2021

Teaching Guidelines for Screening Prostate Cancer in African American Men

Joain Sophie Silvera
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Joain Silvera

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Susan Hayden, Committee Chairperson, Nursing Faculty
Dr. Mark Wells, Committee Member, Nursing Faculty
Dr. Lilo Fink, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Teaching Guidelines for Screening Prostate Cancer in African American Men

by

Joain Silvera

MSN, South University, 2018

BSN, Nova Southeastern University, 2014

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2021

Abstract

African American (AA) men have the highest incidence of prostate cancer (PCa) compared to their White and Hispanic counterparts and a higher mortality rate than any other ethnicity. While biological and socioeconomic factors are to be blamed, many AA men are not aware of the opportunities for screening or the prognoses for the condition. There is an obvious need for increased awareness in AA men concerning preventative screening for PCa. Following the *Walden University Clinical Practice Guideline Manual* and guided by the Appraisal of Guidelines for Research & Evaluation (AGREE II) model to guide and validate the newly developed clinical practice patient education guideline (CPPEG), an evidence-based CPPEG was developed from an in-depth review of peer-reviewed literature and validated to address PCa screening in AA men. The PCa CPPEG was scored by a panel of four content experts using the AGREE II instrument. Domain scores ranged from 92% for Domain 6, editorial independence, to 100% for Domain 1, scope and purpose, with all scores greater than the 75% benchmark indicating that no revisions were needed, and a 96% agreement rate indicating that the expert panel agreed that the PCa CPPEG should be used in the clinical setting, fulfilling the purpose and answering the practice-focused questions. This project will bring about positive social change through educating AA men about PCa screening and early treatment to increase screening and decrease the mortality and morbidity of the disease.

Teaching Guidelines for Screening Prostate Cancer in African American Men

by

Joain Silvera

MSN, South University, 2018

BSN, Nova Southeastern, 2014

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2021

Dedication

This project is dedicated to my father, Eric Austin, who passed away August 16, 2019, from prostate cancer. I would also like to dedicate this to my mother, Hortense Austin, who passed away from cancer. Dad, you got the opportunity to see me halfway through my journey; I wish my mother had gotten the opportunity to see me, but I know she is in heaven smiling down. To my children, Sherika and Romando, thank you for being my biggest supporters.

Acknowledgments

I would like to take this opportunity to express my gratitude and thanks to the DNP committee members, Dr. Hayden, and Dr. Wells. I appreciate their mentorship and guidance, which have allowed me to stay on path to successfully complete this project.

I would like to also acknowledge the support and guidance of my preceptors who assisted me in completing this terminal degree.

Table of Contents

Section 1: Nature of the Project

The prevalence of prostate cancer (PCa) is disproportionately high in African American (AA) men when compared to other ethnic groups in the United States. The reasons for such disparity are still unclear, but factors to which the prevalence is attributed include nutrition, race, family history, and lack of screening (Shenoy et al., 2016). Screening as a preventive measure is recommended early and regularly to ensure that early detection leads to effective treatment and recovery (Tsodikov et al., 2017); however, the stigma surrounding PCa in the AA community, the body part that is affected, the related embarrassment, and fear of the procedure cause barriers to receptiveness to being screened.

Wardle et al. (2015) explained that targeting clinicians with education was an effective means to optimize screening among individuals at risk for cancer. Similarly, Saei Ghare Naz et al. (2018), in a systematic review, found that patient-based education was among the most effective methods in modifying cervical cancer screening behavior of women. Educational programs geared toward practitioners were identified as effective in increasing patients' awareness of the risks for PCa and the benefits of routine screening (Rice et al., 2017). Programs designed to educate AAs about the need for PCa screening have the potential to increase their awareness and compliance. Through developing an evidence-based clinical practice patient education guideline (CPPEG) related to PCa screening practices in AA men, I have provided a tool to better prepare practitioners to educate the population with ethnically sensitive information. Nurses working in the community clinic and any other setting can use the CPPEG to better

educate AA men to make informed decisions in their care. Becoming more aware of the benefits of PCa screening should increase knowledge and screening rates; increased screening for PCa in AA men should produce a positive cultural transformation, ideally leading to a decrease in the disparity by leading to earlier diagnosis and treatment, quality care, and improved health outcomes and quality of life.

Problem Statement

PCa is the second leading cause of male deaths in the United States (Siegel et al., 2020); the American Cancer Society (ACS, 2019) estimated that more than 202,000 men have PCa, of which over 73,000 are expected to die from the disease. According to the ACS (2016), Florida ranks second among all states in the United States for estimated new cases of PCa and second in estimated deaths from the disease. In Florida, AA men continue to face disparities in diagnosis, mortality rates, and access to cancer treatment. According to Healthy People 2020, AA men in Florida were the only group that did not meet the objective of reducing the death rate among the population from 21.2 per 100,000 men. Among males diagnosed with PCa in the United States, AA men are over-represented, with AA men twice as likely to be diagnosed and die from PCa as their non-Hispanic White counterparts (Shenoy et al., 2016). In 2019, an estimated 30,000 cases of PCa were diagnosed in AA men, accounting for 30% of all cancers diagnosed in this group. The lifetime risk of diagnosing PCa is 15.9%, while the lifetime risk of death is 2.8%. PCa incidence is 60% higher in AA men than in Whites. Furthermore, mortality is double in AA men compared to Whites. AA men are collectively observed to have the shortest rate of survival and highest death incidences from most cancers in the United

States compared to all other population groups. The high incidence of PCa in AAs has, for more than 20 years, remained remarkably constant (Tsodivoc et al., 2017).

Through this CPPEG project, I have developed a tool that all practitioners can use to educate AA men with the intention of increasing PCa screening among this vulnerable group. The ACS (2020) has published guidelines that recommend that men begin screening for PCa at age 50 years; however, AAs and others with a high risk should begin at age 45. The screening involves checking prostate-specific antigen (PSA) levels and having a digital rectal exam (DRE) routinely. All men need to be educated on how to recognize the signs of PCa, what a DRE is, what a prostate biopsy entails and when it would be recommended, and interpretation of the PSA results (ACS, 2020). AA men need education tailored to them because they have potential cultural, socioeconomic, and healthcare access barriers (Cobran et al., 2018) that could cause reluctance to be screened. Hahn et al. (2015) found that members of the AA population, in many situations, only become aware of PCa when a close friend or relative is affected by the disease. Many men are not aware of the interlink between race and the prevalence of PCa or even the interlink between age and the onset of PCa. Another fact that many AA men are not aware of is the possibility of PCa being asymptomatic.

Because of AA men's vulnerability and reluctance to be screened, education is needed to address common barriers, including stigma, the body part that is affected, related embarrassment, and fear of the procedure (Shenoy et al., 2016).
Dickey et al. (2017) supported this need in a study that focused on AA men over the age of 40 who had previously had PCa screening even though not previously diagnosed with

the disease. The study findings revealed that participants who received education showed increased participation in screening tests by approximately 21.4%. Another study by Ukoli et al. (2013), also studying PCa education and screening among AA men, showed that education interventions increased knowledge about PCa among AA men; screening test rates rose from 49% to 71%. For high-quality patient education tailored toward the targeted community, AAs, culturally sensitive, evidence-based guidelines should be available. The lack of evidence-based, culturally sensitive education materials was a gap in practice that I addressed by developing the CPPEG. Culturally sensitive education has the potential to increase AAs' participation in getting screened and decreasing mortality from PCa (Ukoli et al., 2013). Although providers may be aware of new PCa screening guidelines, they may lack the knowledge or tools to educate AA men facing screening decisions about how best to proceed. Through this project, I have brought awareness of the need for culturally sensitive patient education as well as provided a culturally sensitive education tool related to AAs and PCa.

Purpose Statement

Practitioners are at the forefront of efforts to promote healthy behaviors, and there is a lack of evidence-based teaching guidelines to assist practitioners in educating AA men about PCa screening (Hoffman, 2020). AA males lack awareness of the importance of or need for PCa screening, despite the availability of such screening. Many AA males have negative attitudes toward annual routine checkups and limited knowledge and skewed perceptions of PCa screening (Hahn et al., 2015). Hence, the practice-focused questions that guided this PCa in AA men project were the following: What evidence

from the literature supports the need for patient education related to PCa screening in AA men? Can a CPPEG be developed and validated to guide nurses in educating AA men on the importance of PCa screening? My goal was to provide a culturally sensitive guideline for all practitioners with relevant information needed to prepare AA men to make informed decisions about PCa screening with the potential to increase compliance with screening and early treatment. AA men are at a higher risk of developing and dying from PCa due to disparities in biological factors such as tumor biology; environmental factors such as exposure to cancer-causing pollutants; and lifestyle factors such as social stress, diet, body weight, physical activity, and smoking (Mucci et al., 2019). For this demographic, the literature lacks clarity and specificity regarding how one should structure an educational plan at the provider level to meet the AA male's unique needs. Hence, there was a need for this Doctor of Nursing Practice (DNP) CPPEG project, PCa in AA Men, designed to increase providers' knowledge of how to increase knowledge about PCa screening among AA men, with the hope of increasing screening and decreasing death rates.

Education has been shown to be effective in changing individuals' attitudes regarding their lifestyles and health practices (Hahn et al., 2015). For example, following education campaigns, mammogram screening increased from 31% to 56% (Tataro et al., 2020); cervical cancer screening improved in five African states (Ebu et al., 2019); and education was found to be successful in increasing cancer screening among Korean American men (Peterson et al., 2018). AA men are often reluctant to visit doctors, or they may have misconceptions and misinformation that hinder them from seeking medical

attention for early detection of PCa; thus, culturally sensitive educational materials are needed. This CPPEG addressed the need for comprehensive, culturally based education guidelines for providers to share with AA men to change their perceptions.

