Community Health Implementation Plan (CHIP) FY 2017-2019

Community Health Action Plan (CHAP) FY 2018

Area Served

Jefferson County, Clear Creek County and a portion of Denver County

Priorities

- Behavioral Health
- Healthy Eating Active Living (HEAL)/Obesity
- Injury Prevention
- Access to Health Care
Introduction

The Patient Protection and Affordable Care Act, enacted March 23, 2010, added new requirements for nonprofit hospitals to maintain their tax-exempt status, including a requirement to conduct a Community Health Needs Assessment (CHNA) once every three years to gauge the health needs of their communities and to develop strategies and implementation plans for addressing them.

Additionally, following the CHNA, a Community Health Implementation Plan (CHIP), which defines specific goals on how the prioritized needs will be addressed, is required. A yearly Community Health Action Plan (CHAP) will provide the specific actions and metrics for each goal.

The CHNA, CHIP, and CHAP were conducted in compliance with these new federal requirements and as an opportunity for St. Anthony Hospital and OrthoColorado Hospital to fulfill our commitment to our organizational mission to “extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.”
Community Health Needs Assessment
Every 3 Years
Posted to www.centura.org and individual hospital websites.

Community Health Implementation Plan
FY2017-2019
An overarching 3 year strategy to address prioritized needs identified by the CHNA with specific goals.

Community Health Action Plan FY 2017
A one year plan with specific, measurable, achievable, relevant, and time bound (SMART) goals and actions with an evaluation design.

Community Health Action Plan FY 2018
A one year plan with specific measureable, achievable, relevant, and time bound (SMART) goals and actions with an evaluation design.

Community Health Action Plan FY 2019
A one year plan with specific measureable, achievable, relevant, and time bound (SMART) goals and actions with an evaluation design.
Prioritized Need:

Behavioral Health

Decrease rate of Mental Health Hospitalizations by 3% and percentage of adults with a lack of social or emotional support from 18% to 17% among people living in St. Anthony Hospital service area. This will be done by building community and organizational capacity and care team skills to promote mental wellbeing, improve utilization of evidence-based practices in mental health screening, promote care team training, and increase awareness and referrals to appropriate mental health resources in partnership with the community.

Our hospitals prioritized behavioral health due to both severity and community alignment. It ranked high in severity due to the relationship between behavioral health status and intentional injury or unintentional injury, such as substance abuse-related injury, as well as poor health outcomes related to comorbidity with chronic diseases.

Jefferson County has a higher prevalence of people without social/emotional support than Colorado (18% vs. 16.9%), which is correlated with poor behavioral health status. Barriers and gaps include lack of screening and, if an issue is identified, stigma associated with behavioral health and insufficient providers to serve the community, especially lower income communities.
Partners and Inputs:

**SAH Resources:** Leadership (SAH and Mountains and North Denver Operating Group), Behavioral Health Providers, Community Health Team, Emergency Departments, Rehabilitation, Discharge, Case Managers, Senior Health, Mental Health First Aid Trainers, Pastoral Care Team, Community Engagement Committee, Agenda for Change Associate Engagement Committee, Volunteer Program

**Centura Resources:** Behavioral Health Council, Centura Health Physician Group, Mental Health First Aid Coordinator, Centura Ambulatory Care Resources: Urgency/Emergency Centers, Home Health, Neighborhood Health Centers,

**Community Resources:** Jefferson County Public Health Preventive Care and Mental Health Resources Coalition, Jefferson Center for Mental Health, Metro Community Provider Network, Family Tree, The Action Center, Jefferson County Public Schools, NAMI, Colorado Community Health Alliance, Jefferson County Human Services, Community Crisis Connection, Consortium for Older Adult Wellness

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Percentage of individuals who lack social or emotional support

<table>
<thead>
<tr>
<th>Jefferson County</th>
<th>Colorado</th>
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<tr>
<td>18%</td>
<td>16.9%</td>
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Goal 1

Improve the detection and treatment of mental health needs through the utilization of evidence-based screening tools in our St. Anthony Hospital service area.

**ACTIVITY 1:** Assess current screening tools, treatment practices and referral processes in Centura Health entry/service points.

