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RESEARCH

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Promoting health literacy by using the Health Literacy Universal Precautions Toolkits: A reflection study

Promoção do letramento em saúde segundo os Health Literacy Universal Precautions Toolkits: Um estudo de reflexão

Promoción de la alfabetización sanitaria basado en los Health Literacy Universal Precautions Toolkits: Un estudio de reflexión

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Abstract

Objectives: To describe the Health Literacy Universal Precautions Toolkits document and reflect on its applicability in promoting health literacy in different contexts. **Method**: This is a reflection that synthesizes the dimensions and action strategies, as well as presents a summary of the implications for clinical practice. **Results**: The toolkits are organized into five dimensions: preparation for improvement, verbal communication, written communication, self-management and empowerment, and support systems. Each dimension is subdivided into 21 tools, accompanied by their respective action strategies. Studies on the applicability of these toolkits in clinical practice indicate a preference for more concise and easy-to-use instruments, and also reveal that implementing changes took more time than originally anticipated. Identified limitations include the need for planning, reorganization of the physical environment, adjustment of service flow, and training of the staff in communication skills. **Final considerations and implications for practice:** The value of this framework lies in the collection of evidence-based recommendations that can be used to promote effective interactions with health care users.

Keywords: Health Communication; Health Education; Health Literacy; Empowerment; Self-management.

Resumo

Objetivos: Descrever os *Health Literacy Universal Precautions Toolkits* e refletir sobre sua aplicabilidade para promover o letramento em saúde em diferentes contextos. **Método**: Trata-se de uma reflexão que sintetiza as dimensões e estratégias de ação, além de apresentar uma síntese das implicações para a prática clínica. **Resultados**: Os kits estão organizados em cinco dimensões: preparação para melhorias, comunicação verbal, comunicação escrita, autogerenciamento e empoderamento, e sistemas de suporte. Cada dimensão é subdividida em 21 ferramentas, acompanhadas de suas respectivas estratégias de ação. Estudos sobre a aplicabilidade desses kits na prática clínica indicam uma preferência por instrumentos mais concisos e de fácil utilização, além de apontarem que a implementação de mudanças demandou mais tempo do que o inicialmente previsto. Entre as limitações identificadas estão a necessidade de planejamento, reorganização da estrutura física do ambiente, ajuste no fluxo de atendimento, e capacitação da equipe em habilidades de comunicação. **Considerações finais e implicações para prática:** Destaca-se que o valor desse referencial reside na reunião de recomendações baseadas em evidências científicas, que podem ser utilizadas para promover interações eficazes com os usuários dos serviços de saúde.

Palavras-chave: Comunicação em Saúde; Educação em Saúde; Letramento em Saúde; Empoderamento; Autogestão.

Resumen

Objetivos: Describir el documento *Health Literacy Universal Precautions Toolkits* y reflexionar sobre su aplicabilidad en la promoción del alfabetismo en salud en diferentes contextos. **Método**: Esta es una reflexión que sintetiza las dimensiones y estrategias de acción, así como presenta un resumen de las implicaciones para la práctica clínica. **Resultados**: Los kits están organizados en cinco dimensiones: preparación para la mejora, comunicación verbal, comunicación escrita, autogestión y empoderamiento, y sistemas de apoyo. Cada dimensión está subdividida en 21 herramientas, acompañadas de sus respectivas estrategias de acción. Los estudios sobre la aplicabilidad de estos kits en la práctica clínica indican una preferencia por instrumentos más concisos y fáciles de usar, y también revelan que la implementación de cambios tomó más tiempo del originalmente anticipado. Las limitaciones identificadas incluyen la necesidad de planificación, reorganización del entorno físico, ajuste del flujo de servicio y capacitación del personal en habilidades de comunicación. **Consideraciones finales e implicaciones para la práctica**: El valor de este marco radica en la recopilación de recomendaciones basadas en evidencia que pueden ser utilizadas para promover interacciones efectivas con los usuarios de los servicios de salud.

Palabras clave: Alfabetización en Salud; Comunicación en Salud; Educación en Salud; Empoderamiento; Automanejo.

