Kentucky Board of Optometric Examiners
Board Meeting Friday, June 20, 2025
Hyatt Regency Hotel, 401 W. High Street, Lexington, Kentucky
11:00 am ET

Transcript of Testimony of Board members of the National Board of Examiners in Optometry to the KBOE.[1]

0:00 Dr. Joe Ellis: We have some guests here, so let's let the guest introduce themselves.

0:12 Dr. Susy Yu: I'm Dr Susy Yu, representing the NBEO.

0:16 Dr. Mike Ohlson: and I'm Mike Ohlson. I'm representing the National Board.

0:53 Dr. Joe Ellis: We do have some guests here, so Michael, if you and Dr. Susy would come on up. The floor is yours to make comments. We know y'all come from great distances so we're anxious to hear your comments and remarks.

1:12 Dr. Mike Ohlson: Well, I'd like to thank you for having us. We were bringing our Executive Director, [Dr. Jill Bryant}, [but] she's never left Charlotte. She tried until late last night, and ultimately her flight was canceled. So, I hope you bear with us. We're going to try to do some of her presentation.

Earlier, I was speaking with two of your board members, and we talked about communication, and we agreed mutually that [we] wish we'd have communicated better. I certainly invite all of you to the testing center if you ever want to speak to me or Jill or Susy or any of us, we'd be happy to- I think we should do that.

2:57 Dr. Mike Ohlson: I'll go ahead and introduce myself now. So anyway, my name is Mike Ohlson. I practice in Minnesota right now. I'm the current National Board president. I graduated from University of Houston in 1990 which means I've been doing this 35 years. Most of my career was in a rural private practice in Iowa. If you've been to Iowa, you know that's redundant, because the state is rural, and I was the only optometrist for quite a distance in any direction. It's mainly a geriatric population. It's the second oldest state in the country. I spent nine years on the Iowa board of Optometry. I was on the ARBO board for 10 years. My practice included being on call basically 24/7, there was a small hospital. I did inpatient care. I was called to the ER about once a week. And I also provided nursing home rounds. My side gig remains doing pediatric low vision rounds across Iowa, anywhere infant to 18 years of age, the infants are mainly non-accidental head trauma and CVI. The kids are usually severe genetic abnormalities with systemic health disorders, and the teenagers are maybe traditional low vision people. Lately I've been at a rural Regional Hospital. We sold our practice over the last eight years. I've been in a regional system. I work for them, not really under anyone, I just work at the hospital, and

[1] This transcript has been lightly edited for readability and to omit comments unrelated to the substantive testimony.

that's been wonderful. I hold diplomate status in comprehensive eye care section in the academy and in medical optometry through ABCMO. I will now turn it over to my colleague, Susy.

4:58 Dr. Susy Yu: Dr. Ellis, chair, and members of the board, thank you so much for the opportunity to address you today. I'm going to be reading some prepared remarks. As you've heard, I'm an optometrist, past president of National Board. I served on a state board of optometry, as you have, for the past- for eight years. I am past president of the Association of Regulatory Boards of Optometry. I'm also a fellow and a diplomat in the public health section of the American Academy of Optometry. I'm also a fellow of the American College of Healthcare Executives. And I currently work in an integrated health system as an administrator, where I have responsibility for close to 400 optometrists.

I speak today from both a regulatory and a health system perspective to explain why NBEO's three-part exam series, especially Part I: Applied Basic Science, is essential for protecting patients and preserving the integrity of our profession. Choosing not to require all licensed optometrists pass Part I would be wrong for patients and for the profession. How can someone be a good doctor without the understanding of basic science, pharmacology, human anatomy? The decisions that we make every day, whether it's detecting systemic conditions through the eye, triaging ocular disease, choosing the safest medication, these are all rooted in foundational knowledge. And Part I, NBEO's three parts together, ensure that every optometrist, regardless of where they're trained, are competent to go into independent practice. This is even more important, because optometrists are often the only point of access to healthcare for many Americans, 6 in 10 adults have at least one chronic disease or condition; diseases like diabetes, heart disease, cancer and neurologic disorders, and these are often manifest first through the eye. 1 in 5 Americans has not seen their primary care physician in over five years. Yet, 60% of Americans have an annual eye exam. So, whether it's in private practice, in a rural setting, in a health system, in a corporate retail setting, optometrists are part of the fabric of healthcare delivery, and that means we have to speak the same language of healthcare. We have to interact with other physicians, clinicians, providers and manage patients with systemic disease, all of which require the kind of baseline competence that the NBEO Part I measures.

