W H I T E P A P E R

Vision & Hearing Loss

Sensory Impairment and Dependency

AMD · Glaucoma · Diabetic Eye Disease · Presbycusis · Dual Sensory Impairment

A Complete Guide for Patients, Families, and Caregivers

Screening · Modern Therapies · Hearing Aids & Cochlear Implants · 2026 Pipeline · Caregiver Support

Published July 2026 | Health Education Resource Center

Sources: NIH National Eye Institute, NIDCD, Lancet Commission on Dementia, FDA, AAO, AOA, HLAA, ASHA

> *This white paper is for educational purposes only and does not constitute medical or legal advice. Consult qualified medical professionals for personal guidance.*

1. EXECUTIVE SUMMARY

Vision and hearing are the two senses through which most human independence flows. When one fails, adaptation is difficult but usually possible. When both fail together — a condition called dual sensory impairment — the risk of falls, cognitive decline, social isolation, driving loss, and dependency rises dramatically. Sensory impairment is one of the most under-recognized drivers of loss of independence in older adults, and it is also one of the most treatable.

The 2024 Lancet Commission on dementia prevention identified hearing loss as the single largest modifiable risk factor for dementia — accounting for approximately 7% of dementia cases at a population level, tied with elevated LDL cholesterol. Vision loss was added as a new risk factor in the 2024 update, accounting for an additional 2%. Combined with the twelve other modifiable factors identified by the commission, aggressive management could prevent or delay an estimated 45% of dementia cases. This makes routine hearing screening and eye examination one of the highest-yield preventive activities in later life.

Approximately 68% of U.S. adults over age 70 have measurable hearing impairment, and roughly one in three adults over 65 has a vision-impairing eye disease. The prevalence of dual sensory impairment globally is around 5.5% and projected to rise 27% by 2050 as populations age. In the U.S., roughly one in nine adults 80 and older has both clinically significant vision and hearing loss. This paper covers the two conditions together because they interact — and because the dependency risk of the combination is far greater than either alone.

Key Facts at a Glance

- **Prevalence:** Approximately 68% of U.S. adults over age 70 have hearing loss; roughly one in three adults over 65 has a vision-impairing eye disease. Dual sensory impairment affects an estimated 5.5% of adults globally and rises steeply with age.
- **Dementia link:** The 2024 Lancet Commission identified hearing loss (7%) and vision loss (2%) as major modifiable dementia risk factors. Each 10-decibel worsening of hearing is associated with a 16% increase in dementia risk. A 25-decibel hearing deficit corresponds to cognitive decline equivalent to about 6.8 years of aging.
- **Fall and fracture risk:** Persistent dual sensory impairment is associated with a 36% higher fall risk and roughly a doubling of hip fracture risk compared with normal sensory function. Post-discharge fall risk after hospitalization is more than three times higher in patients with dual sensory impairment than in those with only vision or only hearing loss.
- **Treatment revolution:** The first drugs to slow geographic atrophy in dry age-related macular degeneration were approved in 2023. Anti-VEGF injections have transformed wet AMD, diabetic macular edema, and retinal vein occlusion. Over-the-counter hearing aids became legal in 2022. Cochlear implants routinely restore functional hearing when hearing aids can no longer help.
- **The 2026 pipeline:** Gene therapy for geographic atrophy is advancing through Phase 2/3 trials. Longer-acting anti-VEGF implants, oral complement inhibitors, and bispecific biologics for retinal

disease are all in registration or late-stage development. Totally implantable cochlear devices and next-generation neural hearing prostheses are entering clinical use.

> *The central message of this paper: sensory impairment is treatable, and treating it matters for far more than sight and sound. Uncorrected hearing loss triples dementia risk in some cohorts; treating hearing loss lowers cognitive decline. Untreated cataract disproportionately increases fall and dependency risk; cataract surgery is one of the most effective interventions in all of medicine. The families who fare best treat vision and hearing as central medical concerns, not as optional aging cosmetics.*

2. UNDERSTANDING SENSORY IMPAIRMENT

Vision loss and hearing loss are not single diseases but families of conditions with different causes, different trajectories, and different treatment options. Understanding what is causing the loss — not simply that loss is present — is the first step toward the right treatment plan.

The Scale of the Problem

~68% of U.S. adults over 70 with measurable hearing loss

~1 in 3 adults over 65 with a vision-impairing eye disease

~5.5% global prevalence of dual sensory impairment

+27% projected rise in dual sensory impairment by 2050

~11 million Americans with vision impairment; ~1 million legally blind

Common Causes of Vision Loss

Condition	Description	Approximate U.S. Prevalence (Adults)
Cataract	Clouding of the eye's natural lens; the leading cause of reversible vision impairment worldwide	About half of adults 75 and older have some cataract
Age-related macular degeneration (AMD)	Progressive loss of central vision; dry (geographic atrophy) and wet (neovascular) subtypes	Roughly 20 million Americans have some form of AMD
Glaucoma	Progressive optic nerve damage, typically from elevated intraocular pressure; painless peripheral vision loss	Approximately 3 million Americans
Diabetic retinopathy	Damage to retinal blood vessels from diabetes; leading cause of blindness in working-age adults	About 1 in 3 adults with diabetes
Refractive error	Uncorrected nearsightedness, farsightedness, or presbyopia; the largest single cause of correctable vision impairment	Universal above age 45 (presbyopia)
Retinal detachment	Separation of the retina from	About 1 in 10,000 annually

Condition	Description	Approximate U.S. Prevalence (Adults)
	underlying tissue; a medical emergency requiring prompt surgery	

Age-Related Macular Degeneration

AMD is the leading cause of severe, irreversible central vision loss in adults over 60. It has two forms. Dry AMD (roughly 85-90% of cases) progresses slowly through drusen accumulation to geographic atrophy — regions where retinal cells have died. Wet AMD (10-15% of cases) develops when abnormal blood vessels grow beneath the retina and leak fluid or blood; without treatment, wet AMD can destroy central vision within weeks to months. Central vision loss makes reading, recognizing faces, and driving progressively impossible; peripheral vision is typically preserved.

Glaucoma

Glaucoma is a group of conditions that damage the optic nerve, most commonly through elevated intraocular pressure. Primary open-angle glaucoma — the most common form — is often painless and asymptomatic until substantial peripheral vision has been lost. It is called the "silent thief of sight" because patients rarely notice the loss until it is advanced. Screening with intraocular pressure measurement, optic nerve examination, and visual field testing detects the disease in its treatable stage.

