Social Determinants of Health (SDOH) and Cultural Competency in Substance Use Treatment

Grant Hovik, MA
UCLA ISAP

Tuesday, July 13th, 2021


OASIS-TTA
Opioid and Stimulant Implementation Support
Training and Technical Assistance
CASE-BASED MAT ECHO CLINICS
Two Monthly ECHO Clinics
– General and Tribal
Clinical Case Reviews
Trauma Informed Approach
MONTHLY STATEWIDE WEB TRAININGS
Treating SUD in Primary Care
Managing Complex Clinical Needs
Addressing Stimulants & Fentanyl
ON-DEMAND LEARNING
EARN FREE CME/CE
Fundamentals of MAT
Buprenorphine Starts
MAT in Special Populations
QUARTERLY TRIBAL PROVIDER TRAININGS
Tribal Health Issues
Culturally Informed Strategies
Rural and Urban Settings
DIRECT MENTORSHIP & CONSULTATION
Individualized Support from Expert Consultants
One-on-One Mentorship by Phone or Video Conference
CALIFORNIA HUB AND SPOKE
IMPLEMENTATION SUPPORT
Learning Collaboratives
Direct Technical Assistance
Enhancing Access to Care
Ensuring Sustainability
OASIS-TTA SERVICES ARE FREE
To register, request services, or learn more visit
www.uclaisap.org/oasis-tta

The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Disclosure

I do not have relevant financial relationships with commercial interests.

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PACIFIC SOUTHWEST attc

UCLA

At the completion of the activity, the learners can:

1. Recall at least two differences between health equity and health equality.
2. Define social determinants of health and identify and explore at least three ways they may affect the population you serve.
3. Discuss stigma and at least three impacts it has on the patients we treat.
4. Explore the theoretical framework of intersectionality and explain at least two ways that multiple overlapping social identities can impact an individual.

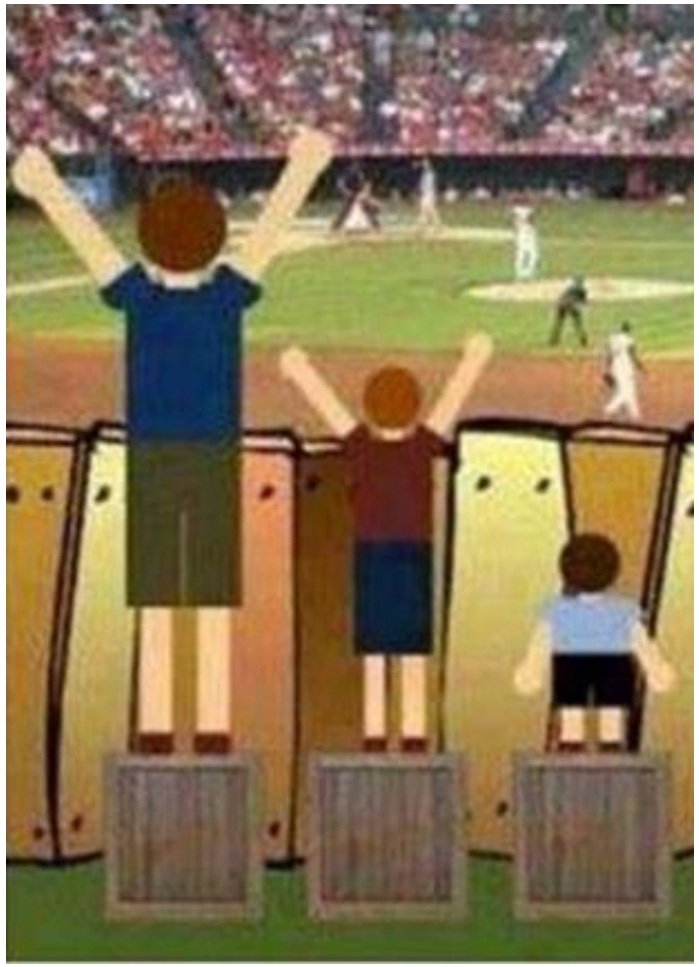
Structural Factors:

Social Determinants of Health and Health Outcomes

Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.

Equality vs Equity

What's the difference?



Equality

Equity

Social Determinants of Health

Life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, *whose distribution across populations* effectively determines length and quality of life.

Reference: James S. (2002)

Health Equity

- The opportunity for everyone to attain his or her full health potential
- No one is disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance.
- Distinct from health equality

Reference: Whitehead M. et al

Health Equity

- “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

Reference: What Is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation, 2017

Health Inequities

- Systematic and unjust distribution of social, economic, and environmental conditions needed for health
  - Unequal access to quality education, healthcare, housing, transportation, other resources (e.g., grocery stores, car seats)
  - Unequal employment opportunities and pay/income
  - Discrimination based upon social status/other factors

Reference: Whitehead M. et al

Health Disparities

- Differences in the incidence and prevalence of health conditions and health status between groups, based on:
  - Race/ethnicity
  - Socioeconomic status
  - Sexual orientation
  - Gender
  - Disability status
  - Geographic location
  - Combination of these

Discussion: Health Inequities

- What social, economic, or environmental conditions affect your whole community (e.g., air pollution, high concentration of fast food restaurants, inadequate public transportation system)?
- What conditions differentially affect subgroups in your community?
- Why are these conditions experienced differentially for subgroups in your community?

Social Determinants of Health

- Access to health care
- Access to resources
- Education
- Employment
- Environment
- Income/Poverty
- Insurance Coverage
- Housing
- Racism/Discrimination
- Segregation
- Transportation

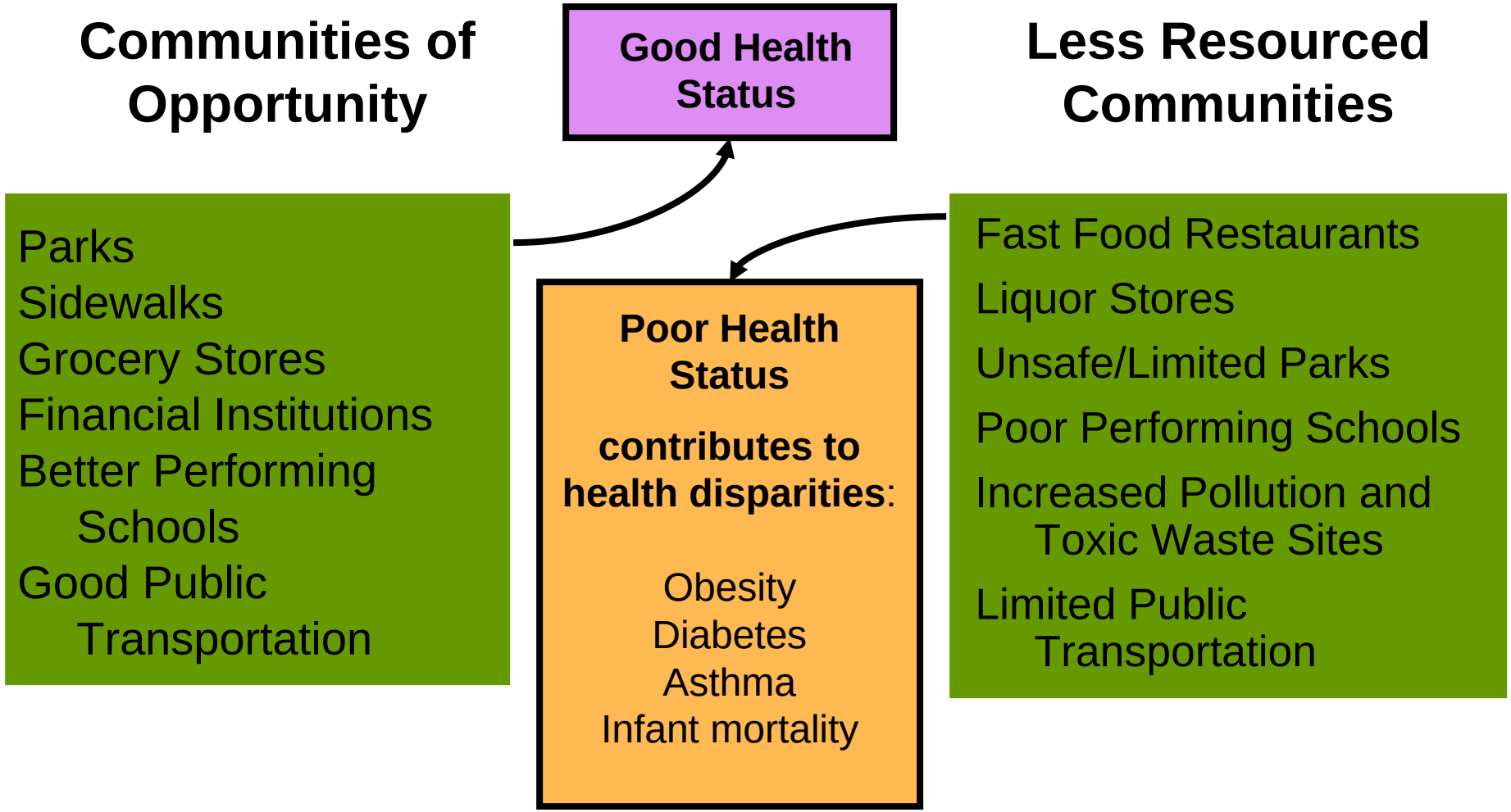
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provide Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education		Stress	Quality of Care
Support	Walkability				
	Zip Code/ Geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Kaiser Family Foundation, KFF, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, May 10, 2018, https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Place Matters



