CALIFORNIA
Health Care Almanac

California Health Care Foundation

REGIONAL MARKETS SERIES

JANUARY 2026

Shasta and Lassen Counties: Facing Dire Health Care Access Challenges with Creativity and Resilience

Summary of Findings

High death rates related to chronic disease, suicide, and drug overdoses compounded by a severe health care workforce shortage and poor access to care are among the challenges facing the rural northeastern California counties of Shasta and Lassen. Shasta County — where about 180,000 of the region's almost 210,000 people live — also struggles with political polarization, with implications for county health services and recruitment of health professionals to the area.

In the face of these difficulties, regional health care and other leaders strive to maximize availability of services and financial sustainability in a policy and regulatory landscape that often fails to recognize the distinctive aspects of rural health care. While some regional providers are thriving, others are financially vulnerable. Moreover, looming budget cuts under the federal House Resolution 1 (HR 1), also known as the "One Big Beautiful Bill Act of 2025," will threaten Medi-Cal coverage for thousands of Shasta and Lassen residents and the viability of essential rural providers. Despite the challenges, local health care leaders remain resourceful and committed to solving problems and collaborating on priorities ranging from reducing workforce shortages to creating new behavioral health care infrastructure that meets essential community needs.

Key factors affecting the local Shasta and Lassen health care market include the following:

- **Access to care is a major problem, with a severe shortage of both primary care providers and specialists.** People often experience long waits to establish a primary care relationship and face difficulty accessing specialty care, with the most significant challenges experienced by those with Medicare and commercial coverage. While Medi-Cal enrollees may also experience access challenges, the network of community health centers (CHCs) in the region prioritizes serving Medi-Cal patients and those without coverage. Despite considerable efforts on workforce development, recruitment, and retention, including many creative approaches, significant gaps remain.
- **While some area providers are on strong financial footing, the survival of others could be threatened by federal funding cuts and state budget woes.** Shasta and Lassen Counties have a greater share of residents — 3 in 5 people — covered by Medi-Cal and Medicare than statewide, and HR 1 cuts to Medi-Cal threaten access to care across the region, regardless of coverage. Often, a CHC or critical access hospital serves as the only source of care in a remote community. Health care leaders are resourceful and resilient, but operating in remote areas without economies of scale and navigating statewide

policies designed for urban settings create challenges to rural sustainability.

- **High mortality rates, including "deaths of despair."** The all-cause death rate in Shasta is almost 60% higher than statewide, while Lassen's all-cause death rate is 31% higher. High death rates in the region related to chronic disease, suicide, firearms, and alcohol and drug use contribute to higher overall mortality rates.
- **Politicalization of public health and health services in Shasta County.** Local politics and divisiveness mirror patterns at the national level, with implications for access to behavioral health services and for provider recruitment to the area.
- **Community organizations in Shasta have joined together to address behavioral health infrastructure needs.** A new treatment facility that can deliver a continuum of crisis stabilization services has been identified as the highest priority for the region; key components include medical detox, a 16-bed psychiatric health facility, and youth crisis services. A long-standing multistakeholder group, Shasta Health Assessment and Redesign Collaborative (SHARC), in partnership with a local nonprofit and a behavioral health care company, is attempting to secure state funding for new infrastructure to address regional needs; but a letter of opposition from Shasta County just days before the application was due could derail the effort.

Market Background

Almost 210,000 people live in Shasta and Lassen Counties, an 8,567-square-mile area about the size of New Jersey (Table 1). Redding, about 160 miles north of Sacramento and the county seat of Shasta, is home to nearly half the region's population, with about 93,000 people, and serves as the area's economic and cultural hub. Shasta County's two other incorporated cities — Anderson and Shasta Lake, with populations of about 10,000 each — lie just south and north of Redding, respectively, along Interstate 5. To the east, Susanville, with a population of about 12,000 people, is the only incorporated city in Lassen County and serves as the county seat. Susanville is closer to Reno, Nevada — about a 90-minute drive — than to Redding, which is about two hours away, resulting in cross-border economic and health care activity.

Historically, mining and timber were the region's main economic engines; the decline of the timber industry and closure of lumber mills throughout the region led to a prolonged recession in the 1970s and 1980s.[1] Today, the strongest industries in Shasta County are health services and tourism. Contrary to common assumption, Mt. Shasta, popular with climbers given its 14,000-foot elevation, is in Siskiyou County, north of Shasta.[2] However, with proximity to Mt. Shasta, Lassen Volcanic National Park, and the Trinity Alps, the spectacularly scenic region is a destination for tourists and adventure seekers. Bethel Church, an influential megachurch in Redding, also attracts thousands from across the globe to its School of Supernatural Ministry and has become an economic and political force in the city.[3]

Lassen County has relied on state and federal prisons for economic activity, alongside ranching, government services, and a community college. In 2007, nearly half of Susanville's adult population worked in one of three prisons, which held about 11,000 inmates in the county.[4] Despite a lawsuit by the city of Susanville to stop the closure, the state shuttered California Correctional Center in 2023. As the prison population declined, so did the county's overall population, with the incarcerated population down now to about 2,800 inmates at High Desert State Prison and 860 prisoners at the Federal Correctional Institution in nearby Herlong.

Outside of Redding and Susanville, much of Shasta and Lassen Counties is remote; many residents live more than an hour's drive from health care providers and services. In

the winter, storms often force road closures, and the mountain passes can be challenging to navigate. Wildfires have emerged as a major issue in recent years. The 2018 Carr Fire in the Redding area resulted in eight deaths and destruction of more than 1,600 structures. The Dixie Fire in 2021 started in Butte County and spread into Shasta, Lassen, Plumas, and Tehama Counties — ultimately burning almost a million acres. The fires have driven up housing and insurance costs and tightened the supply of affordable housing in the region.

Shasta and Lassen's overall population has declined slightly over the last five years (–0.6%), close to the statewide decline of –0.2%. The area's population skews older, with more than 1 in 5 people (21.4%) age 65 years and older compared to 1 in 6 people (16.2%) statewide. The region has the least diverse population — racially and ethnically — of the seven study regions in the Regional Markets Study (see "Background on Regional Markets Study," page 27). Within Shasta and Lassen Counties, 75% of people identify as White, 13.5% as Latino/x, 6.6% as other, 3.2% as Asian, and 1.8% as Black. American Indians comprise a large majority of the "other" category, with approximately 11,700 (5.6% of the population) living in the region in 2023 (data not shown).

While the region's high school graduation rate (90.1%) is higher than the statewide rate (84.6%), Shasta and Lassen residents are less likely to have a college degree compared to Californians as a whole — 21.7% versus 36.5%. About 1 in 7 people (13.7%) in the region had incomes below the federal poverty level in 2023 — or $30,000 annually for a family of four — slightly higher than the statewide rate of 12.0%.[5] Median annual household income in the region in 2023, at $71,083, was about two-thirds of the statewide median income of $96,334. Only about 1 in 3 households (35.6%) could afford to buy a median-priced home in the region; while low, the rate is much higher than the estimated 13.6% of households statewide that could afford a median-priced home.

TABLE 1. Population Characteristics,
Shasta and Lassen vs. California, 2023 Unless Noted

	Shasta and Lassen	California
Population Statistics		
Total population (2024)	209,461	39,431,263
Share of state population	0.5%	100%
Five-year population growth	-0.6%	-0.2%
Age of Population, in Years		
Under 18	21.1%	21.7%
18 to 64	57.5%	62.1%
65 and older	21.4%	16.2%
Race/Ethnicity		
Latino/x	13.5%	40.4%
White (non-Latino/x)	74.9%	34.3%
Asian (non-Latino/x)	3.2%	15.8%
Black (non-Latino/x)	1.8%	5.6%
Other (non-Latino/x)	6.6%	3.8%
Birthplace		
Outside the United States	5.6%	27.3%
Education (Among Those Age 25 and Older)		
High school diploma or higher	90.1%	84.6%
College bachelor's degree or higher	21.7%	36.5%
Economic Indicators		
Income below 100% federal poverty level	13.7%	12.0%
Household income $100,000+ (%)	34.2%	48.4%
Median household income*	$71,083	$96,334
Average (mean) household income	$94,635	$136,730
Unemployment rate	5.2%	4.8%
Households able to afford median-priced home (2024)	35.6%	13.6%

* A weighted blend of county-level median household income figures.

Sources: *Annual Estimates of the Resident Population for Counties in the United States: April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *County Population by Characteristics: 2020–2023* (CC-EST2023-ALLDATA-06 and CC-EST2023-AGESEX-06), *Annual Estimates of the Resident Population for Counties in the United States*: April 1, 2010 to July 1, 2019 (CO-EST2019-ANNRES-06), "American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth, 2019 and 2023," "ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County," "ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019," US Census Bureau; "Current Industry Employment and Unemployment Rates for Counties," California Employment Development Department; and "Housing Affordability Index – Traditional (Q2 2024)," California Association of Realtors.

High Rates of Suicide and Overdose Afflict the Region

Across the seven study regions, the area has the greatest share of people reporting "fair" or "poor" health status — 17.4% versus 15.5% statewide — along with higher prevalence of high blood pressure than statewide (Table 2). Similarly, Shasta and Lassen Counties have the highest infant mortality rate — 6.8 deaths per 1,000 live births — of the study sites and exceed the statewide rate of 4.1 deaths per 1,000 births.

The region's suicide rate is almost three times the statewide rate — 28.2 per 100,000 population versus 10.1 statewide — and drug-related overdose deaths are about 70% higher — 49 per 100,000 population versus 29.1 statewide. Likewise, Shasta and Lassen Counties have the highest rate of drug-related emergency department (ED) visits of the study sites — 229.3 per 100,000 population versus 137.4 statewide. Moreover, the prevalence rates of anxiety (14.8%) and of depression and other mood disorders (13.0%) exceed statewide rates by 3 to 4 percentage points.

TABLE 2. Health Status,
Shasta and Lassen vs. California, 2023 Unless Noted

	Shasta and Lassen	California
Physical Health Status		
Fair/poor*	17.4%	15.5%
Adults with an independent living difficulty†	9.2%	5.8%
Diabetes prevalence††	11.1%	11.3%
High blood pressure prevalence††	27.3%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	6.8	4.1
Behavioral Health		
Anxiety prevalence††	14.8%	10.3%
Depression, bipolar, and other depressive mood disorders prevalence††	13.0%	10.5%
Opioid and other drug-related emergency department visits (per 100,000 population)	229.3	137.4
All drug-related overdose deaths (per 100,000 population)	49.0	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	28.2	10.1

* Fair/poor health status reflects Shasta County only due to small cell sizes.

† An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor's office, or shopping because of a physical, mental, or emotional condition.

†† Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.

Sources: "AskCHIS," UCLA Center for Health Policy Research; "American Community Survey, 2023 5-Year Estimates, S1810. Disability Characteristics," US Census Bureau; "Healthcare Payments Data Measures Data (2018–2023)," California Department of Health Care Access and Information; "Infant Mortality," California Department of Public Health (CDPH); "County Health Status Profiles, 2024: Tables 1–29," CDPH, last updated August 8, 2024; "California Overdose Surveillance Dashboard," CDPH, last updated May 19, 2025.