**METRICS (How we did for FY17):**
Conducted assessment of Mountains and North Denver Operating Group behavioral health practices.
Inventory created with the identified screening tools, treatment practices and referral processes.

**CHAP FY18:** Monitor current screening tools, treatment practices and referral processes in Centura Health entry/service points to ensure validity as SAH progresses on this goal.

**ACTIVITY 2:** Determine potential for standard screening and referral practice alignment between community and St. Anthony Hospital.

**METRICS (How we did for FY17):**
SAH participated in JeffCO Behavioral Health and Prevention CoIN which developed inventory of screening tools, providers and referral practices used within JeffCo and SAH.

**CHAP FY18:** Utilize data collected and community partnerships of JeffCo CoIN and Hot Spotting Alliance to determine potential for standard screening and referral practice alignment between community and St. Anthony Hospital.

**ACTIVITY 3:** Partner with local public health agencies on implementing a mental health stigma reduction campaign.

**METRICS (How we did for FY17):**
SAH Executives participated in launch of Let’s Talk Colorado Mental Health Stigma campaign on 5/1/17 with Lt. Governor.
Partnered with local public health to engage hospitals in Stigma Campaign.
Developed plan for implementation of campaign with 10 local partner organizations.

**CHAP FY18:** Continue to partner with JeffCo Public Health to deliver mental health stigma campaign rollout to SAH services area.
Goal 2

Promote care team training and education of associates in most appropriate evidence-based screening and referral practices.

**ACTIVITY 1:** Train associates and targeted community members (with reach to populations at risk of behavioral health needs) in Mental Health First Aid (MHFA) and Motivational Interviewing.

**METRICS (How we did for FY17):**
- 2 Motivational Interviewing webinars offered to associates.
- Shifted MHFA focus to development of a Jefferson County strategy that is coordinated across partners providing training. SAH participating in the development of this strategy.

**CHAP FY18:** Partner with 2 community partners to deliver MHFA training to specific target populations that will most benefit from Mental Health First Aid. Provide 2 more webinars on Motivational Interviewing for associates.

**ACTIVITY 2:** Specific groups identified for training on behavioral health and reach of people within each targeted group.

**METRICS (How we did for FY17):**
- MHFA training was provided to School of Mines staff and at 3 Neighborhood Health Centers in our SAH services area.
- SAH participating in the countywide strategic planning for MHFA during which target groups will be identified for future efforts.

**CHAP FY18:** Utilize the countywide strategic assessment to identify target groups and begin training in a coordinated manner within the county and among trainers in a variety of organizations.
Goal 3

Increase awareness of and improve referral to mental health resources (leverage/implement relationships so care systems can work with community partners).

ACTIVITY 1: SAH and Jefferson County buy-in for the identified screening tools, referral systems and tracking processes.

METRICS (How we did for FY17): In progress of identifying screening tools and systems used for screening.

CHAP FY18: SAH and Jefferson County buy-in for the identified screening tools, referral systems and tracking processes.

ACTIVITY 2: Expand existing Jeffco Hotspotting Alliance efforts beyond initial pilot, pending evaluation results (Lutheran, St. Anthony Hospital, Arapahoe House, CCHA, MCPN, JCMH, and JeffCo Public Health).

METRICS (How we did for FY17): Brought Bridges to Care program to SAH to complement JCHA high utilizer efforts. Developed a triage and referral system and measurement system for JCHA and Bridges to Care at SAH. In FY 17, enrolled 25 patients into JCHA and 35 enrolled into Bridges to Care Program.

CHAP FY18: JCHA has undergone a strategic assessment progress to determine how the alliance should move forward with their work in the context of new programs, such as Bridges to Care, in the community. This process will determine next steps for SAH.

ACTIVITY 3: Develop a process and implement an access assessment in places to which people are being referred.

METRICS (How we did for FY17): In development.

CHAP FY18: Develop a process and implement an access assessment in places to which people are being referred.
Goal 4

Develop an internal strategy to support resilience in associates.