Reference: PolicyLink

Examples of Health Inequities

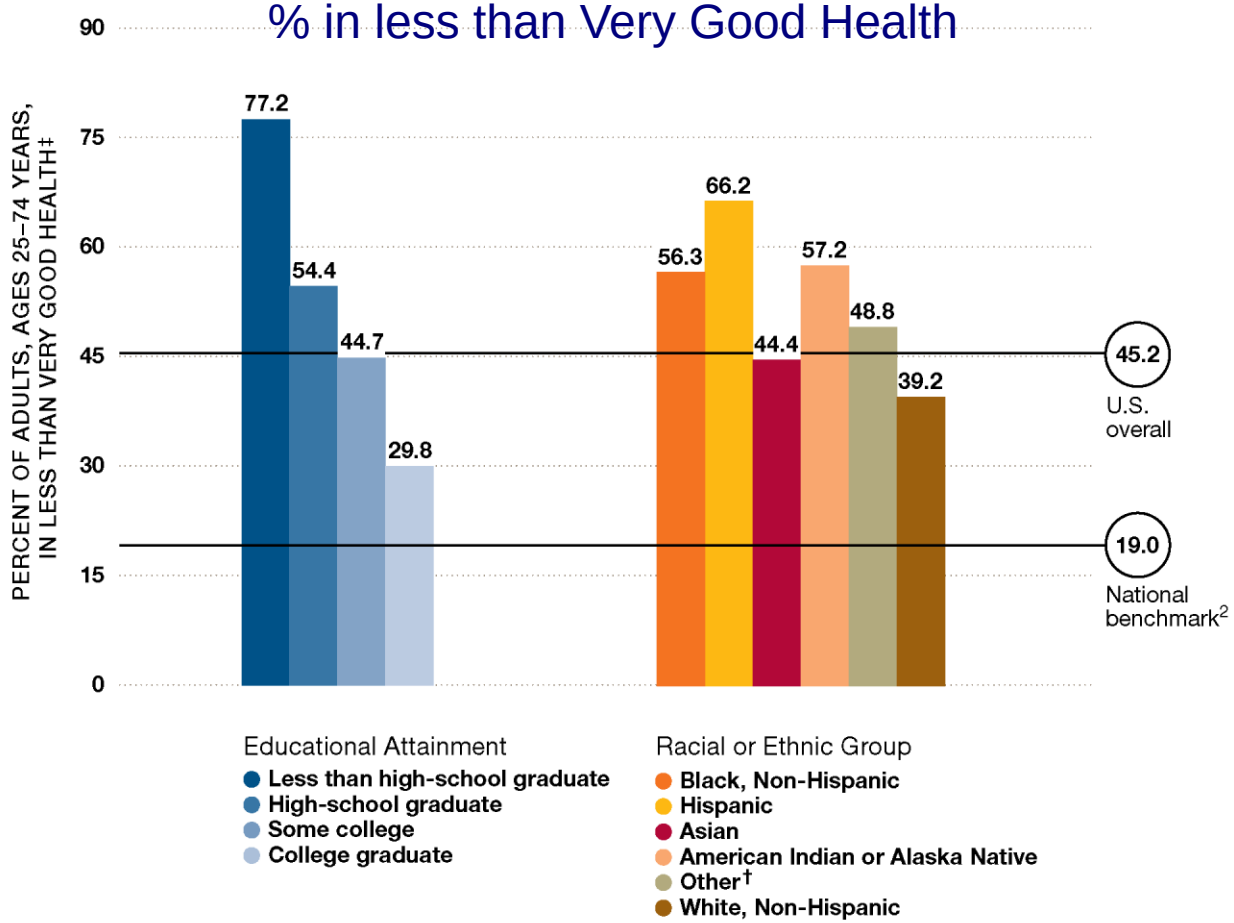
Education	Infants born to African American mothers with only a high school education were **2.2 times more likely to die** in the first year of life compared to their White counterparts.
Income	Low socioeconomic status is associated with an **increased risk for many diseases**, including arthritis, diabetes, chronic respiratory diseases, cervical cancer and frequent mental distress.[1]
Access to resources	Lower income and racial/ethnic minority communities are less likely to have **access to grocery stores** with a wide variety of **fruits and vegetables**.[2,3]

References: [1]Schulz et al. (2018), [2]Williams, Priest, & Anderson (2016), [3]Baker, et al (2006)

UNITED STATES:
Gaps in Adult Health Status

ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

% in less than Very Good Health



In the United States overall, adult health status[1] varies by level of educational attainment and racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are more than 2.5 times as likely—and those who have graduated from high school are nearly twice as likely—to be in less than very good health.
- Non-Hispanic white adults fare better than any other racial or ethnic group.

Comparing these rates against the national benchmark[2] for adult health status reveals that, at every education level and in every racial or ethnic group, adults in this country are not as healthy as they could be.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