Nature of the Doctoral Project

Evidence for the PCa in AA Men project was obtained from an exhaustive literature search that I continued until the newly developed CPPEG was revised and approved by an expert panel, which included a nurse practitioner, an oncologist, an oncology nurse with her MSN, and a primary care nurse practitioner. The Walden University library databases EBSCO host, ProQuest Direct, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, PubMed, and Medline Plus, along with Open Library and SpringerLink, were used to find up-to-date, peer-reviewed articles related to PCa and AAs' beliefs and responses. Search terms that I used included *PCa*, *AA*, *disparities*, and *educational guidelines for PCa teaching*. I ensured relevancy to the topic of AA and PCa by reviewing abstracts. This in-depth search for literature related to AA men and PCa provided me with the most current evidence on the state of the research and how best to address the gap that was the focus for this project.

Approach

The *Walden University Clinical Practice Guideline Manual* and the Appraisal of Guidelines for Research and Evaluation (AGREE) II tool (AGREE Enterprise, n.d.) were the primary guides for addressing the procedural steps of this PCa in AA Men project. Articles selected to help address the gap of AAs not going for PCa screening were obtained from peer-reviewed journals from the Walden library database, published

within the last 5 years unless they were landmark studies, and organized in a literature matrix. I graded the evidence using the Fineout-Overholt (2011) grading system (see Appendix B). The AGREE II tool (AGREE Enterprise, n.d.) was used to guide the development and evaluation of the CPPEG. The AGREE II tool is a valid and reliable framework that is used to evaluate the veracity and quality of newly developed guidelines.

In line with the *Clinical Practice Guideline Manual*, I developed my practice-focused questions and determined my evidence selection criteria. I developed an evidence-based CPPEG based on the literature discovered in the in-depth literature search. An expert panel of four members was identified to include a nurse practitioner, an oncologist, an oncology nurse with her MSN, and a primary care nurse practitioner to evaluate the newly developed CPPEG. Revisions of the guidelines were made based on the recommendations of the expert panel until consensus was reached. Next, a group of key stakeholders (practitioners who care for AA males) was identified and asked to review the newly developed CPPEG for content and usability. I developed a final report and shared it with the expert panel and stakeholders. After I graduate and the restrictions of the pandemic are lifted, I will present the guidelines to related practices in the area and present at local, regional, and national venues to share the tool for widespread use. According to Owens et al. (2019), there is a need to identify some of the most effective methods of promoting PCa awareness among AA men.

The purpose of this DNP project, PCa in AA men, was to develop a CPPEG to bridge the gap in practice by providing resources to providers to educate AAs on the

importance of PCa screening with an ethnically appropriate teaching tool. Providers are often the first access point for health care in the United States; it is imperative to comprehend what mechanisms may underlie the differences between AAs and other populations and what can be done to narrow the gap (Tsodikov, 2017). Early screening for PCa is an effective method of decreasing mortality and morbidity, in that a 5% increase in the rate of screening PCa can avert about 500 related deaths per year (Tsodikov, 2017).

Significance

This CPPEG will impact several stakeholders and organizations, including hospitals, nurses, and patients. Addressing PCa among AA men will benefit the community's health and improve the livelihood of its members. The main positive impact that this project will have on an organization level is financial stability from increased reimbursement related to better patient outcomes. A nurse's role in PCa awareness, prevention, diagnosis, and treatment is essential. Nurses will be impacted by increased job satisfaction due to the significant impact that they will have in helping AAs make informed decisions in their care. The American Nurses Association (2018) noted a 25% increase in nurse job satisfaction over a 2-year span linked with an overall quality of care increase between 5% and 20% due to educating patients in making informed decisions. Nurses will also have the tools necessary to educate AA men to more effectively dispel many myths related to prostate screening.

Patients will be affected by having increased knowledge about the benefits of prostate screening, better enabling them to make an informed decision about their care

and improve their quality of life. According to Reynolds (2008), educational programs associated with PCa will benefit patients by dispelling misconceptions, with medical practitioners playing an important role in the process. The aim of this DNP PCa in AA Men project was to provide resources to all providers involved in the care of AA men so that they would be better equipped to educate these men to raise awareness of the prostate screening process, leading to early diagnosis, intervention, and improved patient outcomes, thus lessening disparity and decreasing mortality and morbidity among the population.

This newly developed CPPEG is transferable to multiple practice areas such as doctors' offices, clinics, and all healthcare settings where AA men are treated, as the myths and mistrust are global (Shenoy et al., 2016). The end product of the project provides an educational approach for practitioners that is culturally appropriate and tailored to AA men to address the unique needs for this group related to PCa. This CPPEG will need to be tailored to apply the guideline to any other population or disease process, addressing the specifics of the disease process and ethnic needs of the target group. While the importance of PCa screening is universal, the AA population has unique fears and beliefs to be addressed to improve their screening rates and decrease the disparity that this vulnerable group faces with regard to PCa. AA men have higher mortality rates from PCa than any other ethnicity (Shenoy et al., 2016).

The positive social change that a CPPEG to address PCa in AA men will bring about is an increase in knowledge related to PCa screening, which should eventually lead to earlier diagnosis and treatment, better patient outcomes, and improved quality of life,

mirroring Walden University's mission to improve human conditions through educational resources. The integrated theory of behavior change (Ryan, 2009) indicates that health behavior change can be improved by promoting knowledge and beliefs, increasing self-regulation skills and abilities, and enhancing social facilitation. According to Hoffman (2020), early PCa screening has benefits of reducing the effects of the disease, especially for men who are at risk for advanced stages of PCa. Some men are motivated to be screened when they learn that early detection of PCa can improve their survival and prevent some of the life changes that will impede a full, healthy life (James et al., 2017).

Summary

This section well defined the problem statement that AA men lack awareness of the importance of or need for PCa screening despite the availability of such screening. Subsequently, my project approach was to develop a CPPEG as a guide for providers to educate AA men on screening methods and the importance of attaining screening. My purpose statement exposed the gap in practice for this project, which was the lack of educational resources for AA men about the benefits of PCa screening. This project is anticipated to have a positive impact on the target population by providing enhanced teaching resources for providers and improved health outcomes for AA men. In Section 2, I will discuss the context of the project, the model selected to guide this project, and my role as a DNP student.

Section 2: Background and Context

PCa is reported to be the second highest cause of male deaths in the United States (Siegel et al., 2020), with AAs disproportionately affected relative to other ethnic groups and twice as likely to die from the disease (Shenoy et al., 2016). Screening is crucial to detect PCa at an early stage to optimize treatment and recovery (Tsodikov et al., 2017). Therefore, the practice-focused questions for this project were as follows: What evidence from the literature supports the need for patient education related to PCa screening in AA men? and Can a CPPEG be developed and validated for PCa screening in AA men to effectively increase screening rates? Through this DNP PCa in AA men project, my purpose was to develop an evidence-based CPPEG to guide clinicians when educating AA men about the methods and importance of PCa screening. In this section, I will describe the AGREE II model that was used to guide this project, as well as address the relevance of the project to nursing practice and my role as a DNP student in the development of this project.

Models

The AGREE II tool was used to guide and validate the newly developed CPPEG. The AGREE II instrument is currently the most applied and comprehensively validated guideline appraisal tool worldwide (Brouwers et al., 2010) and is a standard guide that can be applied to guidelines in any disease area targeting any step in the health care continuum, including those for health promotion, public health, screening, diagnosis, treatment, or interventions (AGREE Enterprise, n.d.). The AGREE II model has been

used to guide the development of evidence-based practice guidelines as well as future research in clinical practice recommendations (Shallwani et al., 2019).

Hoffmann-Eßer et al. (2018) reported that the main quality domains that the tool addresses include the scope and purpose of the teaching, stakeholders' involvement, and the rigor of development for those involved. Other priority domains in the process are clarity in presentation, applicability, and editorial independence. The AGREE II model has been used in various studies, including Shallwani et al.'s (2019) assessment of the strengths of and needed improvements to current guidelines being implemented for physical activity or exercise recommendations for people with cancer. Wang et al. (2019) recommended using the AGREE II tool to make improvements and strengthen specific guidelines for nonvariceal upper gastrointestinal bleeding.

Relevance to Nursing Practice

PCa is the second leading cause of death in men in the United States, with PCa incidence in AA men around 60% higher and death rates 2 or 3 times higher than in Caucasian men (Shenoy et al., 2016). Shenoy et al. (2016) reported a 90% 5-year survival rate for PCa if a prostate tumor is detected early, compared to only 35% for more advanced disease stages. Black men comprise a high-risk group for PCa whose members may profit from precautionary screening for early detection of PCa.

The ACS (2020) has published guidelines that recommend that men at age 50 begin screening for PCa, but AAs and others in high-risk groups should begin screening at age 45; according to He and Mullins (2017), screening at as early as 40 years of age has the benefit of early diagnosis for PCa. Research has shown that the earlier the

detection, the better chance of survival for the patient (Tsodikov et al., 2017). There is no definitive explanation for the disparity in PCa between AAs and non-Hispanic Whites; however, He and Mullins (2017) hypothesized that a genetic difference, a clinical difference in the course of the disease, social barriers, and poor access to healthcare were responsible. Furthermore, Cobran et al. (2018), in their study of AA and Caribbean men, found other reasons for not visiting doctors, such as family history, lack of health insurance, misconceptions about how prostate screening is done, and misinformation from healthcare providers about when to screen. Advanced metastatic PCa occurs at a ratio of 4:1 in AA men and White men, respectively (Shenoy et al., 2016). The disease transforms early from an indolent to aggressive state in Black men. The need to address PCa among AA men is more obvious with the expanding rate among AA men despite the registered decline in White men's mortality rates (Cobran et al., 2018).

The differences in the disease course and differences in social issues that disproportionately affect AA men place a greater health burden on these patients than the rest of the population; hence, early diagnosis may improve overall health outcomes. The U.S Preventive Services Task Force needs to adequately take into consideration racial/ethnic differences when issuing screening guidelines (Shenoy et al., 2016). Establishing separate screening guidelines for men of AA ancestry would help facilitate earlier diagnosis and reduce mortality from the disease. Rice et al. (2017) studied the impact of educational interventions on the risk of PCa with AA men between the ages of 18 and 75, finding that education can increase AA men's understanding of the risk of the

disease and increase their participation in screening. Educational interventions must focus on the main apprehensions of those targeted to enhance prostate screening.