The proposed change would also have serious interstate consequences. Many optometrists move between states, practice in multiple jurisdictions. If Kentucky stops requiring the full NBEO series, its licensees may be barred from practicing elsewhere. In fact, at least one state has already passed legislation, unanimously, stating that it will not recognize licensure by endorsement for any Kentucky OD who has bypassed the NBEO and used the Canadian exam instead. For all of these reasons: public safety, clinical credibility, professional mobility, healthcare integration, the NBEO Part I must remain a requirement for licensure.

8:38 Dr. Mike Ohlson: Now I'll have to read [Dr. Bryant's] remarks: Our three-part licensure exam series works together as one exam. That's actually a huge point. The competency assessment is one competency assessment. So, when people divide up NBEO, it sounds okay. I know other jurisdictions do it, but it's one competency exam. It's actually designed to be just one exam in three parts. It's based upon the scope of practice within the United States. Each part of the exam is developed through

national job task analysis performed by subject matter experts, and by considering stakeholder feedback. We repeat this process every five to seven years to ensure that the exams are aligned with contemporary standards. Internal and external psychometricians – .I'm going to put an aside in there. NBEO doesn't use just their own psychometrics. We actually have a huge firm that specializes in this, and they critique it to make sure it's right. That's their job. The job isn't to say they did good. That their job is to rip it to shreds if it's wrong. Sorry, I interrupted myself. Review every step of the exam development process to ensure it is based upon testing best practices from the testing community and consistent with the standards for educational and psychological testing, and that the exams and the cut scores for passing are valid. The Part I: Applied Basic Science Exam itself is developed by item writers from across the country, including Kentucky, and evaluated by two committees plus a council composed of a diverse group of optometrists. Every question on the exam is reviewed by approximately 25 optometrists prior to being used on the exam. The Part I exam focuses on the application of biomedical science principles to clinical care. Each question that is used on the exam has a direct clinical tie to patient care. The Canadian written exam does not cover the biomedical science information like the National Board Part I exam, the Canadian exam and the National Board Part I are not interchangeable. They're not the same.

11:17 Dr. Mike Ohlson: Now, you're back to me. When I think of the biomedical sciences, if you look at National Board, it says ABS or applied basic science. Those are interchangeable terms. So, when we say biomedical science, we really mean applied basic science. You can think of those as the same. The three main ones are the three P's. That's not an Ohlson phrase. That's a real phrase coming from medicine. Physiology, the mechanisms of health, treatment. Pathology, mechanisms of disease. And pharmacology. In this case, we refer not to just eye medication, but general pharmacology, systemic adverse effects, pregnancy, pediatrics and aging, all of those factor in when we prescribe medications. In terms of the basic sciences, gross anatomy, neuroanatomy, histology, human development, which I do not see on the Canadian exam. Optics are especially valuable because the optics of laser, special refractive techniques, intraocular implants in pre and post operative care, those are the kind of things that are on the basic science test. Biochemistry and nutrition, immunology, and microbiology.

Sadly, I remember COVID, and I had just gone to the hospital, and I assure you, working in a rural hospital during COVID was an ugly, ugly thing. COVID was, from my point of view, cell biology and genetics. Genetics are especially apt. I can't imagine not having a strong foundation in genetics giving my low vision care. And also, the new treatments that are coming down the line. Behavioral sciences, anxiety, depression with vision loss are huge. And also, labs and imaging. You can't just know when to order a lab or when to order an image, but you need to know how they actually work. This has really been brought home to me by being in the hospital for the last eight years.

Just to give this a little background, in 2010 a medical science educator, a person named Pangaro, wrote that experts use understanding basic science in dealing with difficult cases. In other words, when we're doing something routine, we really don't sit and think about biochemistry, but when it comes down to difficult cases, it's a different, different thing. It separates physician level from those providers using algorithms, and that really speaks to me as an optometrist, the more difficult cases require basic

sciences. In 2020, I wanted to stay kind of current, Dickinson wrote in *Medical Science Educator* that the "basic sciences are the foundation of clinical reasoning and decision making. They're required for novel, ambiguous presentations. They're essential for lifelong learning, which comes to our continuing education. They're critical in doctor patient relationships because we educate and empower our patients. And they're essential for applying new technology, therapies, and diagnostics over our careers." Even more current in *Medical Education* -it's a different journal- Albert wrote "A systemic or systematic review regarding basic science retention and its application to clinical practice." Very simply, he wrote "this the foundation of modern practice." These will sound similar, and it's not a coincidence. This is really how national board was founded. Anatomy, physiology, biochemistry, microbiology, pathology, pharmacology, and immunology underpin the understanding of normal structure and function, pathophysiology, diagnosis and treatment modalities. Basic sciences enhance clinical practice, improve diagnostic accuracy- these are coming from other studies, because it was a systematic review- they're crucial and unexpected or complex cases, effective integration of new information and enhancing clinical skills over time (again, CE) and they support clinical reasoning and new information synthesis.