1 Based on self-report and measured as poor, fair, good, very good or excellent.

2 The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

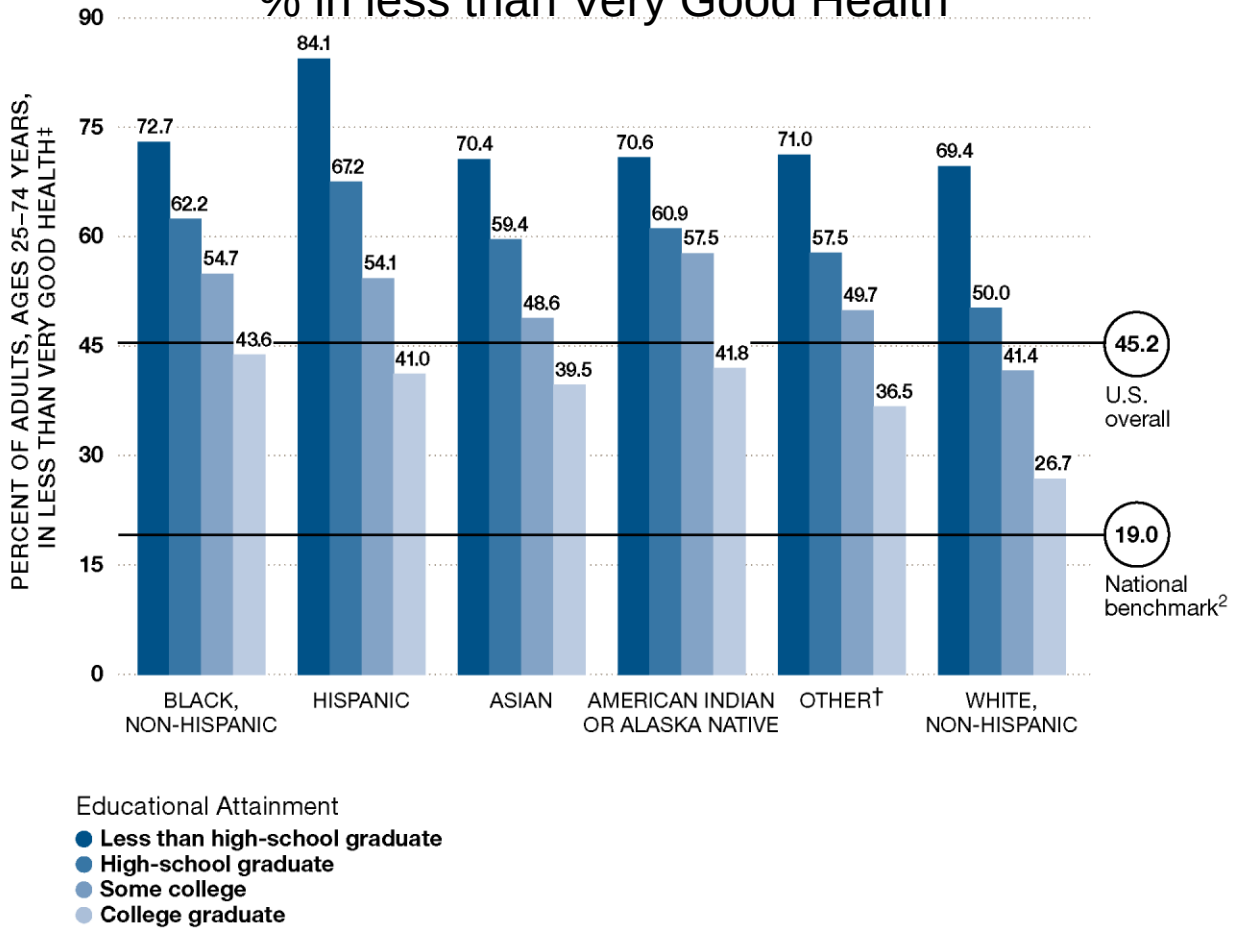
† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults in the state in 2005-2007.

‡ Age-adjusted.

www.commissiononhealth.org

Education Is Linked With Health Regardless of Racial or Ethnic Group

% in less than Very Good Health



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ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

Differences in adult health status[1] by education do not simply reflect differences by racial or ethnic group; nor do they simply reflect differences between the least-educated and most-educated groups. Both educational attainment and racial or ethnic group matter for a person's health.

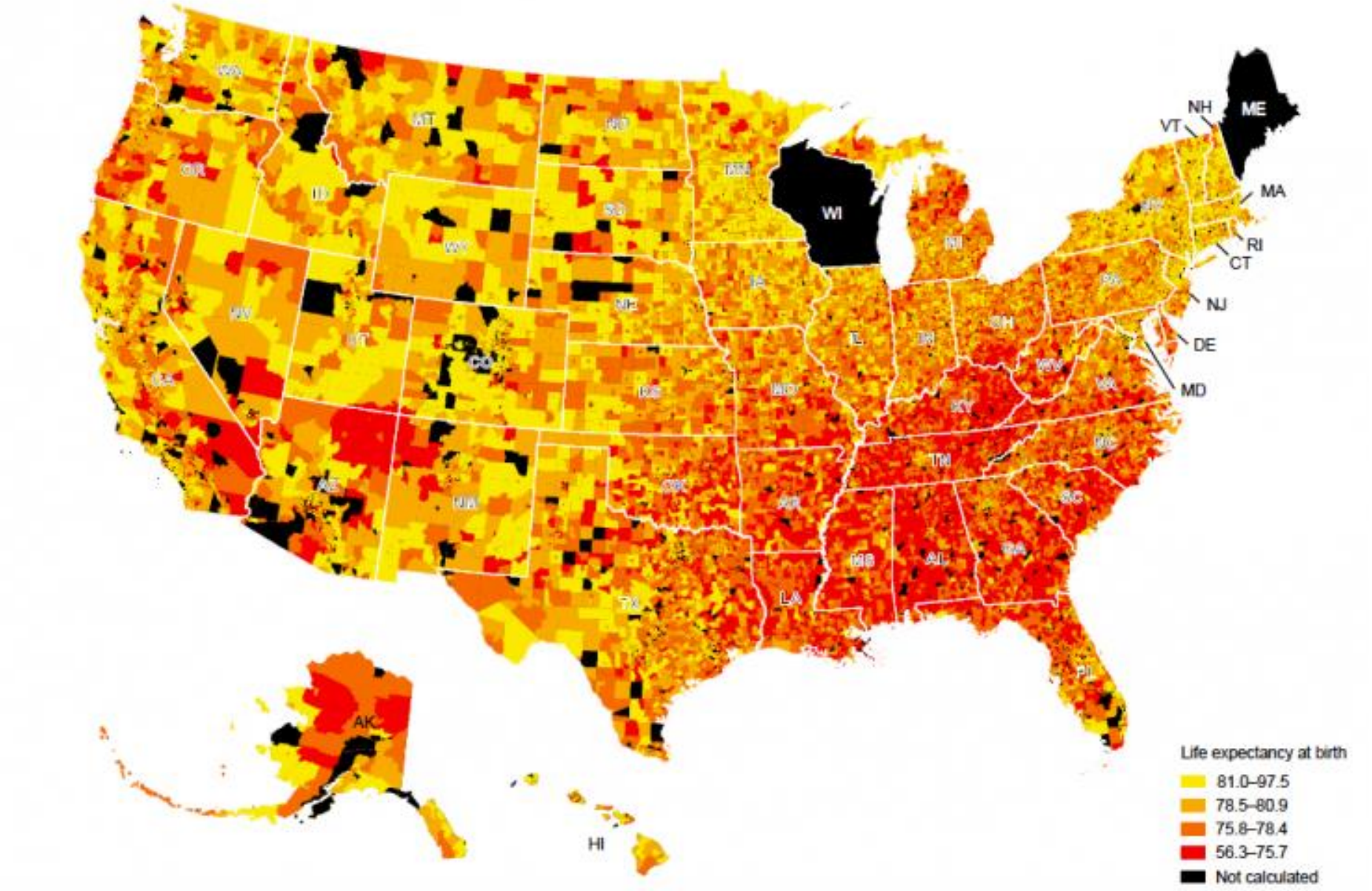
- Within each racial or ethnic group, a steep education gradient is evident. Adult health status improves as educational attainment increases. Among non- Hispanic whites, for example, adults who have not graduated from high school, those who have only completed high school and those who have some college education are 2.6, 1.9 and 1.6 times as likely to be in less than very good health as college graduates.
- At nearly every level of education, non-Hispanic white adults fare better than adults in any other racial or ethnic group.