Both Shasta and Lassen have much higher all-cause mortality rates than the statewide average (Table 3). The all-cause death rate in Shasta is almost 60% higher than statewide and is the second highest of all counties; Lassen's rate is 31% higher than statewide. Shasta death rates are consistently higher than the statewide average: Deaths related to alcohol and tobacco use (chronic liver disease and chronic lower respiratory disease) are 1.8 times and 2.6 times the statewide rate, respectively, while firearm deaths occur at almost twice the statewide rate. Lassen fares somewhat better on several indicators, but data are less reliable due to small numbers.

TABLE 3. Death Rates by Cause,
Shasta and Lassen vs. California, 2021–23

Age-Adjusted Death Rates per 100,000 Population	Shasta	Lassen	California
All causes	996.4	832.9	634.1
All cancers	163.7	115.1	118.7
Coronary heart disease	99.4	95.9	72.2
Accidents (unintentional injuries)	83.4	88.1	49.8
Chronic lower respiratory disease	59.7	26.9	23.0
Stroke	38.6	21.2	35.7
Chronic liver disease and cirrhosis	25.4	*	14.4
Firearm-related deaths	15.5	*	8.4
Motor vehicle crashes	15.1	20.3	11.6

* Unreliable due to high standard error.

Source: *County Health Status Profiles, 2025*, California Department of Public Health.

Shasta County Politics Take a Far-Right Turn, with Implications for Health Services

Politically, Shasta and Lassen Counties lean conservative, with Republican candidates winning sizable majorities in most national, state, and local races for at least the last 50 years. In the 2024 presidential election, Donald Trump received almost 70% of the vote in Shasta and over 75% in Lassen.[6]

At the local level, traditional conservatism took a turn further right as the COVID-19 pandemic created divisiveness, and a voter recall led to a realignment of the Shasta County Board of Supervisors.[7] An early action of the new board majority was to fire the county public health officer, precipitating the

departure of several other experienced county health officials.[8] The resulting loss of institutional knowledge could have implications for the delivery of local health and public health services, and the political upheaval has reportedly contributed to challenges recruiting physicians to practice in the area.

While Lassen has not experienced the turnover of county officials on par with Shasta, the county's Health and Social Services Agency is undergoing change as well. The Lassen County Board of Supervisors recently eliminated the agency's director position, and the department directors for behavioral health, public health, and social services now report directly to the Board of Supervisors.

Health Coverage Sources and Trends

A larger share of the population in Shasta and Lassen obtained coverage through Medicare in 2023 than statewide (Table 4), reflecting the region's relatively older population. About 19.5% of the region's population had Medicare-only coverage, with another 6.1% dually eligible for Medicare and Medicaid, compared to statewide rates of 12.8% and 4.5%, respectively. Shasta and Lassen residents are much less likely to have commercial health insurance than Californians overall (40.1% vs. 50.8% in 2023). Commercial coverage has eroded in Shasta and Lassen in recent years, dropping from 42.6% in 2019 to 40.1% in 2023, while the statewide commercial coverage rate remained stable. Medi-Cal and commercial now account for a similar share of population coverage (41.2% for Medi-Cal, including enrollees dually eligible for Medicare, compared to 40.1% for commercial in 2023). The share of the population without health insurance increased in Shasta and Lassen (to 7.2%), while the rate of uninsured people declined statewide (to 6.4%).

TABLE 4. Sources of Health Insurance,
Shasta and Lassen vs. California, 2019 and 2023

Coverages as Share of Population (Totals > 100%)*	2019		2023	
	Shasta and Lassen	California	Shasta and Lassen	California
Uninsured	6.7%	7.7%	7.2%	6.4%
Medi-Cal and Medicare dually eligible	5.0%	3.7%	6.1%	4.5%
Medi-Cal (no Medicare)	28.0%	28.6%	35.1%	35.6%
Medicare (no Medi-Cal)	20.0%	12.1%	19.5%	12.8%
Commercial	42.6%	50.6%	40.1%	50.8%

* Percentages may sum to more than 100% due to people being included in more than one category.

Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; "Selected Characteristics of Health Insurance Coverage in the United States, American Community Survey, 1-Year and 5-Year Estimates," US Census Bureau; "By Medicare Dual Status, Certified Eligibles," California Department of Health Care Services; and Katherine Wilson, *California Health Insurers, Enrollment Almanac — 2025 Edition*, California Health Care Foundation, February 2025.

Covered California, the state's Affordable Care Act marketplace, plays a small but important role in Shasta and Lassen. In 2023, Covered California accounted for 3.9 and 4.3 percentage points of commercial enrollment in Shasta/Lassen and in the state, respectively, up slightly from 2019. In 2025, comparable coverage through Covered California cost almost 50% more in Shasta and Lassen than the statewide average: $695 versus $472 per month for the lowest-cost silver plan covering a 40-year-old person, assuming no premium subsidy (Table 5). Premiums have grown at a higher rate in the region compared to statewide over the last five years (5.1% vs. 3.5% annually), increasing the affordability gap in Shasta and Lassen. In 2025, monthly premiums (unsubsidized) in the region consumed just over $4 of an hourly wage and just over 24% of a full-time minimum-wage salary — much higher than the statewide figures of $2.72 per hour and 16.5% of minimum-wage income. Almost all Covered California enrollees (96.7%) in Shasta and Lassen receive a premium subsidy that reduces the monthly cost of coverage, making the average net premium paid $82. By comparison, 89.4% of enrollees statewide receive a premium subsidy, paying an average net monthly premium of $134. Enhanced federal premium subsidies enacted during the COVID-19 pandemic expired on January 1, 2026, making premiums less affordable for approximately 9,800 Shasta and Lassen residents who received premium subsidies in 2025.[9]

TABLE 5. Covered California Monthly Premiums,
Shasta and Lassen vs. California, 2020 and 2025

Covered California Premiums*	2020		2025	
	Shasta and Lassen	California	Shasta and Lassen	California
Lowest-cost silver monthly premium, 40-year-old	$542	$398	$695	$472
Percentage higher/lower than California average	36.2%		47.3%	
Average annual premium increase, 2020–25			5.1%	3.5%
Per hour full-time wage needed to pay monthly premium†	$3.12	$2.29	$4.01	$2.72
Monthly premium as share of state minimum wage, full-time†	24.0%	17.6%	24.3%	16.5%
Percentage of members that receive premium subsidy			96.7%	89.4%
Average net monthly premium paid by those receiving subsidy			$82	$134
Median net monthly premium paid by those receiving subsidy			$7	$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes person pays the entire premium (i.e., no subsidy to offset cost).

Sources: *2025 Individual Product Prices*, Covered California; *2020 Individual Product Prices for All Health Insurance Companies*, Covered California; and *Active Member Profiles*, *2025 June Profile* (2020 and 2025), Covered California.

The prevalence of medical debt in Shasta County, at 11.5% in 2022–23, dropped slightly from 13.0% four years earlier and remained just above the statewide rate (Table 6). However, among those with medical debt, 62.7% owed more than $2,000 — a big jump from 52.1% four years prior and a larger share than statewide. The increasing medical debt likely reflects health care affordability challenges in the region.

TABLE 6. Medical Debt,
Shasta vs. California, 2018–19 and 2022–23

Medical Debt*	2018–19 Pooled†		2022–23 Pooled†	
	Shasta	California	Shasta	California
Prevalence (% of adults with medical debt)††	13.0%	10.8%	11.5%	10.2%
Amount of medical debt they are having trouble paying§				
Less than $2,000	47.9%	45.1%	37.3%	43.7%
More than $2,000	52.1%	54.9%	62.7%	56.3%

* Medical debt measures do not reflect Lassen County, as the California Health Interview Survey grouped Lassen results with other small counties.

† Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.

†† Prevalence figure is the percentage of people who answered yes to the question "Ever had problems paying for self or household family's medical bills in past 12 months?"

§ The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.

Source: "AskCHIS," UCLA Center for Health Policy Research.

A larger share of the Shasta and Lassen population is enrolled in Medicare than Californians overall — 25.8% compared to 17.5% in 2024 (Table 7). The share of Medicare beneficiaries in Shasta and Lassen enrolled in private Medicare Advantage (MA) plans has increased significantly in recent years, from 1.8% in 2019 to 12.6% in 2024, but a large majority of Shasta and Lassen residents (87.4%) remain in original fee-for-service Medicare.

TABLE 7. Medicare Enrollment Overview,
Shasta and Lassen vs. California, 2019 and 2024

Medicare Enrollment	2019	2024	2019	2024
	Shasta and Lassen		California	
Total Medicare enrollment	52,575	54,038	6,239,477	6,899,496
Medicare as share of population	25.0%	25.8%	15.8%	17.5%
Share of Total Medicare				
Medicare Advantage	1.8%	12.6%	44.1%	51.2%
Original Medicare	98.2%	87.4%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

As shown in Table 8, Anthem has the largest share of MA enrollment, with 47% (about 3,300 members), followed by UnitedHealthcare with 20% (about 1,300 members). Reportedly, primary care providers in the area generally don't participate in MA provider networks due to low payment rates. As a result, according to several respondents, Medicare beneficiaries who enroll in an MA plan often need to travel out of the area for primary care, frequently to Sacramento. Enrollment in MA may drop as new enrollees realize that access to care is more constrained than in original Medicare. Indeed, some area providers send birthday cards to patients approaching their 65th birthdays to inform them about upcoming eligibility for Medicare and to discourage them from joining an MA plan.

Coverage options for people dually eligible for Medicare and Medicaid in Shasta and Lassen are expected to shift in the coming years. In response to a California Department of Health Care Services (DHCS) mandate, Partnership HealthPlan of California must offer an MA Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (D-SNP) product, known as a "Medi-Medi plan" in California, in all 24 counties where Partnership operates. Meeting the mandate will require Partnership to recruit providers to participate in MA provider networks. In rural areas with provider shortages and access challenges, providers may be unwilling to participate in a D-SNP because they likely will face more reporting and prior authorization requirements for payment rates comparable to original Medicare.

Partnership is phasing in the D-SNP, called Partnership Advantage, with the first eight counties scheduled to go live in January 2027 (Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano, and Sonoma Counties), and Shasta and Lassen will follow in subsequent rollouts. At present, there is no Program of All-Inclusive Care for the Elderly (PACE) operating in Shasta or Lassen County. PACE helps people — typically seniors eligible for both Medicare and Medicaid — meet their health care needs in the community instead of entering a nursing home or other care facility. Shasta Community Health Center, the largest Federally Qualified Health Center (FQHC) in the area, is ready to implement PACE but paused the initiative because of the shifting and uncertain federal and state regulatory and fiscal environments. Dignity Health, which has a hospital in Redding and is part of a larger nonprofit health system, also plans to start a PACE.

TABLE 8. Largest Medicare Advantage Health Plans and Market Share, Shasta and Lassen, 2019 and 2024

Health Plan	2019	2024
Anthem Blue Cross Life and Health Insurance Company	0.0%	47.0%
UnitedHealthcare of California	0.0%	20.0%
Sierra Health and Life Insurance Company (UnitedHealthcare subsidiary)	59.0%	10.0%
Anthem Insurance Companies	11.0%	9.0%
California Physicians' Service (Blue Shield of California)	0.0%	5.0%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Well-Regarded Partnership Serves 24-County Medi-Cal Region

In 2024, approximately 38% of the population in Shasta and Lassen was covered by Medi-Cal, an increase of about five percentage points since 2019 — similar to the statewide share and five-year trend (Table 9). Of Medi-Cal enrollees, 96% were enrolled in managed care, with 4% remaining in fee-for-service Medi-Cal. As a County Organized Health System (COHS), Partnership had all 76,473 Medi-Cal managed care members (67,740 in Shasta and 8,733 in Lassen).