The ACS (2020) has published guideline recommendations for PCa screening, but AAs and other high-risk groups need more targeted education to address barriers. The ACS developed a PCa pamphlet and toolkit in 2019 consisting of an easy-to-read informational flyer translated in 12 different languages that included promotional activities to be used within any organization as well as short messages and helpful resources about PCa screening. Though informative, these resources need to be tailored for the AA population. The gap in practice that has been identified is a lack of educational resources for AA men about the benefits of PCa screening. Despite remarkable gains in overall life expectancy among other ethnic groups, life expectancy for AA men remains the same; specifically, life expectancy for Caucasian men is 74 years and for AA men is 66 years (ACS, 2020). The disparity in life expectancy for AA men is disproportionate due to an excess in cancer incidences, so educating them on the importance of PCa screening to decrease the disparity is essential.

Local Background and Context

Although this project addressed no specific institution, the expert panelists came from my surrounding community and work-related peers. According to ACS (2020), 41,000 American men die of PCa each year, with approximately 65% of this population consisting of AAs. The mortality rate from PCa among AA men is more than double that for Whites, with age-adjusted mortality rates of 64 per 100,000 and 26 per 100,000, respectively (ACS, 2020). The disparity in PCa mortality rates is more distinct in the

southeastern United States, where deaths from PCa among AAs happen at nearly 3 times the national mortality rate for Whites. PCa screenings can provide earlier diagnoses, ultimately improving opportunities for successful treatment and decreasing mortality. The literature indicates that with preventive screening, AA men will be more aware of their prostate health and hence take more precautionary measures (ACS, 2020). AA men must be informed of the need to undergo screening and have fears and myths addressed.

The myths and stigma associated with PCa among AAs are widespread. Likewise, the need for culturally based education is widespread; thus, this CPPEG will be appropriate for all providers who treat AA men. The evidence-based teaching guideline to educate AA men on PCa screening should, over time, decrease morbidity and mortality among the population through early diagnosis and treatment of the disease.

Professional Organizations and Florida State Initiative Reviews

U.S. health organizations have declared that PCa screening, like other related cancer screenings, requires education and counseling so that patients are well-informed about the risks and benefits of screening and make informed decisions about their own healthcare. In 2018, the American Academy of Family Physicians issued updated clinical preventive service recommendations on PSA-based screening for PCa for AA men, based on examination of multiple evidence reviews by the U.S. Preventive Services Task Force to create its final statement of recommendation on PSA screening. Even with these new guidelines, screening rates among AA men remain low while the PCa prevalence among AA males is about 60% higher and the rate of mortality is about 3 times higher than in

Caucasians (Tsodikov et al., 2017). Therefore, developing separate evidence-based guidelines for AA men should reduce the PCa burden among the AA population.

The Florida PCa Advisory Council is a collaborative, multi-institutional, interdisciplinary advisory body that has established a communication platform between PCa stakeholders within the State of Florida by providing informational resources that validate and disseminate PCa information (Gupta et al., 2015). The Florida PCa Advisory Council's mission is to make reliable information resources about PCa screening accessible to patients, advocates, physicians, care providers, researchers, and Florida's governing officials about the need for prostate screening. The World Health Organization (WHO) promotes and emphasizes cancer prevention to improve quality of life. According to WHO, 30%-50% of cancer's risk factors are due to unhealthy lifestyle practices such as poor nutrition, smoking, and lack of exercise. Men of African descent have the highest rate of PCa compared to all other ethnicities (Tsodikov et al., 2017). Therefore, educating the AA population about the importance of prostate screening and preventative measures can help in increasing screening rates and decreasing the disease among this vulnerable group. This PCa in AA Men project provided educational resources for AA men about the methods and benefits of PCa screening along with facts about the disease, thus dispelling myths, addressing fears, and closing the gap in practice.

Role of the DNP Student

My professional context with PCa derived from my years of experience working on an oncology floor. In this DNP PCa in AA Men project, I functioned as the leader. Using Walden University's *Clinical Practice Guideline Manual* and the AGREE II tool

as guides, I developed an evidence-based CPPEG using current, evidence-based sources obtained through an exhaustive literature review. I selected a group of content experts who reviewed the newly developed CPPEG using the AGREE II tool. No revisions were needed, or recommendations were made, and the newly developed CPPEG was sent to the end users (providers in the community who care for AA males) to assess for content and useability; they agreed that the newly developed guideline was pertinent, well written, and all-inclusive and would be easy to use.

My motivation for this project came from my father, who had PCa and died 2 years ago from the disease. With increased knowledge, my father might have been screened and sought treatment earlier, resulting in a better outcome. I understand that I may be biased as to the content that is included in the CPPEG, based on my personal experience; however, I have minimized my biases by developing the CPPEG in concert with the current evidence-based literature and information from organizational sites, avoiding my personal opinion.

Summary

With statistics showing increased deaths and lack of prostate screening among AA men compared to their counterparts, a separate educational evidence-based guideline was needed to address cultural myths and barriers that deter this vulnerable group from receiving prostate screening, thus decreasing the disparity. My DNP PCa in AA Men project has provided providers with culturally sensitive, evidence-based guidelines to educate AA men and increase their awareness of PCa screening for more extended life opportunities. The project was guided by the AGREE II model, and the CPPEG was

developed from an extensive evidence-based literature search. In Section 3, I discuss the collection and analysis of evidence and my practice-focused questions.

Section 3: Collection and Analysis of Evidence

The burden of cancer affects all populations across the world. AA men are a minority community in the United States, and unwittingly they have more reported cases of PCa than their peers; research shows that AA men are 1.6 times more likely to have a positive PCa diagnosis and twice as likely to die from it (Bowen, 2018). Factors such as lack of screening, nutrition, sedentary lifestyle, family history, and race (Shenoy et al., 2016) play a role in causing the disparity. There are many contributing factors, but prostate screening is recommended as a preventive measure to ensure early detection and treatment.

The problem identified for this DNP PCa in AA Men project was the lack of screening among AA men despite the availability of such. I have developed a CPPEG to assist providers in educating AA men about the importance of PCa screening and addressing ethnic beliefs and barriers such as cultural and socioeconomic factors and poor healthcare access. Educational programs geared toward practitioners have been shown to be effective in bringing awareness of the risk for PCa and the benefits of screening. In this section, I discuss the practice-focused questions, the sources of evidence, and a relationship between the evidence and the purpose. The collection and analysis of evidence used to address the practice problem are described.

Practice-Focused Questions

The issue that I addressed in this evidence-based DNP PCa in AA Men project was a lack awareness of the importance of or need for PCa screening in AA men despite the availability of such screening. The gap in practice identified was the lack of

educational resources for practitioners to use when educating AA men about the benefits of PCa screening. Lack of educational resources creates a concern because AA men have limited knowledge and skewed perceptions of PCa screening in addition to negative attitudes toward annual routine checkups (Hahn et al., 2015). Therefore, developing culturally specific evidence-based guidelines for AA men should help to increase PCa screening. Hence, the practice-focused questions that guided this PCa in AA Men project were as follows: What evidence from the literature supports the need for patient education related to PCa screening in AA men? Can a CPPEG be developed and validated to guide nurses in educating AA men on the importance for PCa screening? The purpose of the project was to develop an evidence-based CPPEG to assist providers when educating AA men on the benefits of PCa and the risks and management of PCa so that they are better prepared to make informed decisions in their care.

Sources of Evidence

The CPPEG was based on evidence from current, peer-reviewed, published research discovered in an in-depth literature search of peer-reviewed articles published within the last 5 years unless they were landmark studies. Guidelines from professional organizations and the Florida Advisory Council were also incorporated. The literature was organized in a literature matrix (see Appendix A) and graded using the hierarchy of evidence from Fineout-Overholt et al. (2010; see Appendix B) with articles from all except Level 2 (individual single random control trials) of the seven levels.

This evidence from the literature and recommendations from professional organizations were used to develop the culturally sensitive CPPEG to assist providers

with current, evidence-based tools to educate AA men on the pros and cons of PCa screening. Including higher levels of literature to include systematic reviews of randomized controlled trials added strength to the guideline. An additional source of evidence collected through this project was the results of the AGREE II tool provided by the content experts, which established the quality of the newly developed CPPEG, along with feedback from the end users, the nurses, and the providers, who agreed that the tool would be useful to teach AA men about the importance of PCa screening.

Evidence Generated for the Doctoral Project

Participants

Following recommendations of the AGREE II tool (AGREE Enterprise, n.d.), each guideline was assessed by four appraisers, as this increased the reliability of the assessment; the expert panel consisted of an oncology nurse educator, a nurse practitioner, an oncologist, and an oncology nurse with their MSN. These members were selected for their expertise in PCa, their knowledge in evidence-based guidelines, and the fact that they could relate to the practice-focused questions because of the low numbers in screening in the target population seen in their practices. In addition, their direct interaction with this population was a plus. The end users, three providers from the community, reviewed the guideline for content and usability.

Procedure

After an extensive literature search, I arranged the pertinent articles in a literature matrix and graded the evidence using criteria from Fineout-Overholt (2010). From this current, evidence-based literature, I developed a culturally sensitive CPPEG (see

Appendix E) and mailed a packet consisting of an introductory letter, the CPPEG, the literature matrix, a disclosure form, the AGREE II tool, the AGREE II tool scoring sheet (see Appendix D), and a link to the AGREE site to the expert panelists. The expert panel was asked to review the quality of the CPPEG using the AGREE II tool (www.agreetrust.org) and provide feedback within 2 weeks. The expert panelists reviewed the CPPEG, with no revisions requested or recommendations provided. The CPPEG was then presented to four end users (providers and nurses) who were asked to review it and provide feedback on content and usability. I developed a final report and shared it with the expert panel. After graduation, I will share the newly developed CPG with administrators in the surrounding area for consideration of adoption, at which time I will present the CPPEG to the providers; for wider dissemination, I will present at local, regional, and national organizations' conferences, state board meetings, and community clinics.