Diabetic Eye Disease

Diabetes affects the eye through diabetic retinopathy (damage to retinal blood vessels), diabetic macular edema (swelling of the central retina), cataract (occurring earlier and progressing faster in diabetes), and neovascular glaucoma. Diabetic retinopathy is the leading cause of blindness in working-age adults in the U.S. All adults with diabetes should have a dilated eye examination annually — this is one of the most consistent recommendations across all diabetes care guidelines.

Common Causes of Hearing Loss

Condition	Description	Notes
Presbycusis (age-related hearing loss)	Gradual, symmetric, sensorineural hearing loss beginning in the high frequencies	Present to some degree in most adults over 65
Noise-induced hearing loss	Sensorineural loss from cumulative exposure to loud noise (occupational, recreational, firearms)	Preventable with hearing protection

Condition	Description	Notes
Ototoxicity	Hearing loss from medications: platinum chemotherapy, aminoglycoside antibiotics, high-dose loop diuretics, certain other agents	Often permanent; sometimes preventable with monitoring
Conductive hearing loss	Blockage or dysfunction of the ear canal, eardrum, or middle ear ossicles (wax impaction, otosclerosis, chronic otitis)	Often correctable with medical or surgical treatment
Sudden sensorineural hearing loss	Rapid onset unilateral hearing loss (over hours to days); a medical urgency requiring prompt evaluation and often steroids	Best outcomes when treated within 72 hours
Central auditory processing disorder	Difficulty processing speech (especially in noise) despite normal audiometric thresholds	More common with aging and after concussion or stroke

Presbycusis

The most common form of adult hearing loss is presbycusis — a gradual, symmetric, sensorineural loss that begins in the high frequencies and progresses over years to decades. Because consonants are largely high-frequency sounds, presbycusis makes speech sound muffled or unclear long before it makes it sound quiet. Patients often report that they can hear people talking but cannot understand what is being said, particularly in noisy environments (restaurants, family gatherings). This distinguishing pattern is one of the earliest signs — and one that patients and families frequently misattribute to "mumbling" by others.

Dual Sensory Impairment

Dual sensory impairment (DSI) refers to clinically significant loss of both vision and hearing. Global prevalence in adults is approximately 5.5% and rises steeply with age. In the U.S., roughly one in nine adults 80 or older has both. DSI is not simply the sum of the two individual impairments — the combined effect on function, cognition, and dependency is disproportionately greater than either alone. This is because the primary compensatory strategy for vision loss is often auditory (talking books, verbal directions, telephone contact), and the primary compensatory strategy for hearing loss is often visual (lip reading, watching facial expressions, reading captions). When both channels are impaired, compensation fails.

> *Dependency link: Every adult over 65 should have a hearing screening at least every three years and*

> *a comprehensive eye examination at least every two years — earlier and more often if diabetes, family history of eye disease, or any symptoms are present. These are among the highest-value preventive activities available in later life, and they are among the most frequently postponed.*

3. THE DEPENDENCY CASCADE

Sensory impairment drives dependency through a chain of secondary consequences — falls, cognitive decline, social isolation, driving loss, medication errors, communication breakdown, and depression. Each of these is a well-documented pathway from independent living to supervised care. Understanding the chain helps families intervene at the earliest point rather than at the latest.

3.1 Falls and Fractures

Vision loss roughly doubles fall risk. Hearing loss independently increases fall risk. Combined dual sensory impairment carries the highest risk of all: persistent dual sensory impairment is associated with a 36% higher fall rate and approximately double the hip fracture rate compared with normal sensory function. Post-discharge fall risk after hospitalization is more than three times higher for patients with dual sensory impairment than for those with only vision or only hearing loss. Falls in older adults are the leading cause of hip fracture, traumatic brain injury, and — through cascade of hospitalization, deconditioning, and delirium — often the trigger event for permanent loss of independence.

3.2 Cognitive Decline and Dementia

The 2024 Lancet Commission on dementia prevention identified hearing loss as the single largest modifiable risk factor for dementia — 7% of dementia cases at a population level, tied with elevated LDL cholesterol as the top modifiable factor. Vision loss was added as a new risk factor in the 2024 update, accounting for an additional 2% of cases. Meta-analysis of longitudinal cohort studies estimates a hazard ratio of about 1.37 for hearing loss to dementia. Every 10 decibels of hearing worsening is associated with about a 16% increase in dementia risk. Dual sensory impairment is associated with a 52% greater risk of dementia and a 72% greater risk of longitudinal cognitive decline.

The mechanisms are debated but likely include: reduced cognitive stimulation (fewer conversations, fewer complex environments), increased cognitive load (straining to hear or see leaves less bandwidth for memory and executive function), social withdrawal, depression, and shared vascular risk factors. Whatever the mechanism, treating hearing loss reduces cognitive decline. The ACHIEVE randomized trial reported in 2023 showed that hearing aid intervention reduced three-year cognitive decline in older adults with hearing loss and elevated dementia risk. This is one of the most important prevention findings in geriatric medicine in the past decade.

3.3 Social Isolation and Depression

Sensory impairment produces social isolation through the mechanics of communication. When conversation requires visible strain, when phone calls become difficult, when television requires closed captions, when restaurant conversation becomes impossible — social contact narrows. Depression prevalence rises with sensory impairment, reaching approximately double the general population rate for adults with moderate-to-severe hearing loss and higher still for dual sensory impairment. Social

withdrawal is often the earliest and most reversible symptom family members notice; treating the underlying sensory impairment often restores social function.

3.4 Driving Cessation

Driving depends heavily on both vision (acuity, contrast sensitivity, peripheral vision, glare recovery) and hearing (approaching sirens, horn warnings, engine sounds). Age-related macular degeneration, cataract, glaucoma, and diabetic retinopathy can each independently disqualify a person from safe driving, and all four are common in older adults. Driving cessation is often the single most consequential dependency event in an older adult's life — it changes access to medical appointments, grocery shopping, social contact, and independence itself. Timely intervention on treatable eye disease (particularly cataract surgery) frequently prolongs safe driving by years.

3.5 Medication Errors

Reading medication labels, distinguishing similar-looking pills, hearing pharmacist counseling, and understanding drug interactions all require intact vision and hearing. Older adults with sensory impairment have measurably higher rates of medication errors, missed doses, and adverse drug events. Practical adaptations — pill organizers with large print, medication management systems, pharmacy consultation over phone with hearing aid or telecoil support, family review of medication lists — reduce this risk substantially.