Partnership is a nonprofit managed care organization responsible for more than 900,000 Medi-Cal members in 24 Northern California counties, including many rural or frontier areas. Partnership launched in 1994 with a single county, Solano, and has grown steadily and incrementally for the last two decades. After local advocacy to join Partnership, Shasta and Lassen were added in an eight-county expansion in 2013. Partnership expanded again in 2024, adding 10

counties. As a COHS, Partnership serves as the sole Medi-Cal managed care organization across a vast geographic service area, which lies mostly north of Sacramento and stretches west to include Marin County in the Bay Area.

TABLE 9. Medi-Cal Enrollment Overview,
Shasta and Lassen vs. California, 2019 and 2024

Medi-Cal Enrollment	2019	2024	2019	2024
	Shasta and Lassen		California	
Total Medi-Cal enrollment	69,471	79,298	12,778,575	14,796,389
Medi-Cal as share of population	33%	38%	32%	38%
Share of Medi-Cal in managed care	94%	96%	82%	94%

Source: "Certified Eligibles by Delivery System and Plan" (August 9, 2024), California Department of Health Care Services.

Partnership is generally viewed by providers as a strong partner deeply invested in the region. As one respondent said, "They have been amazing to work with. They are beholden to all the DHCS rules and regulations, but they care about our population." And another said, "They do a quarterly operational assessment. It's great to sit with people from the different departments at Partnership. They tell you how you're doing and give you tips and resources; they are very collaborative."

Partnership offers quality improvement programs for primary care providers, network hospitals, palliative care providers, perinatal care providers (both primary care and specialty), and CalAIM (California Advancing and Innovating Medi-Cal) Enhanced Care Management (ECM) providers. The health plan's Partnership Improvement Academy provides resources and technical assistance to the provider network on such topics as quality improvement, access to care, and managing chronic disease. Partnership's eReports portal enables providers to monitor their performance on quality measures and target efforts to close care gaps.[10] Between 2018 and 2024, Partnership paid more than $25.6 million to providers in Shasta County and $2.1 million to providers in Lassen County through its Primary Care Provider Quality Incentive Program; in 2024, $4.1 million went to Shasta providers and $315,000 to Lassen providers.

Redding Serves as Regional Medical Hub

Redding, in Shasta County, is the medical hub for the North State region, drawing from Lassen County to the east, Trinity to the west, Modoc and Siskiyou to the northern border with Oregon, and Tehama to the south.[11] Much of Shasta County outside of Redding is rural, as is Lassen County. Helicopters are a frequent sight, supporting patient transport to Redding from rural and frontier clinics multiple hours away by car. Of the four acute care hospitals in Shasta and Lassen (Table 10), two are in Redding: Mercy Medical Center and Shasta Regional Medical Center. The other two are critical access hospitals, Mayers Memorial in Fall River Mills (Shasta) and Banner Lassen in Susanville (Lassen), offering 24-hour emergency services and a small number of acute care beds in rural areas. Mercy in Redding offers Level II trauma services; patients needing more specialized care typically travel to the University of California, Davis; UC San Francisco; or Stanford Medical Center.

Shasta and Lassen appear to have many more beds per capita than California overall (302 per 100,000 population compared to 198 statewide), but many beds are not staffed for service. Collectively, the four hospitals have a higher net income margin and lower operating expense per patient day than hospitals statewide. In addition to the four acute care hospitals, Vibra Hospital of Northern California in Redding operates the only long-term acute care facility between Sacramento and the Oregon border. Restpadd operates a 16-bed psychiatric facility for adults (mental health only, no substance use disorder treatment), also in Redding.

TABLE 10. Acute Care Hospitals Overview,
Shasta and Lassen vs. California, 2023

Acute Care Hospitals*	Shasta and Lassen	California
Number of facilities	4	334
Beds (available) per 100,000 population	302	198
Number of discharges	20,137	3,148,191
Net income margin	7.7%	4.5%
Operating expenses per adjusted patient day	$3,426	$5,117

* Net income margin is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. Operating expenses per adjusted patient day equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

Local leaders expressed concern about declining access to care and frustration with "unfunded mandates" from the state of California, including the $25 hourly health care minimum wage and facility seismic regulations. Several reported experiencing long delays in permitting and other state-required processes, resulting in increased project costs and delays in availability of services or facilities. One respondent noted that the "state is a huge cause of health care expenses." Another, considering the uncertainty and associated challenges in federal and state budgets and policies, commented: "COVID was easier than the current legislative environment."

Mercy Medical Center Redding: Strong Competitive and Financial Position

Mercy Medical Center Redding is the largest hospital in the region, accounting for two-thirds of the discharges in Shasta and Lassen Counties (Table 11). Mercy is part of the nonprofit Dignity Health system, which combined with Catholic Health Initiatives in 2019 to create CommonSpirit Health, operating in 24 states. Mercy has 266 available beds, 199 of which are staffed; state regulatory requirements and workforce shortages limit the number of staffed beds in service. Although the hospital lacks any inpatient behavioral health beds, Mercy runs an ED-based Bridge program that provides medication-assisted treatment (MAT) for addiction[12] and is developing an Emergency Psychiatric Assessment, Treatment, and Healing unit that will move appropriate patients from the ED into an outpatient setting that provides tailored resources before discharge.

TABLE 11. Acute Care Hospitals by Number of Beds,*
Shasta and Lassen, 2023

Hospital (System)	Available Beds	Occupancy (Available Beds)	Share of Discharges in Region	Distribution of Discharges by Payer Type			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
				Medicare	Medi-Cal	Commercial			
Mercy Medical Center – Redding (Dignity/ CommonSpirit)	266	68%	65%	48%	29%	23%	12%	2.1	$4,731
Shasta Regional Medical Center (Prime)	226	32%	30%	59%	23%	19%	-5%	1.8	$3,804
Mayers Memorial Hospital	16 acute, 99 LTC	72%	2%	68%	23%	9%	9%	11.6	$684
Banner Lassen Medical Center (Banner)	25	31%	4%	45%	26%	29%	-12%	3.4	$3,866
Shasta and Lassen	**632**	**55%**	**100%**	**51%**	**27%**	**22%**	**8%**	**2.2**	**$3,426**
California	**77,339**	**64%**	**n/a**	**42%**	**31%**	**26%**	**4%**	**1.6**	**$5,117**

* Net income margin is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. Adjusted patient day equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days. Current ratio is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

About half of Mercy's discharges are covered by Medicare, and the other half are split between Medi-Cal (29%) and commercial (23%). To meet the state's 2030 seismic requirements, the hospital will launch a $91 million capital project in 2027 — an enormous infrastructure investment. The hospital's net income margin, at 12%, is the highest of the four acute care hospitals in the area. According to a RAND analysis, Mercy's total facility commercial price was 411% of Medicare payment rates for the years 2020–22, compared to 329% for all hospitals statewide.[13] The facility's US Centers for Medicare & Medicaid Services (CMS) hospital quality rating was two of five stars in the first quarter of 2025, up from one star in 2023.[14] Hospital representatives noted that the shortage of primary care services makes performance on key quality measures, such as readmissions, more challenging.

Mercy is the only hospital providing maternity services in Shasta County and operates the only Level III neonatal intensive care unit north of Sacramento. Along with Mercy, the two other facilities providing maternity services locally — St. Elizabeth in Red Bluff (Tehama County) and Mercy Mount Shasta (Siskiyou County) — also are owned by CommonSpirit Health, which, because of its Catholic affiliation, limits access to reproductive health services such as elective abortions and sterilizations.

Given its size and status as a key provider of essential services for the region, including maternity and trauma care, Mercy is a "must-have" hospital for any health plan provider network. In April 2024, the contract between Partnership and Dignity Health / CommonSpirit expired, disrupting Medi-Cal patient access to nonemergency services at Mercy and resulting in contentious contract negotiations between the plan and CommonSpirit.[15] Patients assigned to Dignity providers received termination notices and were advised to select new primary care doctors or request continuity of care for ongoing treatments. The dispute lasted three months and affected more than 64,000 Partnership members across five counties, including Shasta.

Shasta Regional Medical Center: Striving for Financial Health

Shasta Regional Medical Center (SRMC) is Redding's second-largest general acute care hospital. Based on state data (Table 11), SRMC has 226 available beds, but less than half are staffed due to a combination of seismic restrictions — many "available" beds are in an older building unlikely to return to service — and workforce shortages. The hospital's payer mix (as measured by share of discharges) is heavily Medicare, followed by Medi-Cal; commercial is a smaller share. SRMC had a –5.0% net income margin in 2023 and again in 2024; plans to improve the financial picture in 2025 include staffing more beds and increasing patient admissions and procedures. Availability of beds in skilled nursing facilities (SNFs) to accept SRMC inpatients ready for discharge is a key factor in the hospital's financial performance.

Prime Healthcare, with 51 hospitals in 14 states, acquired SRMC in 2008 from Hospital Partners of America after a bankruptcy filing and stabilized the hospital.[16] Prime, a privately held for-profit system with a nonprofit arm, has a reputation for acquiring struggling hospitals as turnaround candidates.[17] In recent years, SRMC has faced quality challenges, including California Department of Health enforcement actions in 2024 and a decline in CMS hospital quality rating from three stars to one in 2023 (out of five), though Leapfrog Hospital Safety Grade scores show improvement from "C" in 2023 to "A" in 2025.[18] A new CEO took charge in September 2024 with a focus on quality of care, patient service, and improving SRMC's reputation in the community.

SRMC plays an important role in the area as a behavioral health services provider: The consistently full 21-bed licensed inpatient psychiatry unit is one of few in the region. Like

Mercy, SRMC supports substance use treatment by offering MAT in the ED as part of the Bridge initiative.

Mayers Memorial: Critical Access Hospital with Deep Community Roots

Mayers Memorial Healthcare District, a critical access hospital, is in Fall River Mills, about 70 miles northeast of Redding near the junction of the Cascade and Sierra mountain ranges (see "Critical Access Hospitals: Small, Remote Providers of Essential Services," page 13). The hospital opened in 1956 after receiving a fundraising boost from part-time Fall River Mills resident Bing Crosby, who put on a benefit show.[19] Mayers Memorial serves an enormous and sparsely populated area — the size of a small state but with fewer than 10,000 people. The hospital offers 24/7 emergency services, seeing an average of 12 patients daily, and has 16 available acute care beds, with 10 staffed; average daily census is 6. An additional 99 skilled nursing beds are available — about half in Fall River Mills and the other half 20 minutes away in Burney; 84 of the beds are staffed. More than two-thirds of discharges are covered by Medicare, reflecting the large share of SNF beds.

Mayers Memorial provides care for an aging population largely rooted in farming, agriculture, and logging, alongside a substantial Latino/x community with multigenerational family ties. A Rural Health Clinic opened in Burney in 2021, staffed by three full-time-equivalent clinicians. A second Rural Health Clinic is slated to open in Fall River Mills in 2025. In the interim, a mobile clinic has served Fall River Mills since 2023. Mayers Memorial offered maternity services until 2016, when the obstetrics unit closed due to low volume. Deliveries had fallen to approximately one per week, making staffing impractical and raising patient safety concerns.[20] Reopening is unlikely, even if demand were to increase, because of the prohibitive cost of a new inpatient surgery suite.