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INTRODUCTION

The contemporary view of health education is based on the premise that the educator goes beyond the mere transmission of information and becomes a facilitator of the teaching-learning process. In this context, teaching involves deliberate intervention, sharing relevant information to achieve better health outcomes. Thus, learning is seen as a tangible element for incorporating healthy behaviors into one's lifestyle through the acquisition of knowledge, skills, and attitudes.[1]

The role of the health educator as facilitator requires the establishment of a partnership between the educator and the learner. In this context, the educator seeks the most appropriate way to guide learning based on the learner's needs and preferences. In this way, the learner moves from being a passive recipient of information (educator-centered approach) to being an active collaborator in identifying what they need to know in order to take care of their own health (learner-centered approach).[1]

Health and education are inseparable in maintaining the multidimensional well-being of individuals. The pursuit of health information, as well as the correct interpretation of this information to promote health through deliberate and effective action, is essential in a society that understands the interconnectedness of health and education.[2] Considering these premises implies that any health education process must be person-centered and aimed at improving health literacy.[3]

A recent systematic review evaluating the effectiveness of educational interventions to improve health literacy among people with chronic diseases in low- and middle-income countries concluded that such interventions are effective in improving health knowledge, attitudes, and behaviors, particularly among people with diabetes.[4] Health literacy among people with diabetes has been identified as a key factor in improving glycemic control, knowledge of the disease, medication adherence, and satisfaction with treatment.[5]

Research from a variety of fields indicates that people have low levels of health literacy.[6] Low health literacy affects a person's ability to understand, interpret, and use health information, making them highly susceptible to risk factors and leaving them with few resources to make informed decisions during treatment. Therefore, these limitations should be considered at all stages of the educational process.[7]

Health education plans typically include educational materials such as brochures, pamphlets, and posters. These resources have been used for decades to disseminate health information, whether to reinforce verbal instructions about care or to promote healthy behaviors.[8]

Recently, there has been growing concern about the effectiveness of educational materials in achieving educational goals, particularly with regard to the comprehension of health information and the ability of educational materials to promote behavior change. Research has revealed a mismatch between the literacy level required by educational materials and the actual literacy level of the target audience. This mismatch limits the true purpose of the material, which is to generate learning and promote behavior change.[9-12]

Therefore, the educator-learner interaction must be based on strategies that promote health literacy.[7] These strategies include the Health Literacy Universal Precautions (HLUP) Toolkits developed by the Agency for Healthcare Research and Quality (AHRQ), an agency of the U.S. Department of Health and Human Services.[13]

The HLUP Toolkits have been developed on the basis of criteria based on scientific evidence that demonstrates the importance and complexity of health education and literacy. The present study is justified by the potential to use these tools in different contexts, through their recognition and reflective analysis. Thus, the objectives of this article are to describe the HLUP Toolkits and reflect on the applicability of this resource to promote health literacy in different contexts.

METHOD

This study reflects on health literacy strategies that can improve the health education process. The focus is on valuing person-centered care and using scientific evidence to achieve positive health outcomes.

RESULTS AND DISCUSSION

About a decade ago, AHRQ recognized the gap between the health literacy limitations of the American population and the broad spectrum of health care needs in primary care. This spectrum includes various complexities of care, from informing patients about how to prepare for a preventive exam to teaching people with chronic conditions how to use medications properly.[14]

As a result, AHRQ decided to compile strategies that could help primary care practices redesign their workflows to promote health literacy in their interactions with health services users.[14] Thus, the HLUP toolkits bring together a set of effective techniques for health education interventions regardless of the educational level and health literacy of the target audience.

The concept of universal precautions represents the need to consider that every user of primary care services may have health literacy limitations and therefore difficulties in understanding and using health information.[15] The basic purpose is to provide a systematic approach that supports communication in all user interactions and makes the environment more user-friendly, thereby facilitating navigation within the health care system.[13,14]

The latest version of the AHRQ HLUP Toolkits includes 21 tools organized into five dimensions: (1) preparing the way; (2) oral communication; (3) written communication; (4) self-management and empowerment; and (5) support systems. These dimensions were chosen based on the challenges of primary health care, which is characterized by the broad demands of health promotion, prevention, management, and rehabilitation.[14] Understanding each dimension is valuable for understanding its intrinsic relationship to health literacy education.