3.6 Communication Breakdown with Health Care

Older adults with untreated hearing loss have shorter medical visits, ask fewer questions, understand less of what is explained to them, and follow through less reliably on discharge instructions. Vision loss compounds this: patient education materials, prescription labels, discharge instructions, and appointment reminders are typically visual. Health care encounters designed for a fully sighted and fully hearing patient systematically disadvantage those who are not — with measurable consequences for outcomes.

3.7 Caregiver Burden

Family caregivers of adults with dual sensory impairment report substantially higher burden than caregivers of adults with either impairment alone. Practical demands include amplifying and repeating spoken information, reading materials aloud, providing physical guidance in unfamiliar environments, driving to appointments, and managing the equipment (hearing aids, magnifiers, low-vision devices) that both benefits and complicates daily life. The National Alliance for Caregiving estimates that caregivers of adults with sensory or communication impairments spend 25% more hours per week providing care than caregivers of adults without these impairments.

3.8 Mortality

Adults with dual sensory impairment plus cognitive impairment have mortality hazard ratios approximately 1.3 times higher than adults with normal sensory and cognitive function, after adjusting for age and comorbidities. Sensory impairment alone is not directly lethal, but the downstream effects — falls, fractures, decreased physical activity, social isolation, depression, medication errors, hospitalization — accumulate to shorten life expectancy modestly but measurably.

> *The compound effect of falls + cognitive decline + isolation + driving loss + medication errors + communication breakdown produces a cumulative loss of function that no single clinic visit will reveal. Recognizing sensory impairment as a central driver of dependency — not simply an aging inconvenience — is one of the most important shifts a family can make.*

4. DIAGNOSIS AND ASSESSMENT

Both vision and hearing impairment respond best to early diagnosis. Both are frequently under-diagnosed because patients adapt gradually, do not notice the loss, or interpret it as normal aging. Structured screening at the schedule recommended for age is one of the most consistent recommendations in preventive medicine — and one of the most frequently skipped.

Vision Assessment

Test	Purpose	Findings
Visual acuity	Central vision at distance and near	Snellen chart; near card; recorded as 20/xx
Refraction	Determine corrective lens prescription	Refractive error identified and quantified
Slit-lamp examination	Front of eye including cornea, lens, iris	Cataract, corneal disease, dry eye
Intraocular pressure	Screen for glaucoma	Tonometry; normal about 10-21 mmHg
Dilated fundus examination	Retina, optic nerve, blood vessels	AMD, diabetic changes, optic nerve cupping
Optical coherence tomography (OCT)	Cross-sectional imaging of retina and optic nerve	Detects macular thickening, drusen, geographic atrophy, glaucoma damage
Fundus photography and imaging	Documented photograph of retina	Baseline documentation and progression tracking
Fluorescein angiography	Retinal blood vessel imaging with dye	Wet AMD, diabetic macular edema, vein occlusions
Visual field testing	Peripheral vision measurement	Glaucoma progression, stroke, neurologic disease

Screening Schedule for Vision

- Adults age 40-54: comprehensive eye examination every 2-4 years
- Adults age 55-64: every 1-3 years
- Adults age 65 and older: every 1-2 years (at least)
- Adults with diabetes: dilated retinal examination annually regardless of age

- Adults with family history of glaucoma or AMD: individualized schedule (typically annually)
- Any new symptoms (flashes, floaters, sudden vision change, curtain in visual field, straight lines appearing wavy): urgent evaluation, same day or next day

Hearing Assessment

Test	Purpose	Findings
Pure-tone audiometry	Measure hearing thresholds at each frequency	Pattern and severity of loss (mild 26-40 dB, moderate 41-55 dB, moderately severe 56-70 dB, severe 71-90 dB, profound >90 dB)
Speech recognition	Ability to understand words at comfortable loudness	Word recognition score; strong predictor of hearing aid benefit
Speech-in-noise testing	Ability to understand speech against background noise	Often abnormal even when pure-tone audiometry is only mildly abnormal — captures real-world difficulty
Tympanometry	Middle ear function	Detects fluid, eardrum perforation, ossicular problems
Otoacoustic emissions	Function of outer hair cells	Screening test; also monitors for ototoxicity
Auditory brainstem response (ABR)	Neural conduction through auditory pathway	Retrocochlear pathology, sudden hearing loss workup

Screening Schedule for Hearing

- All adults 60+ years: brief hearing screening at least every 3 years
- Any concern about difficulty in noise, need to increase TV volume, family complaints about volume, ringing (tinnitus): comprehensive audiology evaluation
- Sudden hearing loss (over hours or days), one-sided hearing loss, hearing loss with vertigo: urgent evaluation within 72 hours — sudden sensorineural hearing loss is a medical emergency responsive to prompt steroid treatment
- Patients on ototoxic medications (platinum chemotherapy, aminoglycosides, high-dose loop diuretics): baseline and monitoring audiograms per treating physician's protocol

Where to Get Evaluated

Vision: An optometrist (Doctor of Optometry, OD) provides comprehensive eye examinations, prescribes glasses and contacts, diagnoses and manages many eye diseases, and refers to ophthalmologists for

surgery or complex disease. An ophthalmologist (MD or DO) is a physician who provides comprehensive eye examinations and both medical and surgical treatment of eye disease. For screening in adults without diabetes or family history of eye disease, either provider is appropriate. For diabetes, glaucoma, AMD, retinal disease, or surgical decisions, an ophthalmologist is typically the appropriate specialist; retinal, corneal, glaucoma, and cataract subspecialists exist within ophthalmology.

Hearing: An audiologist (AuD) is the primary provider for hearing assessment, hearing aid fitting, and non-medical hearing rehabilitation. An otolaryngologist (ENT physician) is the appropriate provider for medical or surgical hearing problems including sudden hearing loss, cholesteatoma, otosclerosis, tumors, and cochlear implant candidacy. Screening in adults without medical concerns can be initiated with an audiologist; medical findings (asymmetric loss, sudden loss, ear pain or drainage, dizziness, tumor concern) prompt referral to an ENT physician.

> *Medicare Part B covers medically indicated diagnostic hearing exams ordered by a physician (for example, to work up sudden hearing loss). Original Medicare does not cover routine hearing exams or hearing aids themselves. Most Medicare Advantage plans include some hearing benefit; specifics vary widely by plan. Discuss coverage with the plan directly before scheduling non-diagnostic services.*

5. TREATMENTS — VISION

Modern eye care can restore vision in cataract, halt or slow progression in wet AMD and diabetic eye disease, preserve remaining vision in glaucoma, and — as of 2023 — slow progression of geographic atrophy in dry AMD. Refractive error is corrected almost universally with glasses, contacts, or refractive surgery. For advanced vision loss, low-vision rehabilitation dramatically improves function even when acuity cannot be improved further.