After near bankruptcy in the early 2000s, Mayers Memorial converted to a critical access hospital and gradually stabilized its finances, in part due to enhanced cost-based reimbursement through Medicare. California's hospital seismic retrofitting requirements created substantial need for infrastructure investment, which Mayers Memorial addressed through a master facility plan and capital campaign. In 2023, the hospital reported a net income margin of 8.7% and continues to develop initiatives to offer services to the community and generate revenue. For example, Mayers Memorial shares a surgeon and a certified nurse anesthetist with Modoc Medical Center for minor procedures, with plans for expansion, and is collaborating with four neighboring health care districts to build and operate a mobile magnetic resonance imaging unit in a trailer.

Facing clinician shortages experienced by hospitals and clinics throughout northeastern California, Mayers Memorial acquired a historic 13-room fishing lodge alongside a river between the hospital in Fall River Mills and the Rural Health Clinic in Burney, an easy midpoint for clinicians practicing in both locations. Lodging for up to 25 is offered at no cost, but the housing site still generates significant savings through reductions in hotel costs for recruited physicians and traveling clinicians contracted to fill staffing gaps.

Vibra Hospital Fills Long-Term Acute Care Niche

Based in Redding, Vibra Hospital of Northern California is a long-term acute care (LTAC) facility serving patients who need prolonged hospitalization after discharge from an acute care facility or intensive care unit. Vibra can manage patients who are using ventilators or telemetry and those with serious wounds. Additionally, an attached SNF transitional care unit can serve patients with more-acute needs than a standard SNF. The hospital is part of a privately held for-profit system of critical care and rehabilitation hospitals in 10 states.

Vibra has 82 available beds, 50 LTAC and 32 SNF. More than 90% of discharges are covered by public payers — 62% Medicare and 31% Medi-Cal in 2023. Patients admitted with

Medicare coverage are generally medically complex, while patients with Medi-Cal often have a substance use disorder and lack housing; a typical admission might be for dual diagnoses of schizophrenia and endocarditis (heart infection) caused by drug use. Vibra operates at high occupancy and had a 12.7% net income margin in 2023.

Vibra fills a niche in the regional delivery system, enabling patients who need a higher level of care than is available in a SNF to be discharged from an acute care hospital. However, criteria for LTAC reimbursement are stringent, so Vibra must ensure patients will qualify for reimbursement before admission. The hospital has recently experienced increasing challenges with payment denials after initial authorization, primarily from MA plans.

Banner Lassen Meets Community Needs, but Sustainability Is a Concern

Banner Lassen Medical Center is in Susanville, the county seat of Lassen — about two hours from Redding and 90 minutes from Reno. A critical access hospital that opened in 2003, Banner Lassen is the only California hospital in the nonprofit six-state, 33-hospital Banner Health system based in Phoenix. The hospital relies on resources from Banner Health to handle systemwide issues, including recruiting, legal, and crisis responses such as the COVID-19 pandemic and wildfires. The 22-year-old facility is seismically compliant, enabling Banner Lassen to avoid the major capital costs that many other hospitals are grappling with as the deadline to meet California's 2030 seismic standards approaches.

The hospital has 25 available beds, with eight staffed based on the average daily census. Per critical access hospital requirements, 24/7 emergency services are offered. Importantly, Banner Lassen provides maternity services, delivering about 230 babies annually. Without access to these services, residents would need to travel 90 to 120 miles to the nearest obstetrics unit. The hospital also provides inpatient care in a four-bed secure unit for several thousand inmates at nearby federal and state correctional facilities.

A -12.0% operating margin in 2023 underscored the financial challenges facing Banner Lassen, which shoulders additional staffing costs to hire contractors when local providers are unavailable. Hospital respondents noted that state mandates — including the minimum wage for health care workers and mandatory training on maternity care for every employee — exacerbate already high staffing costs. Hospital leaders also cited a lengthy and expensive permitting process for new facilities and services, which can result in delays and higher construction costs.

To increase patient volume and revenue, Banner Lassen has a monitored bed unit for high-acuity patients and a swing-bed program that provides short-term rehabilitation services to patients able to leave an inpatient hospital setting but not yet able to return home. Almost half of discharges are covered by Medicare, with the other half split between Medi-Cal and commercial payers. Critical access hospital status enables cost-based Medicare reimbursement, which helps the hospital financially, although payment reconciliation takes about a year, which can create cash flow challenges. Banner Lassen works closely with Partnership on behalf of Medi-Cal members and relies on commercial payment as an important revenue source.

Although the hospital's financial picture was stabilizing, a key ongoing challenge is the lack of community-based primary care providers. Banner Lassen's Susanville clinic, offering general and orthopedic services, would hire five primary care clinicians if they were available. When patients are unable to access a primary care provider locally, they often go to Reno for routine preventive care such as screenings or well-child visits and continue obtaining care there rather than returning to Susanville.

Critical Access Hospitals: Small, Remote Providers of Essential Services

Critical access hospitals, certified by CMS as meeting specific criteria, often serve not only as vital care providers but also as economic anchors in rural communities. They benefit from cost-based Medicare reimbursement, helping stabilize finances despite serving fewer patients. Critical access hospitals have more flexible staffing rules (to the extent consistent with state licensure laws) and face fewer federal regulations, making operations easier in remote areas. They also have access to federal grants and discounted drug programs. These advantages are instrumental in making critical access hospitals viable, but small rural hospitals still face daunting challenges. As one respondent said, "It feels like we're on an island. Resources are limited. We're able to cover everything, but it's a struggle."

To be considered a Medicare critical access hospital, a facility must meet criteria designed to support rural communities with limited health care options, including location in a rural area and at least 35 miles from another hospital, though that distance can be shorter — 15 miles — if mountain roads or rugged terrain are involved. Critical access hospitals are required to have 24/7 EDs, whether clinicians are on-site or on call. To maintain critical access hospital designation, hospitals can have no more than 25 inpatient beds, which can be used for acute care or as swing beds to provide skilled nursing services, and average inpatient length of stay cannot exceed four days.

Sources: "Critical Access Hospitals," US Centers for Medicare & Medicaid Services, last modified December 30, 2024, and "Critical Access Hospitals (CAH): What Are the Benefit of CAH Status?," Rural Health Information Hub, last modified July 1, 2025.

Primary and Specialty Care Landscape

Three key findings about the primary and specialty care landscape emerged from discussions with multiple health care leaders in Shasta and Lassen; these findings are consistent with the 2020 Regional Markets Study report on Humboldt and Del Norte Counties and an assessment of independent physician practice in Humboldt in 2024.[21]

First, physicians in independent practice have declined significantly in recent years. As physicians reach retirement age, they are selling or closing their practices. The intense stress and clinician burnout associated with the COVID-19 pandemic exacerbated the trend toward retirement. New practices are few; those that do open are often direct-pay models that bypass participation in health plan provider networks. Respondents stressed the challenging combination of factors facing independent practitioners, including low payment rates, increasing input costs, and difficulty recruiting additional providers to share the workload.

Second, access to care is a serious and growing challenge — and most severe for patients with commercial coverage. Telemedicine has grown enormously since the COVID pandemic, which helps but does not substitute for a regular source of care in the community. Respondents noted lists of more than a thousand people interested in establishing a relationship with primary care providers; the wait can take two years. One commented: "The most underserved populations are not the ones we think of — they are the commercial patients and our Medicare patients that don't have a place to land because practices are so full." Another said, "People with private insurance are in worse shape than people with Medi-Cal. If you lose your Medicare doc, you need a concierge doc, or you're going to urgent care."

Third, CHCs are often the main — sometimes the only — care providers in rural and frontier communities. In urban parts of the state, CHCs focus on Medi-Cal members and people without health insurance. In many areas of Shasta and Lassen, CHCs are the only providers of care. As one respondent put it: "We serve the community — everyone in the community. There are no other providers. We are a very important community resource — one of the only resources the community has."

CHCs Play Vital Role in Community-Wide Care

Reflecting the central role of CHCs in Shasta and Lassen, state data show CHCs in the region served about twice the number of patients and provided twice as many encounters per capita in 2023 compared to statewide figures (Table 12). Likewise, a smaller share of Shasta and Lassen CHC patients have household incomes under 100% of the federal poverty level, and area CHCs generate a smaller share of net patient revenue from Medi-Cal, illustrating the role many CHCs play in serving the entire community.

TABLE 12. Community Health Centers Overview,
Shasta and Lassen vs. California, 2023

Community Health Centers*	Shasta and Lassen	California
Number of sites	16	1,139
Patients with incomes under 100% poverty level	52%	70%
Patients per capita	0.39	0.21
Encounters per capita	1.41	0.69
Medi-Cal as share of net patient revenue	63%	78%

* Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

The Health Alliance of Northern California (HANC), the regional CHC consortium for the area, supports seven CHC members in a nine-county region, including Shasta and Lassen. HANC's longtime leader retired in 2024, replaced by an experienced Shasta County public health professional who departed county service during ongoing political turmoil. HANC works closely with the North Coast Clinics Network, which serves several northwestern and coastal counties, to provide policy advocacy and peer learning opportunities to 15 CHCs covering approximately a quarter of California's geography. For example, HANC and North Coast Clinics Network run a quality improvement peer network that provides extensive support to CHCs on data use for quality improvement, helping members strengthen reporting and performance to enable participation in value-based payment programs and to earn payments from Partnership's Quality Incentive Program. Additionally, several CHCs participate in the Medicare accountable care organization (ACO) Shared Savings Program through Aledade, a public benefit corporation that supports independent primary care physicians and CHCs nationally to transition to value-based care delivery. Both Medicare ACO shared savings and Partnership incentive payments can add meaningful revenue to CHC bottom lines.

In addition to supporting CHCs, HANC serves as the fiscal agent and backbone of SHARC, a multistakeholder group that has operated in the county for 15 years and was designated a California Accountable Community for Health in 2023.[22] SHARC's Steering Committee is composed of senior representatives from health and community organizations, including hospitals and other providers, health plans, and others. Multiple subcommittees focus on issues ranging from the health care workforce to behavioral health; each subcommittee recruits additional members to broaden stakeholder representation. SHARC's annual awards, Shasta Health Rock Stars, recognize health care professionals who make outstanding contributions to rural health.[23] Funding comes from a combination of member dues and grants. Multiple respondents highlighted the important role SHARC plays in the community, sharing information and coordinating activity among many stakeholders.

Shasta Community Health Center: Robust Services Include Street Medicine

Opened in 1987, Shasta Community Health Center (SCHC) is the largest CHC in the region by a wide margin, with almost 150,000 patient encounters in 2023 (Table 13). SCHC provides services at eight sites in Redding, Shasta Lake City, and Anderson, the latter two about 15 minutes north and south, respectively, of Redding. Urgent care is available in Redding and Anderson. SCHC delivers extensive street medicine services for Shasta County's homeless population, estimated in 2023 at more than a thousand people, supported by a mobile unit.[24] The C. Dean Germano Women's, Babies' & Children's Center opened in 2024, named after SCHC's founding CEO,

who retired in 2024 after 32 years.[25] SCHC offers a family medicine residency program and a fellowship program for nurse practitioners and physician assistants (see "Dire Health Workforce Shortages Limit Access," page 18).