In all organizational processes involving the implementation of change, it is essential to prepare the work team and structure the necessary resources to achieve the desired results. Therefore, the HLUP emphasizes the importance of "preparing the way" by presenting elements for assembling the team, planning actions, and creating the awareness needed to promote change.[13]

Next, communication is divided into two dimensions: oral and written. These dimensions have traditionally been recognized and incorporated as essential skills to be developed by health care workers, as they are essential for effective communication. Communication failures are recognized as a major cause of patient harm. Therefore, communication should be understood as a process of interaction and not only as an activity aimed at transmitting information.[16,17]

Communication skills are put to the test when the goal of health education is to build self-management skills and empower people with chronic diseases. In the 21st century, the term self-management, also known as self-care, has gained prominence as part of the global strategy to combat and control noncommunicable diseases (NCDs). The concept of self-management stems from the understanding that in the presence of a chronic disease, regardless of its etiology, individuals need to acquire skills to recognize and monitor signs and symptoms, as well as to adjust behaviors related to diet, physical activity, and adaptive psycho-emotional states. Other important skills to be developed in the context of self-management include establishing effective relationships with health care professionals, managing appointments for disease control, and understanding the health care network.[18-20]

Because of the multiple skills required for self-management, the state of empowerment is a highly desirable outcome and is related to another important concept: self-efficacy. Self-efficacy is a person's perceived ability to deal effectively with the situations they encounter. This perception directly influences the ability to self-care and is therefore critical in managing chronic disease and its challenges. High levels of self-efficacy are associated with a sense of control over one's health and improved perceptions of quality of life and well-being.[21,22]

Support systems are also an integral part of the quality of care and empowerment of people with NCDs. The support system includes both institutional social resources, represented by the health care network available to the population, and resources present in individuals' social microsystems.[23]

By bringing together these five dimensions, the AHRQ HLUP Toolkits capture the complexity of health literacy and become a valuable tool for professionals. Each dimension offers specific tools and action strategies that facilitate the implementation of effective health literacy practices.

Each tool includes a set of recommendations designed to support all professionals and support teams (e.g., doctors, nurses, receptionists, and administrators). These recommendations include actions, tools, and methods for monitoring the changes needed to promote health literacy.[13,14] The tools contain three distinct sections: (1) a brief explanation of the topic content, (2) recommended strategies and actions, and (3) resources and methods for tracking the team's progress in implementing the tool.[13] A description of the AHRQ HLUP Toolkits is provided in Chart 1.

Tools are comprehensive and discussing them separately would not be productive in a reflective article. However, some general comments are appropriate. Because of the importance of communication skills in the context of health education, the first point to emphasize is concern for the language used. Emphasis should be placed on using simple language that is easily understood by the target audience, avoiding technical terms and using common words. Visual aids should be used to illustrate written or verbal instructions. In addition, written materials should supplement verbal communication.[13]

Among the recommendations related to oral communication, special attention is given to assessing the learner's actual understanding through the teach-back method. In this method, simple questions are used to assess the learner's understanding of the key elements of an oral message. For example, the document suggests the following questions: "Today we discussed many aspects of your health. Let's review some of them. Can you name three important things you have agreed to do to help manage your diabetes?".[13]

The teach-back method can also include another technique called demonstration, which is particularly useful for procedural content. Having the learner demonstrate a procedure or technique allows verification of the learner's ability to accurately reproduce the explanation.[13] This method provides an opportunity to obtain a real assessment of the results of the training process, which should not be overlooked as it determines the measure of its effectiveness.[3]

The development of written materials should follow guidelines for clear communication, such as those in the Harvard School of Public Health Guidelines for Creating, Assessing, and Rewriting Materials. This document advises that the creation of materials should be based on three key elements: plain language, text organization, and layout and design.[13,24]

Key recommendations from the Harvard School of Public Health for creating materials include: 1) use familiar words, active voice, and short sentences to emphasize key points; 2) present information in context or use questions to engage the reader; 3) group information into short sections separated by white space; 4) provide a summary to find the most important information; 5) organize information logically; 6) seek user feedback on the educational resource used.[24]

Other recommendations from the AHRQ HLUP for written materials include how to present numerical information in an understandable way. For example, it is recommended to: 1) relate the risks and benefits of an intervention; 2) present the proportion of people who might be affected (e.g., 1 in 10,000 people) rather than the percentage of absolute risk (e.g., the risk of infection is 0.01%).[13]

An important aspect of written materials is the recommendation that they be evaluated for readability and understandability.

Chart 1. Description of tools according to the dimensions "Initiating Improvement Path," "Improving Verbal Communication," "Improving Written Communication," "Improving Self-Management and Empowerment," and "Improving Support Systems," and the respective action strategies of the AHRQ Health Literacy Universal Precautions Toolkits, 2015.