5.1 Cataract Surgery

Cataract surgery is one of the most effective and safe procedures in all of medicine. The clouded natural lens is removed and replaced with a clear intraocular lens implant. The procedure is typically outpatient, takes about 15-30 minutes, uses topical anesthesia, and produces functional recovery within days. Multifocal, extended-depth-of-focus, and toric (astigmatism-correcting) lens options allow customization of the visual result. In older adults, cataract surgery reduces fall risk, improves cognitive test scores, delays driving cessation, and — as reported in observational studies — is associated with reduced risk of dementia diagnosis in the years after surgery. If cataract is contributing to visual difficulty, surgery should not be indefinitely deferred.

5.2 Anti-VEGF Injections for Wet AMD, Diabetic Macular Edema, and Retinal Vein Occlusion

Vascular endothelial growth factor (VEGF) inhibitors delivered by intravitreal injection have transformed the treatment of wet AMD, diabetic macular edema, and macular edema from retinal vein occlusion. Approved agents include ranibizumab (Lucentis), aflibercept (Eylea and higher-dose Eylea HD), bevacizumab (Avastin — used off-label but widely), brolucizumab (Beovu), and faricimab (Vabysmo — a bispecific antibody that also blocks angiopoietin-2). Faricimab, approved for wet AMD and diabetic macular edema, allows dosing intervals extended up to every 16 weeks in many patients — a substantial reduction in injection burden.

The port delivery system for ranibizumab (Susvimo) is a refillable intraocular implant that releases medication continuously — extending refill intervals to approximately every 6 months for wet AMD. This changes the treatment experience substantially for patients and families otherwise required to attend monthly clinic appointments for injections.

5.3 Complement Inhibitors for Geographic Atrophy

Geographic atrophy — the late stage of dry AMD — was untreatable before 2023. Two intravitreal complement inhibitors are now FDA-approved to slow its progression: pegcetacoplan (Syfovre, a C3 inhibitor approved February 2023) and avacincaptad pegol (Izervay, a C5 inhibitor approved August 2023). Both drugs slow the growth of geographic atrophy lesions by roughly 14-30% over two years in pivotal trials, with continued benefit accruing in three-year extension data. Neither restores vision; both slow the underlying disease progression. Risks include intravitreal injection complications, small

increases in wet AMD conversion (with pegcetacoplan), and rare occlusive retinal vasculitis. The decision to treat should weigh location of the atrophy relative to central vision, rate of progression, and patient-specific factors.

5.4 Glaucoma Management

Glaucoma treatment lowers intraocular pressure to halt or slow optic nerve damage. Options include:

- Eye drops — prostaglandin analogs (latanoprost, bimatoprost, travoprost, tafluprost) are first-line for most patients; beta blockers, alpha agonists, carbonic anhydrase inhibitors, and Rho kinase inhibitors are added or substituted as needed
- Selective laser trabeculoplasty (SLT) — office-based laser treatment; increasingly used as first-line therapy per updated guidelines
- Minimally invasive glaucoma surgery (MIGS) — small-implant devices placed during cataract surgery or as standalone procedures; lower pressure with a favorable safety profile
- Traditional glaucoma surgery (trabeculectomy, tube shunt) — reserved for more advanced disease or when less invasive options have failed

Consistent adherence to eye drop regimens is one of the largest determinants of glaucoma outcomes. Sustained-release drug delivery systems (bimatoprost implant, others in development) address this by delivering medication for months from a single implant.

5.5 Diabetic Eye Disease

Diabetic macular edema and proliferative diabetic retinopathy are treated with anti-VEGF injections, focal or panretinal laser photocoagulation, intravitreal steroids in selected cases, and — for severe cases — vitrectomy surgery. Faricimab is FDA-approved for diabetic macular edema and offers extended dosing intervals. Systemic diabetes control — glycemic, blood pressure, and lipid — is essential; poor systemic control accelerates all diabetic eye complications regardless of the eye treatments used.

5.6 Refractive Correction and Refractive Surgery

Glasses and contact lenses correct refractive error for the vast majority of adults. Refractive surgery — LASIK, PRK, SMILE, refractive lens exchange — provides another option for patients who prefer to reduce dependence on glasses or contacts. Presbyopia (age-related loss of near focus, universal after age 45) can be corrected with reading glasses, bifocals or progressives, presbyopia-correcting intraocular lenses at the time of cataract surgery, or newer pharmacologic drops (pilocarpine 1.25%, approved 2021) that improve near focus for several hours per dose.

5.7 Low-Vision Rehabilitation

When vision cannot be further improved medically or surgically, low-vision rehabilitation dramatically improves function. Services include prescription of magnifiers (handheld, stand, electronic, and portable video magnifiers), specialty telescopes for distance viewing, high-power reading spectacles, contrast-

enhancing filters, task lighting recommendations, occupational therapy to relearn daily activities (reading, cooking, medication management), orientation and mobility training with a certified specialist (white cane, guide dog referrals), and connection with technology aids (screen readers, voice assistants, smartphone accessibility features). Every patient with significant vision loss should be offered a low-vision rehabilitation referral; many are not.

6. TREATMENTS — HEARING

Hearing treatment options have expanded substantially over the past decade. Prescription hearing aids, over-the-counter hearing aids, bone-anchored devices, cochlear implants, auditory brainstem implants, and assistive listening technology together cover essentially the full spectrum of hearing loss — but only when they are actually pursued. The single largest barrier to hearing treatment in the U.S. is not availability; it is the multi-year delay between onset of hearing loss and first hearing aid trial.

6.1 Prescription Hearing Aids

Modern hearing aids are small, digital, programmable devices that provide frequency-specific amplification tailored to each individual's audiogram. Options include behind-the-ear (BTE), receiver-in-canal (RIC), completely-in-canal (CIC), and invisible-in-canal styles. Features increasingly include: Bluetooth streaming from smartphones for phone calls and music, automatic environmental adaptation, telecoil (T-coil) compatibility with hearing loop systems, tinnitus masking, rechargeable batteries, remote programming, artificial-intelligence-based noise reduction, and smartphone app control. Fitting involves an audiologist who programs the devices to the individual's audiogram, verifies real-ear output, and adjusts through follow-up visits. Getting the best result typically requires 2-4 fitting appointments and 30-90 days of use to fully adapt.

