Testimony of Dr. Adriann Begay
House Natural Resources Committee – Subcommittee on Indian and Insular Affairs
Legislative Oversight Hearing on H.R. 3670, the Indian Health Service Provider Expansion Act
June 11, 2025

Good morning, Chair Westerman, Chair Hurd, Ranking Member Leger Fernandez, and Members of the Subcommittee.

Thank you for this opportunity to testify today in strong support of H.R. 3670, the "IHS Provider Expansion Act."

Yá'átééh, Adriann Begay yinishyé, Tábaahi (Edge of the Water) nishłíí, Bít'ahnii (Folded Arms People) báshíshchiin, Ta'néészahnii (Badlands People) dashíchei, Tl'aashchí'í (Red Cheek People) dashínálí. My name is Adriann Begay, I am Edge of the Water Clan, born for the Folded Arms People, my maternal grandfather is Badlands People, and my paternal grandfather is Red Cheek People. I was born and raised on the Navajo reservation by a very strong and hard hard-working single mother. I had a very circuitous educational pathway, which is true for many American Indian/Alaska Native (AI/AN) students. While raising three children, I completed my undergraduate studies at the University of Arizona and earned a medical degree from the University of North Dakota School of Medicine through the Indians into Medicine program. After completing my residency in Family Medicine at the University of Arizona, I served in the Indian Health Service for over 21 years, initially with the Salt River Pima Maricopa community in Arizona, and then returned home to serve at Gallup Indian Medical Center until my federal retirement.

Today, I'm a Senior Advisor for the University of California San Francisco-HEAL Initiative's global health fellowship. In this role, I serve as an advisor on American Indian/Alaska Native (AI/AN) health care issues, advocating for high-quality care and system change and providing presentations on cultural humility and historical trauma to improve service delivery on reservations. I also lead the development of the Southwest Leadership Cohort program to empower AI/AN health care professionals and foster long-term retention. I do this by building relationships among participants who come from both IHS and tribally operated facilities across the reservation, preparing AI/AN professionals to lead and influence health systems, and mentoring those individuals who will ultimately become mentors to the next generation of AI/AN health professionals.

Challenges in the IHS Health Workforce

Throughout my career, I've worked alongside incredible colleagues - people who go above and beyond to serve their communities. However, rural communities and Indian Health Service, Tribal, and Urban Indian (I/T/U) sites continue to face chronic and devastating shortages in the health workforce.

According to the US Department of Health and Human Services, more than 80 million Americans live in Health Professional Shortage Areas, the majority of which are in rural

communities.[1] The problem is particularly acute in Indian Country. Despite treaty obligations, according to a 2018 GAO report, 21% to 46% of physician positions across IHS regions were unfilled.[2] In rural tribal communities, this is not just an inconvenience- it's a matter of life and death. American Indian/Alaska Native patients experience the lowest life expectancy of any group in the United States at just 65.6 years.[3] Staffing shortages contribute to this unacceptable inequity, as they worsen access to care, increase travel and wait times, and limit the availability of culturally-sensitive providers. The Navajo reservation is about the size of the state of West Virginia and has 4 IHS hospitals, 5 tribally operated hospitals, 1 IHS alternative rural hospital, and 15 IHS or tribal health centers serving the reservation. Inconsistent staffing along with long-distance travel - up to 100 miles at time - across unpaved roads presents a critical access issue, disproportionately affecting rural AI/AN populations and contributing to delayed diagnosis, missed appointments, and worse health outcomes. Inadequate training and mentorship of healthcare providers of the obstacles patients face when accessing care contributes to provider burnout, further magnifying the problem and causing avoidable suffering.

Evidence-Based Solutions: Graduate Medical Education at I/T/U Sites

Recruiting and retaining physicians in tribal communities requires intervention throughout the entire medical education pathway, from early education through residency and beyond. For me, I would not be sitting here in front of you if I did not have a role model in Dr. Taylor McKenzie, our 1st Navajo physician. Born and raised on the reservation, Dr. McKenzie came home to care for his people as an orthopedic physician. He became a strong advocate, as he was a founding members of the Association of American Indian Physicians. He also served as the executive director of Navajo Health Authority, envisioning the development of the first American Indian School of Medicine in the 1970s, and eventually became the Vice President of the Navajo Nation. Watching Dr. McKenzie, on rounds as a teenager, gave me proof that someone who had the same color as me and who was born on the reservation just like me could become a doctor. His mentorship was action which inspires me to this day to live a meaningful life and show the next generation, including my children and grandchildren, how to live with integrity, optimism, determination, compassion and hope which in Navajo is hózhǫ́ or being in balance with one's self, with others and with nature.