Health shortfalls are even more dramatic when considering the level of adult health that should be attainable. At every level of education in every racial or ethnic group, the percentage of adults in less than very good health exceeds the national benchmark.[2]

Examples of Health Disparities

Infant and maternal mortality	Mortality rate for infants of mothers with **less than 12 years** of education was **1.5 times higher** than for infants of mothers with 13 or more years. Higher mortality rate for mothers: 37.3 Non-Hispanic Black women, 14.9 Non-Hispanic White women and 11.8 Hispanic women per 100,000 live births.	CDC, 2008, 2018
Diabetes	From 2017-2018, American Indians/Alaska Native (13.6%), Black, non-Hispanic (11.7%), and Hispanic (12.5%) people were all **significantly more likely to have diabetes** than White, non-Hispanic people (7.5%).	2017-2018 National Health Interview Survey CDC
HIV/AIDS	Black/African Americans (~13% of US pop), accounted for **42% of the new HIV diagnoses** in 2018.	CDC, 2020 – HIV Surveillance Report
Suicidality	From 2009-2018, American Indian/Alaska Native males 15–24 years of age were **over 2 times more likely to die from suicide** compared to the rest of US population.	CDC, 2020

Across America, Differences in How Long and How Well We Live



NATIONAL CENTER FOR HEALTH STATISTICS/CDC

Effects of Racism in Healthcare

- Black Americans are regularly undertreated for pain compared to their white counterparts
  - One study found black children were less likely than white children to receive pain medication during ER visits for appendicitis[1]
  - Black veterans are less likely to be prescribed opioids than white veterans[2]
- A 2016 survey of medical students showed half of white students believed black patients feel less pain than white patients due to physiological differences[3]
  - The white medical students who held these beliefs were also more likely to suggest inappropriate medical treatment for black patients.
  - This is not medically accurate. These myths likely relics of slavery.

SUD Historical Context

- Opioid prescriptions disproportionately went to White patients, due to access to care and insurance issues, and belief that Black patients exaggerated their self-reports of pain
- As non-medical opioid misuse increased in White communities, rather than incarceration, regulators instituted:
  - Prescription Drug Monitoring Programs
  - Voluntary take-back programs for unused medication
  - Dissemination of naloxone to reverse overdoses
  - Passed Good Samaritan laws to protect people calling 911 for a drug overdose
- Arrest rate for sale or possession of Rx drugs was 25% of that for heroin or cocaine use

Source: Hansen & Netherland, 2016

SUD Historical Context (3)

- 2002: FDA approves buprenorphine
- By 2005, 91% of patients on buprenorphine were White, mostly college educated, employed, and dependent on prescription opioids
- Methadone patients, however, more likely to be people of color without college education, often unemployed, and heroin users
- Buprenorphine marketing was demographically targeted, largely featuring images of White people

Source: Hansen & Netherland, 2016

Stigma and SDOH

- 3 important stigma mechanisms:
  - **Enacted stigma:** degree to which people believe they have actually experienced prejudice and discrimination
  - **Anticipated stigma:** degree to which people expect they will experience prejudice and discrimination
  - **Internalized stigma:** degree to which people endorse/ believe society's negative beliefs and feelings

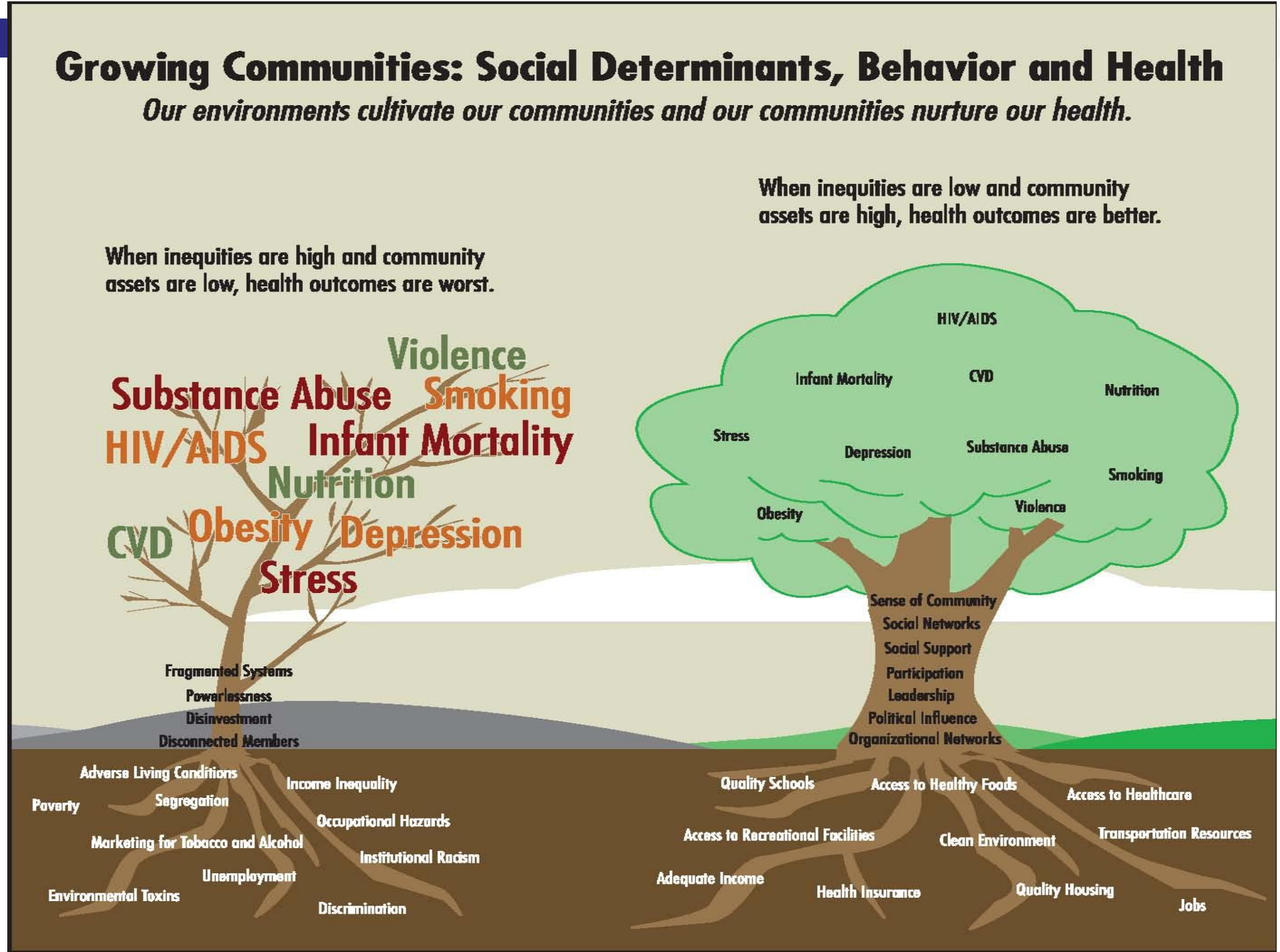
Source: Earnshaw & Chaudoir, 2009

Stigma and SDOH

- In one study (Hatzenbuehler et al., 2008):
  - Enacted stigma predicted substance use
  - Anticipated stigma predicted depression
  - Internalized stigma predicted sexual risk behavior

Growing Communities: Social Determinants, Behavior and Health

Our environments cultivate our communities and our communities nurture our health.