6.2 Over-the-Counter Hearing Aids

As of October 2022, the FDA established a category of over-the-counter (OTC) hearing aids for adults with perceived mild-to-moderate hearing loss. OTC devices are available in pharmacies, big-box retailers, and online without a prescription or audiologist appointment. They are typically less expensive than prescription hearing aids and appropriate for many adults with milder loss. Limitations: they are not intended for moderately severe or worse hearing loss; they cannot be programmed to a specific audiogram unless the manufacturer's app supports self-fitting; and they lack the ongoing audiologist support that comes with prescription fitting. For adults uncertain whether their loss is mild, moderate, or worse, a baseline audiogram before purchasing OTC devices is a reasonable first step. OTC devices are a legitimate first option for many adults and — importantly — a lower-friction entry point for people who have been deferring the traditional prescription pathway.

6.3 Cochlear Implants

A cochlear implant is a surgically placed device that bypasses damaged inner-ear hair cells and directly stimulates the auditory nerve. Modern cochlear implants restore functional hearing in adults with severe-to-profound sensorineural hearing loss for whom hearing aids provide inadequate benefit. Candidacy criteria have expanded steadily: bilateral moderate-to-severe sensorineural hearing loss with poor speech recognition (typically under 50-60% on sentence testing in the ear to be implanted, under 60% in the better ear) is now a common threshold. Single-sided deafness is also an approved indication for cochlear implantation.

The procedure is outpatient in most centers. Recovery is 1-2 weeks; activation occurs 2-4 weeks after surgery; aural rehabilitation over the first 6-12 months substantially improves speech understanding. Most adults with post-lingual deafness (hearing loss after acquiring language) achieve open-set speech recognition and can use the telephone within a year. Original Medicare covers cochlear implantation for eligible candidates.

6.4 Hybrid Approaches — Bimodal and BiCROS

Bimodal hearing (a cochlear implant in one ear and a hearing aid in the other) is common for adults with asymmetric hearing loss. CROS (contralateral routing of signal) and BiCROS devices route sound from a dead or near-dead ear to the better ear, restoring some directional and spatial awareness for adults with single-sided deafness who prefer not to pursue cochlear implantation.

6.5 Bone-Anchored and Middle Ear Implants

Bone-anchored hearing systems (BAHA, Ponto, others) transmit sound through the skull directly to the inner ear, bypassing the outer and middle ear. They are used for conductive hearing loss (chronic outer or middle ear disease that cannot be surgically corrected), mixed hearing loss, and single-sided deafness. Middle ear implants (Vibrant Soundbridge, others) mechanically vibrate the middle ear ossicles and are used in selected patients with sensorineural, mixed, or conductive hearing loss who cannot tolerate conventional hearing aids.

6.6 Assistive Listening Devices

Assistive listening devices supplement or substitute for hearing aids in specific situations:

- Personal amplifiers — pocket-sized devices with a microphone and headphones, useful for one-on-one conversation and clinic visits
- Hearing loop systems — venues (theaters, houses of worship, transit terminals) that broadcast sound directly to hearing aids equipped with telecoils
- Captioned telephones and video relay — federally supported services for telephone communication (CapTel, Sorenson, others)
- Alerting devices — visual and vibrating alerts for doorbells, smoke alarms, alarm clocks, and phone calls
- Real-time captioning apps — smartphone apps (Live Transcribe, Ava, Otter, Google Live Caption) that transcribe speech to text in real time; increasingly useful for restaurants, meetings, and family gatherings

6.7 Aural Rehabilitation

Aural rehabilitation is structured training that helps adults with hearing loss and their communication partners get more benefit from hearing aids or cochlear implants. It includes auditory training exercises, speechreading (lip reading) practice, communication strategies for both parties (facing each other,

reducing background noise, one-at-a-time speaking, rephrasing rather than repeating), and — increasingly — teleaudiology programs delivered remotely. Aural rehabilitation is underused; many audiologists offer it but do not routinely refer, and many patients are not aware it exists. Ask specifically.

> *The 2023 ACHIEVE randomized trial demonstrated that hearing aid intervention in older adults with hearing loss and elevated dementia risk reduced three-year cognitive decline compared with a health education control. This is the strongest evidence yet that treating hearing loss changes cognitive trajectory — a finding with major implications for dementia prevention. Do not defer hearing aid trials in adults with hearing loss and any cognitive concern.*

7. CLINICAL TRIALS AND PIPELINE 2026

Vision and hearing research is unusually active in 2026. Gene therapy for inherited retinal diseases has moved from theory to clinical practice; the first gene therapy for geographic atrophy is advancing in Phase 2 trials; longer-acting anti-VEGF biologics are entering the market; totally implantable cochlear devices are emerging; and drug therapy for sensorineural hearing loss — long considered impossible — is being pursued in serious clinical trials. This section highlights the most consequential developments.

7.1 Gene Therapy for Retinal Disease

Voretigene neparvovec (Luxturna) — the first FDA-approved gene therapy for a retinal disease — treats biallelic RPE65-associated inherited retinal dystrophy. Delivered as a subretinal injection, it restores functional vision in appropriate candidates. Additional retinal gene therapy programs targeting other inherited retinal diseases (RPGR-related X-linked retinitis pigmentosa, choroideremia, achromatopsia, Stargardt disease) are advancing through clinical trials. Genetic testing at diagnosis of inherited retinal disease is essential to identify treatment candidates.

7.2 OCU410 — Gene Therapy for Geographic Atrophy

OCU410, a modifier gene therapy from Ocugen using an AAV5 vector to deliver the RORA gene, is under investigation for geographic atrophy in dry AMD. The Phase 2 ArMaDa trial reported positive 12-month topline results in March 2026, demonstrating statistically significant reduction in geographic atrophy lesion growth compared with control. The program is preparing to advance to Phase 3. If successful, OCU410 would be the first one-time gene therapy for geographic atrophy — a substantial change from the ongoing intravitreal injections required by currently approved complement inhibitors.