**ACTIVITY 1:** Identify several ideas from Associate Engagement internal workgroup to be implemented in FY17.

**METRICS (How we did for FY17):** Implemented the Associate Connection Strategy through which associates are supported to connect outside of work. Two groups supported, affecting 15 associates.

Developed Associated Volunteer strategy to be implemented in FY18.

**CHAP FY18:** Continue to monitor associate engagement opportunities and actively promote the Associate Connection and Associate Volunteer strategies.

**ACTIVITY 2:** Continue quarterly Schwartz Rounds.

**METRICS (How we did for FY17):** 198 associates participated in Schwartz Rounds.

**CHAP FY18:** Continue quarterly Schwartz Rounds and increase associate participation by 5% in FY18.

**ACTIVITY 3:** Conduct a literature review of effective programs in health care for resiliency.

**METRICS (How we did for FY17):** In development.

**CHAP FY18:** Conduct a literature review of effective programs in health care for resiliency.
Goal 5

Build Primary Prevention strategies through providing positive protective factors for youth in partnership with community organization.

**ACTIVITY 1:** Continue internship programming with Warren Tech to introduce high schools juniors and seniors into healthcare.

**METRICS (How we did for FY17):** Reached 30 Warren Tech students in FY 17.

**CHAP FY18:** Continue internship programming with Warren Tech.

**ACTIVITY 2:** Develop one additional program to provide students exposure to healthcare careers.

**METRICS (How we did for FY17):** Provided community practicum and community health clinical hours to Regis University nursing students. 3 students served with a total of 180 community practicum/clinical hours total. Researching opportunities with other schools for health care programs.

**CHAP FY18:** Develop and implement one additional program to provide students exposure to healthcare careers.

**ACTIVITY 3:** Assess current programs offered in schools, e.g., Life Skills and Sources of Strength, and determine potential for expansion in combination with elementary school adoption.

**METRICS (How we did for FY17):** Assessment to be done in FY 18.

**CHAP FY18:** Assess current programs offered in schools, e.g., Life Skills and Sources of Strength, and determine potential for expansion in combination with elementary school adoption.
PRIORITIZED NEED:
Healthy Eating 
Active Living 
(HEAL)

Increase percent of population at a healthy BMI and decrease incidence of Type 2 Diabetes by building community and organizational capacity and care team skills to promote healthy weight and lifestyles. Reduce obesity and improve utilization of evidence-based practices in screening; promote care team training; and increase awareness and referrals to appropriate resources in partnership with the community.

Healthy Eating and Active Living (HEAL) are associated with overweight/obesity, cardiovascular disease, cancer, diabetes and impact upon joints. St. Anthony Hospital and OrthoColorado Hospital see the outcomes of the lack of Healthy Eating and Active Living in our hospital due to the diseases with the high morbidity rates (cancer, diabetes, cardiovascular disease and stroke). Many of the high utilizers within our Emergency Department are those with more than one chronic disease, many of which are HEAL-related. Diabetes is one of the top four diagnoses in our hospital which is increasing as people age, up to 14% of diagnoses for hospital patients among those sixty-five years and older.

Partners and Inputs: Community Health Team, Consortium for Older Adult Wellness, Neighborhood Health Center and Centura Health Physician Group staff, IT Staff, St. Anthony Hospital staff, Community members, Fall Prevention people, Senior Care Center, St. Anthony Hospital Injury Prevention Coordinator, Nutrition Services Director, Facilities Team, Vendors providing food at hospital, MNDOG Nutritionist, JeffCo Schools Wellness Coordinator and Schools, Healthy Beverage Coalition through JeffCo Public Health, Healthy Schools Coalition through JeffCo Public Health.
Increase utilization of evidence-based practices to screen for health factors and indicators for obesity and related conditions.

**Goal 1**

**ACTIVITY 1:** Assess existing Body Mass Index (BMI) screening and referral processes in St. Anthony Hospital system and Neighborhood Health Centers (NHC).

**METRICS (How we did for FY17):** Current dedicated resource focused on BMI screening and referral at 1 NHC.
Will focus on expansion in FY 18 and when new Electronic Health Record system enables greater focus on this process.

