating in an interview.

Getting in-depth information is a long process, and many people are hesitant to give an hour of their time to conduct an interview. This case study heavily relies on the willingness of participants to provide information about what they do, who they work with, and how they work with them on a regular basis. Many administrators are busy people, and getting them to respond to a research solicitation is difficult. Enough data was collected to analyze four of the six networks. However, if I had received back more data from participants, then this would have given me more to compare within and between networks.

Some other limitations of this particular study include jail administrators' fear of being sued or getting involved in litigation over treatment of inmates and HIV care and health care administrators worried about sharing what they are using federal grant money for. The first limitation, the fear of litigation, prevented a lot of administrators from participating. The second limitation, the use of federal funds, was more of a limitation once the participant already started the interview. Although the use of funds appeared to be legitimate, some participants were still weary to answer questions involving how they were using grant money in the jail.

One must also consider endogeneity between variables. Many variables are at work in determining why local networks adopt new policies and practices. The important part is not confusing explanatory variables with the dependent variable. Endogeneity occurs when the values of one's explanatory variables are the consequence, rather than the cause, of the dependent variables. The researcher cannot manipulate the explanatory variables in field research, and the consequence of this lack of control is endogeneity. Qualitative researchers seek

to minimize endogeneity by narrowing-out the dependent variable, and through the case design and selection (King, Keohane, and Verba 1994, 185-191).

It is important to observe whether changes are cumulative and point in the same direction, leading to policy change, so to avoid directionality problems. Endogeneity is also present in the process of policy change research, in that it is important to understand if the change is coming from the external and internal mechanisms selected here, or if it is from something else (Servent 2015). Because the dependent variable is the HIV testing policy and method, there is little feedback from the policy itself to the selected explanatory variables.

IX. Data Collection

a.   The Participants

Participants were either a health care administrator, a jail administrator, or a medical professional. Some respondents were affiliated with nonprofit entities helping with HIV prevention in the community. Data from four of these counties were collected: Clark County, Nevada; Fulton County, Georgia; Harris County, Texas; and Los Angeles County, California. For two networks, Cook and Miami-Dade, no actors responded. A total of eight respondents participated in this study.

b.   Procedures

In each case, I first attempted to contact the county jail through email or phone. The IRB-approved email was sent, which explained the study and included the Informed Consent form as an attachment. All the county jails in the selected cases are operated by a Sheriff's Department, so each Sheriff's office was emailed. If no response to the email was received within a few days, then the email was sent again. If no response was received within two weeks, additional email contact information was acquired through a web search and the same email was sent to those

addresses. If no response was received in two weeks, I called the Sheriff's Department general

information number to try to get a name, phone number, and email for whoever is

knowledgeable about HIV testing policies in the jail. In the case of four counties (Cook County,

Illinois; Harris County, Texas: Fulton County, Georgia: and Miami-Dade County, Florida), I sent

a physical letter through the U.S. Postal Service soliciting participation in the study. Although I

was in touch with the sheriff office of Harris County after mailing the letter, those contacts have

not yet completed the survey and interview.

At least one survey and interview were conducted in Clark County, Nevada (two

participants), Los Angeles County, California (one participant), and Fulton County, Georgia (two

participants). Data was collected from three participants from Harris County, Texas, but an

interview was not fully competed.

All surveys were sent electronically and completed by the participant on their own and

sent back electronically. Most of the interviews were conducted by phone and I recorded all

interviews. Two interviews were sent directly to the participant to complete and I administered

the questions via email. This was due to the participant not wanting to sit down and complete the

interview over the phone in one sitting.

Once the survey and interview were finished for each participant, I transcribed the

recorded interview verbatim. I then saved a copy of the first transcription in an encrypted file.

The transcription was then sent to the participant to review and I highlighted questions where the

answer was unclear or needed more information. The participant then reviewed and added to the

interview transcript and sent it back to me. I then saved a copy of this transcript in an encrypted

file and printed a copy of the survey and edited transcription to be filed in a locked filing cabinet.

After all interviews were filed, I analyzed the collected data by first descriptively mapping the network and level of shared priorities between actors. Then, I coded resource asymmetries so to determine whether the network was primarily in cooperation, bargaining, or conflict. Specifics of the analysis process is detailed in the next section.

X. Data Analysis

The level of analysis is the local administrative network, and its persistent patterns of relationships and interactions between courts, legislatures, administrative agencies, and nongovernmental organizations. Interview questions measure the concepts of conflict, cooperation, and bargaining, the subcategories of horizontal and hierarchical interaction, and degrees of symmetry within the subcategories of resources, priorities, and decision making (Adam and Kriesi 2007). Each interview question is intended to capture data for a particular concept, and each concept is reflected through at least one question. Table 3.4 presents the method of coding interview responses and provides a framework for understanding how the interview data align with the concepts that the questions are intended to illuminate. making, priorities, and resources) is coded, as either asymmetrical or symmetrical. Priorities can by *asymmetric: not shared*, or *symmetric: mostly shared*, or *symmetric: completely shared*. Resources can be *asymmetric: concentration of resources or hoarding*, or *symmetric: resources mostly shared*, or *symmetric: completely shared*. Decision-making can be *asymmetric: one person or group of people make all important decisions*, or *symmetric: decisions mostly shared,"* or *"symmetric: decisions completely shared*. The combination of interaction arrangements and symmetries are reflected in Table 3.5, and provide a method for reflecting a network's power arrangement.

[Table 3.5 about here]

Power arrangements are described as either concentrated or fragmented, and interaction patterns corresponds with each. Table 3.6, below, shows the potential array of interaction patterns. how the interaction patterns are either concentrated or fragmented, based on if they are coded hierarchical or horizontal. In Table 3.6, the far left are the two power arrangements, concentrated and fragmented. On the top of the table are the interaction patterns measured: conflict; bargaining, and cooperation. Each interaction pattern is subcategorized as either hierarchical or horizontal.

[Table 3.6 about here]

Hierarchical patterns describe a network where certain actors have a lot of influence and control over priorities, resources, and decision-making. Horizonal relationships between actors are where many actors discuss priorities, resources, and decision-making. A concentrated power arrangement exists when the structure is hierarchical. A fragmented power arrangement exists when the structure is horizontal. In short, the interaction patterns are used to determine the structure, and the structure is used to determine the power arrangement of concentrated or fragmented.

Each interaction pattern will be described, in turn of cooperation, bargaining, and conflict. Cooperation is operationalized as how often an organization goes along with the consensus of the group or goes along with the ideas of a leader, or champion, in the network (Adam and Kriesi 2007). Resources exchanged in cooperative interaction patterns can include state and federal grant monies, agenda setting, and trust. Cooperation can be either horizontal or hierarchical. Horizontal cooperation is cooperation on equal terms of resources. Hierarchical cooperation is tiered cooperation, and actors are not on equal terms.

Bargaining occurs when actors attempt to seek out areas of agreement. Bargaining is operationalized as how often organizations attempt to convince the others of their ideas, goals, and priorities. Resources available to use in convincing others and that are included in this study were conceptualized as capacity, money, information exchange, and reputation. This bargaining feature of policy making is emphasized by Coleman (1990), who considers social action to be a negotiating process in which actors, constrained by their existing resources and driven by their pursuit to maximize their interests, interact. It is a matter of giving and taking, and the success of individuals depends upon the resources they possess as well as the resources held by others and the strategic and social context constraining their opportunities (Sandstrom 2008).

Bargaining can be asymmetrical or symmetrical based on resources controlled by the actors involved. Asymmetric bargaining is unbalanced, disproportionate bargaining and symmetric bargaining is equal, proportionate bargaining (Adam and Kriesi 2007). Bargaining based on exchange of political resources, rather than cooperation based on trust, can be the main way of interacting between stakeholders to reach well-defined goals. Consequently, the actors' mode of participation and interaction in decision making is central to understand how conflict is managed to produce desirable outcomes (Dupuis and Knoepfel 2015). This interaction pattern is expected to express itself in actors competing for priorities, resources, or who makes decisions.

Conflict can take the shape of a dominant actor being challenged by another actor or many actors in competition with each other. Conflict in priorities can elucidate who is dominant or whether priorities are in competition (Fischer 2014). Indicators of conflict are the number of actors involved, the complexity of interests represented in the network, established rules of order or proceedings, and cost of cooperation involved in being part of that network. Conflict is the result of an actor's ambition to maximize their advantage and utilize the desirable resources to

fulfill their preferences and priorities (Sandstrom 2008; Fischer 2014). Conflict over priorities can be either dominating or competitive conflict between actors. If a dominant actor is being challenged by others in the network, this generates a different set of interactions than if actors who are on more equal footing in terms of resources are in competition (Adam and Kriesi 2007). This interaction pattern is expected to express itself as actors not agreeing on priorities, how to use or who should control resources, and how decisions should be made.

Interview data were used to generate the predominant interaction pattern and power arrangement for each network. Table 3.7 shows how interaction patterns combined with power arrangements result in different options for policy change. These categories of policy change are lined up with the selected dependent variable and if the county's policy stayed the same as before 2006, was updated incrementally, or changed substantially.

[Table 3.7 about here]

A network in conflict and with a concentrated power arrangement has a moderate potential for a rapid serial shift in policy. A network in conflict with a fragmented power arrangement has a high potential for a rapid serial shift in policy. A network in bargaining and concentrated power has a low to moderate potential for incremental change. A network in bargaining with fragmented power has a moderate to high potential for incremental change. A network in cooperation with a concentrated power arrangement has a low potential for change are is the most likely to maintain the status quo. A network is cooperation with a fragmented power arrangement has a low to moderate potential for change and is likely to maintain the status quo. The HIV policy of the county jail will be compared to each of these Expectations to determine if the policy in place lines up with the networks' potential for policy change predicted.

Expectations for policy change can be located along a continuum of change. creates a scale or which kinds of networks are the least to the most likely to maintain status quo policies. Figure 3.2 below is a visual representation of the different levels of policy change that could be reflected by each network since 2006, based on the decisions made by the networks and the actions taken by county jails after the CDC published its HIV testing in healthcare settings recommendations. All county jails have either maintained a status quo policy, had incremental changes to their policies, or has experienced a serial shift. This categorization represents the broad foundation of policy change used in this study. Diffusion of new ideas is reflected in both incremental change and serial shift; the difference is a matter of degree.

Figure 3.2 shows the three categories of policy change on a post-2006 timeline. A network that has maintained status quo policies has the same practices as before the 2006 CDC recommendations. A network that has experienced incremental change has made some updates to their policies or practices, but has not completely shifted over to opt-out and rapid HIV testing. A network that has experienced a serial shift is one that has completely changed their HIV testing policy to convert to opt-out and rapid HIV, as compared to the pre-2006 policies.

[Figure 3.2 about here]

This chapter has presented the research design and expectations about what the data will indicate. The next section will briefly explain the expected findings. In the following chapter, the findings are presented.

XI. Expected Findings

I expect that networks with status quo policies will be in some way resistant to change based on their perceptions of the resources available to make a policy change. Changing HIV testing policies is expected to be perceived as expensive by the networks that serve county jails

with opt-in policies. Local correctional facilities that are hesitant to institute routine screening because of fiscal concerns may not realize that state of the art care costs the facility and community much less than inadequate treatment of HIV (Mayer et al. 2002; Spaulding 2002). However, in counties that may have unstable funding streams to the jail for HIV testing, having an opt-out policy in place would be risky and ill-advised. It does appear from the limited data available that rapid testing is being used more frequently in jails, regardless of whether the policy is opt-in or opt-out. The findings of this study are presented in Chapter Four, and then discussed in Chapter Five.

<u>Chapter Four: Findings</u>

I. Introduction

This dissertation explored the factors that influence the diffusion of innovation at the local level, to better understand why policies change or stay the same in the face of new information, technology, and funding. This inquiry is grounded in the literature of policy diffusion between networks and understandings of power between stakeholders in a local network. I designed a comparative case study to examine interactions between actors in local administrative networks that serve county jails, using secondary data to identify cases most similar on demand and most different on state law alignment, morality valence, and grant funding. I used an interview to collect and catalogue actors' priorities, resources shared, and decision-making processes. This chapter presents the findings from those interviews from four networks. Data were not available from two networks (Miami-Dade and Cook Counties). Data from one network was incomplete (Harris County); the data that were collected for this network are detailed in narrative form but not included in the formal analysis.

II. General Findings

This study examines networks at the local level, however, the laws and regulations of the state influence or mandate the actions of the counties. Each state has different laws and levels of grant funding distributed to counties concerning HIV prevention and testing. Before 2000, most jails had opt-in HIV testing policies, if they had an HIV testing policy at all (CDC 2010; Solomon et al. 2014). Rapid testing was not approved by the FDA until after 2000, and because more prevalently used after 2005 (Kaiser Family Foundation 2015). The CDC has been funding expanded testing efforts for decades, but as shown in the literature and the findings of this study, most states and counties are not investing in rapid testing methods with federal grant money.

Figure 4.1 compares states in compliance with the CDC HIV testing recommendations and rapid HIV testing laws adopted in states over time. It shows that between the year 2000 and 2015 more states adopted CDC recommendations for HIV testing, but the amount of new rapid HIV testing laws being adopted by states has declined. Most states that adopted rapid HIV testing regulations in their codes did so around the year 2005. In 2006, the CDC published its recommendations for opt-out and rapid HIV testing in clinical and correctional settings. As seen in Figure 4.1, fewer and fewer states adopted rapid HIV testing laws in their state codes after 2006. This may mean that before rapid testing was included in the CDC's HIV testing recommendations, states were instead more likely to adopt codified language about how and when rapid testing should be used. In any case, state compliance with CDC recommendations and the adoption of new rapid HIV testing laws do not appear to follow similar trajectories.

[Figure 4.1 about here]

Federal grant money to sub-national jurisdictions is an important incentive for policy change, however, it is not the only way the national government encourages policy adoption on the sub-national levels. The executive branch of the federal government heavily influences where grant money is sent for HIV prevention efforts, and this in turn, affects how the state and local levels can use grant money.

The Obama Administration put out its HIV prevention strategies and goals in 2010 (White House Office of National AIDS Policy 2010). The plan repeatedly indicates that the goal is to reduce HIV infections, and specifically mentions access to health care and reducing racial disparities of HIV occurrence. Increased testing, as a strategy, does not appear in these two strategic plans. Jail and prison populations are not listed as a target high risk groups, although gay and lesbian, black, and Latino populations are listed as such.

The primary data from interviews with practitioners confirms that this strategic plan had an impact on practices. Most grants received by states and counties were written to be used for access to health care for HIV positive people. One finding from primary data of note is that a certain county was using 'access to care' funds for HIV testing, because there was not enough money to continue the testing program in the jail after state budget restructuring. The choice between 'access to care' and increased HIV testing as a policy choice will be further discussed in Chapter Five.

The network that serves the county jail is limited by, among other things, what the state says they must do and the HIV activities that the state is willing to fund. Of the selected cases, the states of California and Florida have state regulations in their codes concerning who can conduct rapid HIV testing and how a confirmatory test is necessary for all rapid tests (Cal. Health & Safety Code § 121023; Fla. Admin. Code Ann. R. 64D-3.02). These states added rapid HIV testing regulations to their codes at different points in time: California in 2012 and Florida in 2008. Florida has an applicable state law that requires that all detainees in correctional facilities accused of sex crimes be tested for HIV. This law was in place before rapid HIV testing regulations were updated in 2008 (Fla. Admin. Code Ann. R. 64D-3.02).

The Center for Disease Control (CDC) has had an evolution of HIV policies and federal funding for prevention activities. The first large-scale effort by the CDC to experiment with new HIV testing policies and testing methods in jails was in 2000. The CDC teamed up with the Health Resources and Services Administration (HRSA) to fund the Continuity of Care Demonstration Project for Incarcerated Individuals within Correctional Settings. This special grant program funded six states, California, Florida, Georgia, Massachusetts, New Jersey, and

New York, and one city, Chicago, Illinois. California, Florida, Georgia, and Chicago, Illinois are all connected to cases selected for this study.

Los Angeles County, Miami-Dade County, Fulton County, and Cook County are all counties of selected networks. Clark County, Nevada, and Harris County, Texas, are selected networks that were not granted the CDC HRSA correctional demonstration project. These jurisdictions were given around one million dollars a year to conduct HIV related service activities in jails, prisons, juvenile detention centers, and community correctional settings.