In addition to primary care, vision services, and dental care, SCHC provides specialty services, including gastroenterology, nephrology, rheumatology, and HIV services, and makes extensive use of telemedicine for psychiatry and pediatric subspecialties. While DHCS has approved an SCHC-sponsored PACE initiative, the program was put on hold in April 2025 due to concerns about the potential impact of federal tariffs on project costs, looming cuts to Medicaid funding, and the Trump administration's restructuring of the US Department of Health and Human Services. SCHC also is considering opening a pharmacy, in part to mitigate the risk of revenue loss from the 340B Drug Pricing Program as pharmaceutical manufacturers and pharmacy benefit managers increasingly restrict access to the discounts.[26]

TABLE 13. Largest Community Health Center Systems,
Shasta and Lassen, 2023

Detail, Largest Organizations*	Encounters	Patient Income Under 100% Federal Poverty Level	Medi-Cal as Share of Net Patient Revenue
Shasta Community Health Center, Shasta	149,878	50%	65%
Hill Country Community Clinic, Shasta	56,814	58%	73%
Northeastern Health Center, Lassen	41,023	52%	52%
Mountain Valleys Health Centers, Shasta and Lassen	25,419	39%	50%
All other	21,997	59%	51%
Shasta and Lassen	**295,131**	**52%**	**63%**
California	**26,871,453**	**70%**	**78%**

* Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024)*, California Department of Health Care Access and Information, last updated October 31, 2024.

Hill Country: Track Record of Integrated Behavioral Health

Celebrating its 40th anniversary in 2025, Hill Country is the area's second-largest CHC, with almost 57,000 patient encounters in 2023. The CHC's flagship location in Round Mountain, about 30 miles northeast of Redding, offers medical, dental, chiropractic, and behavioral health services, and hosts a teen center, public library, and community radio station. Several Hill Country sites in Redding provide medical and behavioral health services. Hill Country has experienced significant financial challenges in recent years, but finances are stabilizing and the sale of a building to SCHC in 2024 strengthened reserves.

Providing integrated primary and behavioral health services has been a focus for Hill Country since inception. The CHC places behavioral health providers on the medical and dental floors to support patients and primary care clinicians; staff include case managers, referral coordinators, and substance use counselors. Hill Country operates an urgent walk-in mental health clinic in Redding funded through a contract with Shasta County. A mobile crisis-outreach team responds to urgent mental health needs in the community. Hill Country became a certified community behavioral health clinic in 2022, meeting federal standards and receiving a four-year grant available to CHCs that focus on increasing access to care for mental health and substance use disorder services.

Mountain Valleys: Serving Remote Communities

Mountain Valleys opened in 1981 in Bieber, about 90 miles northeast of Redding. The CHC now serves parts of Shasta, Lassen, and Siskiyou Counties, operating in rural and frontier spaces over a broad geographic area. Clinic sites provide medical, dental, and behavioral health services — often offering the only access to services in the area. Clinic sites in Shasta and Lassen Counties collectively provided over 25,000 encounters in 2023. Big Valley Medical Center in Lassen County is the most remote site, with a helipad for

emergencies and a service area that extends north into Modoc County and to the Oregon border.

Mountain Valleys manages staffing needs through a combination of persistent recruitment, flexibility with remote team members, and telemedicine. Broadband connectivity is spotty, so patients come to the clinic but may see remote providers via telemedicine. One longtime nurse practitioner with an established patient base moved out of the area and now sees patients via telemedicine, returning for one week each month to see patients in person. In addition to primary care, Mountain Valleys offers some specialty care. An in-house cardiologist, a local resident who has returned to the area, sees patients in person at two sites each week, requiring long drives. A half-time contracted psychiatrist sees patients in person at two sites and virtually at several others, as well as supporting other providers with issues such as pain management. To manage demand for specialty services, Mountain Valleys relies on extensive use of remote specialist consultation resources provided by Partnership: Primary care providers email a specialist with a question and receive a response within five days. Mountain Valleys made remote specialist consultation mandatory in 2025 and observed a large reduction in specialty referrals during the first four months of required use.

Since the closure of Mayers Memorial's obstetrics unit in 2016, deliveries have shifted to Mercy Mount Shasta in Siskiyou County for low-risk patients — but moderate- and high-risk patients must travel to larger facilities, typically 90 minutes or more each way, to access care. A new agreement with SCHC in Redding allows Mountain Valleys to handle early prenatal care, sending the patient to SCHC for a 20-week check-in and then handling ongoing care until the final weeks of pregnancy. At that point, care transitions back to SCHC, with delivery at Mercy Medical Center Redding.

Redding Rancheria Tribal Health System: Expanding Services for Native Americans

Redding Rancheria is a federally recognized sovereign tribal nation that includes descendants of the Pit River, Wintu, and Yana people. The Redding Rancheria Tribal Health System (RRTHS), launched in 1991, focuses on the western two-thirds of Shasta County and all of Trinity County. RRTHS provides medical, dental, pharmacy, behavioral health, and urgent care services to around 22,000 patients, including about 8,000 American Indians (approximately 70% of the American Indian population in the area). RRTHS accepts nontribal patients as space allows. If American Indian patients are unable to obtain a new patient appointment within two weeks, RRTHS pauses acceptance of new nontribal patients. RRTHS accepts all forms of insurance coverage and has about 9,000 assigned Partnership members. RRTHS receives cost-based reimbursement for Medi-Cal and Medicare patients based on federal Indian Health Service rates, supporting a more robust revenue stream compared to most providers in the area.[27]

RRTHS has expanded substantially in recent years. The Center for Advanced Care opened in 2024, providing access to specialty care services. In response to long wait times for American Indians to obtain specialty services, RRTHS hired clinicians in a range of specialties, including neurology, cardiology, and endocrinology, to provide in-house services. Expanding specialty services has reportedly reduced wait times for American Indian patients to two weeks and increased primary care provider satisfaction. An even more ambitious project, a 185,000-square-foot Health Village, broke ground in March 2025 and is scheduled to open in early 2027.[28] Motivated by the dire health status and 52-year life expectancy of tribal members, the Health Village will combine medical care with wellness and prevention services. Western, traditional, and Chinese medicine will be offered alongside extensive athletic facilities, an outdoor garden where people are encouraged to volunteer, and a

kitchen staffed by dietitians providing healthy cooking and eating strategies.

Northeastern Rural Health Clinics: Meeting Lassen County Primary Care Needs

Lassen County's largest CHC, Northeastern Rural Health Clinics (NRHC), based in Susanville, provided more than 41,000 patient encounters in 2023. In addition to Lassen, NRHC provides services to residents of Modoc County to the north and Plumas County to the south. NRHC provides primary care, dental services, behavioral health services, and maternity care, partnering with Banner Lassen Medical Center on deliveries. Walk-in urgent care services are available six days a week. NRHC operates a satellite site in Westwood, about 20 miles southwest of Susanville. NRHC has experienced multiple leadership turnovers in the last decade.

Lassen Indian Health Center: Building a New Clinic to Improve Access to Care

Lassen Indian Health Center in Susanville serves both American Indian patients and the broader Lassen County community while also drawing patients from Modoc and Plumas Counties. The CHC offers medical, dental, behavioral health, and pharmacy services. Construction of a long-planned new clinic facility has been underway since 2022; it is expected to open in 2026.[29] The new center will include dialysis, optometry, and physical therapy, addressing long-standing gaps in local care, especially for patients who have had to travel to Reno for care.

Dignity Health Dominates Physician Services Sector

The largest medical group in Shasta and Lassen is Dignity Health Medical Foundation North State, one of 12 Dignity regional medical groups across California. The group's main clinic is in Redding, with additional sites in Cottonwood (Shasta County) and Red Bluff (Tehama County). Dignity North State has expanded in recent years. In June 2025, an urgent care facility in Redding, Hilltop Medical Clinic, was acquired and rebranded as Dignity Health Urgent Care, which focuses on commercial and Medicare patients and does not currently provide services to Medi-Cal enrollees.[30] In 2024, Dignity Health Advanced Imaging acquired MD Imaging, a local independent radiology group dating back to the 1950s.[31] Depending on the perspective, the acquisition will result in greater integration and availability of specialty care or increased costs and restricted access as imaging services flow through Dignity Health.

In 2016, Dignity Health launched the North State Quality Care Network (NSQCN), a clinically integrated network that includes local independent physicians alongside members of the medical staff at Dignity's three North State hospitals — Mercy Medical Center Redding, Mercy Medical Center Mt. Shasta, and St. Elizabeth Community Hospital in Tehama County. NSQCN was created to assist North State providers with the transition from volume to value and to enable value-based payment arrangements on a larger scale by providing infrastructure and support to independent practices and employed clinicians in the community. The network includes primary care physicians, specialists, and advanced practice providers such as nurse practitioners and physician assistants. Ambulatory care coordination is a key area of support; NSQCN funds care coordination staff to support physicians who manage patients with multiple chronic conditions, high-risk medications, or health-related social needs.[32] NSQCN also supports patient care transitions — for example, following an inpatient discharge — and quality reporting, which can be challenging because independent physicians participating in the network use multiple different electronic health record systems; NSQCN staff conducts on-site visits for those practices without an EHR.

NSQCN focuses on fee-for-service payment arrangements, with shared savings if quality and cost targets are met, rather than risk-bearing contracts. Current contracts cover approximately 10,000 people in the Medicare ACO Shared Savings

Program and another 10,000 people with commercial coverage in Anthem and Blue Shield of California ACO products. Rates are negotiated directly between payers and independent practices; NSQCN's role is to enter into shared savings agreements for the patient population and to support the network's performance to meet cost and quality targets. Quality targets focus on measures such as blood pressure control, preventive screenings, and immunizations, while cost targets include avoidable ED visits and inpatient readmissions. If the network and its participants are successful in these arrangements, shared savings can be substantial.

Shasta Regional Medical Group, affiliated with Shasta Regional Medical Center (owned by Prime Healthcare), operates two primary care sites, in Redding and Anderson, and is planning a third site in Palo Cedro, eight miles east of Redding. The group successfully recruited five primary care providers, including three physicians, to join in 2025 — doubling the number of employed clinicians. While the medical group does not currently hold any contracts for value-based payment arrangements, it is open to moving in that direction.

Dire Health Workforce Shortages Limit Access

Workforce shortages are a challenge across California and are markedly worse in Shasta and Lassen.[33] The region faces a severe physician shortage, with only two-thirds the number of physicians per 100,000 population as are available statewide (Table 14). While primary care physicians are in short supply, data indicate that the most severe challenge is with specialists — Shasta and Lassen have only 62% as many specialists overall compared to statewide and only 39% as many psychiatrists. The picture is much more positive for advanced practice providers and nurses, with higher per capita supply compared to the state overall. The well-established statewide shortage of behavioral health workers is especially severe in Shasta and Lassen. Of note, statewide figures are not a recommended benchmark but rather a baseline for comparison on regional disparities in supply.

TABLE 14. Health Care Workforce Supply,
Shasta and Lassen vs. California, 2024

	Shasta and Lassen (Percentage of Statewide Average)	California
Licensed Providers per 100,000 Population		
License group*		
Physicians	236 (66%)	358
Advanced practice providers	151 (117%)	128
Nurses	1,672 (124%)	1,353
Behavioral health providers	342 (89%)	384
Physician Detail by Specialty and Hours Worked†		
Physicians per 100,000 population		
Physicians working 20+ hours/week	196 (67%))	294
Primary care	87 (74%)	118
Specialty	108 (62%)	176
Psychiatry	7 (39%)	18

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advanced practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychologist, registered psychological associate, and psychiatric technician.

† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.

Source: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025.

Physicians in Shasta and Lassen are more racially and ethnically diverse than the population served: 66% White and 34% non-White compared to 75% White and 25% non-White (Table 15). Latino/x people are underrepresented in all roles compared to their 13.5% share of the regional population, while Asian people are overrepresented. Black people are a small share of the population (1.8%) and of the health workforce (1.4%–4.0%).

TABLE 15. Physician and Health Workforce Characteristics,*
Shasta and Lassen vs. California, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
Race/Ethnicity of Providers†					
Latino/x, any race	8.4%	6.1%	8.8%	8.8%	13.5%
White, non-Latino/x	65.9%	80.9%	76.8%	76.8%	74.9%
Asian, non-Latino/x	19.3%	6.0%	5.7%	5.7%	3.2%
Black, non-Latino/x	4.0%	1.7%	1.4%	1.4%	1.8%
Languages Spoken††					
English only	68%	84%	88%	90%	—
Spanish	11%	6%	4%	4%	—

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). Physicians are MDs and DOs; advanced practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychologist, registered psychological associate, and psychiatric technician.

† Not shown: Other, non-Latino/x.

†† Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: "2024 License Renewal Survey Data, Representing Active Licenses as of December 3, 2024," custom data request, HCAI, received April 14, 2025; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023 (CC-EST2023-ALLDATA) (2023)*, US Census Bureau.

Creative Recruitment and Retention Efforts Help, but Gaps Remain

Health workforce shortages are severe and worsening across the region, reflected in significant barriers to access for both primary and specialty care.[34] In June 2025, Shasta County's public health officer declared a public health crisis due to the physician shortage, stating: "As more physicians retire and fewer take their place, the health care system in Shasta County will continue to lose stability, threatening the long-term health and well-being of our residents."[35] Several provider respondents noted that they are never fully staffed and always have positions posted. Area providers make extensive use of telemedicine, especially for specialists and behavioral health providers. Telemedicine capabilities ramped up rapidly during the COVID pandemic and continue to be important in improving access in the face of workforce shortages. But, as one respondent put it, telemedicine "doesn't replace boots on the ground."

Faced with ongoing health workforce shortages, Partnership conducted a provider network needs assessment in 2024 and shared the results in early 2025.[36] Among organizations assigned at least 500 Partnership members, the vacancy rate for primary care providers was 20% in Shasta (representing 121 positions) and 27% in Lassen (representing 37 positions). The median age of specialists in the Redding region (counties of Shasta, Lassen, Modoc, Siskiyou, Tehama, Trinity) was 61; about half of specialists have reached retirement age or will within five years. Key recruitment barriers, based on survey results, include the rurality of the area, lack of community amenities (e.g., schools, careers for partners), compensation (failing to keep pace with rising costs), and lack of affordable housing. Moreover, health leaders interviewed cited additional barriers to recruitment and retention: the polarized Shasta County political situation, which dissuades candidates from joining the community, and California's mandatory minimum hourly wage of $25 for health care workers, which has increased labor costs, compressed wage scales, and created financial difficulties.[37]

In response, Partnership has strengthened its provider recruitment program, initially launched in 2014, and added a provider retention initiative. Incentives are also available to hire licensed behavioral health clinicians and substance use disorder counselors. The recruitment program pays a bonus to primary care providers — $100,000 for physicians and $50,000 for advanced practice providers over 60 months — and offers a $20,000 bonus to physician residents opting to stay in the area after completing their training (see "Training and Residency Programs Build Local Supply," page 20). A retention initiative pays a bonus of $45,000 to physicians and $30,000 to advanced practice providers over 36 months; eligible clinicians practice in family medicine, internal medicine, pediatrics, obstetrics and gynecology, and psychiatry. Partnership also pays for prospective clinicians to visit recruiting provider organizations. Between January 2024 and April 2025, Partnership paid $460,000 in recruitment awards for 14

providers and an additional $100,000 in retention bonuses for Shasta County providers. Since 2019, Partnership investment in Shasta County workforce recruitment and retention has totaled $2.9 million.

Creative approaches to recruitment and retention and concerted efforts to tap all available resources are in evidence throughout the region. Respondents mentioned an array of approaches, including:

- Providing recruitment and retention bonuses by tapping into Partnership funds and supplementing with internal funds.
- Offering educational loan repayment assistance, through both direct funding and connections to state and federal loan repayment programs.
- Converting "travelers" and locum tenens (temporary contractors hired to fill vacant positions) to permanent staff by building a strong organizational culture and creating internal incentive and recognition programs to reward longevity. In some cases, providers who arrived to fill staffing gaps during the COVID-19 pandemic have stayed to raise their families.
- Hiring recruiters or relying on corporate parents with systemwide recruiting resources. The largest health system in the region, CommonSpirit Health North State (which includes Mercy Redding, along with Dignity hospitals in Mt. Shasta and St. Elizabeth), employs 2.5 full-time equivalent recruiters focused on clinicians and has invested $1 million annually to recruit more than 25 physicians and advanced practice providers in each of the last four years.
- Participating in an initiative that allows licensed physicians from Mexico to practice in the United States for three years; FQHCs are eligible to host visiting physicians starting in 2025.[38]
- Cultivating physicians who moved away to practice but might be willing to return.
- Emphasizing nonmonetary benefits such as team-based care (e.g., availability of case managers, behavioral health professionals, substance use counselors) and artificial intelligence scribes to reduce clinician workload.
- Hiring advanced practice providers to help fill gaps — but they must be supervised by a physician, with limits on the allowable ratio. (California now allows nurse practitioners to practice independently but only if they have completed the required certification program.)[39]
- Offering housing to clinicians during recruitment visits and during transition to employment.

Training and Residency Programs Build Local Supply

Mercy Medical Center Redding has sponsored a family medicine residency since 1975. The program, which has 18 residents (6 in each year) is affiliated with the UC Davis School of Medicine. Shasta Community Health Center launched a family medicine residency in 2013 in affiliation with UC Davis Rural PRIME, a medical school track designed to train physicians committed to advancing health equity in California's rural communities.[40] SCHC's 12 residents (4 in each year) receive outpatient training at SCHC and inpatient training at Mercy. Mercy and SCHC coordinate on a residency recruitment dinner during the first year of residency; provider organizations make a strong effort to get to know residents and to build relationships that will result in a hire. Over time, the programs have reportedly refined the admission process for residents to increase the likelihood they will practice in the area; an estimated 30% to 40% of residents now stay and practice in the region.

In 2023, Shasta Regional Medical Center started an internal medicine residency program, with a goal of 24 residents (8 per year). SRMC has agreements in place with local specialists

to support training in areas such as rheumatology and cardiology and sends residents to Prime Healthcare facilities in Southern California for rotations in obstetrics. With the first two residents completing the program in 2025, it is too early to assess the likelihood that residents will stay. Because most SRMC residents attended medical school outside the United States, they may be less likely to remain in the area.

In addition, SCHC offers a two-year paid fellowship program for newly graduated nurse practitioners and physician assistants, which is intended to support transition to full-time clinical roles in the CHC setting and strengthen the local primary care workforce.[41] In the first year, the advanced practitioners work in a team-based model; in the second year, they build their own patient panels.

Several community colleges and private educational establishments provide training for the health workforce, including Simpson University, a small Christian college in Redding with programs in nursing and counseling, and Shasta College, a public community college with training programs for nurses, medical assistants, dental hygienists, and home health aides. Lassen Community College (LCC) has created several clinical programs in health science, including a registered nurse program in January 2024, with 42 graduating registered nurses expected by December 2025. One respondent commented that "LCC programs are key to supplying the whole region." Supply of some health professionals, such as nurses and licensed marriage and family therapists, is now reportedly sufficient.

However, there are limits to the potential for local training programs in the context of health workforce shortages. The SHARC Healthcare Workforce Development Committee brings together a wide array of educational institutions, alongside hospitals, CHCs, and other stakeholders, to develop pipeline programs for health professionals needed in Shasta County.[42] A committee report noted that "while employers are supportive of local training programs, the required clinical placements are burdensome for organizations that are often understaffed or don't have appropriate resources to supervise and train students on-site. Any proposed growth in training programs should take this challenge into consideration."[43]

CalAIM Rollout Brings New Resources and More Complexity

DHCS began the CalAIM rollout in 2022, with major changes to many aspects of the Medi-Cal program planned for phased implementation over several years.[44] Two foundational aspects of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS) services. A new Medi-Cal benefit, ECM provides resources for care coordination and complex care management for patients with such needs. CS services go beyond traditional Medi-Cal health care services, adding services for health-related social needs such as housing supports, including transitional rent payments, housing transition navigation, and short-term posthospitalization housing; medically tailored meals; sobering centers; home modifications to improve accessibility; and in-home inspections for asthma remediation.[45] These CalAIM programs have prompted more social service organizations to contract with Medi-Cal managed care plans and more health care organizations, especially CHCs, to offer social services directly or through partnerships.

In Shasta and Lassen Counties, about 2.6% of Medi-Cal members were enrolled in ECM, about a percentage point higher than statewide, while about 1.7% of members received any CS service in 2024, similar to the statewide figure (Table 16). In the fourth quarter of 2024, the most-used CS service in Shasta and Lassen was housing transition navigation (615 members), followed by short-term posthospitalization housing (413 members) and medically tailored meals (301 members); other services were used by fewer than 265 members.[46]

TABLE 16. Medi-Cal and CalAIM,
Shasta and Lassen vs. California, 2024

	Shasta and Lassen	California
Enhanced Care Management (ECM) Enrollment*		
ECM enrollment	2,059	206,501
Share of Medi-Cal managed care enrollees receiving ECM	2.6%	1.5%
Community Supports (CS) Enrollment†		
CS enrollment	1,369	258,141
Share of Medi-Cal managed care enrollees receiving CS	1.7%	1.9%

* ECM enrollment is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.

† CS enrollment is the number of members receiving services in the 12 months of the reporting period ending September 2024.

Source: *ECM and Community Supports Quarterly Implementation Report (data through September 30, 2024)*, California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.

Partnership has created a robust CalAIM team that conducts extensive outreach to increase awareness of the new services and opportunities. Partnership convenes monthly town halls and meets one-on-one with CHCs, hospitals, county government personnel, and community-based organizations for "imagination sessions" intended to create a vision for what implementation of CalAIM services might look like for a specific situation. Drill-down sessions on available funding and reimbursement rates are available to help organizations understand the financial potential and program requirements, as are training sessions on billing and reporting. State funding for providers to support CalAIM implementation is available through Providing Access and Transforming Health Capacity and Infrastructure, Transition, Expansion, and Development.[47] Partnership also supports implementation through the DHCS Incentive Payment Program.[48]

Several themes emerged from interviews with provider organizations involved with CalAIM. On the positive side, the programs are working to meet member needs, such as finding permanent, secure housing. "Connecting patients to resources, it feels like we're making a difference," a respondent said. Multiple CHC representatives noted that CalAIM funding enabled them to expand existing services and increase staffing. At the same time, billing and reporting requirements are challenging and complicated but essential to securing revenue and ensuring that costs of services are covered.