7.3 Longer-Acting Anti-VEGF and Complement Therapies

Approach	Status 2026	Significance
High-dose aflibercept (Eylea HD, 8 mg)	FDA approved 2023 for wet AMD, DME, DR	Extended dosing intervals up to every 16 weeks
Faricimab (Vabysmo)	FDA approved for wet AMD, DME, macular edema after RVO	Bispecific VEGF-A + angiopoietin-2; dosing every 12-16 weeks in many patients
Port delivery ranibizumab (Susvimo)	FDA approved 2021 for wet AMD; expanded indications ongoing	Refillable intraocular implant; refills every 6 months
Iptacopan (LNP023)	Phase 2/3 for geographic atrophy	Oral factor B complement inhibitor — first potential oral option for GA
Tinlarebant (LBS-008)	Phase 3 for Stargardt disease and	Oral small molecule reducing

Approach	Status 2026	Significance
	GA	retinal vitamin A cycle byproducts
Elamipretide	Late-stage development	Mitochondrial-targeted peptide for dry AMD
Longer-acting bispecifics (KSI-501, others)	Phase 2/3 for wet AMD, DME	Dual-target biologics with extended-release formulations

7.4 Bionic Vision and Retinal Prostheses

Retinal implants for advanced vision loss (Argus II — earlier device, no longer marketed; PRIMA subretinal photovoltaic implant — in trials for geographic atrophy; other visual prostheses) aim to restore some functional vision in adults with severe retinal disease. Current devices provide limited resolution — enough for shape recognition, ambient light awareness, and mobility assistance — but do not restore detailed reading or facial recognition. The field continues to develop, and next-generation systems (higher electrode density, direct cortical stimulation for adults with no retinal function) are in early clinical study.

7.5 Totally Implantable Cochlear Devices

Traditional cochlear implants have an external speech processor worn on the ear or behind the ear. Totally implantable cochlear implants — with the microphone, processor, and battery all placed internally — have been under development for years and are entering later-stage clinical trials in 2026. If successful, they would eliminate the external component (allowing swimming, sleeping, and daily wear without the current visible device), though they would require periodic battery replacement or wireless recharging.

7.6 Drug Therapy for Sensorineural Hearing Loss

For decades, sensorineural hearing loss was considered permanent and untreatable pharmacologically. That view is changing. Multiple approaches are in clinical trials: intratympanic injection of hair cell regeneration compounds; systemic drugs targeting synaptic connections between hair cells and auditory nerve fibers; and gene therapy for specific hereditary hearing loss syndromes (otoferlin gene therapy trials have shown early success in children with congenital deafness). No agent has yet reached FDA approval, but the direction of research has shifted substantially.

7.7 Neural Interfaces and Brainstem Implants

Auditory brainstem implants — devices that stimulate the cochlear nucleus directly — have been available for decades for adults with neurofibromatosis type 2 whose auditory nerves have been destroyed. Improved electrode designs and stimulation strategies are being developed, and cochlear

implantation in adults with certain profoundly deaf conditions previously considered non-candidates (severe cochlear malformation, cochlear nerve deficiency) is expanding. Neuralink-style neural interface programs targeting hearing restoration are in very early exploratory stages.

7.8 Digital Therapeutics and Tele-Audiology

Smartphone-based hearing screening apps (Mimi, hearWHO, others), remote hearing aid fitting and adjustment, teleaudiology visits, and artificial-intelligence-driven noise reduction algorithms in hearing aids are all moving from research into routine practice. These technologies extend access to hearing care in rural and underserved communities and reduce the friction of ongoing follow-up.

> *Clinical trials for vision and hearing conditions are widely accessible. The National Eye Institute clinical trial finder, the NIDCD (National Institute on Deafness and Other Communication Disorders) clinical trial listings, and ClinicalTrials.gov all list ongoing studies. For inherited retinal diseases, genetic testing at diagnosis and referral to a genetic counselor or retinal genetics specialist is the first step toward identifying trial eligibility.*

8. CAREGIVER BURDEN AND REHABILITATION

Sensory impairment care includes a substantial rehabilitation and communication-support dimension that is often overlooked. Getting the diagnosis and the technology (glasses, hearing aid, cochlear implant, low-vision device) is only the first half of the work. The second half — using the technology effectively, adapting daily routines, modifying the home, and rebuilding communication patterns — determines whether the treatment actually restores function.

The Practical Load

- Transportation — eye and audiology appointments, injection visits for wet AMD (initially every 4-8 weeks; ongoing every 8-16 weeks), surgical follow-ups, hearing aid programming visits, cochlear implant activation and mapping
- Device management — inserting and removing hearing aids, changing batteries or charging, cleaning hearing aid domes and wax filters, cleaning eyeglasses, managing eye drops (glaucoma patients often use multiple drops on complex schedules)
- Medication management — reading small labels, distinguishing similar-looking eye drop bottles, hearing pharmacist counseling, following instructions for anti-VEGF injection preparation
- Communication adaptation — facing the person when speaking, reducing background noise, one speaker at a time in group settings, using written notes when appropriate, learning to use captioning apps
- Home safety modification — improved lighting (particularly stair lighting and task lighting), removal of low-contrast trip hazards, contrasting tape at stair edges, visual and vibrating smoke alarms, telephone amplifiers or captioned phones
- Driving evaluation and cessation — when driving is no longer safe, arranging alternative transportation before the ability is lost is critical for maintaining social and medical access

Communication Strategies for Families

- Face the person you are speaking to; make sure your face is well-lit and visible
- Reduce background noise — turn off the television, close windows to reduce traffic noise, choose quieter restaurants and quieter tables
- Speak at a normal volume, slightly slower, and clearly — shouting distorts speech and often makes understanding worse, not better
- Rephrase rather than simply repeat — if a sentence was not understood, try different words
- One person at a time in group conversations — cross-talk is one of the hardest situations for anyone with hearing loss
- Use captions on television and in video calls whenever available
- Confirm important information (medication instructions, appointment times, driving directions) in writing

- For adults with dual sensory impairment: increased use of touch cues, tactile signals for common phrases, well-lit large-print materials, and slow deliberate speech at close range with the person's better ear

Home Environment Modifications

- Lighting: bright, uniform lighting throughout living areas; task lighting at reading and cooking areas; night lighting for hallways and bathrooms; motion-activated lighting for stairs
- Contrast: contrasting colors between floor and stair edges, between counters and floors, between cups and plates and tablecloths
- Reducing reflected glare: matte finishes; window treatments to reduce direct sunlight; anti-reflective coatings on glasses
- Large-print calendars, clocks, and phone displays; talking watches and timers
- Amplified telephones, captioned telephones, or smartphone captioning apps
- Visual and vibrating smoke alarms, carbon monoxide alarms, and doorbell alerts
- Tactile labels on medication bottles, appliance controls, and thermostats
- Fall-prevention basics: secure or remove throw rugs, install grab bars in bathrooms, ensure well-lit paths from bed to bathroom, and add stair handrails on both sides

Vision Rehabilitation Services

Certified low-vision therapists, occupational therapists specializing in low vision, and orientation and mobility specialists together provide comprehensive rehabilitation. Services include: prescription of optical and electronic magnifiers, task lighting recommendations, retraining daily activities (reading, cooking, medication management, personal care), orientation and mobility training with a white cane, guide dog referral through recognized schools, connection with technology (screen readers, voice assistants, smartphone accessibility settings), and psychological support for adjustment to vision loss. Ask specifically for a referral; these services are underused.