This dissertation relies on data from one grant from the CDC, generally called the HIV Testing and Prevention grant. In 2012, an additional $20 million was granted to Category C of the Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments (PS12-1201), called the Care and Prevention in the U.S. Demonstration Project (CAPUS). This grant was given to states to implement innovative HIV prevention programs. The health departments granted this money were: Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia. Georgia and Illinois are states that include two selected cases, which are the networks in Fulton County, Georgia, and Cook County, Illinois. These states were funded up until 2015. The required uses of the funding include: increased HIV testing; improve surveillance and data systems; enhance navigation services; and address social and structural factors that contribute to the spread of HIV (CDC 2012). Fulton County, Georgia, was successful in using some of this money to implement rapid HIV testing at admission to the Fulton County Jail with help from Emory University's Rollins School of Public Health (Robillard et al. 2003).

All four counties detailed in the next section used grant funding from either the state or county, and federal grant money that was passed down through the state or the county was directly funded. The four counties are metropolitan and have large jail populations. With these general findings in mind, specific findings for each case are presented in the next section.

III. Findings for Each Case

This case study compares most similar counties, as based on demand. All are large metro counties and have a high demand for HIV testing in jails in terms of how many people come through the county jail in a 30-day period. Findings from four of the six counties selected for study are presented in this section. These counties include: Clark county, Nevada; Fulton County, Georgia; Harris County, Texas; and Los Angeles County, California. Full data is available for Clark County, Fulton County, and Los Angeles County. Some data was collected for Harris County, but an interview was not completed. The data that was collected is still presented for Harris County.

This section highlights the most relevant information collected instead of going through each question in turn. Not all data from each question are presented, and instead the most illustrative answers and quotes are presented for each case. A few questions were very successful in collecting relevant data, and are detailed here. These questions are presented in order of topic instead of number. All answers used in analysis are presented in Table 4.7, found in the Analysis section of this chapter. These findings are analyzed and discussed later in this chapter and in Chapter Five.

a. Case Findings

1. Clark County, Nevada

In the Clark County network, there were actors named in the preliminary survey: the jail, the health district, and a private medical contractor. The jail is funded by the state of Nevada, Clark County, a cost sharing agreement with the City of Las Vegas, and grant funding from state and federal sources. Two of these three actors were interviewed. A larger network of decision-makers was named in the interview, which includes the Sheriff's Department, the County Commission, and the Chief Medical Officer. I reached out to this offices, but did not receive a response. Table 4.1, below, lists the actors identified as part of the network on the left and if they were interviewed in the right-hand column.

[Table 4.1 about here]

Clark County, Nevada is the metro county that houses the largest city in the state, Las Vegas. Las Vegas is the largest city in the county based on population, having approximately 583,756 residents. The Census Bureau estimates there are 2,155,664 in Clark County in 2016 (U.S. Census Bureau 2016). Clark County also includes the large cities of Henderson, and Paradise. In the 2016 presidential election, 52 percent of Clark County voted for Hillary Clinton, the Democratic Party candidate for president (Leip 2016).

There are approximately 198 people in jail per 100,000 people in the county. Nevada had 11,582 male inmates and 1,111 female inmates in 2013 (Bureau of Justice Statistics 2014). This includes prison and jail detainees. Roughly half of Clark County is female (50.1 percent) (U.S. Census Bureau 2016) and therefore there is a much larger male prison and jail population per capita as compared to female inmates.

In 2013, an estimated 459 adults and adolescents were diagnosed with HIV in the state of Nevada. Nevada ranked 24th among the 50 states in the number of HIV diagnoses in 2013 (CDC

2015 State profiles). In Clark County, 441 people were diagnosed with HIV in 2014, and has the most reported cases of HIV in the state (CDC HIV Surveillance Report 2015).

Nevada requires mandatory testing at intake to state prison and a non-specific testing policy at release from prison (Aguilar 2012). Nevada follows the CDC's 2006 HIV prevention recommendations for correctional settings. Clark County is not directly funded by the CDC for HIV prevention and relies on the State Health Department to pass money from the CDC through to the county. Clark County does not currently have a needle exchange but could have a program launched next year to serve the Las Vegas area (Health District 2017).

The state of Nevada receives federal grant money from the CDC through PS12-1201, the largest of CDC's HIV prevention grants, and passes that money through to the health department for various HIV prevention activities. In 2016, money was directed by the state away from HIV testing in the detention facility. The health department is currently using another private grant from a large non-profit to conduct HIV testing in the jail.

The CDC funds the Nevada State health department to implement a high impact approach to HIV prevention, prioritizing the delivery of evidence based, cost-effective, scalable interventions to the most affected communities and regions of the state. Funded activities include surveillance, program implementation and service delivery, capacity building, and routine program monitoring and evaluation (CDC 2012). The CDC also supports HIV school health efforts in Nevada (CDC 2015 State profiles). Including all CDC grant funds, Nevada received $2,668,399 in 2014. From the largest CDC HIV/AIDS prevention grant, PS12-1201, Nevada received $2,457,325 (CDC 2012). This money was granted to the Nevada Health and Human Services agency. This information was found through the yearly published CDC grant funding data.

The jail has an opt-in testing policy at admission, and inmates voluntarily sign up to be tested. The health department and the medical contractor do not use rapid HIV testing kits, but are mobile in drawing the blood from inmates. Medical professionals go from dorm to dorm drawing blood from those that requested or are required to have an HIV test and then take the blood samples to the Southern Nevada Health District for testing. Inmates sign up to be tested for HIV at admission to the jail. Both the regional health department and the private medical contractor work through this list, and the health department officials take the samples back for testing.

Respondents cited a few reasons why the jail had an opt-in, voluntary testing policy in the jail. One reason cited was the instability of funding from the state, county, and health department to invest in rapid testing kits or change the policy to an opt-out policy. Investing in the cost of rapid HIV testing was said to not be feasible right now, considering the lack of funds for testing. It was said that rapid testing may become a reality soon, but not in the immediate future. This attitude stems from the hope that the health department will one day have stable funding for HIV testing in correctional facilities. One respondent said he hoped the Health District could have enough funding from the state and cities to test for HIV in all detention facilities in the state, and not just the Clark County Detention Center.

Another respondent said testing and treating inmates for HIV is expensive. She said: "Testing is expensive. Housing inmates in a jail is expensive. Through our cooperation with the health department we were able to get assistance in covering the costs. Our population has a short stay (for many inmates). They may not be around [sic] to receive treatment or evaluation [for HIV]." The jail started asking inmates whether they wished to be tested at admission in

2016. The blood is drawn at admission or a few days later when a medical professional is available to take the blood sample.

When asked about space constraints to testing in the jail, a health administrator in Clark County said they have mobile testing and walk around the facility drawing blood samples. "… But we definitely don't have staff. And historically because the health department has championed the HIV testing effort in the correctional facilities. We've had to figure that out (on our own)." When asked how the current testing policy came to be, a health district administrator in Clark County said: "I would imagine it's a combination of money and logistics. I don't know that booking is currently, the way things work there, I don't think booking is the ideal place for them to do a test. The other program has been there doing testing for so long we've seen different iteration of how the HIV testing was offered."

The Southern Nevada Health District does partner with the detention center to execute HIV testing, and to help the private medical provider with the testing. The Health District was not a part of HIV testing for a few years, due to the state redistributing funding to things other than HIV testing in detention facilities. The Health District applied and received a grant from AIDS United and the Ryan White Act, funded by the Health Resources and Services Administration (HRSA) of the federal government. The grant is used for linkage to health care for HIV positive inmates being released. Part of this grant is used to test for HIV in the Clark County Detention Center. Grant funds were used to hire four new disease investigators that can draw blood and test for HIV in the Health Department's labs. This grant will end in 2018.

The private medical provider has had a contract with the Clark County Detention Center for over ten years. When the health department lost funding for HIV testing in detention facilities, the county absorbed the cost for that in paying the medical contractor to do this testing.

The cost became significant and testing was not done regularly and only in required circumstances. When the Southern Nevada Health District received the AIDS United linkage to care grant, the health department could step in again and start testing inmates regularly in conjunction with the private medical contractor. An actor in the Clark County jail network said, "I think it's a good partnership between us, CCDC [the jail] and NaphCare [the private contractor]. This go around, I think we set the foundation and CCDC added their components, making sure NaphCare's needs were met." Taken as a whole, these comments show a strong inclination of cooperation between these three actors in the network.

The Health District also gets money for HIV testing and prevention efforts from a pass-through grant from the state health department. This money originates from the CDC and is the PS12-1201 HIV Prevention grant. This amount of money alone is not enough to fund HIV testing in the Clark County Detention Center. The Health District uses their own budget and money from the linkage to care grant to fund the costs of HIV testing in the jail. A respondent said, "We used [the grant] as a hook to get back in there. The grant allowed us access, while our program manager was able to secure additional funding to help cover the cost of maintenance labs for HIV positive inmates. This coupled with the [Southern Nevada Health District] being able to pay for HIV testing again, played in our favor to re-establish a working relationship with the correctional facility. We needed to be sure we came to the table with dollars to support any project we were proposing." The Health District had been conducting HIV testing in the Clark County jail since 1993 and had to stop in 2015. Funding to the county and health district was redirected to different priority populations in the region (Clark County is in the midst of a syphilis outbreak) and so there was not enough money for HIV testing that year.

When each actor was asked whether the others in the network shared their priorities for HIV testing in the jail, all responded that they "completely share" each other's goals. The more general goal of testing inmates in the jail is approved by higher political actors, including the chief officer of detention, chief officer of health, and the county board of health. The administrative priorities of how to test inmates in the jail are set by the administrative network interviewed in this study, and this working group creates a memorandum of understanding each year. When asked about how priorities are set, a jail administrator in Clark County said: "Our priorities are evaluated every year as well as through the strategic planning process. As a department, our goals are examined every year and the priorities are set for how we are going to progress in each division." She went on to say that there is a disease, STD, and HIV division that handles HIV testing and care in the jail.

A respondent noted that certain logistical practices impede these shared goals, however. These impediments include limiting health department employees' access to the jail, needing escorts all day to draw blood for HIV testing, or having to sit with a nurse and call inmates one by one to the medical area of the jail to draw blood at that time. For example, the Health District must rely on the jail to give them access to inmates so to test for HIV. Before 2015, the Health District could go into the facility and offer HIV testing in the dorms to the inmates without correctional staff escorts. A new administrator was put in place at the detention center and then required correctional officers to escort health professionals as they went dorm to dorm. One of the respondents said that administrators change often, and this requires the health district to reintroduce their goals and priorities for HIV.

One respondent felt that drawing blood at admission was not a good time to test for HIV due to the lack of space at intake and lack of corrections staff that are trained and available to

draw the blood. The respondent preferred going dorm to dorm drawing blood samples, and said that the jail administrators and the medical contractors are all now working together to make this practice efficient. The biggest problem now, the respondent says, is the lack of sufficient health district staff to draw blood samples in the dorms based on the demand.

At one point between 2014 and 2015, when a corrections nurse was helping draw samples, the health department and detention center considered implementing rapid HIV testing. But because the detention center did not want to pay a staff member to draw the blood sample at the intake medical area, the lack of space for inmates to wait to be tested, and the safety concerns of having multiple inmates in one small area, the jail did not want to invest in rapid HIV testing at that time. Since then, there has been occasional interest in rapid testing, from the health district mostly, but it has not since been seriously considered.

The data suggest that the health department is the entity with the most expertise, staff, technology, money, and reputation. The detention center staff are most influential in deciding how state and county funding is used day to day. An example of this is when the detention center hired the private medical contractor once the health department lost funding for HIV testing in the jail. The private medical contractor does not appear to have a large role in making any decisions, even though they have been serving the detention center for over a decade. They are a part of the working group, but do not have a part in the memoranda of understanding the health district and detention center agree to each year.

Both the jail administrator and health administrator named each other as who they talk to frequently. The private medical contractor was not named as someone who was a part of frequent conversation about HIV testing in the jail. Both respondents mention a memorandum of understanding (MOU) between the health department and the jail. This is the only county from

which I collected data that said they had a formal memorandum of understanding between the all actors in the network. One respondent said that the MOU solidifies the collaborative goals between the jail, health district, and the private contractor. For HIV testing, the health district initiates and sets goals for the group.

Although the health district said they usually set the agenda for the working group, when it comes to HIV testing, the jail called most meetings and set the agenda for that meeting. The jail Captains would communicate with the jail's health staff and the sheriff's office, call a meeting with the health district and medical contractor, and have an agenda ready based on the his or her communications with their internal staff and the Sheriff. However, both respondents said that if something comes up and is important to meet about, then it could be either the health district or jail who calls the meeting or sets the agenda. Deadlines are agreed on by all parties effected, and both respondents said the working work was based on a good partnership and open communication. The working group meets almost every week to speak about action items. The detention center's captains disseminate information to jail personnel to follow whatever the working group has decided.

Both respondents said all involved usually agree on problems and potential solutions. However, if there is a problem, and both recalled this example, then the legal departments of both the jail and the health district usually handle the differences in opinions between the two groups. However, neither respondent said the group has even been contentious, or could recall a time that an important point was a source of disagreement. Both persons interviewed said that the legal departments exchange drafts and dispute word usage instead of substantive issues being argued.

In terms of interactions with other administrators outside the county, both respondents said that they have spoken to a former grant recipient of the AIDS United grant, which was a detention center in New York. They also consulted with a group from Boston University who was facilitating the grant. Both agreed this was the most they had contact with people outside of the state concerning HIV prevention strategies.

When asked, who was the most influential group or person in their working group, the jail said the health district and the health district said the jail. They both thought that the other was best at influencing their group, be it the jail administrators or the health care administrators, to come on board with HIV testing goals and priorities. The health district thought their program manager was the most dependable group or person to get things done and had high praise for keeping the health district and jail on task and target when it comes to HIV prevention programs. When asked, who would they turn to if a political solution was needed, then the health district said the Chief Health Officer, and the jail said the County Commission.

Both respondents said that the detention center has technology everyone relies on to implement HIV testing. The health district said that the private contractor has medical technology already set up in the jail that the health district relies on. The medical contractors have the electronic medical records of all inmates, and the jail maintains the inmate management system. Further, the health district cannot bring any outside technology into the jail, because it is against jail policy. The health district says it is very dependent on what is already in the jail to be able to draw blood samples for HIV testing.

2. Fulton County, Georgia

Five actors were identified through the preliminary survey as operating in this network: the sheriff's department (who runs the jail), the county health department, the state health

department, a private medical contractor, and a university medical school. The Fulton County jail is funded by the county and state health departments, the county and state budgets for corrections, federal grants, and private grants. Of the five actors named in the preliminary survey, one actor was interviewed.

Fulton County is a metro county that is home to part of Atlanta and Atlanta's suburbs. There are approximately 1,023,366 people in Fulton County, and it is the largest county in the state of Georgia (U.S. Census Bureau 2016). In the 2016 presidential election, almost 68 percent of Fulton County voted for the Democratic Party Candidate, Hillary Clinton (Leip 2016).

There are approximately 4,379 inmates per capita in Fulton County. There were 41,307 male inmates and 3,511 female inmates incarcerated in Georgia in 2014 (Bureau of Justice Statistics 2014). More than half of the population of Fulton County is female (51.6 percent) (U.S. Census Bureau 2016) and therefore there are more male inmates per capita than female inmates. In 2013, an estimated 3,011 adults and adolescents were diagnosed with HIV in Georgia. Georgia ranked 5th among the 50 states in the number of HIV diagnoses in 2013 (CDC State Profiles 2015). The metro Atlanta area, which includes Atlanta, Sandy Springs, and Roswell, ranks 5th out of all metro areas in the United States for annual HIV diagnoses. Fulton County has the most reported cases of HIV in the state (CDC HIV Surveillance Report 2015).

Georgia state prisons have mandatory HIV testing at intake (before 2009) and mandatory HIV testing when leaving prison (passed in 2009). Although the county Commission supports a needle exchange to prevent the spread of HIV and other communicable disease, Georgia state law prohibits any needle exchange programs to be run (Kass 2016). The commission passed a resolution in 2016, but state law still has not changed to allow the program to go forward (Kass 2016).

The CDC funds the Georgia State Health Department, local health departments, and community based organizations to implement a high impact approach to HIV prevention. The CDC also funds the state Department of Education and a local school district for HIV school health efforts (CDC state profiles 2015). Total CDC Funding to Georgia in 2014 for HIV/AIDS prevention amounted in $22,328,853. The biggest HIV prevention grant, PS12-1201, funded the Georgia Department of Public Health as well as Fulton County directly. The Fulton County Wellness Department was directly funded for prevention efforts as well (CDC 2014).

Fulton County has led the way in the U.S. in terms of HIV testing in jails. Fulton County jail has an opt-out testing policy and uses rapid testing. A rapid HIV testing initiative started as a CDC demonstration project. A health care administrator working with the jail said they have "opt-out, rapid testing for HIV. It started as a CDC demonstration project—we were grantee, jail partnered with us. It was continued as a Gilead funded demonstration project. For the past year, it was funded by CDC money sent to the Fulton County Department of Health and Welfare." Emory University Rollins School of Public Health was the grantee and Fulton County jail partnered with them to implement the grant. This grant was called the Care and Prevention in the U.S. (CAPUS) demonstration project grantee of 2012. The CDC funded 8 states (out of the 18 eligible and applied for the grant). It was a three year-project focused on decreasing HIV rates among Black and Latino Americans.