Protections

Approval from Walden University's Institutional Review Board and the facility were obtained after the proposal was accepted. No identifying information was collected on the AGREE II website, ensuring that the reviews were anonymous. There were no paper files as the evaluations were completed on the AGREE site. All electronic files will be maintained on a password-protected computer that only I will have access to for 5 years and then deleted. The site name will be masked to maintain anonymity.

Analysis and Synthesis

The AGREE website (www.agreetrust.org) was used for recording, tracking, organizing, and analyzing the evidence. The panelists were instructed to enter their scores through the website. The website analyzed the findings and developed a final report, which was sent to me. I reviewed the findings; all scores were above the benchmark of 75%, and no recommendations were made, nor revisions needed. From the findings, I developed a final report. As the AGREE website gathers no identifying data, all responses were anonymous. Reviewing the end users' comments, I included their responses in the final report. Summary evaluations from the content experts were also reviewed, providing me with an evaluation of the process, the project, and my leadership throughout the process.

Summary

In summary, AA men are a minority community in the United States but have more reported cases of PCa compared to other cultures. The factors linked to the higher PCa incidence include nutrition, lack of screening, family history, race, and sedentary lifestyle. Educational programs geared toward educating men on the importance of having PCa screening can minimize PCa cases among AA men, but AA men are reluctant to be screened. In this DNP PCa in AA Men project, I developed a CPPEG to guide nurses and other providers in addressing the lack of PCa screening among AA men based on peer-reviewed, published research from Walden Library. An expert panel used the AGREE II tool to evaluate the CPPEG; no recommendations were made, and no revisions were needed. I mailed the CPPEG to the end users to review the newly

developed CPPEG for content and useability, receiving positive feedback from them. In Section 4, I address the findings and recommendations based on the analyzed data.

Section 4: Findings and Recommendations

The local problem identified for this DNP PCa in AA Men project was the lack of screening among AA men despite the availability of such. The goal of PCa screening is to reduce death among AA men. The gap in practice was the lack of educational resources for AA men about the benefits of PCa screening. The practice-focused questions that drove the project were the following: What evidence from the literature supports the need for patient education related to PCa screening in AA men? Can a CPPEG be developed and validated to guide nurses in educating AA men on the importance of PCa screening? The purpose of the project was to develop an evidence-based CPPEG to guide practitioners when educating AA men about the significance of PCa screening so that they can make an informed decision about their care. The sources of evidence that were used to develop this CPPEG were peer-reviewed articles found in the Walden library and through professional organizations. The AGREE II instrument was used by the expert panel to evaluate the newly developed CPPEG for rigor and clarity. The end users evaluated the newly developed guidelines for content and usability, and the content experts provided feedback on the process, the project, and my leadership through a summary evaluation. In this section, I will discuss the findings and the implications, recommendations, and strengths and limitations of the project.

Findings and Implications

After an in-depth review of the literature, a literature matrix was developed (see Appendix A) by using pertinent articles that were graded using Melynk grading criteria. Three Level 1 articles, two Level 3, one Level 4, six Level 5, two Level 6, and five Level

7articles were selected for use in the development of the CPG. The vast number of peer reviewed articles and numerous systematic reviews added strength to the CPPEG.

Four expert panelists provided evaluations of the newly developed CPPEG on the AGREE II website. The evaluations addressed the 23 items from the six domains, with scores for each domain above 75%. The threshold for high quality is scores above 50% for each domain; however, any scores below 75% should be evaluated (AGREE Enterprise, n.d.). Domain 1, scope and purpose scored 100%; Domain 2, stakeholder involvement, scored 93%; Domain 3, rigour of development, scored 92%; Domain 4, clarity of presentation, scored 100%; Domain 5, applicability, scored 90%; Domain 6, editorial independence, scored 92%; and the overall appraisal score was 96% (see Appendix D).

The reviewers only scored individuals from all the relevant professional groups being included in the development of the CPG at 24/28; the variety in education and roles of the reviewers addressed this requirement. Also questioned was the monitoring and/or auditing criteria, which were clearly addressed at the end of the introduction with the statement "the guideline should be reevaluated every 3 years or when new recommendations for prostate screening in AAM are published." Auditing is addressed in the recommendations and evaluation of the project. One panelist commented that PCa in AA men is a health issue that needs addressing with educational interventions, while another appraiser commented that there is a demonstrated need for education and culturally based care for the AA community.

Two of the end users who were providers and nurses commented that the CPG was well developed, clear, and concise and that it is a tool that is user friendly and likely to make a change in how AAs are educated, addressing cultural issues and concerns and making them more knowledgeable about PCa screening, ideally improving quality of life for AAs. Both the expert panelists and end users had never seen a CPG specific to AA men and PCa screening, supporting the need for the project. The CPPEG is an evidence-based educational tool to guide providers in teaching AA men and better preparing them to make an informed decision about their care, fostering positive social change by increasing PCa screening in this vulnerable group.

Recommendations

The gap in practice for this DNP project was the lack of educational resources for AA men about the benefits of PCa screening. That gap was addressed by developing a culturally sensitive, evidence-based guideline for providers to use for educating AA men with appropriate knowledge to better equip them in making decisions regarding their care based on knowledge gained through the education that they received on the importance of prostate screening. There was no specific site for the project, but there are several sites that I intend to share the guideline with after graduation; I will present the CPG to administrators at doctors' offices and community clinics for consideration of implementation and then present the information to the nurses and providers. My desire is that this newly developed CPPEG will make a difference in the lives of AA men.

Strengths and Limitations of the Project

The focus of this DNP project was to fill the gap in practice, which was the lack of educational resources for AA men about the benefits of PCa screening, by providing nurses and providers with a culturally sensitive guide tailored to AA men. The end product provides a ready resource of appropriate information needed to aid AA men in making informed decisions regarding their care. One of the strengths of the newly developed CPPEG was the amount of culturally relevant, evidence-based resources available to be included in the newly developed guideline. The positive feedback received from the expert panelists and their willingness to use this tool was another strength. One of the appraisers commented that there is a demonstrated need for education and culturally based care for AA men.

One of the limitations for this DNP project was that there was no set organization affiliated with it due to the pandemic and associated restrictions; this will delay my dissemination until the pandemic restrictions are lifted. Visiting these multiple sites is the only way to have the newly developed CPPEG implemented. Another limitation was my time constraints, as I am currently paying for this terminal degree out of pocket and I am financially strained. In addition to financial obligations, family commitments have been neglected due to work overload and sleepless nights to complete this terminal degree.

The review of the available literature provided me with valuable knowledge that I will use throughout my career. I feel better prepared to be a spokesperson for the prevention and early diagnosis of PCa, especially in AA men. I am also more aware of the barriers that AAs and other minority groups face in receiving quality health care.

These barriers, myths, and fears are all areas that I hope to address in future projects. After my newly developed CPPEG is implemented, I will lead the facilities in evaluating the implementation, comparing screening rates, and, over time, reducing the incidence of PCa in the AA population. Seeing positive changes should further support the validity of the CPPEG.

Summary

The findings and implications for this project were centered around the expert panelists' evaluation using the AGREE II instrument. The panelists favored the CPPEG and gave high scores in all six domains (see Appendix D). Their feedback on the need for this culturally based educational intervention was paramount. The strength of this project was that the gap in practice was addressed, and the differences between ethnicities in PCa screening should be minimized due to providing a culturally sensitive, evidence-based teaching tool to address the fears, myths, and misinformation that have been found to add to the disparity for AA men regarding PCa. In Section 5, I will focus on my self-analysis and summary of the final DNP project, including challenges, solutions, and insights gained on the scholarly journey.

Section 5: Dissemination

The implementation of this project will extend after graduation when I can present the CPPEG to various organizations. I will share the newly developed CPPEG in doctors' offices and community clinics where patients are often seen for their yearly or routine visits. Urology and oncology clinics are other settings that I will approach, as they are the referral sites for the population that this CPPEG will benefit. I plan to meet with administrators and present my newly developed CPPEG to get authorization to offer it to nurses and providers. I will highlight critical information to strengthen screening and embrace a proactive approach toward PCa among AA men. Using a collaborative approach to dispel myths and misconceptions surrounding PCa screening is vital (Shenoy et al., 2016). PCa is widespread, and its occurrence is increasing among AA men.

Although providing the newly developed CPPEG in the surrounding community will impact the local population, it is through publication and presentations at regional, national, and global professional meetings that I will make the biggest impact. Therefore, I will query pertinent journals, to include *Clinical Journal of Oncology Nursing* and *The Journal of the National Black Nurses Association***,** for consideration for publication and submit an abstract to present the project at The Cancer Nursing conference.

Analysis of Self

I started my nursing career as a registered nurse on an oncology unit; I remember saying to myself, "oh no, oncology," but later it became a passion for me, especially after my dad got diagnosed with and died from PCa. I found my passion for educating and addressing the lack of PCa screening among AA men, which led me to pursue a master's

degree and then my terminal degree. I developed this CPPEG so that I can bring awareness of and provide resources on the importance of prostate screening, especially to AA men, by educating providers on how to educate AA men to make informed decisions about their care.

Practitioner

As a DNP student carrying out this project, I was able to take on roles as practitioner, scholar, and project manager. In the role of practitioner, I was able to use my educational background and clinical expertise to review evidence-based practice guidelines, identify the problem that the project was focused on, and develop a CPPEG that nurses and providers will use to enhance the education provided to AA men. In this role, I found that this was one of the ways that a DNP-prepared nurse fosters the bridging of the gap of research and practice. As a practitioner, one of my strengths was my ability to research the literature and find meaningful articles for this project; however, one of my weaknesses was accurately applying the appropriate grade level to each article in relation to the literature matrix, which required me to seek assistance from the Walden Library and my peers. To minimize this weakness, I spent time deciphering the actual grading tool for similarities between grading Level 1 and Level 7 articles.

Cultural differences do affect health beliefs and patient education; therefore, addressing these disparities will positively impact outcomes and enhance learning in the target population. My long-term goal is to find a full-time academic position in the nursing department in a university and to be the spokesperson for culturally sensitive

educational interventions and educating the AA male population about the need for PCa screening.