While IHS provides support for students through scholarships and loan repayment programs, it receives no direct funding for graduate medical education (GME), which includes residency, clinical rotations, and fellowships. In a country that spends over $25 billion on GME every year, this is a glaring gap.[4] Without strong GME infrastructure, I see how IHS struggles to recruit and retain physicians in the communities that need them the most.

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[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas
[2] https://www.gao.gov/products/gao-18-580
[3] https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-12.pdf
[4] Federal payments: https://www.congress.gov/crs-product/IF12583 and State payments: https://store.aamc.org/downloadable/download/sample/sample_id/590

Despite high demand, particularly from AI/AN trainees, there are only eight local residency training programs and five fellowship programs currently operating at I/T/U facilities.[5] While there are dozens of short-term clinical rotation opportunities, these receive no federal support.[6] These programs, however, demonstrate incredible success.

Importantly, these programs empower AI/AN residents to serve in their own communities, as 46% of residents in the Seattle Indian Health Board Family Medicine Residency identify as AI/AN. For both AI/AN and non-AI/AN trainees, they also serve as a powerful recruitment tool. Where physicians complete their training influences where they choose to practice afterward, and it can also shape their cultural understanding of the communities they will eventually serve. These programs work because they immerse young doctors in I/T/U settings and provide them the mentorship to succeed. For example, among four of the tribal residency training programs in family medicine, 51% of doctors have stayed working in the I/T/U system. Incredibly, the Choctaw Family Medicine Residency has retained an impressive 70% of its graduates in their own health system.

Additionally, these programs don't just recruit residents, they also recruit high-quality faculty members. At IHS Shiprock-University of New Mexico, the first federal IHS residency program and only residency program on Navajo Nation, reports 4 full-time staff hires as a result of creating a residency program.

These programs also help address shortages of primary care providers in rural communities. One national study found that residents who spent at least 50% of their training in rural areas were five times more likely to continue practicing in those same settings. Even small amounts of rural exposure—just 1% to 9% of training time—can have a measurable impact.[7] Across the three family medicine residency programs at I/T/Us in Oklahoma, 72% practice in rural or partially rural communities after training.

Fellowships, like the University of California San Francisco's - HEAL Initiative have a similar impact. Our global program pairs US-trained physicians with local site fellows across 19 global and domestic sites, including the Navajo Nation. We embed the values of solidarity, partnership, and long-term capacity building into the fellowship, creating a space for the co-creation of solutions and relationships that last beyond the two years. Of the 37 physicians who served in the Navajo Nation for the first time during their fellowship, 11 have stayed and continued to serve. This is a powerful indicator of what's possible when training is done with cultural humility and structural support.

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5 https://aimesalliance.org/wp-content/uploads/2024/08/LinkedIn-Post-AIMES-Alliance-Senate-Finance-Medicare-GME-Response.pdf

6 https://aimesalliance.org/itu-gme-opportunities/

7 https://meridian.allenpress.com/jgme/article/14/4/441/484914/Family-Medicine-Residencies-How-Rural-Training

Furthermore, data over the last 9 years of HEAL show that AI/AN healthcare workers have grown professionally and personally from their participation in HEAL. They have gained leadership opportunities, a robust network with other fellows & alumni, and new skills leading to retention in their own communities. For instance, a Navajo dietician was a site fellow from a tribally operated or 638 facility in Navajo, received the skills and confidence to start her own business in providing community education on the power of local food systems to empower the local community in increasing their access to healthy and traditional foods. She believes local communities deserve nutrition education with dignity, acceptance, and above all love.