After the demonstration project funding ended, rapid testing efforts were continued as funded by Gilead Science Incorporated, which is a biomedical company. For the past year, efforts were funded by CDC money sent to the Fulton County Department of Health and Welfare. Emory University staff has been helping with data management and provides HIV physicians for the past two years. According to one respondent, the Fulton County Jail must do

universal testing going forward, due to a court settlement. This respondent hopes that rapid HIV testing will continue, considering its lower costs than traditional blood sample tests for all inmates that come through the jail doors.

Network actors include: The Georgia Department of Public Health; Fulton County Sheriff's Department; a private medical contractor; Fulton County Health and Welfare; and Emory University Rollins Schools of Public Health. Data was collected from two doctors, one that is the primary physician for HIV inmates in the jail and the other is from a university in Fulton County that researches access to care for incarcerated persons in Georgia. In Table 4.2, below, the network actors are listed in the left-hand column and if they were interviewed in the right-hand column.

[Table 4.2 about here]

Questions about grant funding measure decision making practices of the network as well as who has control over grant money. Question 8 asks, "Do you receive grant money (for HIV testing)?" and Question 9 asks, "Who decides what grants are needed?" One of the respondents said that the Fulton County Jail began opt-out and rapid HIV testing because of the CDC Demonstration project in 2000. The grantee was Rollins School of Public Health at Emory University. This project created a lasting connection between Emory and the jail. CDC funding for HIV testing in the jail was most recently awarded to the Fulton County Department of Health and Welfare. Rollins School of Public Health and the County Department of Health and Wellness decide what grants they pursue for HIV prevention funding.

One of the respondents is currently the HIV physician for the inmates in the county jail. The other respondent, a physician and employee of another University in Fulton County, commented that primary care doctors usually bear the brunt of HIV diagnosis and care. It is rare

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now that people specialize in HIV prevention and care as a physician. According to this respondent, for Fulton County to have a public health specialist serve as the HIV physician for jail inmates is remarkable.

One respondent said that because her organization, and her office specifically, has been intricately involved in HIV testing and prevention efforts in the jail, they are constantly speaking about it. Even now, when the CDC is funding the Fulton County Department of Health and Welfare instead of her office, her team is helping with HIV data management. Another respondent said that her office is more concerned with issues in primary care in all correctional settings, and the focus of her office is mostly on connection to care after an inmate is released from jail or prison.

A few questions asked how synchronized the actors in the network are about priorities of HIV testing in the jail. One respondent said that "the priorities of the jail revolve around safety and security of the facility," although other actors in the network are concerned with public health and the jail's place in preventing the spread of disease. This respondent said that Georgia has a very large burden of undiagnosed HIV yet the sheriff's office, who is over the jail, and jail officers, are more concerned with medical costs of caring for those with HIV and avoiding legal action. The other respondent confirmed this concern of the jail, in that the medical contractor the jail had employed was recently sued, settled, and in turn their contract to serve the jail was not renewed. The past contractor, Corizon, lost their contract to continue medical care in the jail for 2017. CorrectCare Solutions is the new vendor. Later this year, Fulton County will expect CorrectCare Solution to take over the HIV testing. Neither medical contractor could be reached nor participated in this study.

3. Harris County, Texas

Five actors were identified through the preliminary survey as operating in this network: the sheriff's office (who runs the jail); the state and county health system; the county's Department of Public Health; a private medical contractor; and a nonprofit organization. The Harris County jail is funded by the county and state health departments, the county and state budgets for corrections, federal grants, and private grants. Of the five actors named in the preliminary survey, a full interview was not completed. The information detailed here is from partial interviews from the jail and a nonprofit.

Harris County houses Houston, Texas and a few of its large suburbs, The Woodlands, and Sugar Land. The county has 4,589,928 residents and is the largest county in the state based on population (U.S. Census Bureau 2016). In the 2016 presidential election, almost 54 percent of the county voted for Hillary Clinton, the Democratic Candidate (Leip 2016). In Harris County, roughly 208 people are incarcerated per every 100,000 people. In the county, there were 1,470 HIV diagnoses in 2013, which is the most cases in the state (CDC HIV State Profiles 2014).

The Texas penal system is not listed as in compliance with the CDC's 2006 HIV testing recommendations per the Journal of the American Medical Association. Although the Houston Department of Health is directly funded by the CDC for HIV prevention, Harris County is not the named recipient. The CDC funds the Texas State Health Department, as well as local health departments, to implement a high impact approach to HIV prevention, prioritizing the delivery of evidence-based, cost-effective, scalable interventions to the most affected communities and regions of the state. Funded activities include surveillance, program implementation and service delivery, capacity building, and routine program monitoring and evaluation (CDC 2015). Including all grants, the CDC sent $33,949,785 to Texas for HIV prevention. The largest HIV

prevention grant, PS12-1201, funds the Texas Department of Health Services and funds are directly sent to the Houston Department of Health.

Texas has optional testing at intake to state prisons but mandatory HIV testing for all inmates at release from state prison. There are 128,200 male inmates and 11,679 female inmates incarcerated in Texas (Bureau of Justice Statistics 2014). In 2013, an estimated 4,836 adults and adolescents were diagnosed with HIV in Texas. Texas ranked 3rd among the 50 states in the number of HIV diagnoses in 2013 (CDC HIV State Profiles 2014). Harris County does not have a needle exchange program.

There are five actors in this administrative network: The Sheriff's Office; the Harris County Health System; the Harris County Department of Public Health; LabCorp (the private medical contractor); and AIDS Foundation Houston. In Table 4.3, all network actors are named in the right column and if data was collected from them in the left column. An entire interview was not completed, but two actors finished the preliminary survey.

[Table 4.3 about here]

The Harris County Jail has an opt-out, non-rapid HIV testing policy and method. The test is performed by the Medical/Health Service Division within the Harris County Sheriff's Office. Blood samples are draw on-site by the Sheriff department staff and sent to a medical contractor. Two of the five actors responded to my initial solicitation email and two preliminary surveys were completed. Both actors were also being willing to answer a few specific questions, but did not want to participate in an interview for this study. Therefore, there is not enough data collected from Harris County to code interaction patterns and this county was not included in the comparative analysis.

4. Los Angeles County, California

There are five actors named as involved in this county: the state health department; the county health department; the county commission; the sheriff's office (who runs the jail); and Los Angeles' health department. Los Angeles County Department of Health Services, which is a separate entity from the LA County of Public Health, operates the public hospitals and clinics in Los Angeles County. One actor in this network responded to my request for interview, and one interview was completed.

Los Angeles County contains the city of Los Angeles. Los Angeles County has 10,137,915 residents and is the largest county in the state of California based on population (U.S. Census Bureau 2016). Around 72 percent of Los Angeles County voted for Hillary Clinton, the Democratic candidate in the 2016 presidential election (Leip 2016).

Approximately 1,326 per 100,000 people are incarcerated in Los Angeles County. California had 128,303 male inmates and 6,130 female inmates incarcerated in 2013 (Bureau of Justice Statistics 2014). Approximately half of Los Angeles County is female (50.7 percent) (U.S. Census Bureau 2016) and therefore there are more men incarcerated per capita as compared to women. In 2013, an estimated 5,315 adults and adolescents were diagnosed with HIV in California. California ranked 2nd among the 50 states in the number of HIV diagnoses in 2013. Almost half of all HIV cases in the state of California live in Los Angeles County (CDC HIV State Profiles 2014). This county health district is the second largest municipal health system in the U.S., only behind New York City (California Department of Public Health 2012).

Los Angeles is a large county in a very large state, making it a high-priority of the CDC and health professionals to control, prevent, and treat HIV. California is listed by the Journal of American Medical Association as following the CDC's 2006 HIV prevention recommendations. California has a "voluntary testing, modified opt-out" HIV testing law in state prisons. This

means the provider initials key information points provided to inmate; verbal consent by inmate; and provider signs form to indicate acceptance or declination (California Department of Public Health 2012).

CDC funds the California State health department, as well as two local health departments, to implement a high impact approach to HIV prevention, prioritizing the delivery of evidence-based, cost-effective, scalable interventions to the most affected communities and regions of the state. Funded activities include surveillance, program implementation and service delivery, capacity building, and routine program monitoring and evaluation. CDC supports health department led demonstration projects, and HIV prevention-related research and partnership projects. CDC also funds the State, four local school districts and two capacity building assistance providers for HIV school health (CDC State Profiles 2015).

The CDC sent $69,240,967 to the state of California in 2014 for HIV/AIDS prevention. The largest CDC grant, PS12-1201 provided $16,837,335 to the California Department of Health. This grant sent $16,656,777 directly to the Los Angeles County Public Health Department. Los Angeles County includes the city of Los Angeles. In the county, there were 1,871 new HIV diagnoses in 2014 (CDC 2015).

In terms of case selection, Los Angeles County had a high per-capita jail population and turn-over rate, indicating a high demand for an efficient HIV testing policy and method. There are roughly 191 people in jail for every 100,000 people in the county. Due to the rate of HIV in California and Los Angeles, Los Angeles County is directly funded by the CDC for HIV prevention efforts. Los Angeles County operates a needle exchange program for injection drug users as well (LA Homeless Resource 2010).

There are five primary actors in the administrative network of HIV testing in the jail: Department of Public Health, Los Angeles County; the Los Angeles Sheriff's Department; the Los Angeles Department of Health Services; and California's Department of Public Health. In Table 4.4, all network actors are named in the right column and if data was collected from them in the left column.

[Table 4.4 about here]

This jail has an opt-in testing policy. Inmates are asked whether they would like to be tested for HIV at admission, if not already required by state law to be tested, such as sex crimes, prostitution, or there was blood exposure during the arrest. Rapid test kits are used when the Department of Public Health employees go from dorm to dorm testing those who requested to be tested. Confirmatory tests are sent to a laboratory and a convention blood test is conducted.

Priorities for HIV testing in the county jail appear to be completely shared between everyone but the Sheriff's office. When asked who sets priorities for HIV testing in the county jail, a Los Angeles health administrator said it was a combination of "the Los Angeles County Board of Supervisors, Chief Medical Director, Medical Officer, and the CDC's [recommendations]." The Sheriff's Department has control over the jail and the jail staff, making it difficult for the LA's Department of Public Health to get into the jail as often as they would like. The jail facility schedules when health officials can come in and do the HIV testing in the dorms, and this restricts access to the inmates who requested to be tested. Also, the sheriff's office top priorities do not include HIV testing in the jail, and instead care more about the safety of corrections officers and inmates who are detained in the jail.

Los Angeles County receives pass-through grant money from state health department who receives it from the CDC for HIV prevention. When asked if the CDC was the primary

funding source, this actor said they receive grant money from "various funding sources. One in particular is the CDC." LA County is also a municipality directly funded by the CDC for HIV prevention. This grant is awarded to the LA Department of Public Health. These grants, as used for HIV testing in the county jail, are supervised by the LA Department of Health.

Those named as having political influence and the ability to change HIV prevention strategies are the Los Angeles County Board of Supervisors, the Chief Medical Director, the Chief Medical Officer, and the CDC. The Chief Medical Director and Medical Officer are both part of the LA Department of Public Health. There are many nonprofit organizations that care about HIV prevention in LA, and speak about the jail's activities publicly, but are not directly involved in the administration of HIV testing in the jail.

This data for this county are far from complete. The respondent did not want to answer many of the interview questions, and only a few were answered fully. The respondent requested to end the interview early, leaving many of the later questions unanswered. The best data that was collected comes from what was said about the shared priorities between the sheriff's office that runs the jail and the county health department. The limited data that was collected will still be used for analysis, but is far from the depth of data that I expected to collect.

IV. Analysis

Priorities shared were measured as whether he or she report to completely share, somewhat share, somewhat do not share, or do not share, goals with other actors they named as in the network. In the interview, the respondent was asked why she chose what she did on the survey. The variables that represent resources shared in the network include expertise, reputation, dependability/ trust, and technology. The variables that represent decision-making are processes in place used by the network actors to make decisions, such as: who sets goals for the

group; who sets the agendas, meeting times, or deadlines; how a priority of the group would change; and how grants are found, applied for, and implemented.

Table 4.5 below is a chart of how the explanatory variables of priorities, resources, and decision-making was coded from the interview data. It shows on the right side of the table the variable measured. Priorities, resources, and decision-making were either "completely shared," "mostly shared," or "not shared." The variable categories are listed at the top as "priorities," "resources," and "decision-making." These codes were used to determine the predominant interaction pattern of the network, as listed in the table in the left column. The network's predominant interaction pattern means that of the three variable categories, and all the data collected from that network, most of codes fell into either "completely shared," "mostly shared" or "not shared." Completely shared is interpreted as cooperation, mostly shared is bargaining, and not shared is conflict. These interaction patterns will be paired with the structural alignment of the network to determine the power arrangement.

[Table 4.5 about here]

Each network is coded for it interaction pattern and structural alignment separately. Table 4.2 below is how I coded the network's structural characteristics as either horizontal or hierarchical in nature. This delineation is based on whether most of the data shows that the explanatory variables of priorities, resources, and decision-making are symmetrically or asymmetrically held in the network. The table shows the variable code on the left and the corresponding assigned structure on the right. If most of the variables measured across all the interviews collected in the network were coded asymmetric, the structure is deemed hierarchical. If most variables across interviews in a network were coded symmetric, the structure is deemed horizontal. These structural terms are combined with the interaction patterns to create a power

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arrangement. Such power arrangements have corresponding Expectations that were tested in this study.

[Table 4.6 about here]

To fully show the range of power arrangements based on interactions, as posited by Adam and Kriesi's (2007) framework, the Expectation can be further dived into six specific categories. Each network is catalogued across the categories of Conflict, Bargaining, or Cooperation, and either Fragmented or Concentrated power arrangement. The first category is the same as the general expectation created at the onset of this project: In comparing networks, those in cooperation and a concentrated power arrangement are the most likely to keep status quo policies.

The other categories are as follows: Those in cooperation and in a fragmented power arrangement have a low to moderate potential for change and most likely are maintain the status quo; those in bargaining with a concentrated power arrangement have a low to moderate potential for incremental change; those in bargaining with a fragmented power arrangement have a moderate to high potential for incremental change; those in conflict and with a concentrated power arrangement have a moderate potential for rapid serial shift; and, those in conflict and with a fragmented power arrangement are the most likely to adopt policy change or a rapid serial shift.

Clark County has a fragmented power arrangement, based on their horizontal structure and cooperation as their predominant interaction pattern. All actors share priorities, share access to most of the resources, and make joint decisions. While I selected horizontal instead or hierarchical, it should be noted this was a difficult decision. The reason for this ambiguity is that there is evidence that the Health District solicits and controls the pass-through grants for the state

and the supplemental private grants used for HIV prevention. The Health District has the staff and expertise needed to complete HIV testing. However, there is a large amount of evidence that all actors work together to come to a common agreement and exhibit horizontal decision making. The detention center and the private medical contractor have the technology the network relies on to come into the jail and pull up a list of inmates to test. Further, the detention staff calls meetings, disseminates information, and receives money from both the state and the county to hire a medical contractor to conduct HIV testing when the Health District lost funding and pulled out of the facility as the organization that tested inmates for HIV.

The power arrangement for this network is coded as fragmented. The corresponding Expectation for cooperation and fragmented power is a low to moderate potential for change and a high probability of the maintenance of status quo policies. The jail has an opt-in policy and does not use rapid HIV testing. These findings align with this Expectation.

Fulton County has a fragmented power arrangement. The interview data produced evidence of both horizontal bargaining and horizontal conflict. However, the predominant interaction pattern is bargaining, and it is horizontal, due to the respondent speaking about the symmetrical resources shared more so than the conflicting priorities. The corresponding Expectation predicts there should be a moderate to high potential for incremental change. Fulton County Jail has opt-out and rapid HIV testing, and this aligns more with the Expectation used for a network with a fragmented power arrangement in conflict. There is evidence of conflict in this network, but I had more data that pointed towards a network in bargaining.

Los Angeles County also has a fragmented power arrangement. The structure is horizontal and the predominant interaction pattern is in conflict. The network appears to have symmetric resources between network actors. The sheriff's department and various health

departments involved appear to all have some important resource necessary to complete HIV testing in the jail. There are some indicators of asymmetry in resources on behalf of the sheriff's department. The sheriff's department controls the facility, and has political sway. There is evidence of conflict and bargaining in the network.