Dimension	Tools	Main action strategies
Initiating improvement path	**Tool 1:** Form a Team **Tool 2:** Develop a Health Literacy Improvement Plan **Tool 3:** Raise Awareness	These tools aim to organize the resources and actions necessary to implement the others. They offer instruments and strategies to initiate the process, which includes: (1) forming and organizing a work team, (2) developing an action plan based on selected improvement dimensions, (3) organizing the necessary resources to implement the action plan, and (4) training the team to improve health literacy.
Improving verbal communication	**Tool 4: Communicate clearly**: Oral communication strategies	Maintain eye contact; have a friendly attitude; listen attentively; use simple language; speak slowly; limit and repeat content; avoid vague/subjective terms; use explanatory images; demonstrate how to do something; encourage listener participation and questions; use the teach-back method; discuss these strategies with the work team.
	Tool 5: Use teach-back method: a way of checking the person's understanding, asking them to explain in their own words what they need to know and do to take care of their health	Use a warm tone of voice; show welcoming body language and make eye contact; ask the person to explain what was taught in their own words; plan how to ask questions; ask open-ended questions, avoid yes/no questions; clarify points not understood and ask again; use printed materials to aid understanding; ask the person to demonstrate what they understood, in the case of a procedure or technique.
Improving verbal communication	**Tool 6: Follow up on users**: Contact the person being assisted to assess the progress of treatment since the last visit, in order to identify doubts and/or make adjustments.	Define reasons for follow-up, such as monitoring health, reinforcing knowledge and action plans, confirming medication use, scheduling returns, communicating test results, confirming referrals. Ask the user to record monitored information. Identify professionals who will follow the user in different treatment instances. Choose the follow-up method: phone, email, text message, electronic systems, etc. Organize and supervise follow-up.
	Tool 7: Improve telephone access: Make it user-friendly to facilitate access to the health service.	Evaluate the phone system (busy signal, wait time, time to access desired information, transfer to different channels). Decide on implementing an automatic or personal phone system. Consider using service menus. Improve how the health team communicates by phone. Guide the user on the phone system.
	Tool 8: Assess "brown bag medicine": a practice that involves encouraging the user to bring the medicines and supplements in use to each appointment, with the aim of reviewing correct use and identifying possible errors.	Identify which medications the user should bring. Remind the user to bring them (reminders on appointment cards or when confirming the appointment; posters in the environment). Plan how and when to conduct the assessment. Clarify correct use. Record the process. Provide an updated list of medications. Help the user remember how and when to take the medications.
Improving verbal communication	**Tool 9: Consider language differences**: to include these differences in the communication of health information with foreign users, in order to increase health literacy.	Evaluate preferences and needs for linguistic assistance. Use reliable linguistic assistance services (translators, multilingual professionals, telephone interpreters). Plan interpreter services in advance. Provide written materials in the user's preferred language. Seek funding sources for linguistic assistance (health insurance, community organizations, shared contracts, public funding).
	Tool 10: Consider culture, customs, and beliefs. Understand how these aspects affect people's understanding of and use of health information.	Include aspects related to beliefs, customs, and values in data collection. Avoid judgments. Seek resources to acquire cultural competence (courses, videos, community organizations). Develop cultural competence among health team professionals. Hire people who represent the cultural diversity of the population served.
Improving written communication	**Tool 11: Evaluate, select, and create easy-to-understand materials**. Making written materials (forms or health education resources) understandable, even in the face of limitations in health literacy	Train team members to assess the quality of materials provided to users. Evaluate readability and comprehensibility of materials. Involve users in the evaluation. Choose or develop easy-to-understand materials. Use guidelines to create, evaluate, and rewrite educational materials (e.g., Harvard School of Public Health Guidelines for Creating, Assessing, and Rewriting, PEMAT, or CDC-CC Index).
