Annotating PDFs using Adobe Reader XI

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1. Update to Adobe Reader XI
The screen images in this document were captured on a Windows PC running Adobe Reader XI. Editing of DJS proofs requires the use of Acrobat or Reader XI or higher. At the time of this writing, Adobe Reader XI is freely available and can be downloaded from http://get.adobe.com/reader/

2. What are eProofs?
eProof files are self-contained PDF documents for viewing on-screen and for printing. They contain all appropriate formatting and fonts to ensure correct rendering on-screen and when printing hardcopy. DJS sends eProofs that can be viewed, annotated, and printed using the free version of Acrobat Reader XI (or higher).

3. Comment & Markup toolbar functionality

A. Show the Comment & Markup toolbar
The Comment & Markup toolbar doesn’t appear by default. Do one of the following:

• Select View > Comment > Annotations.
• Click the Comment button in the Task toolbar.

Note: If you’ve tried these steps and the Annotation Tools do not appear, make sure you have updated to version XI or higher.

B. Select a commenting or markup tool from the Annotations window.
Note: After an initial comment is made, the tool changes back to the Select tool so that the comment can be moved, resized, or edited. (The Pencil, Highlight Text, and Line tools stay selected.)

C. Keep a commenting tool selected
Multiple comments can be added without reselecting the tool.
Select the tool to use (but don’t use it yet).

• Right Click on the tool.
• Select Keep Tool Selected.

4. Using the comment and markup tools
To insert, delete, or replace text, use the corresponding tool. Select the tool, then select the text with the cursor (or simply position it) and begin typing. A pop-up note will appear based upon the modification (e.g., inserted text, replacement text, etc.). Use the Properties bar to format text in pop-up notes. A pop-up note can be minimized by selecting the button inside it. A color-coded symbol will remain behind to indicate where your comment was inserted, and the comment will be visible in the Comments List.

5. The Properties bar
The Properties bar can be used to add formatting such as bold or italics to the text in your comments.

To view the Properties bar, do one of the following:

• Right-click the toolbar area; choose Properties Bar.
• Press [Ctrl-E]
6. Inserting symbols or special characters
An 'insert symbol' feature is not available for annotations, and copying/pasting symbols or non-keyboard characters from Microsoft Word does not always work. Use angle brackets < > to indicate these special characters (e.g., <alpha>, <beta>).

7. Editing near watermarks and hyperlinked text
eProof documents often contain watermarks and/or hyperlinked text. Selecting characters near these items can be difficult using the mouse alone. To edit an eProof which contains text in these areas, do the following:
   • Without selecting the watermark or hyperlink, place the cursor near the area for editing.
   • Use the arrow keys to move the cursor beside the text to be edited.
   • Hold down the shift key while simultaneously using arrow keys to select the block of text, if necessary.
   • Insert, replace, or delete text, as needed.

8. Summary of main functions
   A. Insert text - Use Insert Text tool (position cursor and begin typing)
   B. Replace text - Use Replace Text tool (select text and begin typing)
   C. Delete text - Use Strikethrough Text tool (select text and press delete key)
      Note: The Text Correction Markup tool combines the functions of all three tools.
   D. Sticky Note - Use Sticky Note tool to add comments not related to text correction.

9. Reviewing changes
   To review all changes, do the following:
   • Click the Comments button to reveal the comment tools
   • Click the triangle next to Comments List (if not already visible)
      Note: Selecting a correction in the list will highlight the corresponding item in the document, and vice versa.

10. Still have questions?
    Try viewing our brief training video at https://authorcenter.dartmouthjournals.com/Article/PdfAnnotation

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This PDF needs to be proofread and annotated.

Note: these annotations will not actually change the content of the PDF – they just point out the areas where corrections are needed. The actual corrections will be made to the native article files.

1. Insert Text Tool: Text needs inserted into this sentence.
2. Replace Text Tool: Some of the text in this paragraph needs to be replaced.
3. Delete Text Tool: Some of the text in this overly long sentence needs to be deleted.
4. Sticky Note Tool: This image needs to be reduced:

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[Image: Annotation tool interface with comments]
A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration

The United States has the world’s highest incarceration rate. Nonetheless, health care provided during approximately 12 million annual incarcerations remains disconnected from the rest of the nations’ health apparatus. Care delivered to the incarcerated disproportionately impacts the poor, people of color, and those with behavioral health problems. The scope and quality of this care is inconsistent and often directed by security leadership, not health professionals. Additionally, vital information gathered in these settings is rarely used to coordinate care with community providers or consider alternatives to incarceration. To increase the quality and coordination of correctional health care, three key areas must be addressed: the funding model, the scope of services, and correctional health staff.