Aural Rehabilitation Programs

Structured aural rehabilitation extends the benefit of hearing aids and cochlear implants. Programs are available at many audiology practices, hospital-based rehabilitation departments, university programs, and — increasingly — through remote teleaudiology services. Group programs specifically for older adults with hearing loss and their family communication partners are offered by the Hearing Loss Association of America and by many community hearing centers.

> *Caregiver support strategies that work: joining a sensory-impairment-focused caregiver group (through the Hearing Loss Association of America, Lighthouse Guild, Prevent Blindness, or disease-specific organizations), respite through adult day programs or short-term home health services, sharing caregiving across multiple family members, using tele-audiology and tele-ophthalmology to*

> *reduce transportation burden, and — critically — the caregiver's own primary care visits to screen for depression, hypertension, and hearing loss (which is common in the caregiving generation too).*

9. KEY RESOURCES AND WHERE TO GET HELP

The list below is organized by category. Every phone number and website has been checked as current at the time of publication.

Vision — Disease-Specific and General Organizations

Organization	Focus	Contact
National Eye Institute (NEI)	Federal research and comprehensive patient education on all eye conditions	nei.nih.gov · 301-496-5248
Prevent Blindness	Nationwide patient education, screening programs, advocacy	preventblindness.org · 800-331-2020
American Academy of Ophthalmology (EyeSmart)	Patient education from the leading ophthalmology society	aao.org/eye-health
American Optometric Association	Find an optometrist, patient education	aoa.org
AMD Foundation	Age-related macular degeneration patient support and education	macular.org
Macular Society	AMD education, peer support, low-vision guidance	macularsociety.org
Foundation Fighting Blindness	Inherited retinal diseases research and patient support	fightingblindness.org · 800-683-5555
Glaucoma Research Foundation	Glaucoma education and research	glaucoma.org · 800-826-6693
The Bright Focus Foundation	AMD and glaucoma research and patient resources	brightfocus.org · 800-437-2423
Lighthouse Guild	Vision rehabilitation, low-vision services, patient support	lighthouseguild.org · 800-284-4422
American Foundation for the Blind	Advocacy, education, and career support for adults with vision loss	afb.org · 800-232-5463
National Federation of the Blind	Advocacy and peer support for adults who are blind	nfb.org · 410-659-9314
American Council of the Blind	Advocacy, peer support, and	acb.org · 800-424-8666

Organization	Focus	Contact
	information resources	

Hearing — Disease-Specific and General Organizations

Organization	Focus	Contact
National Institute on Deafness and Other Communication Disorders (NIDCD)	Federal research and comprehensive patient education on hearing and communication	nidcd.nih.gov · 800-241-1044
Hearing Loss Association of America (HLAA)	Nationwide patient advocacy, education, chapter meetings, peer support	hearingloss.org · 301-657-2248
American Speech-Language-Hearing Association (ASHA)	Find a certified audiologist or speech-language pathologist	asha.org · 800-638-8255
American Academy of Audiology	Find an audiologist; patient education	audiology.org · 800-222-2336
American Cochlear Implant Alliance	Cochlear implant candidacy information and center directory	acialliance.org
Cochlear Implants Awareness Foundation	Peer support and information for cochlear implant candidates and users	ciafhelp.org
American Tinnitus Association	Tinnitus education, patient resources, and clinical trial information	ata.org · 800-634-8978
Association of Late-Deafened Adults (ALDA)	Peer support for adults who lost hearing after learning language	alda.org · 866-402-2532

Dual Sensory Impairment and Deafblindness

Organization	Focus	Contact
Helen Keller National Center for Deaf-Blind Youths and Adults	Comprehensive rehabilitation and training for adults with combined vision and hearing loss	helenkeller.org · 516-944-8900
American Association of the Deaf-	National peer-led organization for	aadb.org

Organization	Focus	Contact
Blind	deaf-blind adults	
Deafblind Citizens in Action	Advocacy for deaf-blind adults	dbcitizens.org
Perkins School for the Blind — Adult Services	Rehabilitation and support for adults with combined vision and hearing loss	perkins.org

Caregiver and Community Support

Organization	Focus	Contact
Family Caregiver Alliance	Caregiver support, respite information, state-by-state resources	caregiver.org · 800-445-8106
National Alliance for Caregiving	Caregiving policy and family resources	caregiving.org
Eldercare Locator	Federal service connecting to local Area Agencies on Aging	eldercare.acl.gov · 800-677-1116
AARP — Vision & Hearing Resources	Consumer-oriented information for adults 50+	aarp.org/health/conditions-treatments
Meals on Wheels America	Home-delivered meals; useful when vision or mobility limit cooking	mealsonwheelsamerica.org · 888-998-6325
Rides in Sight	Transportation options database for older adults	ridesinsight.org · 855-607-4337
Well Spouse Association	Peer support for spousal caregivers	wellspouse.org · 800-838-0879

Technology and Assistive Devices

Resource	Purpose	Contact
Apple Accessibility	Built-in accessibility features on iPhone, iPad, Mac (VoiceOver, magnifier, Live Captions, hearing aid support)	apple.com/accessibility

Resource	Purpose	Contact
Google Accessibility	Android accessibility, Live Transcribe, Sound Amplifier, Lookout	google.com/accessibility
Microsoft Accessibility	Windows accessibility, Seeing AI, Immersive Reader	microsoft.com/accessibility
Bookshare	Accessible e-books for adults with print disabilities (large text, audio, braille)	bookshare.org
National Library Service — Talking Book Program	Free audiobook and braille loan program for adults with vision loss	loc.gov/nls · 888-657-7323
Federal Communications Commission — National Deaf-Blind Equipment Distribution Program	Free communication equipment for qualifying deaf-blind adults (iCanConnect)	iCanConnect.org · 800-825-4595

Legal and Advance Planning

Resource	Purpose	Contact
National Academy of Elder Law Attorneys (NAELA)	Directory of elder-law attorneys for advance directives, powers of attorney, guardianship	naela.org
American Bar Association — Commission on Law and Aging	Educational resources for advance care planning	americanbar.org/groups/law_aging
Five Wishes	Living will document accepted in most states	fivewishes.org

Coverage and Program Information

Resource	Purpose	Contact
Medicare	Coverage information for eye and hearing services under Original Medicare and Medicare Advantage	medicare.gov · 800-MEDICARE
State Health Insurance Assistance Program (SHIP)	Free Medicare counseling in every state	shiphelp.org

Resource	Purpose	Contact
National Council on Aging BenefitsCheckUp	Screening for federal and state benefit programs including vision and hearing assistance	benefitscheckup.org

For adults with severe vision or hearing loss, the National Library Service Talking Book Program (Library of Congress) and the FCC iCanConnect program are two of the most underused resources in the country. Both are free, both are federally supported, and both provide substantial daily-life benefit. Call to enroll.