There seems to be important resources shared by all actors involved, and this indicates horizontal bargaining. Everything considered, this network appears to be horizontal bargaining, and for this reason, this network is coded as having a fragmented power arrangement. The corresponding expectation is a moderate to high potential for incremental change. This jail has an opt-out policy, but still uses traditional HIV testing. These findings fit with what was expected.

Each question detailed in this section corresponds with the concepts measured (priorities, resources, and decision-making). Table 4.7 shows how the counties are coded based on the data collected through the interview questions. On the right, the county is listed, the questions used for analysis, the concepts they intend to measure, and a summary of the answer, are in the three middle columns, and the detailed code is presented in the far-right column.

[Table 4.7 about here]

The information in Table 4.7 was then coded into the terms created by Adam and Kriesi (2007). Table 4.8, below, shows the counties coded based on their interaction pattern and structural alignment. In the right column is the county's name, which represents the network, and under it are the explanatory variables of priorities, resources, and decision-making. On the top column across are the different combinations of interaction patterns and structural alignments. Check marks indicate the combination of interaction and structure for each case. All three counties analyzed have varying interaction patterns, and structures. Clark County's priorities are

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Cooperation/Hierarchical, its resources are Bargaining/Hierarchical, and its decision making is

Cooperation/Horizontal. I coded its structure as hierarchical and its interaction pattern

cooperation. Fulton County's priorities, resources, and decision-making are all

Bargaining/Horizontal. Los Angeles County's priorities are Conflict/Horizontal, and its

resources and decision-making are Bargaining/Horizontal. I coded its structure as horizontal and

its interaction pattern as bargaining. These categorizations are used to determine the overarching

power arrangement of the network and is used to compare the data to the Expectations nested in

power arrangement framework.

[Table 4.8 about here]

The interaction pattern of each network is used to determine whether the network is in a

fragmented or concentrated power arrangement. Table 4.9 below shows how the interaction and

structural characteristics are used to determine the network's power arrangement. The

predominate code from the above table, which is the product of the three variable categories, is

used to pick one pattern/structure. In the table, the network is listed on the right, and the two

middle columns list the predominate interaction pattern and structural alignment. The far-right

column is the corresponding power arrangement. Clark County is predominately in horizontal

cooperation and therefore has a fragmented power arrangement. Fulton County has horizontal

bargaining, and therefore has a fragmented power arrangement. Los Angeles County has

horizontal bargaining, and therefore has a fragmented power arrangement. The power

arrangement and interaction pattern will be used to show how the expectations lined up with the

dependent variable.

[Table 4.9 about here]

The expectations correspond to the power arrangement of the network and its predominant interaction pattern. In Table 4.10 below, the research expectations are displayed in the framework-determined category. The far-left column lists the power arrangement of concentrated or fragmented, and at the top of the table is the interaction patterns of conflict, bargaining, and cooperation. In the internal cells, under "Cooperation," A lines up with "Concentrated" and B is "Fragmented." Under "Bargaining," C is "Concentrated" and D is "Fragmented." Under "Conflict," E is "Concentrated" and F is "Fragmented." A and B are the most likely to maintain the status quo, C and D are more likely to implement incremental changes, and E and F are likely to experience a rapid serial shift in policy. By using the framework in this way, I can see whether the expectations are supported by the data collected with the selected dependent variable.

[Table 4.10 about here]

These expectations line up on a continuum, ranging from maintaining status quo policies to the network experiencing a rapid shift in policies. In the Figure 4.2 below, this spectrum of potential policy change lines up with the expectations. On the far left, the "status quo" policies are Research Expectations 1a and 1b. In the middle of the figure is "incremental change" and are represented by Research Expectations 1c and 1d. On the far right is "rapid shift" and Research Expectations 1e and 1f are the corresponding Expectations. This means that each pair of Expectations can be categorized into either the network maintaining the status quo, engaging in incremental changes, or have experienced a rapid shift in policies since 2006.

[Figure 4.2 about here]

I compared what I found about policies in place to the expectations that guided this inquiry. Table 4.11 below shows how the networks' policies, identified by their county, are

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related to different power arrangements. The left column is labeled "Power Arrangement" and has two categories presented to compare the policies observed and the corresponding expectation tested. The two rows are "Dependent Variable" and "Expectation." The dependent variable row lists what policies the network has, and the Expectations row lists the corresponding Expectation. There were not any networks that had a concentrated power arrangement, therefore such categories are not presented. The top of the table presents the interaction patterns again (conflict, bargaining, and cooperation).

[Table 4.11 about here]

Fulton County and Los Angeles County both had fragmented power arraignments and were in bargaining, which corresponds with Expectation D. Fulton county has an opt-out policy and uses rapid testing. They had started a rapid testing program from a 2000 CDC grant and therefore already had rapid testing in place before 2006. However, after 2006 they had moved to an opt-out policy. Los Angeles County has an opt-out policy and use both traditional and rapid testing. They did not have an opt-out policy or rapid testing before 2006. The dependent variable for each network align with what was expected in Expectation D: In comparing networks, those in bargaining with a fragmented power arrangement have a moderate to high potential for incremental change. Clark County had a fragmented power arrangement and in cooperation. Clark County has opt-in policy and uses traditional means for HIV testing. This is the same policy they had before 2006. This aligns with what was expected in Expectation B: In comparing networks, those in cooperation and in a fragmented power arrangement have a low to moderate potential for change and maintain the status quo. This means there is strong support for some of the expectations about relationships between power and diffusion.

These findings suggest a relationship between power relationships and different approaches to diffusion and/or adoption. The next section discusses the findings in more detail. The next chapter analyzes the findings and explores the ways in which these results add to the broader discussion of policy diffusion, the role of power in local networks, and HIV testing policies in the criminal justice system.

V. Discussion of Findings

Changing HIV testing policies is perceived as expensive by the networks that serve county jails with opt-in policies. Local correctional facilities that are hesitant to institute routine screening because of fiscal concerns may not realize that state of the art care costs the facility and community much less than inadequate treatment of HIV (Mayer et al. 2002; Spaulding 2002). However, in counties that may have unstable funding streams to the jail for HIV testing, having an opt-out policy in place would be risky and ill-advised. It does appear from the limited data collected at this point that rapid testing is being used more frequently in jails, regardless of whether the policy is opt-in or opt-out.

Of the data already collected, there is a slight pattern emerging that reflects the relationship between different types of power relationships and what we already know about diffusion. Clark County, Nevada is maintaining status-quo HIV testing policies by continuing to have an opt-in policy and traditional blood sample extraction and testing method. As seen from the data collected, that network is in cooperation and has a fragmented power arrangement. The Los Angeles County network is in bargaining and has a fragmented power arrangement. As seen in the Table, this would predict they have a moderate to high potential for incremental change. Following, the county jail still has an opt-in policy but uses rapid HIV testing on site. Not enough data has been collected from Harris County, Texas as of now.

I intend to continue to collect data from counties across the United States. The next project I intend to do will be to do a content analysis of local HIV prevention plans. Farther down the line I intends to collect enough secondary and primary data to do descriptive statistics that will deepen the understanding of HIV testing policies and rapid HIV testing methods. This paper is the beginning of a longer process that will result in meaningful research concerning this understudied topic of HIV testing policies in local jails.

Chapter Five: Conclusions

I. Introduction

Jails are the most frequented correctional setting by the public. They have a unique opportunity, and potentially a normative responsibility, to efficiently and consistently test for HIV. The topic addressed in this dissertation is why most county jails do not follow voluntary federal recommendations for HIV testing in correctional facilities. This study found that jail administrators are reluctant to consider opt-out policies and rapid HIV testing for cost reasons. Also, health administrators do not exude confidence in the county jail to properly conduct HIV testing. More generally, this study tackled the question of why a policy, especially a federal health recommendation, would not diffuse to local levels of government.

Opt-out policies require jails and prisons to test more inmates making rapid testing an efficient method to quickly screen more inmates at admission (Tartaro and Levy 2013; Spaulding 2002). Yet not many jails use the rapid HIV testing method to test inmates (Solomon et al. 2014). Rapid HIV screening is useful in the jail setting because of its speedy, reliable results, and reasonable cost. Rapid HIV testing can increase effective screening, especially for jails and prisons who have adopted opt-out policies, because of the lower cost and speed as compared to traditional testing (Beckwith et al. 2009). Only 18.5 percent of jail inmates report being tested for HIV at admission to jail (Beckwith et al. 2009; Spaulding 2002).

Evidence based strategies for HIV testing in jails have been developing faster than policy implementation in correctional institutions (D'Anno, Pollack, Jiang, Metsch, and Freidman 2014; Ducharme, Chandler, and Wiley 2013). This disparity between policy innovation and implementation is particularly large in the criminal justice system (Belenko et al. 2013). State

correctional facilities that are hesitant to institute routine screening because of fiscal concerns may not realize that state of the art care costs the facility and community much less than inadequate treatment of HIV (Mayer et al. 2002; Spaulding 2002). While the initial cost of implementing opt-out and rapid testing may appear expensive and laborious to jail administrators, the jail would save money in the long term (Spaulding et al. 2015). The more immediate costs of change may drive the decision not to implement new HIV testing policies instead of the long-term benefits of policy change (Spaulding et al. 2015).

The literature points to certain barriers of federalism, and the mechanisms that effect why localities opt in or out of federal recommendations. Further, the policy diffusion literature shines light on how policies spread, either horizontally or vertically. This dissertation stood on these different theories already studied, and adopted a framework of power that has not been widely used to study local administrative networks and how they operate. The results from this study are promising and fit well into what is already known in the literature.

The significance of this study is that it synthesizes the ideas of networks and policy diffusion to understand policy adoption decisions on a local level. It adds a new approach, which is observing power arrangements in local networks. This study adds to the literature methodologically in that it used many suggested independent variables already identified in the literature and approached the study with policy and administrative network theories. The next section goes through the findings of this study, and the section following discusses normative implications.

II. Analysis

To better understand why federal recommendations were not adopted in most county jails, I used the case study method. This method was used to get a deeper look at local

administrative networks, and to hear first-hand from the actors who are necessary in the operation of HIV testing policies in county jails. Though an in-depth survey of the literature, using secondary data available, and interviewing health care and jail administrators, I built this comparative case study.

The general Expectation of this dissertation is that networks in cooperation are more likely to maintain status quo policies as compared to networks in conflict or bargaining. Networks in conflict or bargaining were expected to exhibit policy change over time while networks in cooperation were expected to maintain their pre-2006 policies. This study found support for this general Expectation and merit in using Adam and Kriesi's (2007) power framework to understand local networks.

In this study, many practitioners expressed concern of the cost of adopting an opt-out HIV testing policy and adopting rapid HIV testing methods. These concerned centered around their knowledge of the cost of housing inmates and jail administrators' priority of keeping people safe inside the facility. Further found in this study, jail administrators have safety concerns for the facility and do not prioritize public health concerns. Conversely, health administrators have a disease prevention and control mind-set. These priorities can conflict, but mostly I found the network actors interviewed for this study tend to bargain these differing priorities. Like what Oser et al. found (2007), correctional administrators think implementing rapid HIV testing is hampered by underfunding, a lack of personnel, and limited availability due to the costs of testing.

People interviewed in this study complained that implementation of a new policy required too many resources, such as staff, space, trainings, and money. This flies in the face of many assumptions found in the literature that rapid HIV testing methods will break through those

barriers of capacity, in that the jail could test on-site instead of sending inmates to a clinical setting off-site for HIV testing. Despite this assumption that rapid HIV testing will allow more jails to adopt opt-out policies, capacity and technological concerns were cited by those interviewed as barriers to adopting or adapting the CDC's testing recommendations on a local level. These concerns are present in jail and health administrators despite the millions of dollars the CDC sends to improve testing capacity. This is similar to what Hale and Brown (2013) found concerning localities adopting voting and election policies: capacity, expertise, and technological capabilities really determine if a federal policy will take hold in a locality.

I found that the greatest struggle reported by administrators was the lack of linkage to other key actors and the inability to find strong partners to champion policy change. This confirms what Mitchell et al. (2015) found: interorganizational linkage, or lack thereof, contributed to the ease or difficulty of implementing opt-out testing and using rapid methods. The public health network studied here is made up of elected politicians, public administrators, local government officials, and representatives from non-profit organizations, for-profit organizations, and private firms (Agranoff 2003; Milward and Provan 2000; Sandstrom 2008). A network's success of implementing any policy depends on who promises to do what, based on reciprocity and trust between actors in a network (Thomson and Perry 2006).

If cooperation is not present, whether it be hierarchical or horizontal cooperation, then this could affect implementation but not necessarily lead to policy change (Milward and Provan 2000). I expected to find networks in cooperation less likely to have updated HIV testing policies and are more likely to have maintained their status quo, regardless of the CDC federal guidelines for HIV testing. This general expectation was expressed more specifically in the sub-Expectations, which are based on the interaction patterns of the networks observed. This

framework is based on the idea that repeated interactions can give certain actors a reputation, build trust, or create divisions, and this has policy outcomes (Adam and Kriesi 2007).

None of the selected networks studied here were deemed to be in conflict. This study found evidence of bargaining and conflict based on priorities of other resources, which mostly included money and staff. However, no one network was predominately in conflict. Shared resources were bargained over heavily in the networks observed in this study. The shared resources tested through interview questions were capacity, money, information, expertise, and reputation.

Health administrators interviewed tended to rely on the CDC's data, recommendations, and grant requirements, to create their high-impact HIV prevention strategies. Although grant funding from the federal government did influence priorities of health administrators, in the sense that priorities were already set in the grant, high impact strategies were driven by morbidity data the local health departments had collected. Health administrators worked often with the county, city, and state health departments to collect assessment data.

When it comes to policy choices, most actors reported someone outside of the administrative network, such as an elected official like the Sheriff or the County Commission, as having final say over health and jail policies. Many actors did not feel politically powerful when it came to changing HIV testing policies. Health administrators felt the Chief of Health, or the head health officer they report to, has some influence in changing priorities through research and data presentation of high impact strategies.

This study found that decision-making practices and procedures in the network were formal and informal. Both jail and health administrators had formal decision-making processes required by government actors, their agency's legal department, or organizational rules. The

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administrators interviewed here mostly operated in the informal realm of decision-making, citing that those above them in political or appointed roles create the formal decision-making triage. Because this study was more interested in informal practices, the interview questions delved more into how the group made joint decisions to execute the act of HIV testing in the jail. Some actors may have over-reported their decision-making activities as compared to the others, in that respondents were more likely to say everyone made decisions jointly. But once more detailed questions were asked, it became clearer who had influence over the informal decision making-process within the network. In this study, I observed that the local health departments tended to control the decision-making regarding HIV prevention and testing strategies, while jail administrators had rock-solid control over decisions pertaining to their facilities and the inmates within that facility.

This study shows that power relationships in local networks, as based on the explanatory variables selected, can explain why administrators adopt certain HIV testing policies in jails. The explanatory variables selected to measure power and the interview questions formulated to test them solicited quality information in this case study. If this study were to be replicated, the interview instrument would most likely produce similar data because of the close connection between the measures of power and the questions asked. However, there are limits to the research design and implications of this study, and these are discussed in the next section.

III. Limitations of this Study

This case study heavily relies on the willingness of participants to provide information about what they do, who they work with, and how they work with them on a regular basis. Many administrators are busy people, and getting them to respond to a research solicitation is difficult. Getting in-depth information is a long process, and many people are hesitant to give an hour of

their time to do an interview. I wish I had collected more data to compare. The reach of the findings of this study are limited, mostly because of the low number of people I spoke to and that health administrators or people in higher education were more likely to want to speak to me as compared to jail administrators. Interesting data was still collected from this study, but more should be done to further test Adam and Kriesi's theory of power arrangements.

Some other limitations of this study include jail administrators' fear of being sued or getting involved in litigation over treatment of inmates and HIV care. Jails are places of great uncertainty for those that work in them, because they consider the legality of their actions. Additionally, information of a jail's HIV testing and treatment can create opportunities for litigation if some of the information I collected were used to file a complaint on behalf of HIV inmates. These fears are not unfounded on behalf of the jail employees, yet make collecting data very difficult.

Despite the limitations of making inferences about the data, the research question of this study had to first be studied qualitatively. The nature of power as measured in interaction patterns must be fully understood before quantitative measures can be developed. There is potential to study this topic quantitatively in the future, once more information is collected, but first a case study such as this lays the foundation of understanding power in networks. Measuring power with quantitative indicators may be a possibility in a future study, but the data on jails and HIV testing policies is sparse. This data is still being developed by the CDC, and jails are not required to report such information to the county or state. Health departments have reliable data, but there is not a source that I could find that collects testing policies and methods of all counties in the U.S. systematically. I want to start collecting my own data and build up useable

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information for future. Future of study to increase knowledge on this topic are explained more in a later section in this chapter.