THE FUNDING MODEL

Health care has been a legal right for the incarcerated because of the US Supreme Court Decision Estelle v. Gamble in 1972. However, these health services are generally not Medicaid-reimbursable, and except for the Federal Bureau of Prisons, costs fall on cities, counties, and states. Despite widespread litigation and investigation regarding correctional health, deficiencies remain even in settings with comparatively more resources and attention.2,3 For Sheriffs and Departments of Correction, who oversee virtually all correctional health care in the United States, spending on health costs must be weighed against security staffing and other institutional commitments. Despite some public health models in larger cities, the most common model of correctional health care in the US consists of for-profit vendors with contracts designed and monitored by security authorities.4 Accrediting organizations, such as the National Commission on Correctional Health Care, may promote evidence-based practices; however, participation is voluntary and performance is unrelated to funding. One new source of the Centers for Medicare & Medicaid Services (CMS) funding is newly available “Meaningful Use” funds to help correctional health providers implement electronic medical records (EMRs) in an evidence-based manner.5 This funding can help correctional settings adapt community EMRs to promote evidence-based care while also increasing transparency on health outcomes for the incarcerated.

A key funding opportunity could involve Medicaid waivers to reimburse provision of chronic care inside jails and prisons that was initiated in a community setting, particularly for aspects of care that can reduce postrelease morbidity and mortality. For example, the high prevalence of patients with HIV, hepatitis C, and substance use disorders in correctional settings could render funding of cost-effective treatments for these conditions worthwhile to CMS.

Such an approach would not only benefit these individual patients, but the community health systems and CMS, which bear the financial and management burdens of treatment interruptions and postrelease mortality and morbidity.6 In the case of hepatitis C, jails routinely admit patients during the course of their CMS-funded hepatitis C treatment.7 Local jail pharmacy budgets will not be able to continue this costly care under the current model, and the CMS investment for the community portion of the regimen (typically tens of thousands of dollars) may be lost.

SCOPE OF SERVICES

Most correctional health systems focus their work on brief intake screenings and responding to acute complaints. A small number of settings have secured funding for a correctional public health model, with expanded clinical services, Medicaid enrollment, and improved health outcomes associated with discharge planning.8-10 In these settings, additional resources are dedicated to preventive and chronic care, not simply avoiding morbidity and mortality during incarceration.11

One related innovation is that many states altered Medicaid eligibility so that persons experiencing short-term incarceration have their Medicaid coverage suspended, rather than terminated, to permit rapid reactivation.12

Aside from broadening the scope of in-jail services, correctional health can expand to the prearrainment process, where newly arrested persons may be screened to determine their fitness to pass through to arraignment and incarceration. In these settings, correctional health staff can help triage care for the jail-bound (e.g., persons with a history of alcohol withdrawal), especially if they have access to the correctional EMRs. Health staff in the prearrainment setting can also notify partner organizations about diversion potential for persons who meet criteria for local programs.

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including serious mental illness. This approach is being piloted in the New York City jail system, and one of the early lessons is the utility of the jail EMRs.13 The frequent incarceration of persons with behavioral health problems has resulted in a significant amount of their critical health information being held in jail health records, making the correctional health system a critical resource for acting on new diversion opportunities.

STAFF
Recurrent and retaining mission-driven health staff to work in jails and prisons is a core barrier to improving correctional health care.14,15 Correctional health has sometimes been thought of as a career of last resort, and correctional health professionals provide care in extremely difficult settings, with their decisions are often questioned by patients and security staff alike. Correctional health staff often experience strong dual loyalty pressures that can impact the care they provide as well as their willingness to speak out when they encounter patient abuse or neglect.16 The overwhelming pressures of working in a security setting lead some health staff to stop believing their patients, with dramatic impact on patient care and clinical outcomes. Without a willingness to engage and support staff in these and other areas of human rights, the daily realities of correctional health staff quickly become disconnected from outside perceptions about their ability or willingness to provide high-quality care.

Correctional health can also improve by recruiting a new generation of mission-driven physicians and other staff. The predominance of for-profit organizations in US correctional health is a clear concern for some who might otherwise be drawn to this area of work. The larger issues of mass incarceration, human rights, and social determinants of health are now woven into medical training, and a growing cohort of young doctors are eager to help remake a forgotten area of US medicine and public health. To entice them, new models may be required. Organizations like Doctors Without Borders and Partners in Health are able to recruit outstanding clinical staff to work in extremely challenging settings.17,18 Staff who work for these organizations share a sense of mission and know that their organization supports them and their patients as part of a broad commitment to address health in a social context. Recruiting this caliber of staff to correctional health may require development of mission-driven, not-for-profit organizations that can address the quality void as well as assist partners to rethink conditions of confinement and opportunities for diversion.

TRANSFORMING CORRECTIONAL HEALTH
Transforming correctional health will require local interest in improving care and national policy changes to allow for some efforts to expand reimbursement opportunities. If Medicaid waivers can be developed to allow some settings to explore reimbursement for aspects of care in jail or prison settings, then the potential cost and quality benefits can be explored. Similarly, in settings where correctional and community health systems and state insurance programs forge partnerships to improve continuity of insurance, the benefits of access and coverage will be revealed. Also, working to establish a correctional health foothold in the prearraignment setting will allow the entire criminal justice system in that city or county to explore the benefits of diversion based on reliable health information. Finally, correctional health must become viewed as a noble and rewarding career path for those who seek to bring high quality care to patients in dire need. While these three domains are not the only systemic concerns facing correctional health, they do represent an action plan that can improve the quality and coordination of care and inform opportunities for alternatives to incarceration.

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REFERENCES