**Disparities in CPR Facts**

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* Compared to white children, bystander CPR was 41% less likely for black kids; 22% less likely for Hispanics and 6% less likely among other ethnic groups. Black children living in majority black neighborhoods with high unemployment, low education and low median income were almost half as likely to receive bystander CPR compared to white children with rates of (59.7% versus 32.1%). Targeted CPR training for non-white majority, lower education and low-income neighborhoods may increase bystander CPR rates.[[1]](#footnote-1)
* Bystander CPR is provided less frequently in Latino neighborhoods compared to other areas. Cardiac arrest victims in the most heavily Latino-populated neighborhoods were over 40 percent less likely to survive until discharge from the hospital.[[2]](#footnote-2)
* Minority populations are more likely to incorrectly believe that special training and certification are required to perform Hands-Only CPR on a person and more likely to be hesitant to perform the skill for fear of causing injury. These misperceptions contribute to poor survival rates from out-of-hospital cardiac arrest, which affects more than 350,000 adults in the US annually with survival rates of less than 11 percent.[[3]](#footnote-3)
* In the United States, Latinos and blacks are at a higher risk for out-of-hospital cardiac arrest with a poor prognosis. Latinos specifically are over 30 percent less likely to have bystander CPR performed on them in a cardiac emergency, making them less likely to survive.[[4]](#footnote-4)
* As disparities exist in development and treatment of cardiovascular disease, so do they exist in the incidence, recognition, and treatment of sudden cardiac arrest (SCA). SCA incidence is higher in those with lower socioeconomic status (SES).[[5]](#footnote-5) Similarly, lower SES is associated with an increased risk of out-of-hospital coronary heart disease (CHD) death and SCD.[[6]](#footnote-6) Lee, S. Y., et al. described a similar pattern in a Korean study.[[7]](#footnote-7) Lower SES is also an independent predictor of long-term mortality in survivors of SCA. [[8]](#footnote-8)
* Despite national SCA treatment guidelines, not all patients receive evidence-based therapies, with racial and ethnic minorities and women at particularly high risk for undertreatment.[[9]](#footnote-9) [[10]](#footnote-10) A CARES study demonstrated that specific neighborhood characteristics were associated with bystander AED use in OHCA and that bystander AED use was associated with an increase in favorable functional outcome.[[11]](#footnote-11) [[12]](#footnote-12)
* Citizens from primarily poor, Hispanic, or African American neighborhoods are more likely to have OHCA and are less likely to receive bystander CPR.[[13]](#footnote-13) [[14]](#footnote-14) [[15]](#footnote-15) Language barriers and associated challenges due to limited English in 9-1-1 callers during dispatcher-identified cardiac arrest are also associated with less frequent bystander CPR, as well as delays in both cardiac arrest recognition and implementation of telephone CPR.[[16]](#footnote-16) [[17]](#footnote-17)
* Blacks have the highest incidence of OHCA and are significantly less likely to survive the arrest. OHCA in black neighborhoods is associated with alarmingly low treatment and survival rates and studies have shown lower rates of both bystander CPR and bystander AED use in these neighborhoods.[[18]](#footnote-18)
* While annual rates of CPR training in the United States vary widely across communities, with counties located in the south, those with higher proportions of rural areas, black and Hispanic residents, and those with lower median household incomes all having lower rates of CPR training than other communities. These data contribute to known geographic disparities in survival of cardiac arrest and offer opportunities for future community interventions.7
* In a study in Los Angeles using CARES data, Latinos in Los Angeles received bystander CPR at approximately half the rate of Caucasians.[[19]](#footnote-19) Compounding this problem is a lack of availability, knowledge of, and/or ability to afford CPR programs in minority and low-income neighborhoods. Older age, less education, and lower income are associated with reduced likelihood of CPR training.[[20]](#footnote-20)

1. <https://newsroom.heart.org/news/bystander-cpr-less-likely-for-black-kids-in-poorest-neighborhoods> [↑](#footnote-ref-1)
2. [Bystander CPR less common in Hispanic neighborhoods | American Heart Association](https://www.heart.org/en/news/2019/12/30/bystander-cpr-less-common-in-hispanic-neighborhoods) [↑](#footnote-ref-2)
3. <http://news.heart.org/wp-content/uploads/2017/04/Report-2016-HOCPR-Tracking-Study.pdf> [↑](#footnote-ref-3)
4. [Bystander CPR less common in Hispanic neighborhoods | American Heart Association](https://www.heart.org/en/news/2019/12/30/bystander-cpr-less-common-in-hispanic-neighborhoods) [↑](#footnote-ref-4)
5. Reinier, K., et al. Socioeconomic status and incidence of sudden cardiac arrest. *Cmaj*; 2011. 183(15): 1705-1712. [↑](#footnote-ref-5)
6. Foraker, R. E., et al. Variation in rates of fatal coronary heart disease by neighborhood socioeconomic status: the atherosclerosis risk in communities surveillance (1992-2002). *Ann Epidemiol*; 2011. 21(8): 580-588. [↑](#footnote-ref-6)
7. Lee, S. Y., et al. A disparity in outcomes of out-of-hospital cardiac arrest by community socioeconomic status: A ten-year observational study. *Resuscitation*; 2018. 126: 130-136. [↑](#footnote-ref-7)
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10. Kong, M. H., et al. Addressing disparities in sudden cardiac arrest care and the underutilization of effective therapies. *Am Heart J*; 2010. 160(4): 605-618. [↑](#footnote-ref-10)
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15. Moon, S., et al. (2014). "Disparities in bystander CPR provision and survival from out-of-hospital cardiac arrest according to neighborhood ethnicity." Am J Emerg Med 32(9): 1041-1045. [↑](#footnote-ref-15)
16. Bradley, S. M., et al. Bystander CPR in out-of-hospital cardiac arrest: the role of limited English proficiency. *Resuscitation*; 2011. 82(6): 680-684. [↑](#footnote-ref-16)
17. Nuno, T., et al. Disparities in telephone CPR access and timing during out-of-hospital cardiac arrest. *Resuscitation*; 2017. 115: 11-16. [↑](#footnote-ref-17)
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