IV. Implications

The empirical implications of this study are centered around measuring how actors interact in an administrative network through their shared priorities, resource asymmetries, and decision-making. This exploration of power in networks was fruitful in uncovering how structural and compositional factors can encourage or diminish the chances of policy change. Also, Adam and Kriesi's (2007) framework adapted well to measuring local networks.

Further, there are empirical implications for future study of the chosen dependent variable. The dependent variable used is what kind of testing policy the county jail has: either opt in or opt out, and traditional or rapid testing. Because it is a dependent variable with descriptive but discrete categories, other studies could measure policy change both quantitatively and qualitatively. The dependent variable should be used more often in future policy change studies because many other administrative settings have a range of policy outcomes and not simply a dichotomous choice between adopt and to not adopt. The reality of administrative practice is that there is a spectrum of status quo, incremental, and rapid shift policy changes that can be measured in one dependent variable.

The variables used for case selection and the dependent variable were all successful in measuring power arrangements. The research plans to use these variables to continue researching this topic to expand this study as well as create future research. There are many benefits to the case study research design used in this study, such as the depth and specific nature of the data collected.

The biggest implications center around the nature of networks and grant-making. Most of the research presently about networked arrangements discover broad and expansive networks that all center around public administrative tasks. This study found small networks operating mostly on a local level. This implies there maybe alternative understandings of administrative networks in certain settings or circumstances that do not comport with the current understanding of how government administrators are highly connected vertically are horizontally with other governments and nongovernment organizations.

Further, federal grant funding may not increase the chances of voluntary federal guidelines being adopted on the local level. Milward and Provan's 2000 study found that health networks dominated by a powerful organization that functioned like a monopoly and had much higher levels of client and family satisfaction than other network structures (Milward and Provan 2000). Their findings fall into line with how grant-makers select who to give the high dollar amounts, which are organizations and agencies that have the capacity to administer large grants. The implications from this study are if the grant-maker, such as the CDC, wants to encourage policy change, they should fund networks that do not have one powerful actor. The implications here are that by funding the powerful actor, they will continue with the status quo policy instead of instituting policy change.

It is also important to understand the choices that states make when the federal government suggests, but does not require, a particular course of action. It appears that federal recommendations, as opposed to mandates, take much longer to be adopted or adapted on the local level. While there is grant money sent to administer and improve HIV testing and methods of testing, there is evidence from this study that networks are more likely to use the money to support and continue whatever policies they already have in place.

Other implications include civic rights considerations and health care policy. There are costs associated with medical care required after a person is newly diagnosed with HIV in a correctional setting. Because of *Estelle v. Gamble* (1976) and other Supreme Court precedent involving the 8th and 14th Amendments, state correctional and detainment institutions are constitutionally required to give inmates appropriate care for HIV and AIDS (Belenko et al. 2013). Some correctional systems may engage in willful ignorance so to avoid costs of medical care to those diagnosed with HIV through an opt-out policy. Although implementing opt-out policies may be efficient from a public health perspective, the correctional facility may see it as a liability. The cost of caring for inmates with HIV is very large, and jails may not want that cost or legal responsibility.

Health care policy is also abounded with normative implications generally. The Affordable Care Act, written and implemented under the Obama Administration, had certain outcomes for HIV prevention and care funding. Further, healthcare insurance coverage has been a politically-charged topic for almost a decade now. In terms of HIV health care insurance, there are three major federally funded health care coverage plans. These include Medicaid, Medicare, and the Ryan White Program (amfAR 2007).

In 2006 almost all state Medicaid laws listed routine HIV testing as an optional service, and was therefore not covered by insurance. Each state Medicaid program determines its own definition of medical necessity, although it generally refers to procedures recommended by a physician. In the case of HIV, for example, HIV testing is clinically indicated based on a patient's risk factors and/or signs of HIV infection. Similarly, Medicare recipients only provided coverage for HIV testing whether deemed medically necessary and did not cover routine screening (amfAR 2007). States can opt to provide routine HIV screening as part of the more

general "diagnostic, screening, or preventive" benefit (42 U.S.C. 1396; The Social Security Act 1905(a) (13)).

To pick up any gaps in coverage of low-income populations, Ryan White Program money was paying for HIV tests on the local level. The Affordable Care Act of 2010 complicated funding under the Ryan White Program because more people were required to have health insurance, which made them ineligible for Ryan White funding for HIV testing (Institute of Medicine 2011). Such concerns are most relevant to low-income and incarcerated persons, who may not know that whether they agree to a routine test offered to them that they would have to pay for the test after they are released (amfAR 2007).

Wagner, Wu, and Sood (2014) predicted more people would get tested for HIV if their insurance covered the testing. Therefore, they concluded that the Affordable Care Act would increase HIV testing (Wagner, Wu, and Sood 2014). Although this question is not the call of this dissertation, it must be said that I found no evidence that the ACA changed how often jail inmates were tested or how health care and jail administrators approached inmates about HIV testing being covered by insurance whether they agreed to be tested. This is because HIV testing for most inmates is covered by Medicaid, Medicare, or the Ryan White Act funding due to an inmate's income level. This high-risk population in jails and prisons was not helped--and may be hurt--by the ACA's reallocation of money away from the Ryan White Fund for free HIV testing for those without insurance.

Further, the Obama Administration's healthcare goals as a legacy of the administration is relevant to why jails have not changed their testing policies after 2006. The White House Office of National AIDS Policy (2010) repeatedly says the goal is to reduce HIV infections, and specifically mentions access to health care and reducing racial disparities of HIV occurrence.

Increased testing, as a strategy, does not appear in these two strategic plans. Jail and prison populations are also not listed as a target high risk groups. Jails are a prime location for increased testing of high-risk populations, such as drug users. Federal recommendations from the CDC or an executive agency should consider testing in correctional settings as testing sites a higher priority.

This dissertation found, from interviews with practitioners, federal strategic plans had an impact on HIV testing practices. Federal priorities and the funding for HIV prevention efforts effect HIV prevention efforts locally, and imply that health departments and correctional facilities must follow the money and will implement HIV prevention efforts according to what they are funded to do. Most grants received by states and counties were written to be used for access to health care for HIV positive people instead of increased HIV testing of inmates. One finding from primary data of note is that a certain county was using "access to care" funds for HIV testing, because there was not enough money to continue the testing program in the jail after state budget restructuring. The choice between "access to care" and increased HIV testing as a policy choice is one that all medical professionals support, but does not make sense unless new infections are detected early (Spaulding 2002). After conducting this study, I advocate for federal grant funds to be used for increased testing in jails as well as access to care after release. These two policy goals should be paired to make an impact on HIV prevention. The next section, Policy Recommendations, make clear what I advocate going forward based on my findings in this study.

V. Policy Recommendations

HIV policies have broad significance across public life (Fletcher et al. 2007; Harrison et al. 1998). Opt-out policies used with rapid HIV testing methods is cost-effective in the long run

for the jail and the public health community at large. The issue of HIV testing in jails is important to study because HIV persists as a chronic disease in jails, prisons, and the criminal justice system at large. HIV rates are four times greater for inmates than the general population (Maruschak 2012). Public health concerns should become more of a priority of correctional facilities, and this study shows that jails think very differently about HIV prevention as compared to health administrators. Further, the idea that federal voluntary guidelines are not widely adopted is an important issue.

My first policy recommendation is that health administrators from the CDC and state health departments should incentivize the adoption of opt-out testing policies in jails by paying for the transition costs of traditional testing to rapid testing conducted on-site at the jail. This can be done with budgeted money from the state or grant funds from the CDC.

Further, I recommend health departments consider HIV testing in correctional settings as part of their high-impact prevention strategies. It is perplexing to academics and physicians why states and counties do not rank HIV testing and prevention in correctional facilities higher in their strategic prevention plans. Local health departments interviewed in this study used morbidity data to design their high-impact prevention strategies. Considering the amount of people that filter through county jails each day, testing in jails will increasing HIV diagnoses. Further, increasing HIV testing may reduce transmission rates because people change their behaviors when they know they are HIV-infected (Wolf, Donoghoe, and Lane 2007). It can also reduce morbidity by helping people who are HIV-infected get appropriate treatment (Wolf, Donoghoe, and Lane 2007). Although there are costs to expanded testing, studies demonstrate that routine HIV testing is a cost-effective means of achieving these public health goals, even in low-prevalence populations (Wolf, Donoghoe, and Lane 2007).

Administrators may not see the jail as a place to implement a high-impact strategy because not many people may die in jail from HIV as seen in the morbidity data they rely on to make decisions. Further, many health administrators interviewed in this study expressed they were following federal strategies as recommended by the Obama Administration. These impact strategies are based on race and gender, focusing HIV prevention efforts on men who have sex with men and African Americans, because both groups have higher rates of HIV (White House Office of National AIDS Policy 2010). I consider this a more reactive strategy (who is dying from HIV/ AIDS) instead of a preventative strategy of increased testing efforts. I also think, after commissioning this study, that the criminal justice system is an opportune place to increase testing efforts. Federal grants should reflect this opportunity. Further, the executive branch and the CDC should coordinate goals, based on empirical research that the CDC and others have produced showing that correctional facilities are an efficient place to test for HIV.

VI. Going Forward

This dissertation scratches the surface of power in networks and changes in HIV testing policy in correctional settings. There is a hidden reality of power within networks, as can be inferred from this study. It is possible that concentrated power can detract from collaborative potential for policy change. The next steps in studying power in networks should include measuring power exercises between actors, and how this can stymie or encourage the adoption of new policies or adopting more effective administration practices of policies.

HIV testing and policy data in correctional facilities are sorely underdeveloped, and more efforts should be focused on collecting reliable data. I want to continue to collect qualitative data from correctional and health administrators and move forward into collecting quantitative data as

well. I want to forward this research into a mixed methods study that can speak to the HIV testing policies and methods of more counties.

I will continue to explore network theory research in different contexts and topic areas. Most of my interests revolve around health care and corrections, and these topics will produce many lines of inquiry. I will incorporate more law and policy styles of research once I have collected more primary data to explore and understand the causes of policy change. This study is the beginning of much work to be done, and I am excited to do it.

References

Adam, Silke, Hanspeter Kriesi 2007. "Chapter Five: The Network Approach." *Theories of the Policy Process*. Eds. Sabatier, Paul A. and Christopher M. Weible. Boulder, CO: Westview Press: 129-54.

Aguilar, Jemel P. 2012. "HIV Testing in State Prisons: A Call for Provider-Initiated Routine HIV Screening Policy." The Institute for Urban Policy Research and Analysis. The University of Texas at Austin: Austin, Texas.

Agranoff, Robert. 2003. *A New Look at the Value-Adding Functions of Intergovernmental Networks*. Paper prepared for Seventh National Public Management Research Conference, Georgetown University, October 9 – 11, 2003.

Agranoff, Robert. 2007. *Managing within networks: Adding value to public organizations*. Washington, D.C.: Georgetown University Press.

Agranoff, Robert, 2012. *Collaborating to manage: A primer for the public sector*. Georgetown University Press.

Agranoff, Robert, and Michael McGuire. 2001. "Big questions in public network management research." *Journal of Public Administration Research and Theory* 11(3): 295-326.

Agranoff, Robert, and Michael McGuire. 2003. "Inside the matrix: Integrating the paradigms of intergovernmental and network management." *International Journal of Public Administration 26*(12): 1401-1422.

AIDS.gov. 2014. "What is the National HIV/AIDS strategy?" Washington (DC): Department of Health and Human Services, http://aids.gov/federal-resources/nationalhiv-aids-strategy/overview/ (January 2014). Accessed January 2017.

Allen, Mahalley D., Carrie Pettus, and Donald P. Haider-Markel. 2004. "Making the National Local: Specifying the Conditions for National Government Influence on State Policymaking." *State Politics and Policy Quarterly* 4 (3): 318-44.

AmfAR. 2007. "amfAR Policy Statement on Routine HIV Testing." www. amfAR.org (September 2007). Accessed December 30th, 2016.

Arnold, Gwen. 2015. "When Cooperative Federalism Isn't: How U.S. Federal Interagency Contradictions Impede Effective Wetland Management." *Publius: The Journal of Federalism* 45 (2): 244-269.

Arnold, Gwen, and Forrest D. Fleischman. 2013. "The Influence of Organizations and Institutions on Wetland Policy Stability: The Rapanos Case." *Policy Studies Journal* 41(2): 343-364.

Baumgartner, Frank R. and Brian D. Jones. 1993. *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Baumgartner, Frank R. 2012. "Ideas and Policy Change." *Governance* 26 (2): 239–58.

Beckwith, Curt G., Lauri Bazerman, Alexandra H. Cornwall, Emily Patry, Michael Poshkus, Jeannia Fu, and Amy Nunn. 2011. "An Evaluation of a Routine Opt-Out Rapid HIV Testing Program in a Rhode Island Jail." *AIDS Education and Prevention* 23(3): 96-109.

Beckwith, Curt G., Joseph Bick, Walter Chow, Cari Courtenay-Quirk, Renata Ellington, Timothy Flanigan, and Kirk Henny. 2009. "HIV Testing Implementation Guidance for Correctional Settings." *Centers for Disease Control and Prevention* January 2009.

Beckwith, Curt G., Timothy Flanigan, Carlos del Rio, Emma Simmons, Edward Wing, Charles Carpenter, and John G. Bartlett. 2005. "It is time to implement routine, not risk-based, HIV testing." *Clinical Infectious Diseases* 40(7): 1037-1040.

Belenko, Steven, Christy Visher, Michael Copenhaver, Matthew Hiller, Gerald Melnick, Daniel O'Connell, Frank Pearson, and Bennett Fletcher. 2013. "A cluster randomized trial of utilizing a local change team approach to improve the delivery of HIV services in correctional settings: study protocol." *Health & Justice* 1(1): 8.

Bennett, Colin J., and Michael Howlett. 1992. "The Lessons of Learning: Reconciling Theories of Policy Learning and Policy Change." *Policy Sciences* 25 (3): 275–94.

Berry, Frances Stokes and William D. Berry. 1990. "State Lottery Adoptions as Policy Innovations: An Event History Analysis." *The American Political Science Review* 84 (2): 395-415.

Boushey, Graeme. 2012. "Punctuated equilibrium theory and the diffusion of innovations." *Policy Studies Journal* 40(1): 127-146

Bushouse, Brenda K. 2011. "Governance Structures: Using IAD to Understand Variation in Service Delivery for Club Goods with Information Asymmetry." *The Policy Studies Journal*, Vol. 39, No. 1: 105-119.

Carpenter, Daniel P. 2001. *The forging of bureaucratic autonomy: Reputations, networks, and policy innovation in executive agencies, 1862-1928*. Princeton, New Jersey: Princeton University Press.

Carpenter, Daniel P., and George A. Krause. 2012. "Reputation and public administration." *Public Administration Review* 72(1): 26-32.

Centers for Disease Control and Prevention. 2007. "Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests Waived Under the Clinical Laboratory Improvement

Amendments of 1988." U.S. Department of Health and Human Services and Centers for Disease Control and Prevention, http://www.cdc.gov/hiv (2007). Accessed March 2017.

--. 2010. "HIV Prevention Funding Allocations at CDC-Funded State and Local Health Departments." *Department of Health and Human Services, Centers for Disease Control and Prevention*, http://www.cdc.gov/od/pgo/funding (June 2012). Accessed June 22, 2016.

--. 2012. HIV testing implementation guidance for correctional settings (2009). HIV Testing Implementation Guidance for Correctional Settings (2009).

--. 2012. PS12–1201: Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments. *Divisions of HIV/AIDS Prevention NCfHA, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention.*

---. 2014. "CDC-funded HIV Testing: United States, Puerto Rico, & U.S. Virgin Islands 2014." National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention and Division of HIV/AIDS Prevention. http://www.cdc.gov/hiv/library/reports/index.html. (2014). Accessed July 5, 2016.

---. 2015. "HIV Surveillance Report, 2015." Vol. 27. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2016. Accessed January 11, 2017.

Coleman, James S. 1990. *Foundations of Social Theory*. Cambridge, MA: Harvard University Press.

Coleman, William D. and Anthony Perl. 1999. "Internationalized Policy Environments and Policy Network Analysis." *Political Studies* 47(4): 691-709.

Code of Maryland, Annotated (COMAR). 10.10.12.04. http://mgaleg.maryland.gov/webmga/frmStatutes.aspx. Accessed December 2016.

Code of State Regulations of Missouri (CSR). 19 CSR 25-33.010. http://www.sos.mo.gov/adrules/csr/csr.asp. Accessed December 2016.