Scholar

The road to my DNP has been filled with great experiences—experiences of both joy and sadness as my father passed away from PCa before I could complete this terminal degree. As a scholar, I focused on my courses and learning everything possible. In reflecting on my journey, I have learned to look at what it takes to be a scholar in a different light, such as the ability to research and break down the elements into usable components that nurses can use to improve nursing care. I was able to identify and overcome many challenges (personal and professional), which I had to navigate sometimes single-handedly, to be able to be at this juncture. The education obtained has solidified the many aspects of integrating changes within the nursing sector that will align with current healthcare legislation recommendations as it pertains to evidence-based research. In my professional career, I have advanced by sitting on committees to implement changes to patient care aligned with evidence-based practice through research. Additionally, I have aided in implementing patient safety policies through data analyses to identify patient safety issues using evidence-based interventions, demonstrating that a new approach will lead to improved quality and patient safety. My long-term professional goal is to find an adjunct faculty position teaching online and continue working as an advanced practice registered nurse.

Project Manager

Being a project manager was stressful, as I did not know anything about the AGREE II website. I was fortunate that three of my expert panelists were familiar with the website, but I had to be familiar with the site so that I could aid the other expert panelist. This was a tedious, even stressful, task for me. As it was my first time encountering the AGREE II website, I had to reach out to my peers for guidance on how to navigate the site. However, the end product, the newly developed CPPEG for nurses and providers, gave me a sense of fulfillment, knowing that providers would now have access to an evidence-based guideline specific to AA men for teaching them about PCa screening and addressing culturally sensitive barriers.

Challenges, Solutions, Insights Gained

The challenges that I faced during this process were personal and academic. Completing some of the core courses was extremely challenging for me, as some courses lacked clarity and I had to keep reaching out to the professor for assistance; sometimes, the clarification took 2 to 3 business days or even longer, which increased my anxiety even more. I was not aware that while working on the core courses I could have initiated the proposal. While working on my project, my father passed away from PCa, which led me to take a semester off. However, the greatest challenges that I faced were the revisions of this scholarly project; another challenge was learning how to navigate the AGREE website to aid the panelists who had no knowledge of the site.

I have gained new insights on the importance of seeking early guidance—for example, how to write in the template instead of creating a new document with each

revision, which would have fostered a quicker completion of my DNP project. Other personal obligations, including taking care of family responsibilities and working while trying to complete school, were very demanding. The biggest academic challenges that I faced were making the necessary revisions and doing the literature matrix. In addition, trying to understand the AGREE II tool was not an easy task to accomplish. The completion of this project has provided me the opportunity to gain further insights about myself and the profession of nursing. I have a better understanding of the importance of the DNP role as it relates to converting evidence-based information into evidence-based practice. Finally, through this role, I can make a difference in the lives of patients, nurses, and providers, ensuring that clinical practices are based on scientific methodologies.

Summary

PCa is significant disease that impacts men globally, but with an excellent survival rate when it is detected early. AA men are 50% more likely to develop and die from PCa compared to men of another ethnicity. They have the lowest rate of prostate screening when screening is readily available. The purpose of this doctoral project was to develop a CPPEG for nurses and providers to use to educate AA men on the importance of prostate screening. The supporting literature supported the need for nurses to know the significance of culturally related barriers that AA men have related to PCa. The implementation of the newly developed CPPEG will fill the gap of not having a standardized, culturally sensitive educational teaching tool. Working through endless challenges of writing the guideline and having an appraisal completed by a diverse panel of experts was a task like no other I have done before. The creation of this CPPEG

afforded me the latitude of providing other healthcare practitioners a CPPEG that is grounded in scientific underpinnings. Culturally sensitive education will always be imperative, and it is one of my responsibilities, as an advanced nurse practitioner, to assist nurses and clients in promoting and enhancing quality individual care. Finally, the evaluations from the expert panelists reinforced that this newly developed evidence-based CPPEG should positively impact nurses' and patients' knowledge when it comes to educating and performing self-care practices toward self-screening for PCa, decreasing the burden that AA men face due to lack of prostate screening.

References

AGREE Enterprise. (n.d.). *Appraisal of guidelines for research & evaluation*. https://www.agreetrust.org/resource-centre/agree-ii/

AGREE Research Trust. (2018). *About the AGREE Enterprise*. https://www.agreetrust.org/about-the-agree-enterprise/

American Cancer Society. (2016). *Facts & figures of prostate cancer*. https://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures

American Cancer Society. (2019). *Key statistics for prostate cancer: Prostate cancer facts*. https://www.cancer.org/cancer/prostate-cancer/about/key-statistics.html

American Cancer Society. (2020). *Prostate cancer early detection*. https://www.cancer.org/content/dam/CRC/PDF/Public/8795.00.pdf

Brouwers, M. C., Kho, M. E., Browman, G. P., Burgers, J. S., Cluzeau, F., Feder, G., & Littlejohns, P. (2010). AGREE II: Advancing guideline development, reporting and evaluation in health care. *Canadian Medical Association Journal*, *182*(18), E839–E842. https://doi.org/10.1503/cmaj.090449

Cobran, E. K., Hall, J. N., & Aiken, W. D. (2018). African American and Caribbean-born men's perceptions of prostate cancer fear and facilitators for screening behavior: A pilot study. *Journal of Cancer Education, 33*(3), 640–648.

Dickey, S. L., Whitmore, A., & Campbell, E. (2017). The relation between prostate cancers knowledge and psychosocial factors for prostate cancer screening among African American men: A correlational study. *American Institute of Mathematical Sciences Public Health, 4*(5), 446–465.

https://doi.org/10.3934/publichealth.2017.5.446

Ebu, N. I., Amissah-Essel, S., Asiedu, C., Akaba, S., & Pereko, K. A. (2019). Impact of health education intervention on knowledge and perception of cervical cancer and screening for women in Ghana. *BioMed Central Public Health, 19*(1), Article 1505.

Fineout-Overholt, E., Melnyk, B. M., Stillwell, S. B., & Williamson, K. M. (2010). Evidence-based practice step by step: Critical appraisal of the evidence: Part I. *The American Journal of Nursing, 110*(*7*), 47–52.

Gupta, M., McCauley, J., Farkas, A., Gudeloglu, A., Neuberger, M. M., Ho, Y. Y., & Dahm, P. (2015). Clinical practice guidelines on prostate cancer: A critical appraisal. *The Journal of Urology, 193*(4), 1153–1158.

Hahn, R. A., & Truman, B. I. (2015). Education improves public health and promotes health equity. *International Journal of Health Services: Planning, Administration, Evaluation, 45*(4), 657–678.

He, T., & Mullins, C. D. (2017). Age-related racial disparities in prostate cancer patients: A systematic review. *Ethnicity & Health, 22*(2), 184–195.

Hoffman, R. M. (2020). *Screening for prostate cancer*. https://www.uptodate.com/contents/screening-for-prostate-cancer/print

Hoffmann-Eßer, W., Siering, U., Neugebauer, E., Brockhaus, A., McGauran, N., & Eikermann, M. (2018). Guideline appraisal with AGREE II: Online survey of the recommendation for use. *BioMed Central Health Services Research, 18*(1). https://doi.org/10.1186/s12913-018-2954-8

James, L. J., Wong, G., Craig, J. C., Hanson, C. S., Ju, A., Howard, K., Tong, A., Usherwood, T., & Howard, L. (2017). Men's perspectives of prostate cancer screening: A systematic review of qualitative studies. *PloS one*, *12*(11), https://doi.org/e0188258

Owens, O. L., Tavakoli, A. S., Rose, T., & Wooten, N. R. (2019). Development and psychometric properties of a prostate cancer knowledge scale for African American men. *American Journal of Men's Health*, *13*(6), https://doi.org/10.1177%2F1557988319892459

Peterson, K., Anderson, J., Boundy, E., Ferguson, L., McCleery, E., & Waldrip, K. (2018). Mortality disparities in racial/ethnic minority groups in the Veterans Health Administration: An evidence review and map. *American Journal of Public Health*, *108*(3), e1–e11.

Reynolds, D. (2008). Prostate cancer screening in African American men: Barriers and methods for improvement. *American Journal of Men's Health*, *2*(2), 72–177. https://doi.org/10.1177/1557988307312784

Rice, L. J., Jefferson, M., Briggs, V., Delmoor, E., Johnson, J. C., Gattoni-Celli, S., & Halbert, C. H. (2017). Discordance in perceived risk and epidemiological outcomes of prostate cancer among African American men. *Preventive Medicine Reports*, *7*, 1–6.

Ryan, P. (2009). Integrated theory of health behavior change: Background and intervention development. *Clinical Nurse Specialist*, *23*(3), 161–170. https://doi:10.1097/nur.0b013e3181a42373

Saei Ghare Naz, M., Kariman, N., Ebadi, A., Ozgoli, G., Ghasemi, V., & Rashidi Fakari, (2018). Educational interventions for cervical cancer screening behavior of women: A systematic review. *Asian Pacific Journal of Cancer Prevention: APJCP*, *19*(4), 875–884.

Shallwani, S. M., King, J., Thomas, R., Thevenot, O., De Angelis, G., Aburub, A.S. Brosseau, L. (2019). Methodological quality of clinical practice guidelines with physical activity recommendations for people diagnosed with cancer: A systematic critical appraisal using the AGREE II tool. *PLoS ONE 14*(4), e0214846. https://doi.org/10.1371/journal.pone.0214846

Shenoy, D., Packianathan, S., Chen, A. M., & Vijayakumar, S. (2016). Do African American men need separate prostate cancer screening guidelines. *Bio Med Central Urology*, *16*(1), 19.

Siegel, R. L., Miller, K. D., & Jemal, A. (2020). Cancer statistics, 2020. *CA: A Cancer Journal for Clinicians*, *70*(1), 7-30. *Med Central Public Health, 20*(1), 1-10.