Improving written communication	**Tool 12: Use health education materials effectively**. Use only as a resource to assist in the process of health education, seeking understanding and behavior change.	Consider that received material is not always read. Highlight or emphasize the most relevant points of the material during the educational process. Personalize the material by adding specific information (e.g., name, medications). Use the teach-back method to assess understanding. Use the material as a resource during verbal instructions. Check if the user knows how to use audiovisual or digital resources. Train the user to use these resources. Obtain user feedback. Organize and manage resources.
	Tool 13: Welcome users - useful attitudes, signs, and more: make the environment welcoming, receptive, and easy to navigate.	Guide the user through the environment. Evaluate the visibility and readability of signs. Train the team to welcome users warmly. Offer help to fill out forms. Create a brochure with contact information, services offered, what the user should bring to appointments. Use the waiting room to disseminate important information, such as educational content, names and titles of health team members, and posters encouraging reflection and action. Use written or audiovisual materials.
Improving self-management and empowerment	**Tool 14: Encourage questions**: Create an environment where people do not feel embarrassed or inhibited to ask questions as a way to actively engage in their care.	Encourage simple questions with open-ended prompts. Ask if the user has any doubts during the appointment. Use non-verbal language to encourage questions (stay seated, close to the person; observe and be attentive to everything said; do not interrupt). Encourage the health team to answer all questions. Remind the user to record questions that may arise outside the appointment.
	Tool 15: Develop action plans: Plan health goals with the user to improve self-management of chronic disease, change diet, quit smoking, increase physical activity, reduce stress, improve sleep patterns, take medications correctly.	Obtain user consent to discuss health behaviors, such as weight loss. Observe if there is motivation to change lifestyle. If not, identify the user's perception of difficulties and benefits of behavior change. Ask the user to set goals that are important and motivating to them. Offer options for behavior changes (do not give suggestions). Help the person break down a goal into small, realistic steps. Use an appropriate form to record. Assess the person's confidence to follow the plan using a numerical scale. Identify barriers or difficulties in following the plan. Help the person plan the next step when the plan is achieved.
Improving self-management and empowerment	**Tool 16: Help users remember how and when to take medications**: reduzir erros no uso de medicamentos, ajudando o usuário a entender seu regime terapêutico	Ask how the person usually remembers to take their medications. Offer a list of medications or a form with names and schedules. Evaluate the possibility of using online tools for medication management (lists with simple explanations about the purpose of the medication; tutorials to help the person know how to take them; emails or text messages to remind the person to take them). Include precise instructions on how to take the medications. Inform which oral medications may change in color, shape, and pill size. Offer pillboxes and guide how to organize them based on the prescription. Involve family members to help with proper medication use. Record the strategies used and agreed upon with the user.
	Tool 17: Obtain user feedback: Obtain user evaluation on difficulties faced during the appointment (e.g., filling out forms, understanding health information, navigating the system).	Make a health team member available to accompany the user and get their perspective on the service. Conduct a guided tour to get user feedback on the physical environment. Observe how the user utilizes the resources offered by the health service's online site. Ask the user to evaluate forms and other written materials. Provide a suggestion box. Conduct methodologically sound surveys with users (sampling, reliable instruments, and analyses).