Cornforth, Chris, John Paul Hayes, and Siv Vangen. 2015. "Nonprofit Collaborations: Understanding Governance Dynamics." *Nonprofit and Voluntary Quarterly* 44(4): 775-795.

Desmarais, Bruce A., Jefferey J. Harden, and Fredrick J. Boehmke. 2015. "Persistent Policy Pathways: Inferring Diffusion Networks in the American States." *Political Science Review* 109(2): 392-406.

Dupuis, Johann, and Peter Knoepfel. 2015. "Chapter 2: Institutions and the Environmental

Management of Contaminated Sites: A Theoretical Framework." *The Politics of Contaminated Sites Management*. Dordrecht, Switzerland: Springer International Publishing.

Durant, Robert F. 2015. "Whither Power in Public Administration? Attainment, Dissipation, and Loss." *Public Administration Review*, 75(2): 206-218.

Emerson, Richard M. 1962. "Power-dependence relations." *American Sociological Review* 27(1): 31-41

Estelle v. Gamble 429 US 97 (1976).

Fischer, Manuel. 2014. "Coalition Structures and Policy Change in a Consensus Democracy." *The Policy Studies Journal* 42(3): 344-366.

Fletcher, Bennett W., Wayne E. K. Lehman, Harry K. Wexler, and Gerald Melnick. 2007. "Who Participates in the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS)?" *The Prison Journal* 87(1): 25-57.

Friedmann, Peter D., Randall Hoskinson Jr, Michael Gordon, Robert Schwartz, Timothy Kinlock, Kevin Knight, Patrick M. Flynn et al.2012. "Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): availability, barriers, and intentions." *Substance Abuse* 33(1): 9-18.

Fry, Brian R., and C. N. Jos. 2008. *Raadschelders. Mastering Public Administration: from Max Weber to Dwight Waldo.* CQPress.

Graham, Erin R., Charles R. Shipan, and Craig Volden. 2013. "The diffusion of policy diffusion research in political science." *British Journal of Political Science* 43(3): 673-701.

Hale, Kathleen. 2011. *How Information Matters: Networks and Public Policy Innovation*. Washington, D.C.: Georgetown University Press.

Hale, Kathleen and Mitchell Brown. 2013. "Adopting, Adapting, and Opting Out: State Responses to Federal Voting System Guidelines." *Publius* 43(3): 428-51.

Hall, Peter A. 1993. "Policy Paradigms, Social Learning, and the State: The Case of Economic Policy Making in Britain." *Comparative Politics* 25: 275-297.

Harrison, Lana. D., Clifford A. Butzin, James A. Inciardi, Steven S. Martin. 1998. "Integrating HIV-Prevention Strategies in a Therapeutic Community Work-Release Program for Criminal Offenders." *The Prison Journal* 78(3): 232-243.

Hawkins, Christopher V. 2011. "Smart growth policy choice: A resource dependency and local governance explanation." *Policy Studies Journal* 39(4): 679-707.

Health District, Southern Nevada. 2017. "Health District, Trac-B Exchange, launch Southern Nevada's first needle exchange." April 17, 2017. https://www.southernnevadahealthdistrict.org/news17/20170412-health-district-trac-b-exchange-launch-southern-nevadas-first-needle-exchange.php. Accessed May 4th, 2017.

Huxham, Chris, and Siv Vangen. 2004. "Doing things collaboratively: realizing the advantage or succumbing to inertia?" *IEEE Engineering Management Review* 32(4): 11-20.

Kalu, N. Kalu. 2012. "All That Glitters: Competing Narratives and Transaction Costs in Complex Collaborative Environments." *Administration and Society* August (2012): 1-23.

Kass, Arielle. 2016. "Fulton County commissioners support needle exchange." The Atlanta Journal-Constitution. Wednesday, Nov. 16, 2016. http://www.ajc.com/news/local-govt--politics/fulton-county-commissioners-support-needle-exchange/T6pvywJI66bKxLtEYVkksN/. Accessed on May 10, 2017.

Knoke, David. 1996. *Comparing policy networks: labor politics in the US, Germany, and Japan*. Cambridge University Press.

Kickert, J.M. Walter, Erik-Hans Klijn and Johannes Franciscus Maria Koopenjan. 1997. *Managing Complex Networks: Strategies for the Public Sector*. London: Sage Publications.

Kriesi, Hanspeter. 1990. "The structure of belief systems in the Dutch general public." *European Sociological* Review 1: 165-180.

Kriesi, Hanspeter, and Maya Jegen. 2001. "The Swiss energy policy elite: The actor constellation of a policy domain in transition." *European Journal of Political Research* 39(2): 251-287.

Kriesi, Adam, and Jochum 2006 Kriesi, Hanspeter, Silke Adam, and Margit Jochum. 2006. "Comparative analysis of policy networks in Western Europe." Journal of European Public Policy 13(3): 341-361.

Ingram, Helen, and Steven Rathgeb Smith, eds. 2011. *Public policy for democracy*. Brookings Institution Press.

Ingold, Karin. 2011. "Network Structures within Policy Processes: Coalitions, Power, and Brokerage in Swiss Climate Policy." *The Policy Studies Journal* 39(3):

Institute of Medicine of the National Academies. 2011. "HIV Screening and Access to Care Series Summary." *Report Brief*. www.iom.edu/hivscreening (April 2011). Accessed December 30th, 2016.

Kaiser Family Foundation, kkf.org. 2015. "HIV Testing in the United States." *The Henry J. Kaiser Family Foundation*. June 23. http://kkf.org/hivaids/fact-sheet/hiv-testing-in-the-united-states/ (April 12 2016).

Kettl, Donald F. 2002. "The transformation of governance: Public Administration for the 21st Century." *Baltimore, MD: Johns Hopkins University*.

King, G., Keohane, R. O., and Verba, S. 1994. *Designing Social Inquiry: Scientific Inference in Qualitative Research.* Princeton, NJ: Princeton University Press.

LA Homeless Resource. 2010. "Current PDF List of Needle Exchange Sites, Locations and Hours." *Needle Exchange Program*. http://lahomeless.wikia.com/wiki/Needle_Exchange_Program. Accessed May 10, 2017.

Lasswell, Harold D. 1936. *Politics: Who Gets What, When, How*. Cleveland, Ohio: Meridian Books.

Laumann, Edward O., and U. Pappi. 1976. "Networks of collective actions." New York: Academic Press.

Levi, Margaret. 1997. "A model, a method, and a map: Rational choice in comparative and historical analysis." Comparative politics: *Rationality, culture, and structure* 28: 78.

Long, Norton E. 1949. "Power and administration." *Public Administration Review* 9(4): 257-264.

Lejano, Raul, Mrill Ingram, and Helen Ingram. 2013. *The power of narrative in environmental networks*. Cambridge, Massachusetts: MIT Press.

Leip, Dave. 2016. "Dave Leip's Atlas of U.S. Presidential Elections." http://uselectionatlas.org/RESULTS/. Accessed May 23, 2017.

Makse, Todd, and Craig Volden. 2011. "The role of policy attributes in the diffusion of innovations." *The Journal of Politics* 73(1): 108-124.

Malatesta, Deanna, and Craig R. Smith. 2014. "Lessons from resource dependence theory for contemporary public and nonprofit management." *Public Administration Review* 74(1): 14-25.

Maruschak, Laura M. 2012. "HIV in prisons, 2001–2010." *AIDS* 20.25.10 (2012).

May, Workman, and Jones 2008 May, Peter J., Samuel Workman, and Bryan D. Jones. 2008. "Organizing attention: Responses of the bureaucracy to agenda disruption." *Journal of Public Administration Research and Theory* 18(4): 517-541.

Mayer, Kenneth H., Anne Spaulding, Becky Stephenson, Grace Macalino, William Ruby, Jennifer G. Clarke, and Timothy P. Flanigan. 2002. "Human immunodeficiency virus in correctional facilities: a review." *Clinical Infectious Diseases* 35(3): 305-312.

McGuire, Michael. 2006. "Collaborative Public Management: Assessing What We Know and How We Know It." Public Administration Review 66(1): 33-43.

Mears, Daniel P. and Joshua C. Cochran. 2012. "U.S. Prisoner Reentry Health Care Policy in International Perspective: Service Gaps and the Moral and Public Health Implications." *The Prison Journal* 92(2): 175-202.

Meek, Jack W., and Kurt Thurmaier, eds. 2012. *Networked governance: The future of intergovernmental management.* Washington, DC: CQ Press.

Meier, Kenneth J., and Laurence J. O'Toole. 2001. "Managerial Strategies and Behavior in Networks: A Model with Evidence from US Public Education." *Journal of Public Administration Research and Theory* 11(3): 271-294.

Mossberger, Karen and Kathleen Hale. 2002. "Polydiffusion' in Intergovernmental Programs: Information Diffusion in the School-to-Work Network." *American Review of Public Administration* 32(4): 398-422.

Milward, H. Brinton, and Keith G. Provan. 1998. "Measuring network structure." *Public Administration* 76(2): 387-407.

Milward, Brinton H. and Keith G. Provan. 2000. "Governing the Hollow State." *J-PART* 10(2): 359-379.

Mooney, Christopher Z. and Mei-Hsien Lee. 1995. Legislative Morality in the American States: The Case of Pre-Roe Abortion Regulation Reform. *American Journal of Political Science* 39(3): 599-627.

Moe, Terry M. 2005. "Power and Political Institutions." *Perspectives on Politics* 3(2): 215-233.

Moynihan, Donald P. 2008. *The dynamics of performance management: Constructing information and reform.* Georgetown University Press, 2008.

Mitchell, Shannon Gwin, Jennifer Willett, Holly Swan, Laura B. Monico, Yang, Yvonne O. Patterson, Steven Belenko, Robert P. Schwartz, and Christy A. Visher. 2015. Defining Success: Insights from a Random Assignment, Multisite Study of Implementing HIV Prevention, Testing, and Linkage to Care in the U.S. Jails and Prisons. *AIDS Education and Prevention* 27(5): 432–445.

Nicholson-Crotty, Sean and Jill Nicholson-Crotty. 2015. "Politics, Capacity, and Pass Through Decisions in the American States: Evidence from the American Recovery and Reinvestment Act." *Publius: The Journal of Federalism* 45(3): 475-494.

Nicholson-Crotty, Sean. 2009. "The politics of diffusion: Public policy in the American states." *The Journal of Politics* 71(1): 192-205.

Nohrstedt, Daniel. 2010. "Do Advocacy Coalitions Matter? Crisis and Change in Swedish Nuclear Energy Policy." *Journal of Public Administration Research and Theory* 20: 309–33.

Ostrom, Elinor. 1998. "A behavioral approach to the rational choice theory of collective action: Presidential address, American Political Science Association, 1997." *American Political Science* Review 92(1): 1-22.

Ostrom, Elinor. 2005. "Self-governance and forest resources." *Terracotta reader: A market approach to the environment*: 131-154.

O'Leary, T. 2006. *Foucault and the Art of Ethics*. A&C Black.

O'Toole, Laurence J. 2015. "Networks and networking: the public administrative agendas." Public Administration Review 75(3): 361-371.

O'Toole Jr., Laurence J. 1997. "Treating Networks Seriously: Practical and Research-Based Agendas in Public Administration." *Public Administration Review* 57(1): 45-52.

O'Toole, Lawrence. 1987. "Policy Recommendations for Multi-Actor Implementation: an Assessment of the Field. *Journal of Public Policy* 6 (2): 181-210.

O'Toole, Laurence J., and Robert K. Christensen. 2012. "American intergovernmental relations: Foundations, perspectives, and issues." Washington, DC: CQ Press.

Pierson, Paul. 2000. "Increasing returns, path dependence, and the study of politics." *American Political Science* Review 94(2): 251-267.

Pierson, Paul. 2000. "The limits of design: Explaining institutional origins and change." *Governance* 13(4): 475-499.

Pope, James Lee. 2009. "HIV Testing in State Correctional Systems." *Journal of Law and Health* 21(17): 17-52.

Provan, Keith G., and H. Brinton Milward. 2001. "Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks." *Public Administration Review*: 61(1).

Rapposelli, Karina, May G. Kennedy, John R. Miles, Melinda J. Tinsley, Kathryn J. Rauch, Lynn Austin, Samuel Dooley, Barbara Aranda-Naranjo, and Richard A. Moore. 2002. "HIV/AIDS in correctional settings: a salient priority for the CDC and HRSA." *AIDS Education and Prevention* 14(5): 103-113.

Rogers, Everett M. 1962. "Diffusion of Innovations." New York: The Free Press of Glencoe.

Rhodes, Roderick Author William. 1997. *Understanding governance: Policy networks, governance, reflexivity and accountability.* London: Open University Press.

Rhodes, Roderick Arthur William. 1981. *Control and power in central-local government relations.* Gower and Brookfield Vermont: Ashgate.

Sabatier, Paul A. 1987. "Knowledge, Policy-Oriented Learning, and Policy Change: An Advocacy Coalition Framework." *Science Communication* 8: 649–92.

Sabatier, Paul A., and Hank Jenkins-Smith, eds. 1993. *Policy Change and Learning: An Advocacy Coalition Approach.* Boulder, CO: Westview Press.

Sabatier, Paul A., and Christopher M. Weible. 2007. "The Advocacy Coalition Framework." In *Theories of the Policy Process*, ed. Paul A. Sabatier. Boulder, CO: Westview Press, 189–222.

Sabatier, Paul A. and Christopher M. Weible. 2014. *Theories of the Policy Process*. Third edition. Boulder, CO: Westview Press.

Sandström, Annica. 2008. "Policy Networks: The Relation between Structure and Performance." Doctoral Thesis, Lulea University of Technology. http://epubl.ltu.se/1402-1544/2008/25/ (Accessed October 29, 2016).

Sandström, Annica, and Lars Carlsson. 2008. "The performance of policy networks: the relation between network structure and network performance." *Policy Studies Journal* 36(4): 497-524.

Saz-Carranza, Angel, Susanna Salvador Iborra, and Adrià Albareda. 2015. "The power dynamics of mandated network administrative organizations." *Public Administration Review* 76(3): 449–462

Schattschneider, E. E. 1960. *The Semi Sovereign People*. New York: Holt, Reinhart, and Winston.

Scharpf, Fritz W. 1997. *Games real actors play: Actor-centered institutionalism in policy research.* Boulder, Colorado: Westview Press.

Schneider, Anne and Helen Ingram. 1997. *Policy Design for Democracy*. Lawrence, Kansas: University of Kansas Press.

Schneider, Anne, and Helen Ingram. 1993. "Social construction of target populations: Implications for politics and policy." *American political science review* 87(2): 334-347.

Servent, Ariadna Ripoll. 2015. *Institutional and policy change in the European parliament: Deciding on freedom, security and justice*. New York City, New York: Springer.

Shipan, Charles R. and Craig Volden. 2006. "Bottom-Up Federalism: The Diffusion of Antismoking Policies from U.S. Cities to States." *American Journal of Political Science* 50 (4): 825-43.

Shipan, Charles R. and Craig Volden. 2008. "The Mechanisms of Policy Diffusion." *American Journal of Political Science* 52(4): 840-857.

Shipan, Charles R. and Craig Volden. 2012. "Policy Diffusion: Seven Lessons for Scholars and Practitioners." *Public Administration Review* 72(6): 788-796.

Sykes, Bryan L., and Alex R. Piquero. 2009. "Structuring and re-creating inequality: Health testing policies, race, and the criminal justice system." *The ANNALS of the American Academy of Political and Social Science* 623(1): 214-227.

Solomon, Liza, Brian T. Montague, Curt G. Beckwith, Jacques Baillargeon, Michael Costa, Dora Dumont, Irene Kuo, Ann Kurth, and Josiah D. Rich. 2014. "Survey finds that many prisons and jails have room to improve HIV testing and coordination of post release treatment." *Health Affairs* 33(3): 434-442.

Spaulding, Anne C., Robin J. MacGowan, Brittney Copeland, Ram K. Shrestha, Chava J. Bowden, Min J. Kim, Andrew Margolis. 2015. "Costs of Rapid HIV Screening in an Urban Emergency Department and a Nearby County Jail in the Southeastern United States." *PloS One* 10(6): e0128408

Spaulding, A., B. Stephenson, G. Macalino, W. Ruby, J.G. Clark and T.P. Flanigan. 2002. "Human Immunodeficiency Virus in Correctional Facilities: A Review. *HIV/AIDS* 35: 305-312.

Spaulding, Anne C., Min Jung Kim, Kiemesha T. Corpening, Taptola Carpenter, Portia Watlington, and Chava J. Bowden. 2014. "Establishing an HIV Screen Program Led by Staff Nurses in a County Jail." *Journal of Public Health Management Practices* 00(00): 1-8.

Steelman, Toddi A. 2010. *Implementing Innovation: Fostering Enduring Change in Environmental and Natural Resource Governance*. Washington, DC: Georgetown University Press.