**CHAP FY18:**
METRIC 1: Strengthen processes for BMI screening and referral for replication to additional 2 sites.
METRIC 2: Upon receiving validated EHR data, identify additional gaps in screening and referral within hospital.

**ACTIVITY 2:** Develop referral systems for patients and community members into evidence-based classes.

**METRICS (How we did for FY17):** Resource list developed
Resources identified, and work toward electronic referral system in progress post final wave of new EHR implemented.
261 people participated in evidence-based HEAL programs offered at NHC’s.

**CHAP FY18:**
Increase number of referrals through education of referral system.

Implement continuing education for associates to increase knowledge of clinical tools, methods, and communication strategies to promote healthy weight.

**Goal 2**

**ACTIVITY 1:** Identify 2-3 opportunities to support Motivational Interview training for key clinicians.

**METRICS (How we did for FY17):** To be developed in FY18.

**CHAP FY18:** Focused Motivational Interviewing training strategy will be developed in FY 17.
Goal 3

Increase awareness of and improve referral to healthy eating active living resources at points of service.

**ACTIVITY 1:** Participate in Jefferson County Community Health Improvement Plan, Prevention and Screening Workgroup.

**METRICS (How we did for FY17):** Dedicated community health improvement team staff member participating in workgroup.

**CHAP FY18:** Participate in Jefferson County Community Health Improvement Plan, Prevention and Screening Workgroup.

**ACTIVITY 2:** Increase referrals and participation in evidence-based programs.

**METRICS (How we did for FY17):** Developed summary of evidence-based HEAL programs to increase access to resources. 261 people participated in the programming. Increased HEAL resources through community partnerships: a) GoFarm CSA: access to healthy foods through SNAP, b) Golden Farmers’ Market: SNAP Double Up Bucks program, and c) Weigh and Win at 2 NHC’s.

**CHAP FY18:** Increase number of people referred to evidence-based programming by 25%.

**METRICS (How we did for FY17):** Institution of additional resource to influence primary care providers to integrate referral to evidence based programs for healthy lifestyle self-behavior change programs.

**CHAP FY18:** Expand current education efforts to at least 2 additional primary care settings.
**Goal 4**

**Obtain gold award for the Healthy Hospitals Compact by June 30, 2018. (Current St. Anthony Hospital Baseline: Bronze).**

**ACTIVITY 1:** Create a local advisory team to meet quarterly to assess progress.

**METRICS (How we did for FY17):** Advisory team created and Gold status achieved.

**CHAP FY18:** Maintain status and identify ways to reach platinum status, as possible.

**ACTIVITY 2:** Provide a training on healthy meeting guidelines for administrative support and leaders.

**METRICS (How we did for FY17):** Standards adopted in Community Health and Mission Department for FY17. To be implemented across hospital in FY18.

**CHAP FY18:** Provide a training on healthy meeting guidelines for administrative support and leaders.

**Goal 5**

**Increase water availability and accessibility in area schools to decrease daily caloric consumption through sugar sweetened beverage and soda consumption.**

**ACTIVITY 1:** Work with the JeffCo Health Improvement Network to identify and implement water dispensary program in 9 schools.

**METRICS (How we did for FY17):** METRIC 1: 17 water dispensers placed in 8 schools by leveraging SAH funding.

**CHAP FY18:** Monitor change in use of water consumption in partnership with Jefferson County Schools.

**ACTIVITY 2:** Get feedback and report on progress to coalitions focusing on schools and beverages.

**METRICS (How we did for FY17):** To be done in FY18.

**CHAP FY18:** Get feedback and report on progress to coalitions focusing on schools and beverages.
PRIORITIZED NEED:

Access to Care

Increase the percentage of adults with a regular doctor and percent people who are insured.

St. Anthony Hospital and OrthoColorado Hospital identified access to health care as an urgent issue in our community. As such, we have prioritized access to health care and have developed an implementation plan to increase the number of patients in our communities who have a designated primary care medical home and decrease the number who are uninsured. We will work with the community including The Action Center, local human services, Jefferson County Public Schools, and Metro Community Provider Network, among others.