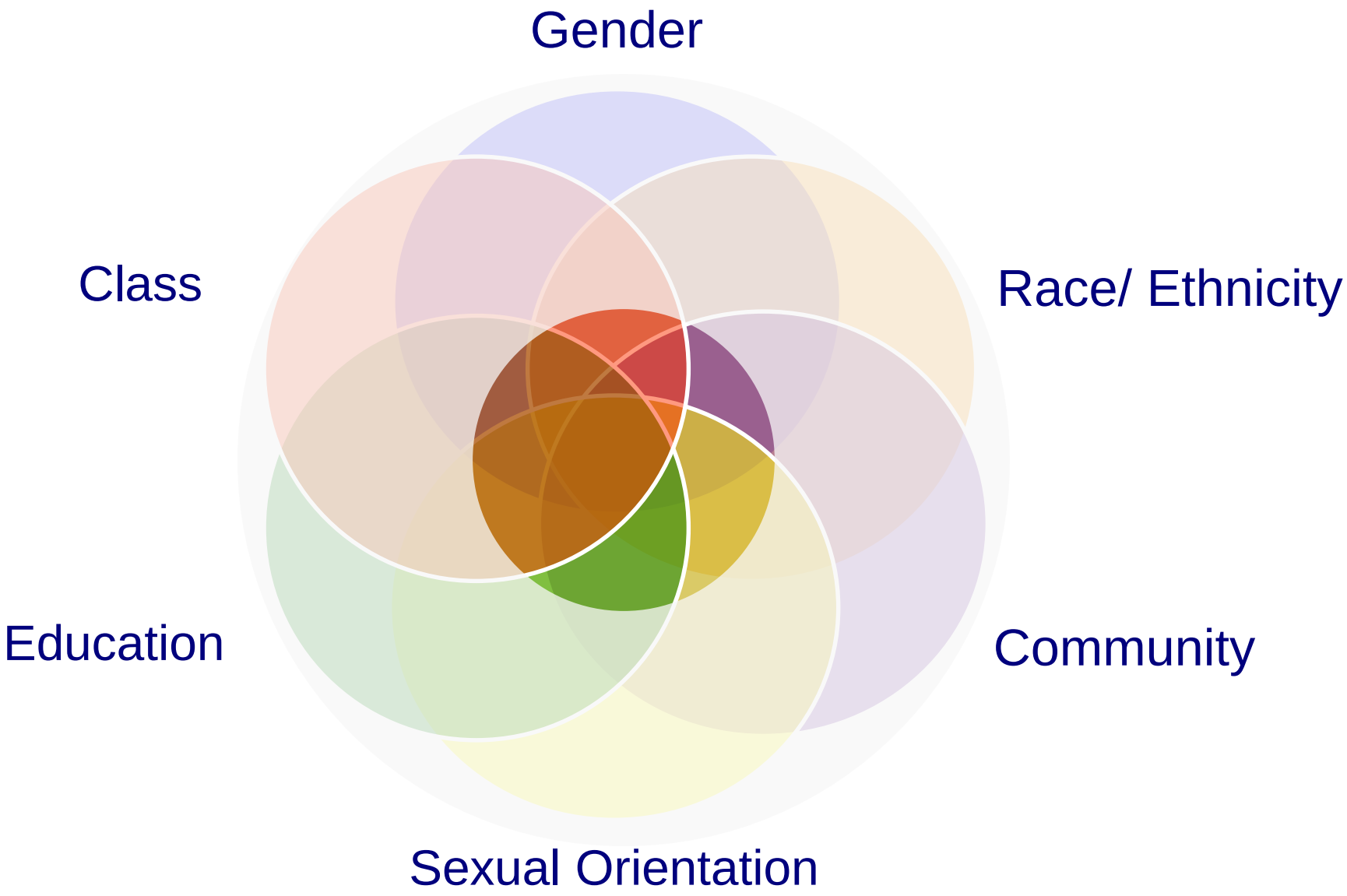
Working with an Individual:

Cultural Competency and Cultural Humility

Intersectionality

Intersectionality: “a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e. racism, sexism, heterosexism, classism) at the macro social-structural level.” (Bowleg, 2012)

Intersectionality



Intersectionality

- Black & Latina sexual minority women are 4 times more likely to have substance use problems than heterosexual women of color.
- Black & Latina sexual minority women and twice as likely as White sexual minority women to have substance use problems (Mereish & Bradford, 2014)
- This differences highlight the importance of taking into consideration multiple intersecting social identities.

Cultural Practice Perspectives

What Is

…an integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, roles, relationships, manners of interacting, and expected behaviors of a racial, ethnic, religious or social group.

National Center on Cultural Competence, http://www.nccccurricula.info/glossary.html

Cultural Patterns

Can be used to understand groups of people

These patterns are not frozen, or static, but open to exceptions since many individuals have experiences that are not shared by their group.

Cultural Competence

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations

US Department of Health & Human Services, Office of Minority Health, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11

Cultural Humility:

Cultural Humility

- "Lifelong process of learning, self-examination & refinement of one's own awareness, knowledge, behavior and attitudes on the interplay of power, privilege and social contexts."

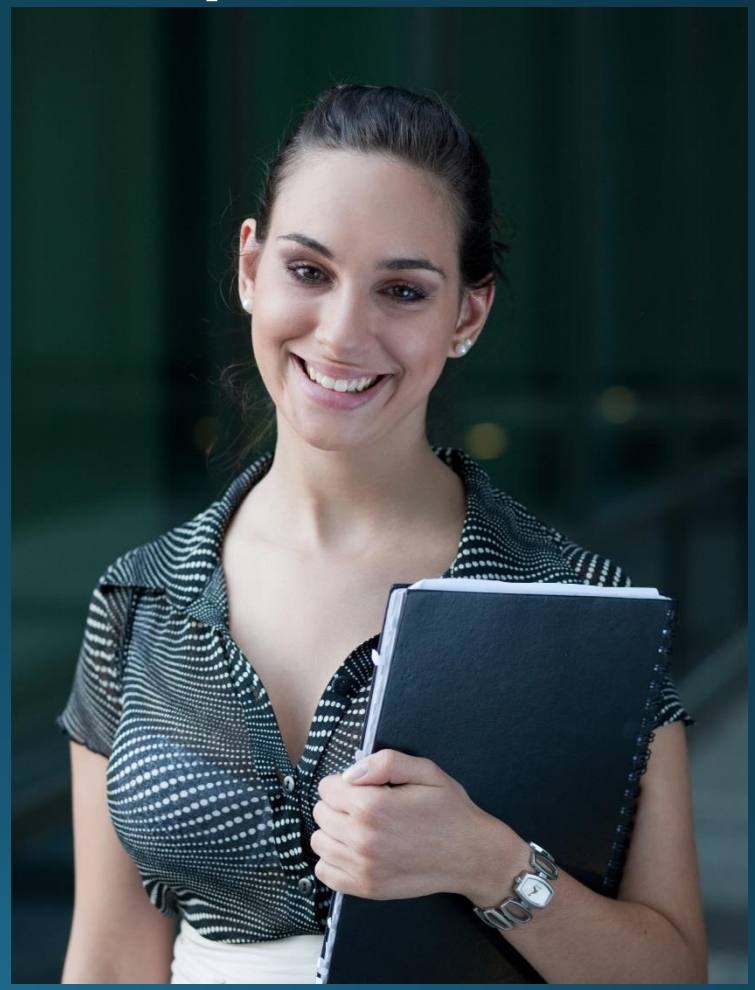
Tervalon, M. & Murray-Garcia, J. (1998, Journal of Health Care for the Poor and Underserved, 9(2), 117

Practice Cultural Humility:

Cultural humility invites providers to:

- Engage in self-reflection and self-critique.
- Bring into check the power imbalances, by using patient-focused interviewing and care.
- Assess anew the cultural dimensions of the experience of each patient.

Tervalon & Murray-Garcia 1998; Office of Minority Health. 2000; Smedley, et al., 2003



Practice Cultural Humility:

Cultural humility invites providers to cont.:

- Relinquish the role of expert to the patient, becoming the student of the patient.
- See the patient's potential to be a capable and full partner in the therapeutic alliance.
- Redress the imbalance of power inherent in physician-patient relationships.
- Challenge ourselves in identifying our own values as not the "norm."
- Remain open to learning.

Tervalon & Murray-Garcia 1998; Office of Minority Health. (2000); Smedley, et al., 2003.