Takahashi, Lois M., and Gayla Smutny. 2002. "Collaborative windows and organizational governance: Exploring the formation and demise of social service partnerships." *Nonprofit and Voluntary Sector Quarterly* 31(2): 165-185.

Tartaro, Christine, and Marissa P. Levy. 2013. "An evaluation of an HIV testing program in the jail setting: results and recommendations." *The Prison Journal* 93(1): 57-79.

Thomson, Ann Marie and James L. Perry. 2006. "Collaboration Processes: Inside the Black Box." *Public Administration Review* 66: 20-32.

Van Bortel, Gerard, David Mullins, and Mary Lee Rhodes. 2009. "Exploring network governance in urban regeneration, community involvement and integration." *Journal of housing and the built environment* 24(2): 93-101.

U.S. Census Bureau. 2016. "Quick Facts." *Census.gov.* https://www.census.gov/quickfacts (Accessed Nov. 19, 2017).

Wagner, Zachary, Yanyu Wu, and Neeraj Sood. 2014. "The Affordable Care Act may increase the number of people getting tested for HIV by nearly 500,000 by 2017." *Health Affairs* 33(3): 378-385.

Walker, Jack L. 1969. "The Diffusion of Innovations among American States." The American Political Science Review 63(3): 880-899.

White House Office of National AIDS Policy. 2010. National HIV/AIDS Strategy for the United States. Washington, DC: The White House; July 13, 2010. Available at: http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf2. Accessed April, 2017.

White House Office of National AIDS Policy. 2010. Federal Implementation Plan. Washington, DC: The White House. Available at: http://aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-implementation.pdf3. Accessed April 2017.

Wolf, Leslie E., Alexis Donoghoe, and Tim Lane. 2007. "Implementing Routine HIV Testing: The Role of State Law." *PLoS ONE* 2(10): e1005. doi:10.1371/journal.pone.0001005.

Yin, Robert. 2009. *Case Study Research: Design and Methods*, 4th ed. Los Angeles: Sage Press.

Yin, Robert and Andranovich, Gregory. D. 1987. *Getting Research Used in the Natural Hazards Field: The role of Professional Associations*. Washington, DC: Cosmos Corporation.

Zaller, Nick, Portia Thurmond, and Josiah D. Rich. 2007. "Limited Spending: An Analysis of Correctional Expenditures on Antiretroviral for HIV-Infected Prisoners." *Public Health Reports* Jan.-Feb. (122): 49-54.

Figure 2.1. Mechanisms of Policy Adoption
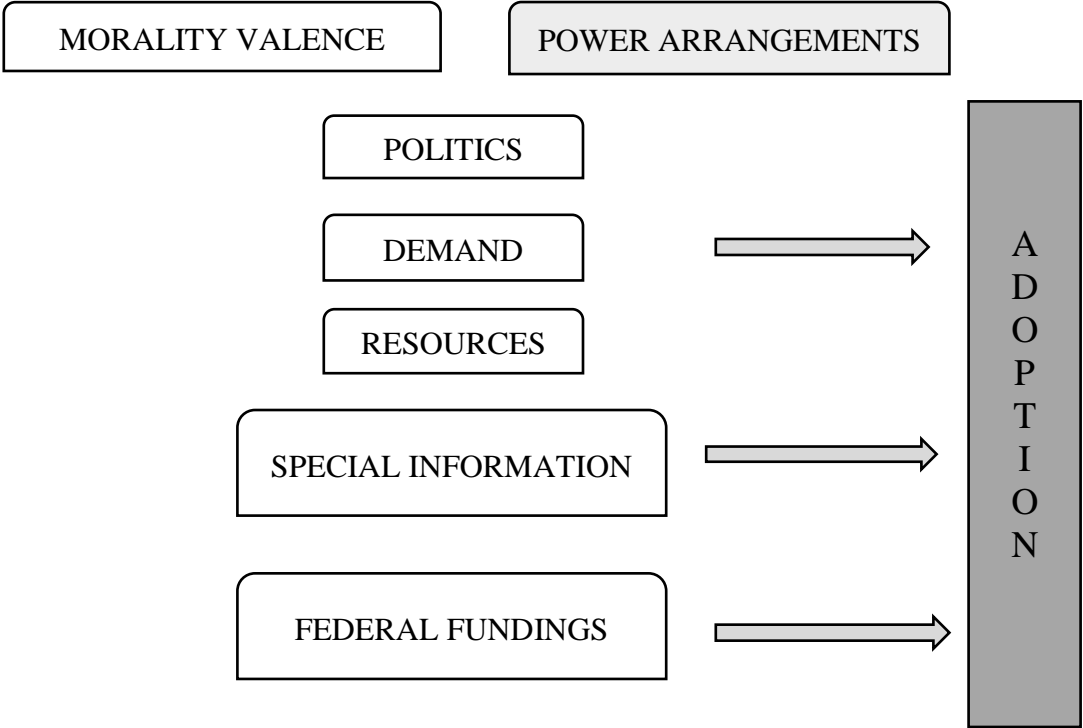
Figure 3.1. The Dependent Variable: Categories of Testing Policies

Opt-in or High risk only Policies	Opt-out Policies
Traditional or Rapid Testing	Traditional or Rapid Testing
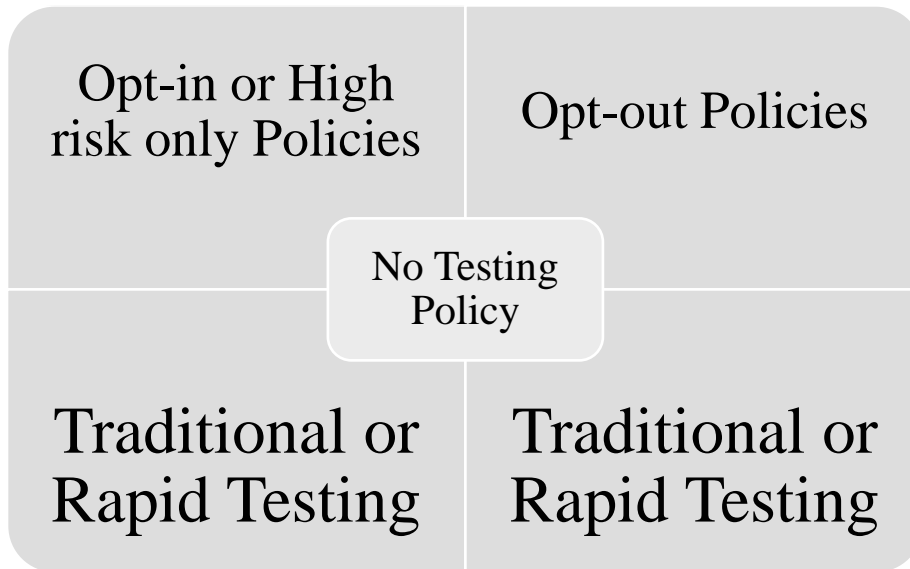
No Testing Policy

Figure 3.2. Rapid Shift, Incremental, and Status Quo Policies

Rapid Shift: Complete change of policies to reflect CDC recommendations

Incremental Changes: Pre-2006 policies but with few updates.

Status Quo Maintained: Pre-2006 policies continued despite CDC Recommendations

2006
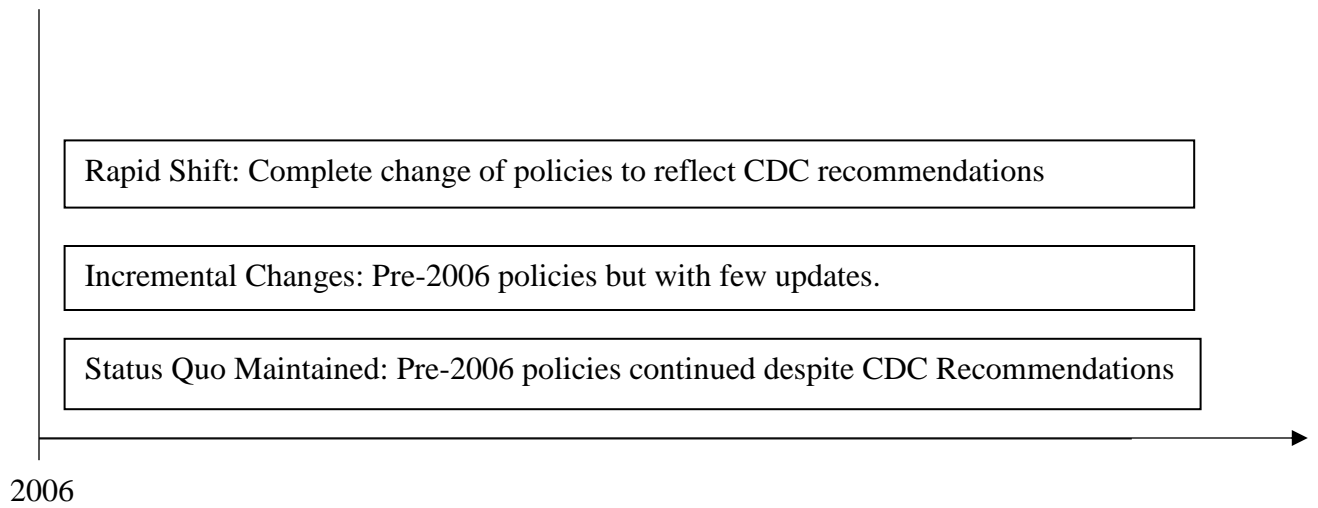
Figure 4.1. CDC HIV Testing Recommendations and Rapid HIV Testing Laws in States
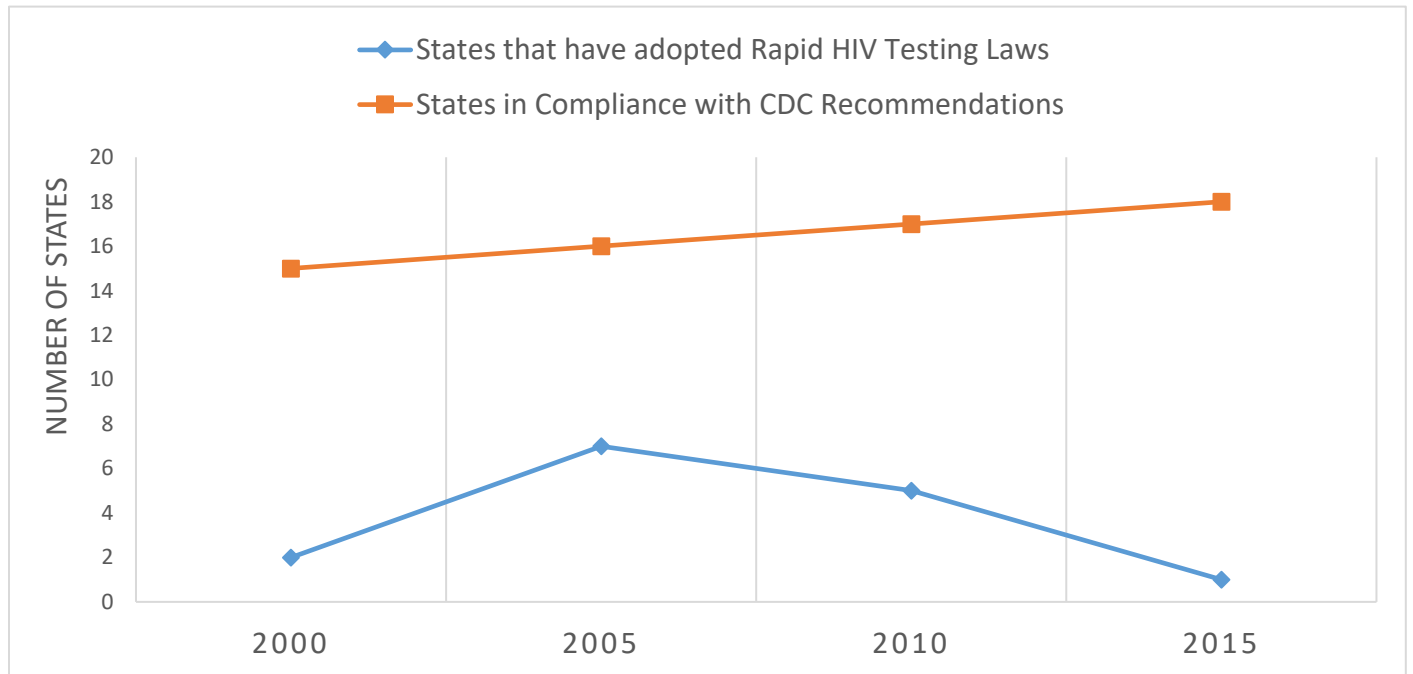
Figure 4.2. Possibilities of Policy Outcomes

| Status Quo (H1a; H1b) | Incremental Change (H1c; H1d) | Rapid Shift (H1e; H1f) |
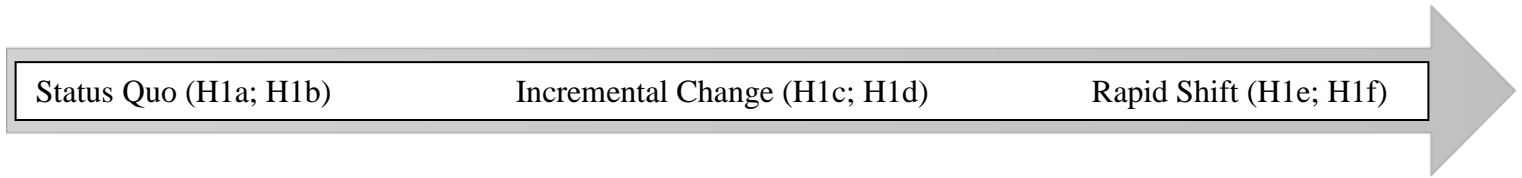
Table 2.1. State HIV Testing Policies

STATE	Test when Admit to Prison	State Requires Jails Test for HIV	Rapid HIV Testing Law
Alabama			X
Alaska			
Arizona			
Arkansas			
California	X		X
Colorado	X		
Connecticut			
Delaware			
DC	X		
Florida		X (sex crimes)	X
Georgia	X		
Hawaii	X		
Idaho	X		
Illinois			
Indiana	X		
Iowa	X		
Kansas			
Kentucky			
Louisiana			
Maine			
Maryland	X		X
Massachusetts			X
Michigan			
Minnesota			
Mississippi	X		
Missouri	X		X
Montana			X
Nebraska	X		
Nevada	X		X
New Hampshire	X		X
New Jersey			X
New Mexico			
New York			X
North Carolina			X
North Dakota			
Ohio	X		
Oklahoma	X		X
Oregon			
Pennsylvania			X
Rhode Island	X		X
South Carolina			
South Dakota			
Tennessee			X
Texas	X		
Utah	X		
Vermont			
Virginia			
Washington			X
West Virginia			
Wisconsin	X		
Wyoming	X		

Table 2.2. State Rapid HIV Testing Laws

	State Rapid HIV Testing Laws	Date Adopted
1	New Hampshire	1987
2	New Jersey	1990
3	Nevada	1993
4	Tennessee	2002
5	Washington	2002
6	Missouri	2003
7	North Carolina	2003
8	Oklahoma	2003
9	Maryland	2005
10	Massachusetts	2005
11	Alabama	2006
12	Florida	2008
13	Montana	2009
14	Rhode Island	2009
15	New York	2010
16	California	2012

Table 2.3. CDC Grant Funding to States for HIV Prevention and Testing

STATE	PS12-1201 A	PS 12- 1201 B	PS 12-1201 C	PS 12-1210
Alabama	X	X		
Alaska	X		X	
Arizona	X	X	X	
Arkansas	X			
California	X	X		
Colorado	X	X	X	
Connecticut	X	X		
Delaware	X			
DC	X	X		
Florida	X	X		
Georgia	X	X	X	X
Hawaii	X		X	
Idaho	X			
Illinois	X	X	X	X
Indiana	X	X		
Iowa	X			
Kansas	X			
Kentucky	X			
Louisiana	X	X	X	X
Maine	X			
Maryland	X	X	X	
Massachusetts	X	X		
Michigan	X	X	X	
Minnesota	X		X	
Mississippi	X	X		X
Missouri	X	X		X
Montana	X		X	
Nebraska	X		X	
Nevada	X			
New Hampshire	X			
New Jersey	X	X	X	
New Mexico	X		X	
New York	X	X	X	
North Carolina	X	X		X
North Dakota	X			
Ohio	X	X		
Oklahoma	X			
Oregon	X		X	
Pennsylvania	X	X	X	
Rhode Island	X		X	
South Carolina	X	X	X	
South Dakota	X			
Tennessee	X	X		X
Texas	X	X	X	
Utah	X		X	
Vermont	X		X	
Virginia	X	X		X
Washington	X		X	
West Virginia	X			
Wisconsin	X		X	
Wyoming	X			

Table 2.4. Municipalities Directly Funded by the CDC in 2012 by PS12-1202

Municipality Funded	Amount Awarded	State Funded	Amount Awarded
City of Baltimore	$3,113,447	Maryland	$8,803,824
City of Chicago	$8,149,330	Illinois	$3,721,864
Fulton County	$4,522,675	Georgia	$6,923,296
City of Houston	$7,128,513	Texas	$15,826,842
Los Angeles County	$14,991,550	California	$16,837,335
City of New York City	$32,359,386	New York	$22,271,257
City of Philadelphia	$7,294,118	Pennsylvania	$5,512,624
City of San Francisco	$7,669,832	California	$16,837,335

Table 2.5. Power Dynamics in Networks

Type of Variable	Concept Measured	Variables Used
Compositional	Interaction Patterns	Conflict
		Bargaining
		Cooperation
Structural	Power Arrangements	Concentrated
		Fragmented

Table 3.1. Power in Networks

Distribution of Power	Type of Interaction between Actors		
	Conflict	Bargaining	Cooperation
Hierarchical	Asymmetric delineation of priorities by one or few	Asymmetric resources in one actor or few actors	Top down leader(s) but accepted by group
Horizontal	Competition of priorities between many actors	Symmetric resources	Shared decision making

Table 3.2. Secondary Data Used

Source Name	Purpose	Mechanism
Annual Survey of Jails	Most inmates admitted in 30 days	Demand
Center for Disease Control	Grant data	Resources
County Health Department Websites	Needle exchange program existence	Morality Valence
Center for Disease Control	State HIV testing laws	Politics
Leip (2016)	Presidential Election Data	Politics
Pope (2009)	State HIV testing laws	Politics
State Legislative Codes	State HIV testing laws	Politics

Table 3.3. Case Selection Table

	Cook County, Illinois	Clark County, Nevada	Fulton County, Georgia	Miami-Dade County, Florida	Harris County, Texas	Los Angeles County, California
Jail pop per 100K*	181.42	197.81	249.62	183.60	207.76	190.93
State law alignment with CDC	✓	✓				✓
Direct grant funding from CDC			✓			✓
County has needle exchange program	✓			✓		✓

*These numbers are BJS for the average number of inmates in a 30-day period in 2014. This average jail population is weighted by county population, and then transformed into a per capita/ per 100K person number used in this table.