**Partners and Inputs:** Community Health Advocate (CHA), Eligibility Specialists, Centura Health (system) support of CHA within St. Anthony Hospital, Leadership Support for Eligibility Specialists, Emergency Department Team, including social workers, Centura Health Physician Group Staff, The Action Center, JeffCo Public Schools, Jefferson County Hotspotting Alliance, Emergency Department Staff, Bridges to Care Navigator (Metro Community Provider Network), Community Health Advocate
**Goal 1**

**Increase the number of people enrolled into Medicaid or Commercial Coverage.**

**ACTIVITY 1:** Open Enrollment: Reach out to all uninsured at ER and Urgency centers to assure available coverage.

**METRICS (How we did for FY17):** Coverage availability assessment completed and coverage implemented at SAH ER.

**CHAP FY18:** Open Enrollment: Reach out to all uninsured at ER and Urgency centers to assure available coverage.

**ACTIVITY 2:** Place CHA in Emergency Department and Neighborhood Health Centers for enrollment and Partner with community partners for enrollment assistance.

**METRICS (How we did for FY17):** CHA placed in Golden NHC and Emergency Department. 889 people enrolled into Medicaid and commercial insurance coverage.

**CHAP FY18:** Expand CHA availability for NHC’s based upon need for enrollment assistance.

**Goal 2**

**Decrease overutilization of Emergency Department.**

**ACTIVITY 1:** Participate in county-wide Hotspotting pilot.

**METRICS (How we did for FY17):** Active participant and serving on Leadership Team. Alliance is undergoing a community assessment to determine focus for future.

**CHAP FY18:** Participate in county-wide Hotspotting Alliance, the community assessment and future iterations designed to meet community health needs.

**ACTIVITY 2:** Identify a baseline data set to determine “overutilization” and develop system to screen and identify those eligible for high utilizer programs.

**METRICS (How we did for FY17):** Baseline data set of “overutilization” developed. 60 patients enrolled into Bridges to Care and Hotspotting Alliance programs.

**CHAP FY18:** Continue to refer ED high utilizers to care management programs in the community.
Goal 3

Increase number of people with Primary Care Medical Home (PCMH).

**ACTIVITY 1:** During open enrollment, assess those without PCMH and create process for engagement with primary care provider based on health need/location, etc.

**METRICS (How we did for FY17):** In development.

**CHAP FY18:** During open enrollment, assess those without PCMH and create process for engagement with primary care provider based on health need/location, etc.

**ACTIVITY 2:** Link patients in ED with PCMH following enrollment and when receiving case management.

**METRICS (How we did for FY17):** To be implemented in FY18.

**CHAP FY18:** Link patients in ED with PCMH following enrollment and when receiving case management.
PRIORITIZED NEED:

Injury Prevention

Decrease the number of preventable injuries in the community and those which come into St. Anthony Hospital.

Unintentional Injury was our third priority. The incidence of unintentional injury in our community is higher than in Colorado (50.6/100,000 vs. 45.1/100,000 in population, respectively). The impact of injury upon our hospital system is significant as a Level 1 Hospital treating the most serious injuries within our region and an orthopedic hospital addressing injuries. Additionally, as a community with a large aging population, falls are a contributor to both Emergency Department and in-patient admissions.

**Partners and Inputs:** Injury Prevention Coordinator, Centura Health Physician Group, Emergency Department, St. Anthony Hospital Leadership Support for expansion, Community Health Faith Nurse, Jefferson County Public Health Safe Routes to School Coalition, Community Partners providing bikes to community members, Regional Emergency and Trauma Advisory Council, JeffCo Schools

### Incidence of unintentional injury per 100,000

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<tr>
<th></th>
<th>St. Anthony Community</th>
<th>Colorado</th>
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<tbody>
<tr>
<td>Incidence</td>
<td>50.6</td>
<td>45.1</td>
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50.6

45.1
Goal 1

Decrease the number of hospitalizations due to a preventable fall by increasing the number of people reached through evidence-based programming by 20%.

ACTIVITY 1: Expand STEADI training for health care providers into four new areas of the hospital system, and identify areas in which to expand and provide trainings to associates in these departments.