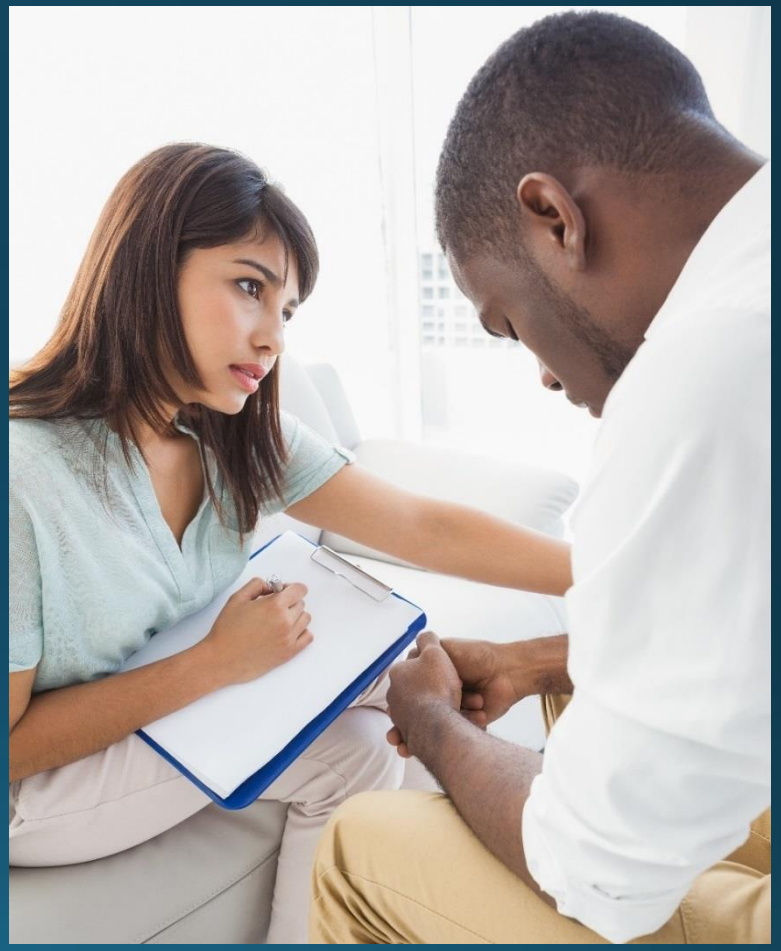
Cultural Humility:

Skills for bridging perspective:

- Active listening, by focusing attention on to what the person is saying and use head nods and utterances that indicate you are listening to them.

- Reflecting, by using the client's words to say back to them what it is you heard – "be a mirror".

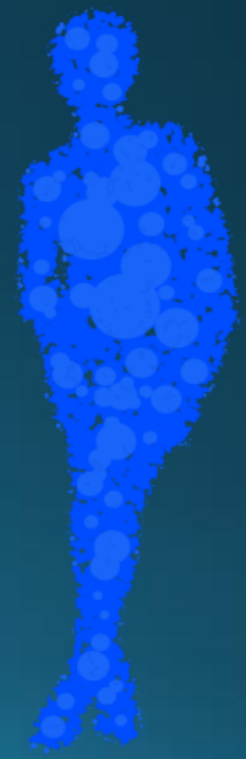
"Cultural humility requires consistent self-reflection; check in with yourself… forever"



Implicit Bias

- **Recognize** that implicit bias is in you through a lifetime of conditioning
- **Know** that implicit bias adversely affects decision making
- **Take measures** to identify and assess for your own implicit bias

"Be open to someone's individuality. Just because you've worked with one _____, doesn't mean the next _____ will be anything like them."



Diana Padilla, Cultural Expert, Program Manager, NeC-ATTC, NDRI-USA

Provider Considerations:

Provider recommendations cont.:

- Seek clinical supervision if there are issues or feelings about working with any individuals.
- Working with your feelings and reactions toward a client (counter-transference) is an ethical obligation and requires supervision

Working with an Organization:

Culturally and Linguistically Appropriate Services (CLAS) Standards

Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

"The CLAS Standards are intended to advance health equity, improve quality of care and help eliminate health care disparities by providing a blueprint for ***individuals*** and health and health care ***organizations*** to implement culturally and linguistically appropriate services."

OMH Home, Blog: National Partnership for Action, What Do the New CLAS Standards Mean for Behavioral Health? Huang, L., PhD, 7/30/13

Why Implement CLAS Standards in Your Settings?

- To respond to current and projected demographic changes in the United States
- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds
- To improve the quality of services and health outcomes
- To meet legislative, regulatory and accreditation mandates
- To decrease the likelihood of liability/malpractice claims

The National Center for Cultural Competence, The Compelling Need for Cultural and Linguistic Competence, Retrieved on March 16, 2020.

Enhanced National CLAS Standards


(1)


(2-4)


(5-8)


(9-15)

1. Principle Standard
2. Governance, Leadership, Workforce
3. Communication and Language Assistance
4. Engagement, Continuous Improvement and Accountability

Principle Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. (How?)
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance (1 of 2)

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Communication and Language Assistance (2 of 2)

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia **materials** and signage in the languages commonly used by the populations in the service area.

Questions to Consider

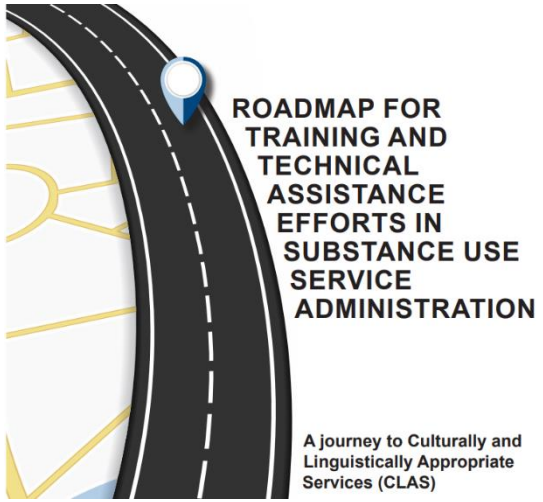
1. What cultures do you see in your community of practice?
2. What groups or communities in your service are do you feel are especially vulnerable in your setting?
3. What questions or concerns do you have about navigating cultural and language barriers for persons of specific racial, ethnic and linguistic minorities, people with disabilities, and sexual orientations and gender identities?

Resources

Organizational Assessment Tools

- **Coalition for Communities of Color, Tool for Organizational Self-Assessment Related to Racial Equity**
  https://racc.org/wp-content/uploads/buildingblocks/foundation/CCC%20-%20Tool%20for%20Organizational%20Self-Assessment%20Related%20to%20Racial%20Equity.pdf
- **Racial Equity Tools, Organizational Assessment Tools and Resources,**
  https://www.racialequitytools.org/resources/plan/informing-the-plan/organizational-assessment-tools-and-resources
- **Michigan State University, Equity Organizational Self-Assessment,**
  Microsoft Word - equity org self assessment_11-5-18.docx (systemexchange.org)
- **Annie E. Casey Foundation, Organizational Self-Assessment,**
  https://www.culturalyork.org/wp-content/uploads/Organizational-Self-Assessment.pdf

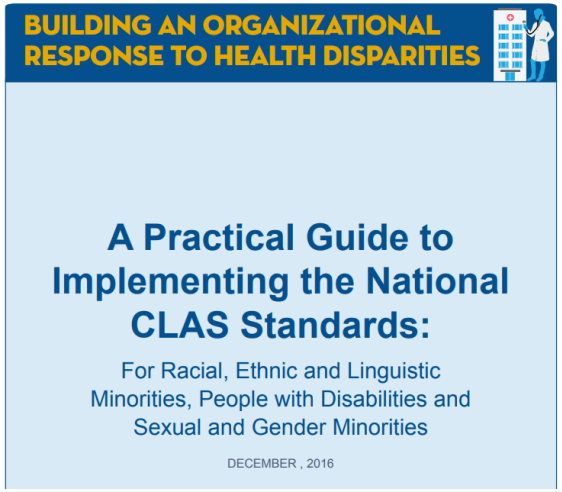
CLAS Standards Resources



Roadmap for Technical Assistance Efforts in Substance Use Services Administration