One tangible example of CalAIM's impact in the region: CS funding has enabled the SCHC HOPE Medical Respite Program to expand.[49] The program started in 2020, offering short-term housing and care for people in the Redding area who are discharged from the hospital with unstable housing and need a safe place to heal. The partnership between SCHC, which provides medical care and case management, and Pathways to Housing, which provides housing and hospitality services (e.g., meals, laundry), has a capacity of 20 and has served more than 500 people since inception.

Demand for Behavioral Health Care Overwhelms Capacity

Specialty mental health and substance use disorder services are county responsibilities, and both Shasta and Lassen struggle to meet demand for services. The counties contract with Partnership to provide Drug Medi-Cal Organized Delivery System services (for substance use disorder) in Shasta, Lassen, and five other counties (called the Wellness and Recovery program) through a contract with Carelon.[50]

Inpatient behavioral health services are scarce in Shasta and nonexistent in Lassen. Patients often get stuck in EDs — assessed by the county as unsafe to release because they are a threat to themselves or others — waiting for an appropriate placement, sometimes at facilities as distant as the Bay Area. An online tool introduced by Shasta County in 2024 to share information with its network of psychiatric hospitals has shortened time to inpatient placement, reducing patient ED wait times and freeing up ED beds. Even so, bottlenecks often exist in EDs, with beds occupied by patients whose needs go unmet. Additionally, many psychiatric hospitals do not provide substance use withdrawal services, limiting patient options.

Even when hospitals have availability, they may refuse to take patients needing behavioral health services for a variety of reasons, including comorbidities, behavioral issues, or low payment rates. For example, many county-contracted facilities reportedly no longer take patients with commercial coverage due to low payment rates.

Shasta County's mental health director resigned during the political turmoil associated with changes in the Board of Supervisors.[51] The department is currently overseen by the director of Shasta's Health and Human Services Agency; she does not meet the mental health director position requirements but has been granted approval from the state to serve in the role for 12 months.[52] Behavioral health services have reportedly long been "woefully understaffed and underfunded," a situation exacerbated by the leadership challenges. In recent years, CHCs and tribal health systems have ramped up behavioral services to the extent possible to fill gaps, hiring psychiatrists, psychiatric nurse practitioners, licensed clinical social workers, substance use counselors, and other behavioral health providers. Telemedicine is widely used to augment services, especially for children.

Shasta Substance Use Coalition Works to Reduce Overdose Deaths

The driving force for regional collaboration is the Shasta Substance Use Coalition, a SHARC subcommittee that brings together a wide range of stakeholders, including community-based organizations, county health and human services, law enforcement, courts, the fire department, hospitals, CHCs, tribal health providers, substance use disorder service providers, educational institutions, Partnership, and others. HANC serves as the fiscal sponsor, and three years of funding through Shasta County's Opioid Settlement Fund (2024–27) supports an experienced facilitator who actively manages the effort. Subcommittees focus on prevention and harm reduction, youth prevention, and substance use disorder treatment. In January 2025, the coalition released a StoryMap, "Shasta County's Rising Fentanyl Problem," demonstrating a dramatic increase in overdoses and deaths due to fentanyl between 2019 and 2023.[53] More promising is recently released data showing the number of fentanyl overdose deaths in Shasta County decreasing from 58 in 2023 to 33 in 2024.

The reduction in deaths may be due, at least in part, to the work of the coalition's harm reduction subcommittee. The group divided the county into geographic areas, with volunteers and community organizations doing naloxone distribution; to date, over 100 local businesses have agreed to be trained and to keep naloxone available for emergency response. An opioid monitoring and response plan defines thresholds for an overdose spike in each area, and Shasta County epidemiologists monitor overdoses weekly and notify the network if a spike is observed. All the information is compiled on a map so participants can see what's happening in near real time and target responses.

Region Pins Hopes on State Funding for Behavioral Health Infrastructure

Created in 2021, the Behavioral Health Continuum Infrastructure Program (BHCIP) authorized DHCS to award local grants to support infrastructure investments related to behavioral health.[54] The original authorization resulted in $1.8 billion in awards over five rounds of BHCIP funding. During the first phase, Lassen County was awarded funding for mobile crisis units but did not accept the money (see "Small Rural Counties Need Flexibility and Support," page 24) and a small grant for county and tribal planning. Shasta did not apply for or receive infrastructure funding. In comparison, neighboring counties received substantial funding: Humboldt, $30 million; Glenn and Mendocino, $17 million each; and Lake, $2 million.[55] Voter approval of Proposition 1 in 2024 resulted in an additional $4.1 billion in state funding, of which $3.3 billion was awarded in May 2025. The allotment included $36 million for adult substance use treatment facilities in Shasta County based on applications submitted by

two private nonprofit organizations.[56] Additionally, Redding Rancheria proposed an inpatient medical detox center but was not awarded funding.[57]

The final $800 million in BHCIP funding will be awarded for "unmet need" in rural or remote areas with insufficient behavioral health infrastructure. Led by Arch Collaborative and supported by SHARC, community organizations across Shasta came together to collaborate on an application for the October 2025 due date.[58] Based on extensive community engagement and assessment, including gathering input from families with lived experience, law enforcement, mobile crisis and response teams, current service providers, and hospitals, the group has identified the highest priority to be a new crisis behavioral health continuum treatment facility delivering crisis stabilization, medical detox, social rehabilitation, a 16-bed inpatient psychiatric health facility, and youth crisis and intensive outpatient services. Currently, the sole Shasta residential detox program generally has a long waitlist, and the treatment approach is social rather than medical (i.e., MAT is not available to support substance withdrawal). As one respondent said, "Our EDs and jail are overwhelmed by people with mental health issues. There is no way to accommodate that population and treat them so that they are stabilized and restored or get the long-term care they need." A 13-county gathering in July 2025 to discuss regional behavioral health solutions reportedly generated strong stakeholder support for the effort.

Just days before the application deadline, the County Board of Supervisors called a special meeting and voted 3-2 to approve a letter of opposition to the effort from the Shasta County Health and Human Services Director.[59] Project leaders decided to move forward with the application, which requests $150 million from the state and would pair those funds with a $50 million contribution from lead applicant Signature Healthcare Services.[60] A month after the application was due, several key leaders – including the Health and Human Services Director and a Supervisor – reversed direction and came out in support of the effort.[61] A decision is expected from DHCS in spring 2026.

Small Rural Counties Need Flexibility and Support

Lassen County's experience implementing the new Medi-Cal mobile crisis service benefit, effective January 2023, illustrates the challenges small rural counties face when operationalizing the same programs as more-populated and better-resourced jurisdictions. To offer mobile crisis services, counties must provide 24/7 availability, transportation, and qualified staff who potentially must travel long distances to the remote corners of the county — all costly expenditures for a county of Lassen's size. Moreover, Lassen only receives revenue when mobile crisis services are used; funding does not support standby resource requirements. Based on utilization and revenue to date, the mobile crisis service is not financially feasible for Lassen. As one respondent said, "Programs we develop take time and cost — and then they don't generate any revenue and don't meet a community need. Give us flexibility!" A higher priority for Lassen County, based on community need, is transitional housing for mental health clients. Lassen's successful application for funding from the Behavioral Health Bridge Housing Program created five housing units, and more are needed. Another priority: a sobering center that could serve as an ED alternative.

While the provision of mobile crisis services is a federal requirement, other states have opted for statewide implementation rather than requiring each county to set up its own service. Options to increase flexibility might include shared services across multiple counties, providing crisis services by phone in remote and frontier areas, and additional implementation funding and technical assistance. However, funding is not always the answer: Lassen County's Department of Behavioral Services applied for and was awarded $1 million in BHCIP funding to purchase two new vehicles outfitted for mobile crisis services, but the Board of Supervisors turned the funding down due to concerns about the sustainability of the investment, given that the county is responsible for ongoing expenses for gas, maintenance, and insurance.

Source: Behavioral Health Bridge Housing, accessed September 15, 2025.

Severe Cutbacks Expected to Worsen Access Challenges

Interviews with regional health leaders were conducted after the Trump administration took office in January 2025 but before HR 1 (P.L. 119-21) was signed into law on July 4, 2025. HR 1 is projected to result in more than $900 billion in Medicaid cuts nationally over 10 years. Respondents were aware of the potential changes in the funding environment but did not yet have sufficient information to adjust course. As one noted: "We're tracking, concerned, but we can't change the plan until we know what's coming." Another said, "We're holding our breath for what will happen at the federal level."

The scale of HR 1's Medicaid cuts is vast, with the potential for significant adverse impact on providers and patients in Shasta and Lassen Counties. Given that more than 40% of the region's population is covered by Medi-Cal and that CHCs are often the sole providers of care in remote communities, the loss of Medi-Cal funding could significantly worsen already dire access challenges. When asked to reflect on the potential consequences of major Medi-Cal cuts, one respondent said, "The programs we offer are needed in this part of the state. If I have to cut, people move to urban areas or live at higher risk." Another noted that, without the intergovernmental transfers targeted by HR 1, "we wouldn't be in a solid financial position."

Two of the four general acute care hospitals in the region operated in the red in 2023; both were optimistic about an improved financial picture, but significant revenue loss could threaten their survival. HR 1 includes a $50 billion allocation over five years for a Rural Health Transformation Program to be administered by CMS; states can submit a transformation plan and receive a portion of that funding if approved. KFF estimates that the new funding could offset about 37% of the estimated cuts in rural areas.[62] However, the funding is temporary, while the cuts are permanent.

Concurrently with the federal cutbacks, California is grappling with a $20 billion deficit for the 2025–26 fiscal year budget, reducing the state's ability to backfill federal cutbacks. Responding to significantly higher expenses than anticipated, the state has rolled back Medi-Cal eligibility for undocumented residents, freezing new adult enrollment starting in 2026. The loss of the enhanced premium tax credits for enrollment in Covered California, which expired at the end of 2025, will add to the difficulties. The state and federal budget environment will likely create serious challenges for patients and providers across northeastern California in the coming years.

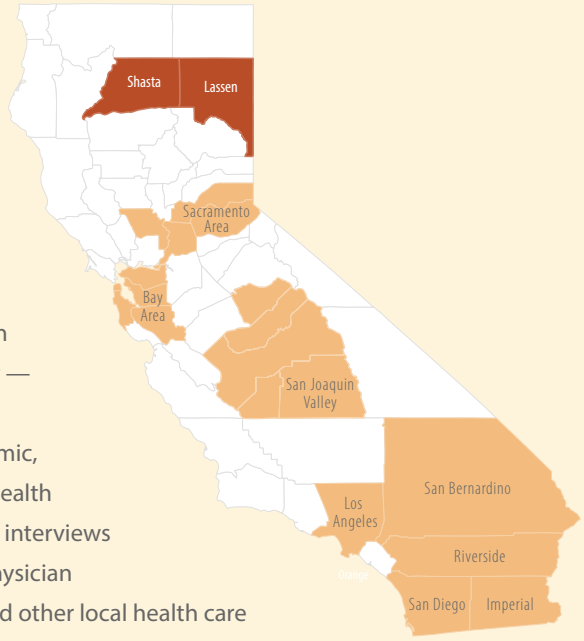
Issues to Track

- How will Shasta County's political polarization impact delivery of health services in the coming years? Can elected officials restore stability to professional leadership roles in county government?
- Will Shasta's community-based coalition win state funding to build critically needed behavioral health infrastructure, including a medical detox facility? If so, when will new services come online, and to what extent will they meet demand?
- How will Shasta and Lassen residents and health care providers deal with the HR 1 Medicaid cuts, especially in a region where 2 in 5 people depend on Medi-Cal for health coverage?
- Will the two hospitals with negative 2023 margins, Shasta Regional Medical Center and Banner Lassen, regain solid financial footing? Or will state and federal Medicaid cuts hurt the hospitals' financial turnarounds?
- How will provider recruitment and retention efforts accelerate to meet the growing need for clinicians, especially primary care and behavioral health providers?

