Testimony Supporting Senate Bill 36 Senate Health Committee

Dr. Michael Earley, October 15, 2025

Chairman Huffman, Vice Chairman Johnson, Ranking Member Liston, and members of the Senate Health Committee: my name is Dr. Michael Earley, and I am here today to express my strong support for Senate Bill 36.

I speak to you as a practicing optometrist of 37 years and a past president of the Ohio Optometric Association. I also bring the perspective of an educator, having served as Associate Dean of Academic Affairs at The Ohio State University College of Optometry for 11 years, and as Chair of the college's Admissions Committee for 21 years, until my retirement in May.

Today, I want to emphasize three key points. First, The Ohio State College of Optometry currently cannot provide training in a live clinical setting for the procedures listed in SB 36. This limitation is a recruitment barrier to attract the best students to our program and will become an even bigger obstacle as more states and their schools begin direct patient based clinical training in these procedures.

Second, the inability to perform these procedures in Ohio is a major reason our graduates choose to leave Ohio to practice elsewhere; and third, the curriculum at Ohio State, and indeed at every college of optometry, has a proven very strong history of educating doctors to perform these procedures successfully with identical outcomes to when these procedures are performed by ophthalmologists. [1]

As Chair of Admissions and Associate Dean of Academic Affairs I had direct interactions with both applicants and current optometry students. I was personally involved in every offer of acceptance to our college, and I supervised all faculty and staff who worked in career planning and job search. Despite any claims you may hear in later testimony on this bill, I can tell you without reservation that Ohio's current scope of practice for doctors of optometry is limiting to both our recruitment efforts and our efforts to retain our graduates. Our current scope of practice DOES impact Ohio's workforce, both in terms of building that workforce and enhancing and maintaining that workforce regarding quality vision care.

The Ohio State University College of Optometry is considered nationally as one of, if not THE, premier program in the country. Our college leads EVERY outcome measure used for accreditation, including academic strength of incoming students, first-time national board passage rates, residency match percentages, and satisfaction of employment after graduation. We recruit the best, educate at the highest level, and graduate the best educated optometry students in the country. We are the applicants "reach school," as our graduates are heavily recruited around the country.

However, competing for the best applicants is getting harder despite this reputation of excellence. Optometry schools in states immediately surrounding us tell applicants "Yes, OSU is a great school, but WE practice to the highest level of patient care, and you will graduate with the necessary hands-on experiences to meet the state requirements for licensure in ANY state." We cannot refute that statement. Our graduates DO have to receive post graduate proctored clinical

experiences in the procedures addressed in our bill. They never have issues getting certified because of the quality of their education in our coursework that Dr. Zimmerman covered, but they do need hands-on involvement. As more and more colleges of optometry gain this clinical experience through state scope expansion, we are more and more fighting on an uneven playing field and cannot afford to become an outlier in this clinical educational area. There are currently 11 more states with similar bills in the process. That is in addition to the 14 states that already have these privileges.

I would now like to address the issue of retaining our graduates as practitioners in Ohio. Opponents of this bill have and will state that there is no evidence of graduates leaving Ohio. They present total numbers of licensed optometrists in Ohio as convincing evidence of this claim without considering critical factors such as how many of these licensees are dual licensed and actually practicing in other states, or how many are older doctors practicing heavily reduced schedules.

More importantly, these claims ignore the FACT that over the last three years, of the 197 graduates from our college, 102 have left to practice in other states. We have retained only 48% of our graduates. This is verified by data from our college, from the Ohio Optometric Association and from national data from the American Optometric Association. In addition, as is covered in detail in the written testimony of Dr. Edlow, the number of doctors in Ohio that fall in the 26-35 age bracket is only 19% of our practicing doctors. Every other age bracket is 23% of the workforce total. This is not a promising trend for the future of access to eyecare. We can all wait until this evolves from a trend to a critical shortage like what ophthalmology is experiencing, or we can act now to avoid that critical shortage.

We work with students to identify what drives their long-term job satisfaction. Across the board, they seek the ability to practice independently to the full scope of their training. Ohio is not only the 7th largest state by population, but it also has one of the fastest growing populations of older adults. This significant increase in the need for vision care comes at a time when the number of ophthalmologists both nationally and in Ohio is expected to decrease. We tell our students - this is an OPPORTUNITY.

But this opportunity does not exist if the ability to fully care for your patients is not present. When those opportunities are limited, frustration replaces fulfillment, and many look outside Ohio to practice. While we can't change what other states can offer, we *can* strengthen Ohio's appeal by allowing doctors to practice at the top of their training.

Senators, the growing need for eye care professionals to perform the procedures outlined in this bill is undeniable. This brings me to my third and final point: the question of whether Doctors of Optometry are qualified to provide this care. Unfortunately, this debate has too often shifted from a discussion grounded in facts to one clouded by misinformation and fear-based rhetoric.

The claim that a 32-hour course is insufficient training for these procedures is misleading as it ignores the comprehensive education doctors of optometry receive as well as how continuing education works for all physicians already in practice when learning new procedures.

Previous testimony has suggested that the key concern isn't just performing the procedures but determining whether a patient is an appropriate candidate. Tests like optical coherence tomography (OCT) and dilated retinal exams were cited previously as essential preoperative evaluations. These are, in fact, routine tests that doctors of optometry already perform regularly *BEFORE* referring patients to ophthalmologists, and it is misleading for our opponents to suggest in testimony otherwise. Opponents of SB 36 may also argue that our profession only has an optional residency program. While our training pathway differs, it is rigorous, comprehensive, and specifically designed to prepare doctors of optometry to safely perform the procedures outlined in this bill.

I'd like to share key data from states that have already expanded optometric scope of practice to the benefit of their patients. Optometrists in Oklahoma, for example, have safely performed laser procedures for nearly four decades. A 2024 peer reviewed, retrospective study, reviewed over 146,000 laser procedures performed by optometrists and found only two negative outcomes, a complication rate of 0.001%.[1] This safety record is further supported by letters of attestation from the State Boards of Examiners in Oklahoma, Kentucky, Alaska, and Louisiana. These states offer real-world evidence that doctors of optometry can safely and effectively perform the procedures outlined in SB 36 with the education received from their optometry school and, if necessary, the post graduate certification course.

Lastly, and very importantly, our professional association would never ask the General Assembly to authorize procedures we are not properly trained to perform. Patient safety is, and has always been, our top priority. We do not seek changes to the law simply based on our training or aspirations; we come before this body when we see a clear need to improve patient care. Our request represents a conservative, evidence-based expansion rooted in the best interests of our patients.

Mr. Chairman, members of the committee, thank you again for the opportunity to testify in support of SB 36. I respectfully ask that you consider the evidence-based facts presented today, as well as the written testimonies submitted from supportive ophthalmologists, optometrists who have left Ohio to safely perform thousands of laser procedures in neighboring like Kentucky, and the documentation regarding the rigor of the laser certification courses used in other states.