ATTCnetwork, Building Health Equity and Inclusion, Free Resources

Think Cultural Health (OMH)

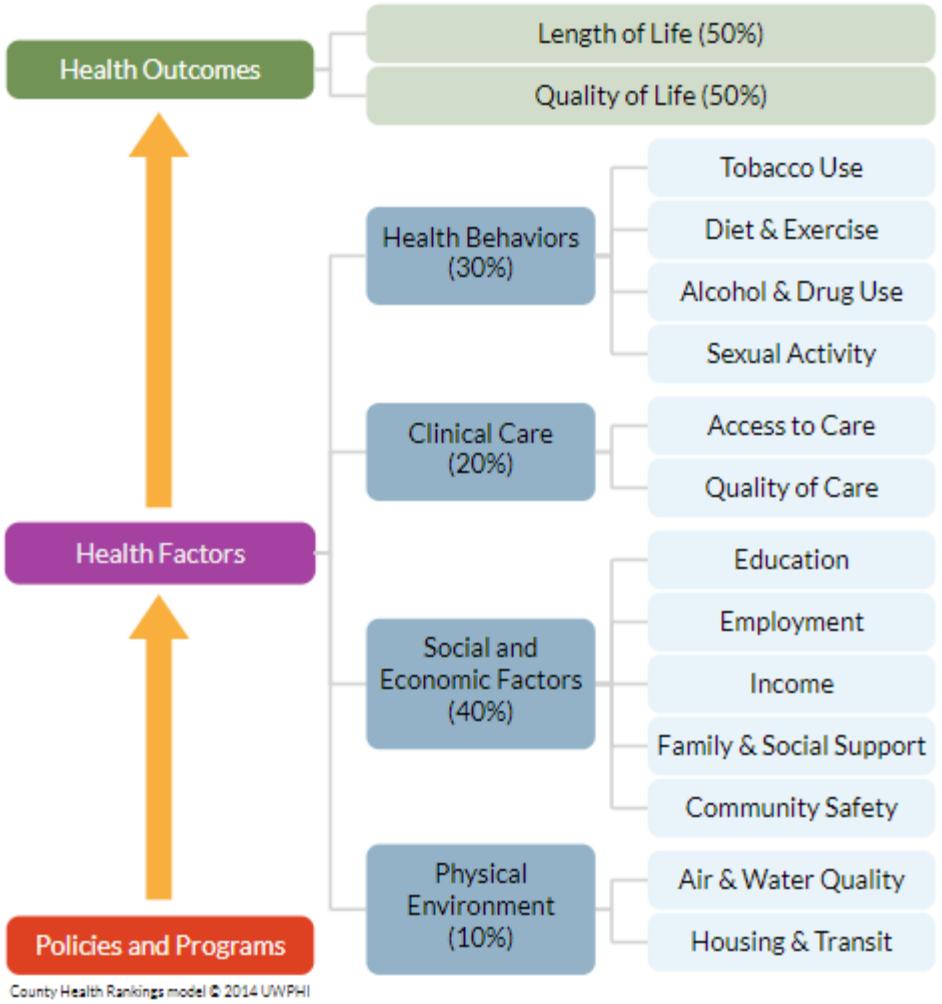


A Practical Guide to Implementing the National CLAS Standards

County Health Rankings

- The County Health Rankings & Roadmaps program compares the health of nearly all counties in the United States to others within its own state.
- The program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
- https://www.countyhealthrankings.org/

County Health Rankings



https://www.countyhealthrankings.org/

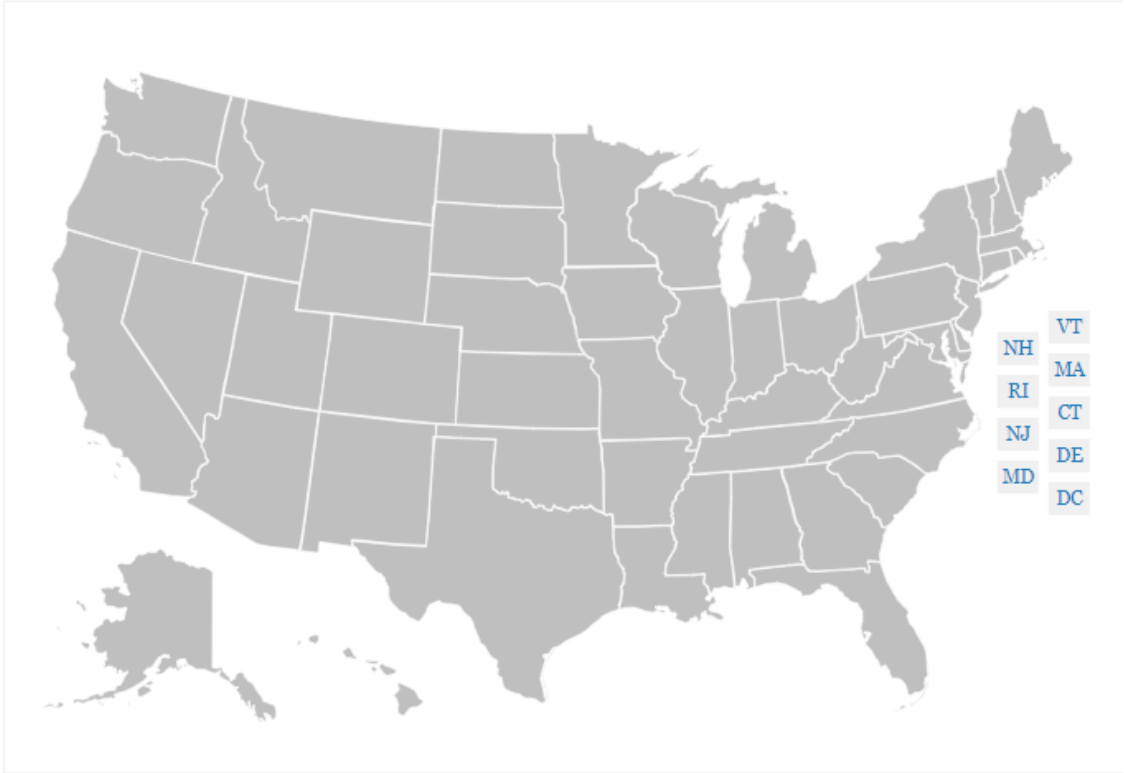
County Health Rankings

How Healthy is Your Community?

The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work, and play. They provide a starting point for change in communities.