- How will CalAIM services fare after the existing Medi-Cal waiver expires? Will ECM and CS services for medically complex patients and those with health-related social needs continue?
- Will the state of California, including DHCS, begin to assess the implications of legislation, regulations, and other health care requirements from the perspective of small rural counties and consider adapting more flexible requirements for rural and remote communities?

Background on Regional Markets Study

Between March and June 2025, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in Shasta and Lassen Counties in northeastern California to study the market's local health care system. Shasta/Lassen is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fifth round of the study; the first set of regional reports was released in 2009. This is the first time the Shasta/Lassen region was included in the study. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25–30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, community health centers, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.



VISIT OUR WEBSITE FOR THE ENTIRE **ALMANAC REGIONAL MARKETS SERIES**.

ABOUT THE AUTHOR

Jill Yegian, PhD, is the principal of Yegian Health Insights, LLC, which provides consulting services to health systems, nonprofit organizations, foundations, and government agencies focused on health care and health policy.

REGIONAL MARKETS STUDY TEAM

Jill Yegian, Project Director and Regional Lead for Shasta/Lassen and Los Angeles

Ted Calvert, Project Manager

Caroline Davis, Regional Lead for San Francisco Bay Area and San Diego/Imperial

Len Finocchio, Regional Lead for San Joaquin Valley and Sacramento

Marian Mulkey, Regional Lead for Inland Empire

Katy Wilson, Data Lead

Alwyn Cassil, Editorial Lead

Karen Shore, Events Lead

Jessica McLaughlin, Research Assistant

ACKNOWLEDGMENTS

The author thanks all the respondents who graciously shared their time and expertise to aid understanding of key aspects of the health care market in the Shasta/Lassen region, external reviewers for thoughtful feedback, and the California Health Care Foundation for support and contributions.

ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

ENDNOTES

1 "Shasta County History 1940 to Present," Shasta Historical Society, accessed September 8, 2025.

2 "Shasta County Economic Dashboard," California Center for Jobs & the Economy, accessed September 8, 2025.

3 Bethel School of Supernatural Ministry, accessed September 8, 2025; and Nevin Kallepalli, "How Bethel Church Leverages the Power of 'Prophecy' to Influence Politics," *Shasta Scout,* October 5, 2024.

4 Robert Taylor, " 'Prison Town' a View from Outside," *Contra Costa Times*, July 28, 2007.

5 "2023 Poverty Guidelines," Office of the Assistant Secretary for Planning and Evaluation, accessed September 8, 2025.

6 Election Results Archive, County of Shasta, California, accessed September 15, 2025; and "Election History for Lassen County," Lassen County, California, accessed September 15, 2025.

7 Anita Chabria and Hailey Branson-Potts, "Threats, Videos and a Recall: A California Militia Fuels Civic Revolt in a Red County," *Los Angeles Times*, May 19, 2021.

8 Hailey Branson-Potts, "Shasta County Appoints Public Health Officer Who Fought COVID-19 Vaccine Mandates," *Los Angeles Times*, October 19, 2023; and David Benda, Jenny Espino, and Damon Arthur, "Shasta County Executives Who Left: A Timeline of Retirements, Resignations, Terminations," *Redding Record Searchlight*, last updated May 1, 2025

9 Ali Swenson, "Health Subsidies Expire, Launching Millions of Americans into 2026 with Steep Insurance Hikes," Associated Press, January 1, 2026; and "Data & Research," Active Member Profiles, 2025 June Profile, Covered California.

10 *Population Health Management Strategy & Program Description* (PDF) (MCND9001), Partnership HealthPlan, last updated June 14, 2023, 30.

11 Community Profiles: North State Region, Cowell Foundation, accessed September 8, 2025.

12 "California Bridge: Transforming Addiction Treatment Through 24/7 Access in Emergency Departments," California Department of Health Care Services (DHCS), accessed September 19, 2025.

13 "Sage Transparency Dashboard," Employers' Forum of Indiana (Forum), accessed September 8, 2025.

14 "Sage Dashboard," Forum.

15 Sophia Bruinsma, "Dignity Health and Partnership HealthPlan Secure New Contract, Restoring Care Access," KRCR TV, last updated June 11, 2024.

16 "Prime to Take Over Shasta Regional," *Modern Healthcare,* October 29, 2008.

17 Alan Condon, "Hospital Turnarounds Done Right: Prime CFO's 'Playbook' for Success," Prime Healthcare, December 6, 2024.

18 Jesse Angelo, "Shasta Regional Cited for 2 Violations from California Department of Public Health Since January," *Action News Now*, last updated May 1, 2024; "Sage Dashboard," Forum; and "Leapfrog Hospital Safety Grade: Shasta Regional Medical Center," Leapfrog Group, accessed September 8, 2025.

19 "A History Through the Decades: Mayers Celebrates 60 Years! 1956–2016," Mayers Memorial Healthcare District, accessed September 8, 2025.

20 Amber Sandhu, "Mayers Hospital to Close Its Obstetrics Ward," *Redding Record Searchlight*, August 23, 2016.

21 Jill Yegian and Katrina Connolly, *Humboldt and Del Norte Counties: Community Collaboration in the Face of Health Adversity*, California Health Care Foundation (CHCF), October 2020; and Jill Yegian, *Strengthening Independent Primary Care Practice in California*, CHCF, November 2024.

22 Shasta Health Assessment & Redesign Collaborative, accessed September 15, 2025; and California Accountable Communities for Health Initiative, accessed September 15, 2025.

23 "Shasta Health Rock Stars Awards," Shasta Health Rock Stars, accessed September 15, 2025.

24 Jessica Skropanic, "What the Point-in-Time Survey of Shasta County's Homeless Population Could Teach Us," *Redding Record Searchlight*, January 16, 2025.

25 Sarah Kirby, "Shasta Community Health Center Brings Advanced and Compassionate Care to Northern California Families" (PDF), *North State Parent*, May 2024.

26 *340B: A Critical Program for Health Centers* (PDF), National Association of Community Health Centers, June 13, 2022.

27 89 Federal Register 101607, December 16, 2024.

28 Michele Chandler, "Health Village Coming to Redding Designed to 'Take Care of the Whole Body,' " *Redding Record Searchlight*, February 11, 2025.

29 Jeremy Couso, "Photofeature: Lassen Indian Health Center Groundbreaking Ceremony," *Susanville Stuff*, November 4, 2022.

30 *Frequently Asked Questions: Hilltop Medical Clinic Transitioning to Dignity Health Urgent Care* (PDF), Dignity Health, accessed September 15, 2025.

31 Marty Stempniak, "Healthcare Giant Dignity Health Acquiring 70-Year-Old Radiology Practice," *Radiology Business*, November 15, 2023.

32 "The Care Coordination Program," North State Quality Care Network, accessed September15, 2025.

33 Kristin Schumacher, *How California Is Strengthening Its Health Workforce: Five Key Questions and Answers*, CHCF, May 2024.

34 Heather Stringer and Shaun Walker, *New Survey Highlights Worsening Shortage of Physicians in Rural Northern California*, CHCF, June 2025.

35 Shasta County, "Health Officer Dr. Mu Declares Public Health Crisis Due to Physician Shortage in Shasta County," press release, June 11, 2025.

36 David Lavine, "Physician Advisory Committee Workforce Development Update" (PDF), March 12, 2025, 76–99, *in Physician Advisory Committee ~ Meeting Notice*, Partnership HealthPlan of California.

37 Ana B. Ibarra, "California's New Health Care Minimum Wage Is Changing. Here Are Answers to Your Questions," CalMatters, last updated June 22, 2024.

38 A.B. 2860, 2023–24, Reg. Sess. (Cal. 2024).

39 Laurie Bauer et al., *Accelerating Impact: How to Support Nurse Practitioners in Expanding Access to Care*, CHCF, November 2022.

40 "Rural PRIME," UC Davis Health, accessed September 15, 2025.

41 "Shasta Community Health Center's NP/PA Fellowship Program," Shasta Community Health Center, accessed September 15, 2025.

42 "Healthcare Workforce Development Committee," Shasta Health Assessment and Redesign Collaborative, accessed September 15, 2025.

43 Shasta County, personal communication with author, February 2025.

44 "CalAIM Initiatives," DHCS, accessed September 15, 2025.

45 "Enhanced Care Management and Community Supports: Medi-Cal Transformation," DHCS, accessed September 15, 2025.

46 *ECM and Community Supports Quarterly Implementation Report (data through September 30, 2024)*, DHCS, last updated March 2025, data tables for chart 3.9.3.

47 "CalAIM Providing Access and Transforming Health Initiative," DHCS, accessed September 15, 2025.

48 "Incentive Payment Program," DHCS, accessed September 15, 2025.

49 "SCHC HOPE Medical Respite Program: The Hartman House," Pathways to Housing, accessed September 15, 2025.

50 "Mental Health Services," Partnership HealthPlan of California, accessed September 15, 2025.

51 Annalise Pierce, "Shasta County's Director of Mental Health Will Resign in August," Shasta Scout, 6/16/2024

52 *Staff Report* (PDF) (board meeting date May 13, 2025), Shasta County, accessed September 19, 2025.

53 "Shasta County's Rising Fentanyl Problem," Shasta Substance Use Coalition, January 22, 2025.

54 *Behavioral Health Continuum Infrastructure Program (BHCIP) Outcomes* (PDF), DHCS, July 2025.

55 Gabriel Petek, Building California's Behavioral Health Infrastructure: Progress Update and Opportunities for the Proposition 1 Bond, Legislative Analyst's Office, February 5, 2025.

56 "Bond BHCIP Round 1: Launch Ready Data Dashboard," Behavioral Health Continuum Infrastructure Program, accessed September 15, 2025.

57 Michele Chandler, "Redding Rancheria Doesn't Get Grant to Build Residential Drug Detox Center. What Now?," *Redding Record Searchlight*, May 29, 2025.

58 Shasta Health Assessment and Redesign Collaborative, "Behavioral Health Continuum Infrastructure Plan (BHCIP), Solutions for Shasta & Rural Northern California: A Unified Plan for Behavioral Health Investment," accessed November 4, 2025.

59 Annelise Pierce and Nevin Kallepalli, "Chaotic Process, Uncertain Outcome as Shasta Supervisor Attempts to Sideline Behavioral Health Proposal," *Shasta Scout*, October 24, 2025.

60 Annalise Pierce, "Protest Over Board's Opposition to True North Behavioral Health Facility Draws Nearly 100," *Shasta Scout*, October 29, 2025.

61 Annalise Pierce, "Shasta Health and Human Services Director Reverses Course on True North Project," *Shasta Scout*, November 26, 2025.

62 Zachary Levinson and Tricia Neuman, "A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law," KFF, August 4, 2025.