Table 3.4. Specific Interview Questions and Concepts Measured

CONCEPT	QUESTION #	QUESTION
Decision-making	19	Who usually sets the goals for your collaborative work?
Decision-making	20	Who sets meeting times, the agenda, or deadlines for this working group?
Decision-making	6	How would this priority change?
Decision-making	8	Who decides how state and federal funding is used?
Priorities	4	What is the top priority of this organization?
Priorities	5	Who sets that priority?
Priorities	22	Do you find that the members of this group usually share goals for policy changes?
Priorities	23	Does this working group tend to have similar opinions about the goals of the jail?
Priorities	24	Would you say that the organizations you work with often have trouble coming to a consensus or often do not agree?
Priorities	25	What happens when members of the group do not come to a consensus?
Priorities	26	Of these organizations you work with, who shares your goals the most?
Priorities	27	Who shares your goals the least?
Resources: Capacity	15	What kind of space is there for HIV testing, or is there mobile testing?
Resources: Information	21	How does information from the working group get disseminated?
Resources: Information	32	Who has technology everyone relies on for the work they do?
Resources: Reputation	28	Do you feel you are always trying to change other's opinions in the group?
Resources: Reputation	29	Is there one influential member who leads the group in decisions?
Resources: Reputation	30	Why is this person influential?
Resources: Reputation	33	Who is the most politically connected as compared to the others you work with?
Resources: Trust	31	Who among this working group do you believe to be the most dependable person?

Table 3.5. Key Concepts

	Priorities	**Resources**	**Decision-Making**
Asymmetric	Main goals not shared	Concentration of resource or hoarding	One person or group of people make all important decisions
Partially Shared	Goals partially shared	All resources partially shared	Process of making important decisions partially shared
Symmetric	Goals completely Shared	All resources completely shared	Decisions completely shared

Table 3.6. Power Arrangements and Interaction Patterns

Power Arrangement	Type of Interaction		
	Conflict	Bargaining	Cooperation
Concentrated	Hierarchical	Hierarchical	Hierarchical
Fragmented	Horizontal	Horizontal	Horizontal

Table 3.7. Potential for Policy Change

Power Arrangement*	Type of Interaction		
	Conflict	Bargaining	Cooperation
Concentrated	Moderate potential for rapid serial shift	Low to moderate potential for incremental change	Low potential for change-maintenance of status quo
Fragmented	High potential for rapid serial shift	Moderate to high potential for incremental change	Low to moderate potential for change-maintenance of status quo

*This table is based on the framework already created by Adam and Kriesi (2007).

Table 4.1. Priorities, Resources, and Decision-Making and Interaction Patterns

Variable Coded	Interaction Pattern
Completely Shared	Cooperation
Mostly Shared	Bargaining
Not Shared	Conflict

Table 4.2. Structural Variables Coded

Variable Code	Structure
Asymmetrically held	Hierarchical
Symmetrically held	Horizontal

Table 4.3. Actors in Clark County

Network Actor	Interview Completed?
Southern Nevada Health District	Yes
Clark County Detention Center	Yes
NaphCare	No
Sheriff	No
County Commission	No
Chief Medical Officer	No

Table 4.4. Actors in Fulton County

Network Actor	Interview Completed?
Emory University's Rollins School of Public Health	Yes
Georgia State Health Department	No
Fulton County Wellness Department	No
Correct Care	No
Corizon	No
Sheriff	No

Table 4.5. Actors in Harris County

Network Actor	Interview Completed?
Harris County Health System	No, but a prelim. survey completed
Harris County Department of Public Health	No, but prelim. survey completed
LabCorp	No
AIDS Foundation Houston	No
Sheriff	No

Table 4.6. Actors in Los Angeles County

Network Actor	Interview Completed?
Department of Public Health, Los Angeles County	Yes
California's Department of Public Health	No
Los Angeles County	No
Los Angeles Department of Health Services	No
Sheriff	No

Table 4.7. Key Conceptual Findings

County	Question	Variable	Answer	Code
Clark	11. When was this policy put in place?	Expertise	Health District makes decisions on testing method.	Cooperation. Hierarchical
	22. Do you find that the members of this group usually share goals for policy changes?	Priorities	Share goals.	Cooperation. Horizontal
	24. Would you say that the organizations you work with often have trouble coming to a consensus or often do not agree?	Decision Making	Rarely do not come to consensus.	Cooperation. Hierarchical
	20. How does information from the working group get disseminated?	Information	Jail disseminates info for group. Health District has info about HIV grants and research.	Bargaining. Hierarchical
	31. Who among this working group do you believe to be the most dependable person?	Dependability	Health District.	Cooperation. Horizontal
	32. Who has technology everyone relies on to do the HIV testing?	Technology	Jail for access to inmate computer system. Health District for HIV testing tools.	Bargaining. Hierarchical
	33. Who is the most politically connected as compared to the others you work with?	Reputation	Health District	Bargaining. Hierarchical
Fulton	8. Who decides how state and federal funding is used?	Decision Making, Money	Emory University and County Dept. of Health and Wellness	Bargaining. Horizontal
	32. Who has technology everyone relies on to do HIV testing?	Information	Emory University	Bargaining. Hierarchical.
	28. Do you feel you are always trying to change other's opinions in the group?	Reputation	No, mostly in agreement. But Emory and CDC set the direction of testing policies.	Cooperation. Hierarchical.
	23. Does this working group tend to have similar opinions about the goals of the jail?	Priorities	Shared between jail, county, and nonprofit.	Conflict. Horizontal.
Los Angeles	17. Who do you usually meet with to talk about jail policies and practices.	Expertise	LA Dept. of Public Health.	Bargaining: Horizontal.
	8. Who decides how state and federal funding is used?	Decision Making	Sheriff's Office.	Bargaining: Horizontal.
	32. Who has technology everyone relies on to do HIV testing?	Technology	LA Dept. of Public Health.	Bargaining. Horizontal.
	28. Do you feel you are always trying to change other's opinions in the group?	Priorities	Difference in priorities for HIV testing between the sheriff's office and the LA Dept. of Public Health	Conflict. Horizontal.

Table 4.8. The Interaction Patterns of the Counties

	Cooperation/ Hierarchical	Cooperation/ Horizontal	Bargaining/ Hierarchical	Bargaining/ Horizontal	Conflict/ Hierarchical	Conflict/ Horizontal
Clark County Priorities	✓					
Resources			✓			
Decision-Making		✓				
Fulton County Priorities				✓		
Resources				✓		
Decision-Making				✓		
Los Angeles County Priorities						✓
Resources				✓		
Decision-Making				✓		

Table 4.9. Networks and their Power Arrangement

Network	Structure	Interaction	Power Arrangement
Clark County	Hierarchical	Cooperation	Fragmented
Fulton County	Horizontal	Bargaining	Fragmented
Los Angeles County	Horizontal	Bargaining	Fragmented

Table 4.10. Expectations Tested

Power Arrangement	Interaction Pattern		
	Cooperation	Bargaining	Conflict
Concentrated	A: In comparing networks, those in cooperation and a concentrated power arrangement are the most likely to keep status quo policies in place.	C: In comparing networks, those in bargaining with a concentrated power arrangement have a low to moderate potential for incremental change.	E: In comparing networks, those in conflict and with a concentrated power arrangement have a moderate potential for rapid serial shift.
Fragmented	B: In comparing networks, those in cooperation and in a fragmented power arrangement have a low to moderate potential for change and maintain the status quo.	D: In comparing networks, those in bargaining with a fragmented power arrangement have a moderate to high potential for incremental change.	F: In comparing networks, those in conflict and with a fragmented power arrangement are the most likely to adopt policy change or a rapid serial shift.

Table 4.11. The Power Arrangement and Policy Outcomes

Power Arrangement	Type of Interaction		
	Bargaining	Cooperation	Conflict
Fragmented (Dependent Variable)	**Fulton**: Opt-Out; Rapid (Pre-2006 they had started a rapid testing program from a 2000 CDC grant). **Los Angeles**: Opt-Out; Traditional (They did not have an opt-out policy before 2006).	**Clark**: Opt-In; Traditional testing (same policy they had pre-2006).	
Fragmented (Expectation)	H1d: In comparing networks, those in bargaining with a fragmented power arrangement have a moderate to high potential for incremental change.	H1b: In comparing networks, those in cooperation and in a fragmented power arrangement have a low to moderate potential for change and maintain the status quo.	

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(NOTE: DO NOT SIGN THIS DOCUMENT UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN
APPLIED TO THIS DOCUMENT.)

INFORMED CONSENT
for a Research Study entitled
"Policy Adoption and Networked Governance: How Power Arrangements Explain Local
Approaches to HIV Testing"

You are invited to participate in a research study that explores the HIV testing practices used in correctional settings. It seeks to understand who is screened for HIV, how, and why that decision was made. The study is being conducted by Avery Livingston, a PhD student at Auburn University under the direction of Dr. Kathleen Hale, Associate Professor in the Auburn University Department of Political Science. You were selected as a possible participant because you are a jail administrator or someone who works closely with the county jail and are age 19 or older.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to answer a series of questions about who you work with, how you work with them, and HIV testing policies in the county jail. Your total time commitment will be approximately one hour.

Are there any risks or discomforts? The risks associated with participating in this study are that confidential information may be shared during the course of an interview. To minimize these risks, I will keep all interviews confidential and no personal identifiers of you or the people you work with will be included in the dissertation, presentations, or publications.

Are there any benefits to yourself or others? If you participate in this study, you can expect to be part of a meaningful study about HIV testing policies in local jails. I cannot promise you that you will receive any or all of the benefits described.

Will you receive compensation for participating? No compensation is offered for participation.

Are there any costs? If you decide to participate, the interview will take approximately an hour. Your information may be identifiable only by the office, organization, or agency you work with. No personal identifiers are included in the dissertation, conferences, or future publications.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University or the Department of Political Science.

The researcher wishes to record our interview. The audio data will be transcribed and deleted by the researcher by August 30th, 2017. Do you consent to be recorded?   Yes, I Consent ☐
No, I do not Consent ☐

Participant's initials _____   Page 1 of 2

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Your privacy will be protected. Any information obtained in connection with this study will remain confidential. Information obtained through your participation will be included in the researcher's dissertation, conference presentations, and future publications.

All data with personal identifiers will be deleted by August 30th, 2017.
If you have questions about this study, *please contact*

Avery Livingston at livingstonacl@gmail.com or acl0033@auburn.edu.
The advisor for this study is Dr. Kathleen Hale at halekat@auburn.edu.

A copy of this document will be given to you to keep.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE INDICATES YOUR WILLINGNESS TO PARTICIPATE.

_____   _____
Participant's signature   Date   Investigator obtaining consent   Date

_____   _____
Printed Name   Printed Name

Good day, Mr./Ms. X:

This email is for the jail administrator, or the most knowledgeable person of jail policies.

I am a PhD student of Public Policy and Administration at Auburn University. I am doing my dissertation on county jail HIV testing policies and why policies change. Would you be willing to sit down with me, via phone interview or webcam, and answer a few questions about your jail's policies and how they are made?

I have an interview that will take approximately one hour. You were selected as a possible participant because you are a jail administrator or someone who works closely with the county jail and are age 19 or older. If you decide to participate in this research study, then you will be asked to answer a series of questions about who you work with, how you work with them, and HIV testing policies in the county jail. All information gained from the interview will be kept confidential to preserve your privacy. There is no compensation provided to you for participation in my study. However, you will be a part of research that will contribute to the overall understanding of policy making in local networks.

Attached is an informed consent form that explains the details of my study. There is no need to sign it just yet if you have further questions for me about this study and the interview. However, I will ask you to sign it and scan it back to me before I conduct the interview. Please review it and let me know if you have any questions about your participation in this study.

Thank you for your time.

Sincerely,

Avery

--
Avery C. Livingston, Esq.
Graduate Teaching and Research Assistant
Doctoral Candidate for a PhD in Public Policy and Administration
Auburn University
Office: Haley 7013

Survey: Who Do You Work with the Most**?**

Please list people and their organizations that you work with the most to conduct jail policy design and HIV testing in the jail. For all listed, please circle if you "completely share," somewhat share," "somewhat do not share," or "completely do not share," priorities and goals.

Name who you work with to   How much do you share priorities?
complete HIV testing in the county jail:

                                                  completely share
1.   somewhat share
                                                  somewhat do not share
                                                  completely do not share

2.   completely share
                                                    somewhat share
                                                  somewhat do not share
                                                  completely do not share

3.   completely share
                                                    somewhat share
                                                  somewhat do not share
                                                  completely do not share

4.   completely share
                                                    somewhat share
                                                  somewhat do not share
                                                  completely do not share

5.   completely share
                                                    somewhat share
                                                  somewhat do not share
                                                  completely do not share

Interview Questions

1. What is your job title?

2. What are your primary roles/ responsibilities?

3. Who do you consider your employer?

4. What is the top priority of this organization?

5. Who sets that priority?

6. How would this priority change?

7. How is HIV testing funded?

8. Who decides how state and federal funding is used?

9. Do you receive grant money for HIV testing?

10. What are the HIV testing policies in the county jail?

11. When was this policy put in place?

12. If no systematic testing is done, why not?

13. Does this jail use rapid or traditional HIV testing?

14. Who conducts HIV testing of jail inmates?

15. What kind of space is there for HIV testing in the jail, or is it mobile testing?

16. What organizations do you work with frequently who focus on HIV prevention and testing?

17. Who do you usually meet with to talk about jail policies and practices?

18. Does this working group have regularly scheduled meetings?

19. Who usually sets the goals for your collaborative work?

20. Who sets meeting times, the agenda, or deadlines for this working group?

21. How does information from the working group get disseminated?

22. Do you find that the members of this group usually share goals for policy changes?

23. Does this working group tend to have similar opinions about the goals of the jail?

24. Would you say that the organizations you work with often have trouble coming to a consensus or often do not agree?

25. What happens when members of the group do not come to a consensus?

26. Of these organizations you work with, who shares your goals the most?

27. Who shares your goals the least?

28. Do you feel you are always trying to change other's opinions in the group?

29. Is there one influential member who leads the group in decisions?

30. Why is this person influential?

31. Who among this working group do you believe to be the most dependable person?

32. Who has technology everyone relies on to do the HIV testing?

33. Who is the most politically connected as compared to the others you work with?

34. Was any question unclear?

35. Is there something you think I've missed that's important?