Tsodikov, A., Gulati, R., de Carvalho, T. M., Heijnsdijk, E., Hunter-Merrill, R. A., Mariotto, A. B., de Koning, H. J., & Etzioni, R. (2017). Is prostate cancer different in Black men? Answers from 3 natural history models. *Cancer*, *123*(12), 2312–2319. https://doi.org/10.1002/cncr.30687

Ukoli, F. A., Patel, K., Hargreaves, M., Beard, K., Moton, P. J., Bragg, R., & Davis, R. (2013). A tailored prostate cancer education intervention for low-income African Americans: Impact on knowledge and screening. *Journal of Health Care for the poor and Underserved*, *24*(1), 311- 331.

Wang, Y., Guo, J., Rao, Y., Xiao, G. R., & Zhao, X. (2019). Quality evaluation of the non-variceal upper gastrointestinal bleeding guidelines/consensuses via AGREE II tools. *Journal of the College of Physicians and Surgeons Pakistan*, *29*(10), 977-985.

Wardle, J., Robb, K., Vernon, S., & Waller, J. (2015). Screening for prevention and early *diagnosis of cancer. American Psychologist, 70(2), 119.*

Appendix A: Literature Review Matrix

Melnyk al (2010) grading criteria
DNP Project Title: Teaching Guidelines for Screening Prostate Cancer in African American Men

Reference	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Research Methodology**	**Analysis & Results**	**Conclusions / Recommendations for future research/practice**	**Grading the Evidence**
American Cancer Society. (2020). Prostate cancer early detection. https://www.cancer.org/content/dam/CRC/PDF/Public/8795.00.pdf	N/A	To clarify whether screening for prostate cancer is important	N/A	overall screening and feedback reduced the risk for prostate cancer in African American Men (AAM)	Screening for prostate cancer can save lives	VII
American Cancer Society. (2019). Key statistics for prostate cancer: Prostate cancer facts. https://www.cancer.og/cancer/prostate-cancer/about/key-statistics.html	N/A	To determine how common prostate cancer is and the risks involved	N/A	191,930 new cases diagnosed in men of all races of which 33,330 did died from prostate cancer	Prostate cancer is a common health deviation and one of the high causes of cancer deaths in men	VII
American Cancer Society. (2016) facts & figures of prostate cancer. https://www.cancer.org/cancer/prostate cancer	N/A	To determine why AA men in Florida face high mortality rates	N/A	AA men in Florida continue to face disparities in diagnosis, mortality rates, and access to cancer treatment.	Florida ranks second among all states in the United States with estimated new cases of PCa and second in estimated deaths from the disease	VII

Cobran, E. K., Hall, J. N., & Aiken, W. D. (2018). African American and Caribbean-born men's perceptions of prostate cancer fear and facilitators for screening behavior: A pilot study. *Journal of Cancer Education*, *33*(3), 640–648.	N/A	To explore Caribbean-born and AA men perception of prostate cancer.	Pilot study, mixed method	Black men of Caribbean descent scored a higher percentage (8.23) in screening rates due to their perception and willingness to seek prostate cancer treatment when compared to AA men score of 6.14	Prostate cancer screening is low among AA men than Caribbean born due to negative perception, barriers, and misinformation t is important to create public awareness of prostate cancer screening	VI
Dickey, S. L., Whitmore, A., & Campbell, E. (2017). The relation between prostates cancers knowledge and psychosocial factors for prostate cancer screening among African American men: A correlational study. *American Institute of Mathematical Sciences Public Health*, 4(5), 446–465. https://doi.org/10.3934/publichealth.2017.5.446	N/A	To investigate the African American's knowledge on PCa and psychological factors concerning prostate cancer	Correlational study	AA men lacked sufficient knowledge about prostate cancer and the psychosocial factors concerning the decision to go for screening for cancer	Providing education is vital in increasing AAM's knowledge about the importance of prostate cancer screening Healthcare organizations need to examine the inconsistencies and barriers to prostate cancer screening.	IV
Ebu, N. I., Amissah-Essel, S., Asiedu, C., Akaba, S., & Pereko, K. A. (2019). Impact	N/A	To investigate the effect of an education-	Interviews	There was a significant difference in women who have	women of different ethnic backgrounds and exposure	VI

of health education intervention on knowledge and perception of cervical cancer and screening for women in Ghana. *BioMed Central Public Health, 19*(1), 1505.		centered health interventio n on cancer of the cervix.		had education vs women who did not in managing cervical cancer	who have been exposed to various education seek treatment faster than women who had limited or no education of cervical cancer	
Hahn, R. A., & Truman, B. I. (2015). Education improves public health and promotes health equity. *International Journal of Health Services: Planning, Administration, Evaluation,* 45(4), 657–678.	N/A	To determine if educationa l policies promote public healthiness and equity.	Literature review	The ability to comprehend the literature was instrumental to the components of health	Education is the key to foster and promote public health and equity in relation to the determinant of improved health outcomes	V
He, T., & Mullins, C. D. (2017). Age-related racial disparities in prostate cancer patients: A systematic review. *Ethnicity & Health, 22* (2), 184–195.	N/A	To compare prostate cancer's rates of mortality and survival for cancer patients across age and race	Systematic review	Age is a vital element to prostate cancer's survival and mortality rate	There is a decrease in disparities with age There is a need for further studies to expound on prostate cancer disparities on racial backgrounds	I
Hoffman, R. M. (2020). Screening for prostate cancer. https://www.uptodate. com/contents/screening-for-prostate-cancer/print	**N/A**	To determine the efficacy of prostate	Meta-analysis	Screening is vital in reducing prostate cancer mortality	Screening needs to be done to have the patients begin treatment	I

		cancer screening			early before the disease can cause death	
James, L. J., Wong, G., Craig, J. C., Hanson, C. S., Ju, A., Howard, K., Tong, A., Usherwood, T. & Howard, L. (2017) Men's perspectives of prostate cancer screening: A systematic review of qualitative studies. *PloS one, 12*(11), e0188258	N/A	To determine men's attitudes, beliefs, and experiences of prostate cancer screening	A systematic review	Five themes were identified (Social prompting, gaining decisional confidence, preserving masculinity, avoiding the unknown and uncertainties, and prohibitive costs).	Men are willing to participate in prostate cancer screening to prevent cancer and gain reassurance about their health	V
Owens, O. L., Tavakoli, A S., Rose, T, Wooten, N. R (2019). Development and psychometric properties of a prostate cancer knowledge scale for African American men. *American Journal of Men's Health, 13*(6), 1557988319892459 https://doi.org/10.1177%2F1557988319892459.	N/A	Target interventions are instrumental in enhancing knowledge on prostate cancer in Black men	Exploratory factor analysis of AA men knowledge of prostate cancer to ensure they are equipped to make an inform decision	The study described the psychometric evaluation by using the Knowledge and Attitude Survey	The knowledge on prostate cancer is multidimensional and reliable. Future studies are required to ascertain this factor in a diverse and socio-demographic of African Americans. There is high cancer-related mortality among African American men	III

Peterson, K., Anderson, J., Boundy, E.,Ferguson, L., McCleery, E., & Waldrip, K. (2018). Mortality disparities in racial/ethnic minority groups in the Veterans Health Administration: An evidence reviews and map. *American Journal of Public Health, 108*(3), e1-e11.	N/A	To inform the agenda of equity research in health.	N/A	There was a modest mortality disparity for Black veterans	Black Veterans have a low mortality rate. Additional studies are required to examine health disparities for Asians, Americans, and Hispanic Veterans	VII
Reynolds, D. (2008). Prostate cancer screening in African American men: Barriers and methods for improvement. *American Journal of Men's Health, 2*(2), 172-177. doi: 10.1177/1557988307312784	N/A	Questionnaire was used to investigate the racial disparities in the diagnosis and treatment of prostate cancer	Literature review exploring causes of disparities between prostate cancer incidence and mortality in African American men	Men of African American descent occasionally participate in screening practices than Caucasian men.	Factors such as socioeconomic status, inadequate knowledge, fear, patient-provider communication, distrust of the medical profession, and aversion to digital rectal exam contribute to the greater prevalence of prostate cancer in men from African American background. More research is required on	V

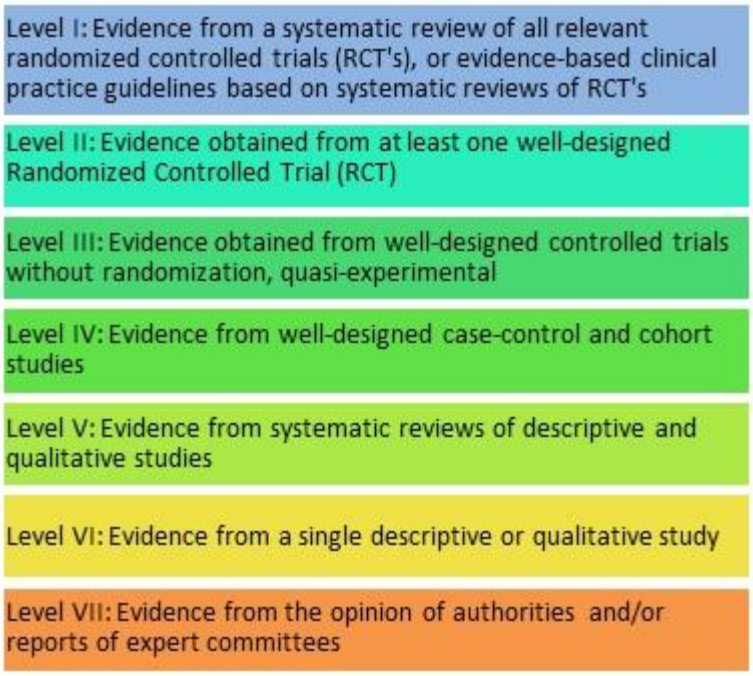
					the influence of inadequate knowledge on the prevalence of prostate cancer.	
Rice, L. J., Jefferson, M., Briggs, V., Delmoor, E., Johnson, J. C., Gattoni-Celli, S., & Halbert, C. H. (2017). Discordance in perceived risk and epidemiological outcomes of prostate cancer among African American men. *Preventive Medicine Reports*, 7, 1–6.	Heath belief	Explore the challenges on the screening of Prostate Cancer Among High-Risk Black Men	Epidemiology Study	Overall, AA men did not think that they were at great risk of developing prostate cancer. Guideline' s screening of prostate cancer has changed. Screening starts at age 50	For high-risk black men, screening alone is not enough Risk education interventions about susceptibility for multiple diseases should be developed for African American	V
Saei Ghare Naz, M., Kariman, N. Ebadi, A., Ozgoli, G., Ghasemi, V., & Rashidi Fakari, F. (2018). Educational interventions for cervical cancer screening behavior of women: A systematic review *Asian Pacific Journal of Cancer Prevention: APJCP, 19*(4), 875–884.	N/A	Evaluate the women's screening behavior on cervical cancer.	Descriptive Systemic review	Health education methods such as mother/daughter education, picture books, and educational brochures can help reduced cervical cancer-associated morbidity.	To effectively modify screening for cancer of the cervix, there is a need to use different health education methods that are appropriate Further research is required on educational methods focusing on a particular	V