16:24 Dr. Mike Ohlson: So, I reflected a bit on some of my cases over my career, and one when I was in Iowa and kind of all alone, a woman came in and she wanted a second opinion. This was a young woman. She'd been diagnosed with a migraine in the emergency department of another in another town that one day prior. She had blurred vision; it just didn't seem right to her. Her signs and symptoms did not match a typical migraine. She had subtle changes in the vasculature of her right eye. University of Houston was brutal to me, so I went and grabbed my stethoscope, and sure enough, she had a bruit. I sent her for a stat referral. The bruit sounded exactly like it would on a recording. It was perfect. She had her first stroke when they were doing the Doppler, and then she went on and had two more. But thankfully, they were minor strokes, and she turned out fine. I cannot imagine not having a knowledge of anatomy, pathology, imaging, patient education, communication with other healthcare providers, the cardiovascular system and neurology. I just can't, and so that's an example of a complex case.

Since I've been in the hospital, I go to rural outreach, and outreach is a hoot. It's very rural location where I'm at. I saw a nursing home patient brought over [with] severe herpes zosterophthalmicus – shingles. Patient also had diabetes, was wheelchair bound and was young. My definition of young is he's younger than me. He had a ptosis, fixed pupil. I had to clean him all up to lift his pupil, to lift his eyelid, to see the pupil. His extraocular muscles were restricted. He had orbital apex syndrome. Again, without a knowledge of neuroanatomy, imaging, pharmacology, pathology, virology, immunology, and hidden function, I couldn't possibly have managed that case. The hospital system, for those that care about optometry, wants me operating at full scope. So many times, I'm the only person in the hospital, and I'm always the only person at outreach.

18:57 Dr. Mike Ohlson: The last case was a corneal ulcer case, which is pretty basic for optometrists nowadays. This was a young woman. However, she only has one eye. She has a prosthetic in the other eye, the good eye has a corneal transplant. She has a history of trauma. An ophthalmologist removed a broken suture a day or two before, without complication. She presented with a dense corneal ulcer

where the suture was removed, and antibiotics were not obtained in case she was using her steroid but not her antibiotics. This case brings up corneal physiology, which is [on] Part I, microbiology, pharmacology, immunology, and trauma informed care.

I just cannot press enough how OD's treat complicated cases, particularly rural ODs, and the basic sciences are not the same as the clinical sciences, and that's really why we're here. The simple reason why I care is because I really don't believe Canada's written [exam] is the same as National Board Part I. In fact, if you look at the Canadian website, you'll see that for study references, they recommend studying NBEO Part II's study guide for their [written exam]. And I think that's very telling. Other than that, I thank you for having us.

21:22 Dr. Joe Ellis: We appreciate you taking both y'all to come down, and tell Dr. Bryant, we wish she could have made it.

23:33 Dr. Joe Ellis: We'll take this under consideration here, about your comments here, but appreciate you being here in person, and I'm like you, Dr. Ohlson, I really wish we had convened together, you know, much earlier in the communication.

24:42 Dr. Susy Yu: Thank you very much for your time. I believe we have a shared mission. NBEO's mission includes public protection, just like your state board does, and we couldn't silently stand by. So, thank you for this opportunity.

25:27 Dr. Mike Ohlson: Thank you very much for having us, and sincerely, we do want you- I don't know, sometimes state boards are restricted in their travel, but if you get more curious on National Board, I'm certain we can arrange a visit, and you can meet staff and even see the Part III live, and that might help you. I think when people actually meet the staff, they come away not feeling like it's this distant bureaucracy, but like it's optometrists. Watching the meetings work, if you watch the exam committees work or the standard setting committee's work these decisions on cut scores or what goes on the test are made by us. They're made by optometrists. They're not made by me sitting around making some judgment call or Susy. They're made by very broad and diverse groups. The majority of the colleges are represented, and everyone is attuned to the abilities of candidates at the level tested. In other words, I don't come in and say, I've done this 35 years, and I want you to know this, it's oftentimes professors or preceptors who are very familiar with the abilities of students at that level tested, and that's what the test is, which is very different than what you might read or hear.