Source: authors.

Chart 1. Continued...

Dimension	Tools	Main action strategies
Improving support systems	**Tool 18: Link users to support systems:** Guide and supervise referrals to available community resources.	Assess access to community resources for each user (e.g., difficulties in general health care, problems obtaining healthy foods). Identify available community resources. Direct the user to the resources they need.
	Tool 19: Provide easy access to medications: Facilitate access to free or low-cost medications.	Assess the user's ability to purchase medications. Check if this cost is covered by health insurance. Refer the user to medication assistance programs.
	Tool 20: Refer users to literacy resources: Refer users to learning centers to improve literacy and math skills.	Assess reading comprehension and numeracy skills. Identify community resources for this purpose. Help the user connect to the resource.
	Tool 21: Facilitate referral to other services: Increase the chances of treatment follow-up.	Increase the chances of treatment follow-up. Develop and maintain relationships with teams from other services. Establish a formal referral network, determining participation rules. Share information directly with the other service. Include information about the user's need for linguistic assistance. Explain to the user the reasons for the referral. Provide clear information. Monitoring the referral process.

Source: authors.

Readability refers to how easy the material is to read, based on sentence length, word complexity, and number of syllables. Readability can be measured using formulas developed for this purpose.[13]

The understandability of written material includes how well the reader can interpret and explain the key messages.[25] To assess understandability, the AHRQ HLUP cites the following tools: (1) the Patient Education Materials Assessment Tool (PEMAT), which evaluates written and audiovisual materials; (2) the Suitability Assessment of Materials (SAM), which assesses the suitability of educational materials to promote learning; and (3) the Centers for Disease Control and Prevention (CDC) Clear Communication Index (CCI).[13]

Although PEMAT was created for the purpose of evaluating health education materials, this tool provides guidelines for developing resources that can promote understandability and actionability. The actionability of educational materials is understood as the ability of the resource to prompt action based on the information provided.[25,26]

In 2019, the CDC released the CCI to serve as both a guide for developing communication resources and a tool for assessing the clarity of existing materials. The CCI includes 20 criteria based on plain language techniques, as described in the Plain Language Guidelines.[27] Chart 2 describes the criteria used in the PEMAT and the CCI that are recommended for ensuring clear communication in educational materials.

The development of the CCI is linked to the goals of the National Action Plan to Improve Health Literacy and the CDC Health Literacy Action Plan.[13] This is important because it underscores the U.S. government's commitment to outlining public policies that promote health literacy.

Since their development, studies have been conducted to evaluate the applicability of universal precautions in clinical practice.[14-15] Initially, a prototype of these toolkits was tested for four months in eight primary care clinics in the North Carolina Network Consortium (NCNC). Results showed that clinics preferred to use the more concise and user-friendly tools, and that implementing changes took more time than originally anticipated.[14]

Subsequently, the University of Denver conducted a national demonstration of the HLUP Toolkits and evaluated its use in 12 selected primary care clinics. The qualitative study found that implementation of the tools was challenging due to competing demands (staff and time constraints; lack of team interest and commitment), bureaucratic barriers (delays in approving changes), technological challenges (inability to make changes to electronic health records), limited quality improvement experience (difficulties in implementing and evaluating the tools), and limited leadership support (lack of leadership involvement).[15]

However, the professionals and support staff who participated in this study recognized the effectiveness of the toolkit, especially when combined with other quality improvement efforts. They also recommended specific changes to some of the tools to increase their effectiveness.[15]

The results of this study led to the publication of the Guide to Implementing the Health Literacy Universal Precautions Toolkit, which provides concrete recommendations for facilitating the use of the precautions in clinical settings. This guide highlights four dimensions that should be considered as critical points for promoting health literacy: oral communication, written communication, self-management and empowerment, and support systems.[28,29]

Some studies have already validated this approach. A review of the Design Easy-to-Read Material tool was conducted based on the results of a study to understand what strategies were used to implement the tool and whether its use resulted in materials that were more readable, understandable, and actionable. The interviews conducted indicated that the recommendations were followed flexibly, especially when modifying simple materials such as patient letters and information forms. The evaluation of more extensive written materials (e.g., brochures) concluded that these required a higher level of health literacy. The results highlighted the need to involve multiple stakeholders to improve the quality of written materials.[25]

A recent study using data from the Medical Expenditure Panel Survey (MEPS), a national survey in the United States that measures indicators of the use of health literacy strategies, concluded that the use of these strategies is not as widespread as recommended. Strategies such as providing easy-to-understand instructions, using the teach-back method, and offering assistance with completing forms were more likely to be used with vulnerable populations (e.g., the elderly, people with

Chart 2. Description of the criteria used in PEMAT and the CDC Clear Communication Index to ensure clear communication in educational materials.[19,20]