					situation of the client	
Shenoy, D Packianathan, S., Chen, A. M., & Vijayakumar, S. (2016). Do African American men need separate prostate cancer screening guidelines. *Bio Med Central Urology*, 16(1), 19.	N/A	To lower the prevalence of prostate cancer by encouraging screening practices	Literature review of general information	Caucasians and men of African American descent have varied aspects of cancer. Prostate cancer's prevalence is two to three times greater in men of African American descent than the Whites	Separate guidelines for the screening of prostate cancer are imperative in lowering the prevalence of prostate cancer. Further studies are required on the efficacy of guidelines for prostate cancer screening	V
Siegel, R. L., Miller, K. D., & Jemal, A. (2020). Cancer statistics, 2020. *CA: A Cancer Journal for Clinicians, 70(1), 7-30. Med Central Public Health*, 20(1), 1-10.	N/A	To determine the rates of cancer-related mortalities	N/A	Lung cancer caused more deaths when compared to brain cancer, colorectal and breast cancer combined.	Cancer mortality rates continue to show a significant increase.	VII
Tsodikov, A., Gulati, R., de Carvalho, T. M., Heijnsdijk, E., Hunter-Merrill, R. A., Mariotto, A. B., de Koning, H. J., & Etzioni, R. (2017). Is prostate cancer different in Black men? Answers from	National History Models	To investigate the degree to which the disparities in prostate cancer are prevalent and aggressive	Randomized Control Trials Integrated and Synthesized	**Black men developed preclinical prostate cancer by age of** 85 years, a risk that is higher by 28% to 56% higher than	There is metastatic progression among Black men. There is a need for further research into the significance of screening	I

3 natural history models. *Cancer*, *123*(12), 2312–2319. https://doi.org/10.1002/cncr.30687		in Black men.		any other ethnicity	policies for Black men	
Ukoli, F. A., Patel, K., Hargreaves, M., Beard, K., Moton, P. J., Bragg, R., & Davis, R. (2013). A tailored prostate cancer education intervention for low-income African Americans: Impact on knowledge and screening. *Journal of Health Care for the Poor and Underserved*, 24(1), 311- 331.	Health Belief	To examine the prostate cancer's disproportionate burden in Black men	Quasi-experimental Study	The taxable income of 65.3 percent of men of African American descent was less than $25,000 annually.	Free physical annual examinations can maintain the positive trends of prostate cancer. There is a need to explore further the barriers to prostate cancer screening	III

Note. Evidence graded using the hierarchy of evidence model from "Evidence-based Practice Step by Step: Critical appraisal of the evidence: Part I," by E. Fineout-Overholt, B. M. Melnyk, S. B Stillwell, and K. M Williamson, 2010, *American Journal of Nursing, 110*(7), p.47-52.

Appendix B: Melynk and Fineout's (2011) Levels of Evidence



Adapted from Melnyk & Fineout-Overholt's (2011) model.

Appendix C: AGREE II Instrument

Domain 1. Scope and Purpose

1. The overall objective(s) of the guideline is (are) specifically described.
2. The health question(s) covered by the guideline is (are) specifically described.
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2. Stakeholder Involvement

4. The guideline development group includes individuals from all the relevant professional groups.
5. The views and preferences of the target population (patients, public, etc.) have been sought.
6. The target users of the guideline are clearly defined.

Domain 3. Rigor of Development

7. Systematic methods were used to search for evidence.
8. The criteria for selecting the evidence are clearly described.
9. The strengths and limitations of the body of evidence are clearly described.
10. The methods for formulating the recommendations are clearly described.
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.
12. There is an explicit link between the recommendations and the supporting evidence.
13. The guideline has been externally reviewed by experts prior to its publication.

14. A procedure for updating the guideline is provided.

Domain 4. Clarity of Presentation

15. The recommendations are specific and unambiguous.
16. The different options for management of the condition or health issue are clearly presented.
17. Key recommendations are easily identifiable.

Domain 5. Applicability

18. The guideline describes facilitators and barriers to its application.
20. The guideline provides advice or tools on how the recommendations can be put into practice.
21. The potential resource implications of applying the recommendations have been considered.
22. The guideline presents monitoring or auditing criteria.

Domain 6. Editorial Independence

23. The views of the funding body have not influenced the content of the guideline.
24. Competing interests of guideline development group members have been recorded and addressed.

Appendix D: AGREE II Scores

A critical group appraisal of:
Clinical Practice Guideline
using the AGREE II Instrument

Created with the AGREE II Online Guideline Appraisal Tool.

No endorsement of the content of this document by the AGREE Research Trust should be implied.

Co-ordinator: Joain Silvera

Email: joain.silvera@waldenu.edu

Date: 30 July 2021

URL of this appraisal: http://www.agreetrust.org/group-appraisal/15094

Guideline URL:

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6	OA 1	OA 2
100%	93%	92%	100%	90%	92%	96%	Yes - 4, Yes with modifications - 0, No - 0

Domain 1. Scope and Purpose				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 1	7	7	7	7
Item 2	7	7	7	7
Item 3	7	7	7	7
Domain 2. Stakeholder Involvement				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 4	6	6	7	5
Item 5	6	7	7	7
Item 6	7	7	7	7
Domain 3. Rigour of Development				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 7	6	7	7	6
Item 8	7	7	6	7
Item 9	6	6	7	5
Item 10	7	7	7	6
Item 11	7	7	7	7
Item 12	7	6	6	7

Item 13	6	6	6	7
Item 14	6	6	7	7
Domain 4. Clarity of Presentation				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 15	7	7	7	7
Item 16	7	7	7	7
Item 17	7	7	7	7
Domain 5. Applicability				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 18	6	6	6	7
Item 19	7	6	7	7
Item 20	7	7	7	6
Item 21	5	5	6	7
Domain 6. Editorial Independence				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
Item 22	7	6	6	7
Item 23	7	7	6	6
Overall Assessment				
	Appraiser 3	Appraiser 1	Appraiser 2	Appraiser 4
OA1	7	7	6	7

Created online at www.agreetrust.org 30 July 2021

(a) Domain 1. Scope and Purpose

Item 1

- Appraiser 3: Yes, the CPG was described in detail
- Appraiser 4: Very well presented.

Item 2

- Appraiser 3: Yes, the question described the issue at hand
- Appraiser 4: Presented by candidate.

Item 3

- Appraiser 3: Yes, African American men population
- Appraiser 4: The population is identified, and description is noted.

(a) Domain 2. Stakeholder Involvement

Item 5

- Appraiser 4: Clearly identified.

Item 6

- Appraiser 3: Yes, nurses and providers

(b) Domain 3. Rigour of Development

Item 8

- Appraiser 3: Yes, the evidence selecting African American men disparity to prostate cancer was clear and concise

Item 9

- Appraiser 4: Described

(a) Domain 4. Clarity of Presentation

Item 15

- Appraiser 4: Clearly defined

Item 16

- Appraiser 4: Well, presented.

(b) Domain 5. Applicability

Item 18

- Appraiser 4: Noted

Item 19

- Appraiser 4: Recommendations noted

c) Domain 6. Editorial Independence

No comments found for this domain.

(c) Overall Assessment

- Appraiser 3: Prostate cancer in African American men is a health issue that needs addressing with educational intervention.
- Appraiser 4: There is a demonstrated need for education and culturally based care for the African American community. This guide minority-based health disparities.

Appendix E: Teaching Guidelines for Screening Prostate Cancer in African American Men (AAM)

Purpose:

To provide teaching guidelines to assist providers in educating AAM on the importance of prostate cancer screening. This CPG will address the need for comprehensive, culturally based education guidelines for providers to share with AAM aged 40 and older to change their perceptions, with the intention of increasing prostate screening among AAM.

Procedure:

- Education will start at the doctor's office
  - nurses will communicate the importance of prostate cancer screening at the male's annual well checkups.
- The nurse will:
  - explain what prostate cancer is
  - discuss signs and symptoms of prostate cancer
    - explain how prostate cancer can be asymptomatic at times so screening is essential
    - discuss the potential risks of prostate cancer
    - explain the benefits of prostate cancer screening
    - discuss the meaning of a PSA test
    - explain what a digital exam is
    - Allow for discussion are questions related to the procedure
    - Answer questions and clarify questions as needed
- The nurse will review information at every visit

Question:

What information specific to AAs do providers need to educate AAM, potentially increasing screening and decreasing the disparity of morbidity and mortality from prostate cancer?

Target Population:

AAM aged 40 and older due to the high-risk factors for being diagnosed prostate cancer

Recommendations:

Prostate cancer is a significant health issue for AAM. It is essential to adequately plan and implement educational interventions that target behaviors through screening to reduce morbidity rates and raise awareness about the disease

- Because AAM are more vulnerable and reluctant to be screened
- Wardle et al. (2015) explained that providing clinicians with education was an effective means to optimize screening among individuals at risk for cancer.
- Educational programs geared towards practitioners were identified as effective in increasing the patients' awareness of the risk for prostate cancer and the benefits of routine screening (Rice et al., 2017).
- Screening as a preventive measure is recommended early and regularly to ensure that early detection leads to effective treatment and recovery (Tsodikov et al., 2017).
- Routine screening has been touted to be the most effective strategy for identifying prostate cancer in males (Van Hoof et al., 2018).

