

Barriers to Cochlear Implant Uptake and Ways We Can Improve Access

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Introduction:

Barriers exist that inhibit those that qualify for a cochlear implant (CI) to pursue implantation. Understanding these barriers may help to expand access to those that would benefit from a CI. Existing literature has shown that this is a multifactorial issue that exists globally with some barriers unique to country of study. These barriers can be defined as either patient-driven or clinician-driven. The purpose of this scoping review is to map and outline the existing literature in our field pertaining to CI uptake and to report on innovative ways that we can improve.

Methods:

A preliminary search was performed in PubMed, EMBASE, and Web of Science. This search revealed 28 unique articles relating to CI uptake in adults. A more thorough search was conducted revealing over 100 articles relating to cochlear implant barriers.

Results:

Prospective questionnaires and interviews: Groups that have been surveyed are those currently wearing hearing aids that may or may not be a CI candidate, current CI users, those awaiting surgery for their CI, those that chose to forgo a CI, hearing healthcare professionals, and the public. Patient-driven barriers were found to include fear of the unpredictable nature of CI outcomes and whether the CI will do better than their current hearing aids, surgical complications, and sound quality. When surveying clinician-driven barriers there is a reported lack of consistent referral criteria and resources.

Retrospective analysis: At a study-group level socioeconomic status and education level do not seem to influence the decision to pursue a CI. Implantation rates increase with age, but this could be due to the increase in hearing loss. Those with bilateral or symmetrical hearing losses are more likely pursue a CI. Distance to a CI center does not seem to impact the decision.

Conclusion:

Patient-driven barriers can be directly addressed if uncovered during evaluations or intake forms. Consistent referral criteria and resources can be overcome by providing outreach and education to non-CI audiologists and other healthcare providers. However, there is a disparity in the populations that we are implanting and therefore studying. In general, hearing healthcare does not extend to those of lower socioeconomic statuses or education levels. Community outreach can help to overcome some of these disparities, but audiology advocacy and lobbying can help to introduce hearing healthcare into community clinics. A new way of understanding the audiologist-patient relationship such as an intake survey that probes the patient's satisfaction with their current hearing aid audiologist could also be beneficial for patient counseling.