These programs also yield cost savings, as it is possible to bring in multiple residents and fellows for the cost of one locum tenens provider. A residency slot funded through HRSA's Teaching Health Center GME program costs up to $160,000 annually, and a fellowship can cost up to $220,000 annually.[8] In contrast, hiring a single locum tenens physician as a short-term, stopgap solution can exceed those amounts without providing a lasting impact. Investing in GME means investing in people who build trust and stay.

The Promise of HR 3670: The IHS Provider Expansion Act

HR 3670, the IHS Provider Expansion Act, is a crucial piece of legislation to establish a pathway of health professionals. It will expand access, improve the quality of care, and strengthen the health workforce for tribal communities. The bill establishes an Office of Graduate Medical Education within IHS, finally giving the agency the authority and resources to coordinate, fund, and grow GME opportunities across Indian Country.

There are three reasons why this bill is so important:

1. Scaling up Residency and Fellowship Training

While the US spends $25 billion annually to train 145,000 doctors each year, only 77 residents are in full-time training at I/T/U facilities, representing just 0.05% of trainees.[9] None of the residents are funded through IHS. To meet the urgent needs of tribal communities, increasing the number of trainees working and learning at I/T/U sites is essential.

2. Creating New GME Pathways

Developing and accrediting residency, clinical rotation, or fellowship programs requires time, technical assistance, and funding. HRSA's GME development grants have been productive in supporting the development of the eight existing residency training programs, but this funding does not meet the scale of need. Additionally, they do not account for the unique needs of tribal systems. This legislation would support the launch of new, sustainable GME programs tailored to tribal communities.

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8 https://bhw.hrsa.gov/funding/apply-grant/childrens-hospitals-graduate-medical-education/faq-teaching-health-center-graduate-medical-education-thcgme-program#:~:text=The%20THCGME%20Program%20payment%20is,be%20%24160%2C000%20per%20resident%20FTE.

9 https://aimesalliance.org/wp-content/uploads/2024/08/LinkedIn-Post-AIMES-Alliance-Senate-Finance-Medicare-GME-Response.pdf

3. Improving Coordination

Currently, there is no central hub to connect medical students and residents with potential training opportunities at an IHS facility, and IHS is the only large federal health system to lack formalized partnerships with academic medical centers or community-based medical schools. In comparison, the Veterans Health Administration has had 75 years of active partnership with teaching hospitals through its Office of Academic Affiliations.[10] The VHA budget of over $850 million for GME supports 75,000 individual trainees and nearly 12,000 GME positions.[11] Academic partnerships provide many benefits, including stability, shared faculty, clinical, and research staff, and a wealth of experience. Virtually all of VHA GME programming is sponsored by an academic affiliate, and 99% of medical schools are affiliated with VHA.

In addition to partnerships with academic medical centers, this bill creates an interagency working group with key agencies such as CMS, HRSA, and VHA. Given the longstanding precedent across I/T/Us of regional coordination and local self-governance, funding should be made available for GME coordination at multiple levels of governance.

This proposal is supported by many partners, including the American Indian Medical Education Strategies (AIMES) Alliance. The Alliance is a collaboration of 25 urban and rural Tribal organizations, medical schools, health plans, teaching hospitals, medical residencies, and physician advocates, whose mission is to address physician shortages in Tribal communities with one focus: advancing and advocating for federal policies that bring GME partnerships to more urban and rural Tribal medical facilities.

Conclusion

HR 3670 is about more than just training physicians. It's about transforming rural and tribal health systems to ensure that they are not an afterthought in medical training.

We must move beyond temporary fixes and invest in long-term, community-rooted solutions. By expanding and coordinating medical education opportunities at I/T/U sites, we can strengthen care, increase access, and build a health workforce that reflects and serves our people. HR 3670, the IHS Provider Act, does exactly that.

Thank you again for the opportunity to provide testimony today on HR 3670, and I respectfully ask the members of this subcommittee to bring this bill to a markup and advance the bill to final passage. I've dedicated my life to empowering AI/AN students who can come home and care for their people, and this legislation is crucial to building the systems and support they need to succeed. I would be happy to answer any questions you have for me.

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[10] https://www.va.gov/oaa/

[11] https://www.va.gov/budget/docs/summary/fy2024-va-budget-volume-ii-medical-programs.pdf and https://www.va.gov/oaa/medical-and-dental.asp