Patient Education Materials Assessment Tool (PEMAT)	Clear Communication Index (CCI)
Understandability	
Content: Ensure the purpose of the material is clear; do not include information that deviates from this purpose; use everyday language; avoid medical terms unless the intent is to educate; use active voice; use numbers only when necessary, without requiring mathematical calculations.	**Main Message and Actionability:** Describe the main message in one to three sentences; highlight it at the beginning of the text; use visual effects (e.g., bold, colored text, different font styles); complement or reinforce the message with images or figures; encourage the person to change a behavior, attitude, or seek more information.
Organization: Arrange information in short sections; use informative headings about the section's content; present information in a logical sequence; provide a summary of the main points covered.	**Language:** Use active voice (direct, clear, simple to understand); select familiar words and terms; avoid slang, colloquial language, metaphors, abbreviations, and culturally sensitive language; explain unusual words or expressions when used.
Layout and Design: Use visual cues to draw attention to key points (e.g., arrows, boxes, bullets, bold, larger font, highlighting).	**Information Structure:** Break text into items or sub-items with bullet lists; divide long texts into blocks with short sentences and paragraphs; use headings to organize text blocks; connect the blocks for smooth reading; manage the amount of information (do not overload); present the most important information at the beginning (essential to know; interesting to know more; what can help; what can be done; action strategies and available community resources).
Acionability	
Clearly identify at least one action the person can take.	**State of scientific knowledge:** Explain what reliable sources (experts, government representatives) know or do not know about the topic.
Directly address the user to describe actions. Arrange actions in feasible steps.	**Behavior recommendation (not applicable to all materials):** Express one or more desired behavior recommendations; link the behavior to information about the consequences of performing or not performing it; include specific instructions on how to perform the behavior (sequential steps).
Provide concrete tools to help the user act (e.g., agendas, checklists). Present simple instructions or examples on how to perform calculations when applicable (e.g., how to calculate calories per meal; carbohydrate counting).	**Numbers (not applicable to all materials):** Describe numerical information in common terms, with whole numbers, not decimals; use familiar expressions (e.g., 8 out of 10 people instead of 80%); provide context to explain numerical information, such as clarifying whether the value is higher or lower than expected or its significance individually or collectively; avoid qualitative expressions (e.g., high and low, small and large).
Explain how to use charts, tables, graphs, or diagrams to act. Usar recursos visuais para apresentar instruções de uma ação	**Risks (not applicable to all materials):** Explain the attributed meaning (probability of an event occurring, such as risk of contamination; threat or harm to an individual or group, such as health risk; result of a threat or harm, i.e., risk of getting sick); do not qualify as high or low, large or small; explain how the risk may affect the person, i.e., the relationship between risk and its effect (is the effect immediate or long-term? can the person get sick or die? what is the chance of the outcome occurring?); characterize the benefits versus risks relationship; describe probabilities with easily understood terms or images (e.g., 1 in 4 people get sick; there is a 6% chance of the disease occurring).

Source: Authors.

lower levels of education, and ethnic/racial minorities) rather than universally. The authors noted that selective use of these tools, given the low health literacy of the population, could perpetuate adverse health outcomes, such as high costs. In addition, they emphasized that the applicability of the AHRQ HLUP requires a restructuring of health care delivery to be effective.[30]

In this context, the applicability of health literacy strategies depends on the training of healthcare teams to use them. Lack of knowledge and confidence in using these strategies was identified by health care teams as a barrier to implementation with older patients in rehabilitation.[31]

AHRQ recognized the need to promote communication skills training for health care workers and developed the Seek, Help, Assess, Reach, Evaluate (SHARE) approach.[32] This acronym guides the process of shared decision-making based on evidence-based information, the knowledge, and experience of the healthcare professional, and the values and preferences of the person receiving care.[33]

Difficulties identified in implementing the AHRQ HLUP suggest that promoting health literacy requires health literate organizations. In these organizations, responsibility for promoting literacy should be shared by all information providers, including health care, government, and civil society.[2]

Within this perspective, the U.S. Department of Health and Human Services proposed the Health Literate Care Model (HLCM), which incorporates the principles and tools of the AHRQ HLUP. This approach recognizes that care and literacy are inextricably linked, as excellence in care depends on the active participation of individuals in their own health.[6]

As a result, health care organizations seeking to achieve high quality care must structure themselves in terms of teams, resources, and time to promote positive interactions with their users. This includes creating an organizational culture that facilitates the understanding of information and supports navigation within the health care system. It also requires teamwork, leadership commitment, and monitoring of outcomes.

Limitations of this article lie in the inherent characteristics of a reflective article based on convenience scientific literature. Therefore, it is limited to a few documents and the analytical perspectives of the researchers.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The AHRQ HLUP provides effective recommendations for promoting health literacy, organized into five essential dimensions:

preparing the way, oral communication, written communication, self-management and empowerment, and support systems.

For each dimension, the document highlights tools that can be used to successfully promote health literacy. These tools include: 1) promoting simple and culturally sensitive language; 2) organizing and designing written text clearly; 3) creating educational materials that are understandable and promote behavior change; 4) using experiential strategies to manage procedural care. These tools help individuals better understand their health situation, develop skills, and gain the confidence needed to make informed decisions that can solve problems and improve their quality of life and well-being.

Studies have identified limitations to the applicability of the AHRQ HLUP Toolkits. These limitations include the need to plan and reorganize the physical structure of the environment and workflow, and to train staff in communication skills. Despite these difficulties and challenges, the value of the AHRQ HLUP Toolkits lies in the compilation of evidence-based recommendations to assist health professionals in the challenging task of health literacy education.

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