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2026

COPD and the single inhaler question

Why triple therapy for COPD isn't being prescribed to every Canadian who needs it



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About this investigation

This report is produced by RESPIPLUS, a Canadian non-profit organization that has spent two decades developing education and self-management programs in chronic respiratory disease, delivered through its ChronicLungDiseases.com platform. RESPIPLUS led the design, fielding, and analysis of the national investigation described here, and convened the scientific and patient committee whose input shaped both the survey instruments and this report.

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- **Henry Roberts,** Patient representative, Executive Committee, COPD Canada

Committee members reviewed the survey instruments and this report and contributed their clinical and lived experience throughout the investigation.

Canadian Thoracic Society (CTS)

Canada’s national interprofessional specialty society for respirology, representing specialists, physicians, researchers, and respiratory healthcare professionals. It develops the national COPD guideline referenced throughout this report and promotes respiratory health through research, education, and advocacy.

Family Physician Airways Group of Canada

Supports family physicians and other primary care providers in building the skill and confidence to manage airway disease, particularly asthma and COPD. The group maintains a speaker bank, a data bank, and practical clinical tools, and brought the primary care perspective to this investigation.

COPD Canada

A national, independent patient advocacy association founded in 2005. It works to educate people living with COPD, raise public awareness of the disease, and serve as a bridge between patients and the healthcare system they navigate.

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Executive summary

Chronic obstructive pulmonary disease (COPD) is one of Canada's most common and most costly chronic diseases, affecting more than two million Canadians aged 35 and older and ranking among the leading drivers of hospital admission and healthcare spending nationally.[1]

Clinical, guideline-based evidence supports single inhaler triple therapy (SITT) in reducing COPD attacks (exacerbations) and, compared with long-acting beta-agonist/long-acting muscarinic antagonist (LABA/LAMA) dual therapy, in reducing the risk of death in selected high-risk patients.[2] Real-world evidence suggests that SITT further improves treatment implementation compared with multiple inhaler triple therapy (MITT), with higher adherence and persistence and, in observational studies, lower risk of moderate-to-severe exacerbations and further reduction in mortality.[3,4]

Yet a national investigation of 219 healthcare professionals (HCPs) and 292 patients living with COPD across Canada finds that SITT is not being prescribed to everyone who could benefit.

The investigation's central finding is that clinicians believe in the value of SITT, but gaps in prescribing remain. The large majority of HCPs report using SITT as a preferred option for high-risk patients, believe it improves adherence compared with multiple inhaler triple therapy (MITT), and believe stable MITT patients should be proactively considered for a switch to SITT. The barrier sits downstream of clinical belief, in coverage rules, administrative processes, and the moments of care where a medication review should happen but often does not.

511

Healthcare professionals and patients surveyed across Canada.

65%

of clinicians identify cost or coverage as a major barrier to prescribing SITT.

79%

of patients seen by a clinician or admitted to hospital for a flare-up had no change to their inhalers.

64%

of patients on multiple inhalers were never asked if they could be combined.

What the investigation found

- Clinicians see cost and coverage as the dominant barriers, not clinical doubt. 65% of HCPs rated cost or coverage limitations a major barrier to prescribing SITT over MITT, well ahead of any clinical concern such as pneumonia risk or eosinophil count. This reflects how clinicians perceive the barrier, not a comparison of actual drug prices.

- Administrative burden runs a close second. Special Authorization forms and Limited Use code requirements were called a major barrier by 42% of HCPs, and 67% of HCP respondents reported that these requirements sometimes, often, or very often block SITT initiation.

- That barrier is largely invisible to patients. Only 3% of patients say insurance coverage was the reason for their current treatment, versus 55% who cite effectiveness, even though cost and coverage are what HCPs themselves rate as the single biggest obstacle.

- The hospital or emergency department discharge moment is a missed opportunity, confirmed from both sides. This points to hospitalists and emergency physicians, as well as discharge-planning teams, as groups to engage. Only 32% of HCPs say medication review at discharge is always part of standard process, and 79% of patients who were actually seen or admitted for a COPD attack (exacerbation) requiring a doctor visit, antibiotics, or a hospital stay reported that their inhalers were not changed afterward.

- Patients are confident in their inhaler technique, but that confidence is rarely checked. 78% call themselves very comfortable using their inhaler correctly, yet 35% say a healthcare professional has never watched them use it.

- Patients are rarely the ones who start the conversation about changing or optimizing their COPD treatment. Three out of four say their doctor or specialist first raised the idea; only about one in nine raised it themselves.

- Half of patients are still on multiple separate inhalers, and among them, 64% say combining their medications into one device has never been raised with them, even though patients who have made the switch overwhelmingly describe it as simpler.

The findings point toward a clear, practical opportunity, because the clinical case for SITT is already largely accepted by the people who prescribe it and recommended by current COPD guidelines. The fastest path to better COPD care in Canada runs through coverage policy changes, administrative simplification, and better-designed moments of care.

Introduction

For those who live with COPD, a bad day can mean planning a trip to the mailbox the way most people plan a trip to another city. Chronic obstructive pulmonary disease (COPD) is a progressive, largely irreversible narrowing of the airways that makes ordinary breathing difficult and unpredictable flare-ups (exacerbations) can occur at any time. For many patients, that unpredictability makes daily life exceptionally challenging.

Guidelines such as the Canadian Thoracic Society (CTS) COPD pharmacotherapy guideline (2023) and current expert recommendations now call for every person at high risk of flare-ups to receive single inhaler triple therapy (SITT).[2] This therapy combines an inhaled corticosteroid (ICS), a long-acting beta agonist (LABA), and a long-acting muscarinic antagonist (LAMA). SITT delivers all three medications in a single inhalation from one device; multiple inhaler triple therapy (MITT) splits them across two or more devices. The use of multiple inhalers is not a minor convenience question, but shapes whether a COPD treatment gets optimally followed and the medications can provide their benefits.