Key Evidence:

The American Cancer Society (ACS, 2019) estimated more than 202,000 men have prostate cancer of which over 73,000 are expected to die from the disease.

- In 2019 an estimated 30,000 cases of prostate cancer were diagnosed in AAM.
- Prostate cancer is disproportionately higher in AAM compared to other ethnic groups in the United States. Prostate cancer incidence is 60% higher in AAM than white men.
- Mortality rate is double in AAM than white men.
- The high incidence of prostate cancer in AAM has remained remarkably constant for more than 20 years (Tsodikov et al., 2017).
    - The reason for such disparity is unclear but probably due to socioeconomic factors such as race, family history, lack of education, and health insurance (Shenoy et al., 2016).
- Culturally sensitive education has the potential to increase AAM participation in getting screened and decreasing mortality from prostate cancer (Ukoli et al., 2013).

Guideline Monitoring:

- The guideline should be reevaluated every 3 years or when new recommendations for prostate cancer screening in AAM are published.
- Barriers to the application of this guideline should be addressed as they arise by the providers and before application.

This Prostate Cancer in AAM project did not request or receive any funding for the development of the CPPEG

Teaching Guidelines for Screening Prostate Cancer in African American Men

This guideline is intended to increase knowledge about prostate screening among African American men (AAM)

What is Prostate Cancer?

Prostate cancer is a type of tumor that occurs in the prostate, which is small walnut-like shaped gland in males that functions to produce seminal fluid that moves and nourishes sperms. The body part that is affected is the prostate gland. The prostate gland is a part of the male reproductive system, between the penis and the rectum, that secretes fluid to mix with semen during ejaculation.

- **Signs and symptoms of Prostate Cancer:**
  - Early prostate cancer may show no symptoms, but some patients may experience
    - difficulty voiding
    - urinary retention
    - pain in the hip, back, or bones
    - constipation and/or blood in the urine or semen
- **Potential risk factor for prostate cancer:**
  - **Age-** the risk of prostate cancer increases with age, especially over the age of 50
    - With family member having prostate cancer
      - begin screening at age 40
  - **Race-** Black men are diagnosed with prostate cancer more than men from other ethnicities
    - Start annual screening by age 50
  - **Socioeconomic status**
    - African American men are more likely to have a lower socioeconomic status than other men.
    - Low socioeconomic status has links to a higher chance of cancer

- Low income
  - financial barriers are a major contributor to prostate cancer outcomes (Shenoy, et al, 2016).
    - provide easy access to providers
- **Lack of education**
  - provide easy to understand materials
- **Cultural**
- Health practices, illness beliefs, and behaviors are motivated by Black men's ideas about being macho or manly.
  - Generally, Black men are said to take pride in having and maintaining a high level of wellness without needing to consult a health care provider (Allen et al., 2007)
    - being ill threatens what it means to be a man
- **Racial bias in health care-**
  - AAM may face racial bias in healthcare due to the color of their skin
    - Provider's lack of understanding of how to converse with AAM
      - May avert treatment
      - Less likely to be told about prostate screening and prostate specific antigen test (PSA) in preventive care compared to their White counterparts.
- **Family History**
  - Having a relative with prostate cancer increases the risk of developing the disease

- There is nothing to do to prevent it, but early detection could save one's life
    - Talk to each patient about when to start screening, based on their individual history
    - All AAs, by the age of 50
    - At least by the age of 40, with one family member having prostate cancer

How is prostate cancer screening done?

- **PSA** is a blood test which measures the amount of protein cells in the body
    - The body produces normal protein cells, as well as cancerous ones which causes prostate cancer
    - PSA levels of 4.0 ng/mL and lower are considered normal
        - a PSA level above 4.0 ng/mL is considered abnormal
            - doctors would often recommend a prostate biopsy to determine if prostate cancer is present
                - any inflammation or irritation of the prostate can also cause an elevation
- **Digital exam**
    - providers insert a lubricated finger in the rectum to check for swelling and inflammation
        - this is uncomfortable and could be embarrassing, but is necessary
            - The results would indicate an enlarged prostate, abscesses, or rectal cancers
            - If abnormality is found the provider would indicate further testing such as an ultrasound

    - a small probe inserted in the rectum to take a picture of the prostate gland
- A prostate biopsy will also be done
    - a thin needle is inserted into the prostate to collect tissue. The tissue sample is examined in a lab to determine if cancer cells are present

What are the benefits of prostate screening?

- Screening for prostate cancers will help reduce the spreading of the cancer
    - treatment before it spreads may lower the chance of death from prostate cancer in some men
    - Given the high risk of developing and dying from prostate cancer, AAM are more likely to be saved by screening.

- Screening consists of:
    - a prostate specific antigen test (PSA)
        - a blood test which measures the level of PSA in the blood.
    - digital rectal exam
        - provider will insert a well lubricated finger in the rectum to check for swelling and inflammation.

PROSTATE CANCER SCREENING
Patient Education for the AA Male

What is Prostate Cancer?

Prostate cancer is a type of tumor that occurs in the prostate gland, which is a small walnut-like shaped gland in males that functions to produce seminal fluid to nourish and move sperm. The body part that is affected is the prostate gland. The prostate gland is a part of the male reproductive system, between the penis and the rectum, that secretes fluid to mix with semen during ejaculation.

- **Signs and symptoms of Prostate Cancer:**
  - Early prostate cancer may show no symptoms, but some patients may experience
    - difficulty urinating (passing water)
    - urinary retention (unable to pass urine)
    - pain in the hip, back, or bones
    - constipation and/or blood in the urine or semen
- **Potential risk factor for prostate cancer:**
  - **Age-** the risk of prostate cancer increases with age, especially over the age of 50
    - Begin prostate screening by age 50
    - With family member having prostate cancer
      - begin screening at age 40
  - **Race-** Black men are diagnosed with prostate cancer more than men from other groups
    - Start annual screening by age 50, 40 if you have a family history
  - **Socioeconomic status**
    - Do you need help paying for your medicines?
      - YES – see APPENDAGE A
    - Do you have insurance?
      - YES – see APPENDAGE B
  - **Cultural**
    - Health practices, illness beliefs, and behaviors are motivated by Black men's ideas about being macho or manly.

- **Access to healthcare**
  - **Trouble finding a provider?**
  - **Provider too far away?**
    - **See APPENDAGE C**
  - **Lack of transportation to provider?**
    - **See APPENDAGE D**
  - Promote good health practices, at an early age that will promote AAM to seek early medical attention
    - See APPENDAGE E

How is prostate cancer screening done?

- **PSA (prostate screening antigen)** is a blood test that measures the amount of a specific protein cells in your body produced by the body
  - These can be normal cells or cancerous ones which cause prostate cancer
  - PSA levels of 4.0 ng/mL and lower are considered normal
    - a PSA level above 4.0 ng/mL is considered abnormal
      - any inflammation or irritation of the prostate can also cause an elevation
        - doctors would often recommend a prostate biopsy to determine if prostate cancer is present
- **Digital exam**
  - Provider will insert a lubricated finger in the rectum to check for swelling and inflammation
    - this is uncomfortable and could be embarrassing, but is necessary
      - The results would indicate an enlarged prostate, abscesses, or rectal cancers
      - If abnormality is found the provider would indicate further testing such as an ultrasound
        - a small probe inserted in the rectum to take a picture of the prostate gland
      - A prostate biopsy will be done
        - a thin needle is inserted into the prostate to collect tissue. The tissue sample is examined

in a lab to determine if cancer cells are present

What are the benefits of prostate screening?

- Screening for prostate cancers will help reduce the spreading of the cancer
  - treatment before it spreads may lower the chance of death from prostate cancer in some men
  - Given the high risk of developing and dying from prostate cancer, AAM are more likely to be saved by screening.

Patient Signature _____Date_____

Witness Signature _____Date_____

APPENDAGE A
Financial Concerns

If you need help paying for their medication:

- call your provider's office to see if they have any medication samples available
- call your pharmacy to see if you are qualified for any patient assistance program
    - patients who meet certain criteria can receive their medications for free or up to 80% paid for them
- Contact the drug manufacturer (contact information often available on the medicine bottle or on the internet)
    - They often have financial assistance available for those who qualify

APPENDAGE B
Insurance Courage

No insurance?

- Talk to the case manager
    - They may be able to help you find an affordable program you qualify for
    - They may be able to assist with paperwork
- Call Medicaid
    - Provide number (1-877-711-3662)

APPENDAGE C
Access to Providers

Trouble finding a provider?

- Free community clinics:
    - Jackson Health System 305 585 xxxx
    - Citrus Health System 305- 825 xxxx
    - Jessie Trice Health System 305 637 xxxx
    - Community Health of South Florida 786 293 xxxx
        - These clinics provide assistance to patients with and without insurance to obtain screening and also provide wellness visit

APPENDAGE D
Transportation

Lack of transportation to providers?

- Call your clinic
    - some of the clinics provide free transportation, picking you up at your home and bringing you to the clinic
- Ask your provider's office about telehealth
    - Telehealth services are often available if you have access to a phone or a computer
        - you can see the physician from the comfort of your home.

APPENDAGE E
Health Practices

Begin good health practices that promote seeking early medical attention **NOW:**

- includes healthy lifestyle, such as
    - not smoking
        - need help quitting?
            - ask your provider, help is available
    - reduce alcohol drinking
        - need help?
            - AA is free and available, ask your provider for information
            - your minister often can provide resources
    - reduce fatty foods
        - a nutritionist is usually available through your provider
            - ask for a referral
    - eat more fruits and vegetables
        - a nutritionist is usually available through your provider
        - does your community have a “free garden” ?
        - do you qualify for grocery assistance?
            - ask for a referral
    - maintain a healthy weight by exercising

- exercise can reduce infection, improve immune function and fight some of the negative health effects
    - many insurances cover gym membership or exercise classes
    - You tube and Google have many free exercise tapes
        - ask your provider for suggestions