METRICS (How we did for FY17): Expanded STEADI at Lakewood Senior Health First clinic. Patients with a positive screening are referred to community based health coach for full screening and warm referral to appropriate evidence based program.

CHAP FY18: Continue to expand STEADI and utilize EPIC as a tool for screening and referral.

ACTIVITY 2: Establish referral processes from hospital and NHC’s of patients at risk of falling to fall prevention classes in the community.

METRICS (How we did for FY17): 121 people attended evidence-based fall prevention programs. Continue to expand STEADI and utilize EPIC as a tool for screening and referral. Health outcomes data on fall risk patients referred from pilot clinic showing strong outcomes of successful process.

CHAP FY18: Continue to educate providers on benefit of referral to programs. Expand successful pilot to at least 2 additional community sites and 1 hospital site.

ACTIVITY 3: Coordinate and promote fall prevention classes in the community.

METRICS (How we did for FY17): 10 Stepping On Workshops offered with an average attendance of 10 people per workshop (100 total).

CHAP FY18: Continue to offer Stepping On Workshops in the community setting.
Goal 2

Decrease the number of recreation/leisure activity-related traumatic brain injuries through safe biking practices.

**ACTIVITY 1:** Participate in six community events or school programs to provide helmet fitting and distribution, helmet use promotion and injury prevention education.

**METRICS (How we did for FY17):** 8 events/opportunities to provide helmet fitting and distribution, helmet use promotion and injury prevention education.

**CHAP FY18:** Continue to seek opportunities to partner with our community to promote and provide helmet fitting and distribution, helmet use promotion, and injury prevention education.

**ACTIVITY 2:** Provide bike helmets to people not likely to be able to access them within community.

**METRICS (How we did for FY17):** 1290 helmets provided to people in the community.

**CHAP FY18:** Continue to seek out opportunities to support organizations and events to provide bike helmets to people not likely to be able to access them within the community.
ACTIVITY 3: Participate in coalitions in which policy and environmental changes to promote safe biking are discussed.

METRICS (How we did for FY17): SAH participates in the Jefferson County “Healthy Jeffco” Active Living Coalition, SafeKids Denver Metro, and Foothills RETAC.
Partnering with City of Golden City Planners and the Golden Bicycle Library to promote safe bicycling in the Golden area. Golden Bicycle Library adopted policy to require all participants to wear a helmet with their bicycles.
Partnering with JeffCo coalitions to increase safety on roadways for pedestrians, drivers, and bicyclists, including Complete Street Policies and to support the School Wellness Coalition’s Safer Routes to School.

CHAP FY18:
Continue to actively participate in coalitions and maintain SAH representation on all that align with our CHAP in which policy and environmental changes are discussed.
Population Demographics in St. Anthony Hospital Service

Race

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<tr>
<th>Race</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>White</td>
<td>85.3%</td>
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<tr>
<td>Black</td>
<td>1.38%</td>
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<tr>
<td>Asian</td>
<td>3.11%</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>0.99%</td>
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<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.06%</td>
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<tr>
<td>Other</td>
<td>6.17%</td>
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<tr>
<td>Multiple races</td>
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Ethnicity

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<tr>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Non-Hispanic</td>
<td>66.9%</td>
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<tr>
<td>Hispanic</td>
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Associate's Degree or Higher

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<th>Area</th>
<th>Percentage</th>
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<tr>
<td>St. Anthony Service Area</td>
<td>48.5%</td>
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<tr>
<td>State Average</td>
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High School Graduation Rate

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<th>Area</th>
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<tbody>
<tr>
<td>St. Anthony Service Area</td>
<td>67.6%</td>
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<tr>
<td>State Average</td>
<td>77.6%</td>
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Limited English Proficiency

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<th>Area</th>
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<tr>
<td>St. Anthony Service Area</td>
<td>8.3%</td>
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<td>State Average</td>
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Unemployment Rate

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<th>Area</th>
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<td>3.8%</td>
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<tr>
<td>State Average</td>
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Households Below 200% of Federal Poverty Level

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<th>Area</th>
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<tbody>
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<td>St. Anthony Service Area</td>
<td>28.2%</td>
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<tr>
<td>State Average</td>
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