10. NEXT STEPS

Vision and hearing rewarded early action more than most conditions in medicine. The families who fare best move deliberately through the following sequence, adapted to individual circumstances.

1. Get Screened at the Recommended Schedule

Comprehensive eye examination every 1-2 years for adults 65+ (annually if diabetes, family history, or any symptom). Hearing screening at least every 3 years for adults 60+ (more frequently with any symptom or complaint from family). Sudden vision or hearing change is urgent — same-day or next-day evaluation. These schedules are among the highest-value preventive activities available in later life, and among the most postponed.

2. Do Not Delay Cataract Surgery Once Vision Is Affecting Function

Cataract surgery is one of the safest, most effective, and most under-utilized interventions in older adults. If cataract is contributing to visual difficulty, driving concerns, fall risk, or cognitive strain, do not defer surgery indefinitely. The procedure is outpatient, low-risk, and produces functional recovery within days. Delayed cataract surgery is associated with higher fall risk, faster cognitive decline, and earlier driving cessation.

3. Treat Wet AMD, Diabetic Macular Edema, and Retinal Vein Occlusion Aggressively

Anti-VEGF injections stop and often reverse the vision loss of wet AMD, diabetic macular edema, and retinal vein occlusion. Adherence to the injection schedule is one of the largest determinants of outcome. Longer-acting agents (faricimab, high-dose aflibercept, port delivery system) reduce injection burden substantially for eligible patients — ask specifically about extended-interval options if the standard 4-week schedule is difficult to maintain.

4. Consider Complement Inhibitors for Geographic Atrophy

Pegcetacoplan and avacincaptad pegol slow the progression of geographic atrophy — the first treatments ever approved for this condition. They do not restore vision but they slow the disease. Decisions should weigh lesion location, rate of progression, and treatment burden with an experienced retinal specialist. Gene therapy for geographic atrophy (OCU410) is advancing in trials and may become available in coming years.

5. Screen and Treat Glaucoma Early

Glaucoma is painless until vision is substantially lost. Routine screening with intraocular pressure measurement, optic nerve examination, and visual field testing identifies patients in the treatable stage. Prostaglandin eye drops, selective laser trabeculoplasty, and minimally invasive glaucoma surgery together provide effective treatment for most patients. Consistent adherence to eye drop regimens is critical; sustained-release drug delivery systems address the adherence problem for eligible patients.

6. Get Hearing Aids Early — Do Not Wait Years

The single most consistent hearing loss finding is that adults delay treatment by 7-10 years on average. This delay costs cognitive function, social engagement, and — as the 2023 ACHIEVE trial demonstrated — increases dementia risk. Prescription hearing aids fitted by an audiologist provide the best outcomes for most adults; over-the-counter hearing aids are a legitimate first option for adults with mild-to-moderate loss who have been deferring the traditional pathway. Either way, act.

7. Pursue Cochlear Implantation When Hearing Aids No Longer Help

Cochlear implants restore functional hearing in adults with severe-to-profound sensorineural hearing loss for whom hearing aids provide inadequate benefit. Candidacy criteria have expanded steadily; many adults who assume they are "too old" or "not deaf enough" are in fact candidates. Original Medicare covers the procedure for eligible adults. Ask specifically for a cochlear implant candidacy evaluation if hearing aid benefit has become limited.

8. Address Modifiable Risk Factors

Smoking cessation is the single largest modifiable risk factor for AMD and cataract; smoking approximately doubles AMD risk and accelerates cataract formation. Ultraviolet protection with sunglasses reduces cataract and possibly AMD risk. Hearing protection at loud recreational and occupational exposures prevents noise-induced hearing loss. Diabetic glycemic control, blood pressure control, and cholesterol control reduce the vascular contributors to both diabetic eye disease and — increasingly recognized — some forms of hearing loss.

9. Build Home Safety and Communication Environment

Bright uniform lighting, contrasting surfaces at stair edges and countertops, matte finishes to reduce glare, large-print calendars and clocks, amplified or captioned telephones, visual and vibrating alerts for smoke alarms and doorbells, secure grab bars in bathrooms, and removal of trip hazards are all inexpensive interventions with substantial effect. Home visits by occupational therapists trained in low-vision or hearing-loss rehabilitation identify problems families do not notice on their own.

10. Use Community Resources Proactively

Do not wait for crisis to contact Prevent Blindness, the Hearing Loss Association of America, the Lighthouse Guild, the American Cochlear Implant Alliance, or the Eldercare Locator. Transportation assistance, home-delivered meals, in-home aide services, adult day programs, caregiver respite, patient navigation, low-vision therapists, and aural rehabilitation programs are all available through disease-specific organizations, Area Agencies on Aging, and hospital-based rehabilitation departments. Cochlear implant centers and comprehensive low-vision programs have social workers and patient navigators who know the local landscape — ask specifically.

> *Sensory impairment dependency is not inevitable — it is a probability that shifts substantially based on how early conditions are diagnosed, how aggressively treatable conditions are treated, how promptly hearing aids and low-vision devices are adopted, how thoroughly the home environment is adapted, and how proactively community resources are engaged. The clinical toolkit in 2026 — complement inhibitors, longer-acting anti-VEGF, gene therapy, over-the-counter hearing aids, cochlear implantation, aural and low-vision rehabilitation — is better than at any point in history. But only if it is used.*

DISCLAIMER

This white paper is provided for educational purposes only. It does not constitute medical advice or legal advice. Information about clinical trials and medications is current as of July 2026 and may change. Consult qualified medical and legal professionals for guidance specific to your situation.