Enter your state, county, or ZIP Code

Search



https://www.countyhealthrankings.org/

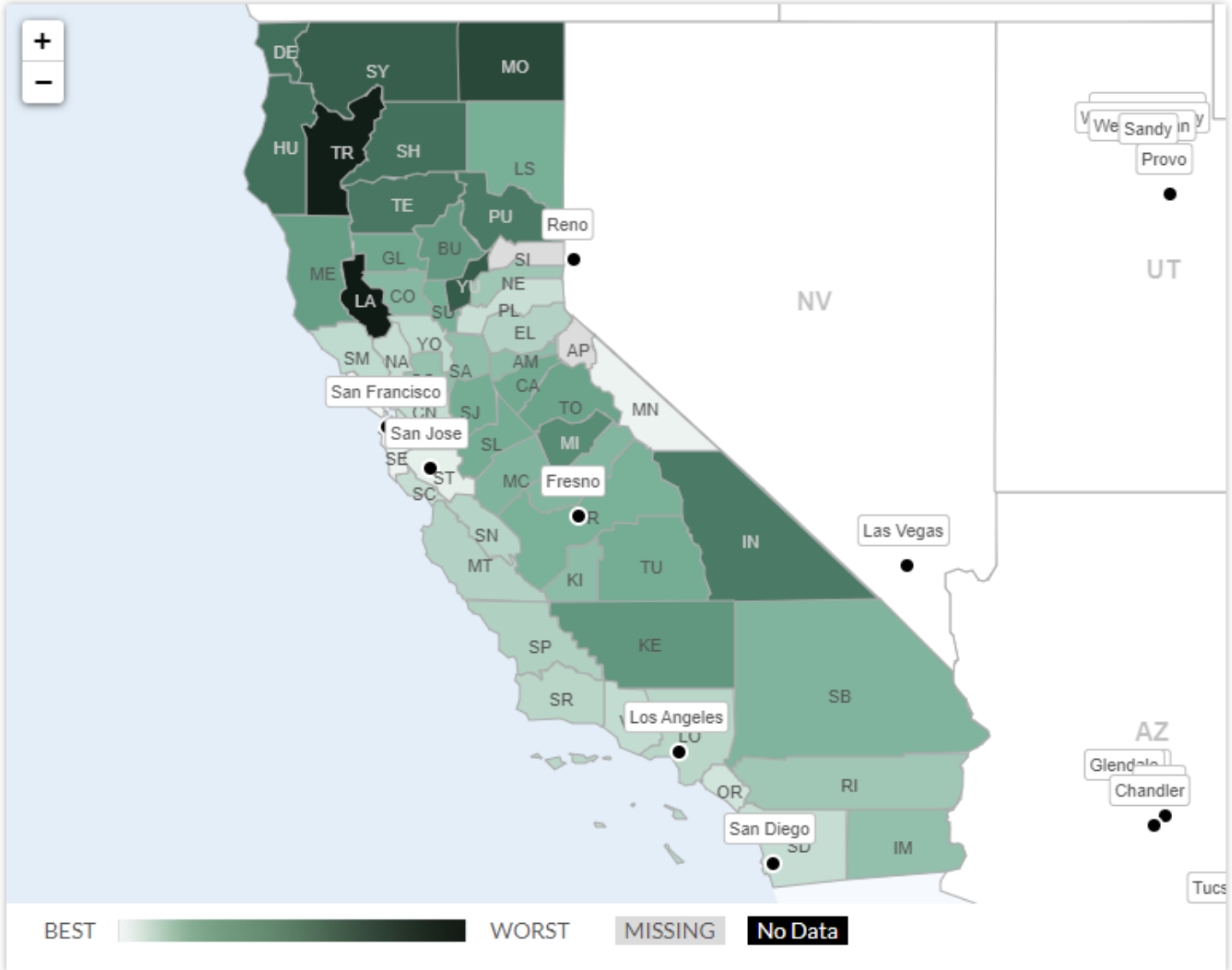
County Health Rankings

Premature death

Years of potential life lost before age 75 per 100,000 population (age-adjusted).

The 2020 County Health Rankings used data from 2016-2018 for this measure.

Map | Data | Description | Data Source



County Health Rankings

Los Angeles (LO)

Show areas to explore Show areas of strength

County Demographics +

		Los Angeles County	Trend	Error Margin	Top U.S. Performers	California	Rank (of 58)
Health Outcomes							21
Length of Life							16
Premature death		5,000		5,000-5,100	5,500	5,300	
Quality of Life							27
Poor or fair health		16%		16-17%	12%	17%	
Poor physical health days		3.6		3.5-3.6	3.1	3.5	
Poor mental health days		3.6		3.5-3.7	3.4	3.5	
Low birthweight		7%		7-7%	6%	7%	
Additional Health Outcomes (not included in overall ranking) +							
Health Factors							32
Health Behaviors							12
Adult smoking		11%		11-11%	14%	11%	
Adult obesity		22%		20-23%	26%	24%	
Food environment index		8.5			8.6	8.9	
Physical inactivity		16%		15-18%	20%	18%	
Access to exercise opportunities		98%			91%	93%	
Excessive drinking		19%		18-19%	13%	19%	
Alcohol-impaired driving deaths		25%		25-26%	11%	30%	

County Health Rankings

	Los Angeles County	Trend	Error Margin	Top U.S. Performers	California	Rank (of 58)
Clinical Care						49
Uninsured	10%		10-10%	6%	8%	
Primary care physicians	1,370:1			1,030:1	1,260:1	
Dentists	1,160:1			1,240:1	1,180:1	
Mental health providers	290:1			290:1	280:1	
Preventable hospital stays	4,346			2,761	3,598	
Mammography screening	32%			50%	36%	
Flu vaccinations	38%			53%	41%	
Additional Clinical Care (not included in overall ranking) +						
Social & Economic Factors						30
High school graduation	82%			96%	83%	
Some college	63%			73%	65%	
Unemployment	4.7%			2.6%	4.2%	
Children in poverty	20%		19-21%	11%	17%	
Income inequality	5.4		5.3-5.4	3.7	5.3	
Children in single-parent households	35%		34-35%	20%	31%	
Social associations	5.7			18.4	5.9	
Violent crime	488			63	421	
Injury deaths	39		39-40	58	50	

County Health Rankings

	Los Angeles County	Trend	Error Margin	Top U.S. Performers	California	Rank (of 58)
Physical Environment						58
Air pollution - particulate matter	14.2			6.1	9.5	
Drinking water violations	Yes					
Severe housing problems	33%		33-34%	9%	27%	
Driving alone to work	74%		74-74%	72%	74%	
Long commute - driving alone	50%		49-50%	16%	41%	
Additional Physical Environment (not included in overall ranking) +						

Centers for Disease Control and Prevention (CDC)

https://www.cdc.gov/socialdeterminants/

- Great repository of research
- Tools for Putting SDOH into Action
- Policy Resources to Support SDOH

Background

- WHO Commission on SDOH
  www.who.int/social_determinants/thecommission/en/index.html
- *Unnatural Causes* documentary
  www.unnaturalcauses.org/
- NACCHO Health Equity and Social Justice Committee
  www.naccho.org/topics/justice/mission.cfm
- RWJ Commission on SDOH
  www.rwjf.org/pr/product.jsp?id=41008
- CDC Expert Panel on SDOH
  www.healthyohioprogram.org/ASSETS/AF886060E94E4823A9338F7E68139947/hepanel.pdf
- IOM Committee in SDOH
  www.iom.edu/Activities/SelectPops/HealthDisparities.aspx
- IOM Local Government Actions to Prevent Childhood Obesity Report
  www.iom.edu/Reports/2009/ChildhoodObesityPreventionLocalGovernments.aspx
- Healthy People 2020 Report
  www.healthypeople.gov/
- PolicyLink
  http://www.policylink.org/site/c.lkIXLbMNJrE/b.6728307/k.58F8/Why_Place___Race_Matter.htm#

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OASIS-TTA On-Demand Courses

Fundamentals of Medications for Addiction Treatment (MAT)		
Course Title and Link	**Course Length**	**Credit / Contact Hours**
Addiction Overview	30 Minutes	0.5 CME
Demystifying DEA's Role in MAT Regulation & Implementing a Zero Risk Program	1 Hour	1.0 CE 1.0 CME
Opioids as an Emergency	1 Hour	1.0 CE 1.0 CME
Substance Use Navigators: Changing Roles in the Pandemic	1 Hour	1.0 CE 1.0 CME
Buprenorphine		
Course Title and Link	**Course Length**	**Credit / Contact Hours**
Starting Treatment: Buprenorphine Induction 101	1 Hour	1.0 CE 1.0 CME
Understanding Buprenorphine Formulations and Clinical Guidelines for Use	1.5 Hours	1.5 CE 1.5 CME
Shared Medical Appointments for MAT Treatment	1 Hour	1.0 CE 0.75 CME
MAT in Special Populations		
Course Title and Link	**Course Length**	**Credit / Contact Hours**
Treating Pregnant Women with Opioid Use Disorder	1 Hour	1.0 CE 1.0 CME
Treating Pain and Opioid Use Disorder	1 Hour	1.0 CE 1.0 CME