Real-world evidence suggests that SITT further improves treatment implementation compared with multiple inhaler triple therapy (MITT), with higher adherence and persistence and, in observational studies, lower risk of moderate-to-severe exacerbations and further reduction in mortality.[3,4] Patients with severe exacerbations are often not escalated to triple therapy; longer delay in initiating SITT is associated with greater risk.[5,6,7]

This report summarizes RESPIPLUS' national investigation into why SITT is not yet the default choice everywhere it is needed. Two linked surveys, one for healthcare professionals involved in COPD care and one for patients living with COPD, were fielded across Canada in English and French. Together they gathered 511 responses, making this one of the more substantial recent looks at the practical, on-the-ground barriers to SITT use in Canadian COPD care.

What follows is organized in four parts:

1. The scale of COPD as a Canadian health challenge.
2. A plain explanation of the differences between SITT and MITT.
3. The major findings of the investigation itself.
4. A set of recommendations addressed to the different groups, payers, hospitals, clinicians, and patients, who each have a role in closing the gap this dataset reveals.

COPD: A Canadian health challenge

COPD is far more common, and far more expensive, than most Canadians realize. Gaps in care also persist across the whole pathway, including diagnosis, exercise and pulmonary rehabilitation, vaccination, airway clearance, smoking cessation, optimized pharmacotherapy and comorbidity management. SITT is one part of that picture.

- **COPD is very common and more Canadians are diagnosed with it each year.** Over 2 million Canadians aged 35 and older were living with a diagnosis of COPD as of 2012 to 2013, up 82% from 1.1 million just over a decade earlier. [1] More recent data estimates that 9% of Canadians aged 35 and older are diagnosed with COPD, rising to about 1 in 5 among those aged 75 to 79, and highest of all in Nunavut. [8]
- **COPD is substantially underdiagnosed.** Studies using direct spirometry testing, rather than relying on self-reported symptom diagnosis, have found that airflow obstruction consistent with COPD is two to six times more common than diagnosis rates alone would suggest.[9] In Ontario it is estimated that only roughly one in five people with COPD have been diagnosed with the condition.[10]
- **COPD is the leading cause of hospital admission in Canada,** and COPD exacerbations are the leading cause of unplanned hospitalizations specifically.[11] COPD patients are hospitalized and readmitted at higher rates than patients with heart failure or angina. [12]
- **COPD is a major driver of healthcare costs.** Chronic lung disease as a category accounts for more than 6% of annual healthcare spending in Canada, and three major chronic lung diseases together cost the Canadian economy an estimated $12 billion in 2010. [13] A separate modelling analysis found that fully implementing the 2023 Canadian Thoracic Society (CTS) guideline recommendations on single inhaler triple therapy could meaningfully reduce COPD exacerbations and mortality nationally, pointing to real cost offsets alongside the clinical benefit. [14] One modelling study projected the annual societal cost of COPD alone would grow from $4.52 billion in 2011 toward $7.33 billion (undiscounted) by 2035, a cumulative societal cost of roughly $147.5 billion over that 25-year span. [15] At the patient level, the average total cost of COPD has been estimated at $2,444 to $4,391 per patient from a patient perspective, rising to $3,910 to $6,693 per patient from a full societal perspective once lost productivity and caregiving are included. [16]

KEY FACT - ECONOMIC BURDEN

COPD's societal cost is projected to climb from $4.52 billion in 2011 to $7.33 billion by 2035 - a cumulative burden of roughly $147.5 billion over 25 years.[15]

- **COPD is a leading cause of death, and it is most likely undercounted.** COPD is generally ranked among the top four or five leading causes of death in Canada and was recorded as the underlying cause of 4.4% of all deaths among Canadians aged 40 and older in 2011.[17] Because COPD patients often have coexisting conditions such as heart disease or pneumonia, the true toll is likely higher than official cause of death statistics show. One study found that COPD was not mentioned anywhere on 21% of death certificates for patients known to have the disease and was not listed as the main cause in a further 34% of adjudicated COPD deaths.[18]

- **The burden falls unevenly across the country.** Respiratory disease death rates in Nunavut run nearly five times the Canadian average, and COPD prevalence is highest in the Atlantic provinces, Quebec, and the territories, patterns linked to higher rates of smoking, second-hand smoke exposure, and in northern and remote communities, poorer living conditions and reduced access to care. [19]

Set against this backdrop, gaps remain at nearly every step of COPD care: timely diagnosis, exercise and pulmonary rehabilitation, vaccination, airway clearance, smoking cessation, management of coexisting conditions, and optimized pharmacotherapy. This investigation focuses on one of these gaps, the use of single inhaler triple therapy. SITT can improve adherence and health outcomes for the people who need it. For a disease this common, this expensive, and this unevenly distributed, closing even part of the gap between guideline-supported care and what patients actually receive can make a real difference to people's health and to short- and long-term healthcare costs.



Understanding triple therapy: SITT and MITT

Triple therapy combines three medication classes for people with COPD who continue to have symptoms or flare-ups despite simpler treatment: an inhaled corticosteroid (ICS) to reduce airway inflammation, a long-acting beta-agonist (LABA) to relax airway muscles, and a long-acting muscarinic antagonist (LAMA) to further open the airways. Current Canadian and international guidelines, including the Canadian Thoracic Society (CTS) 2023 guidelines and the Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2026 report, support triple therapy for patients at high risk of exacerbation.[2]

In July 2026, Canada's Drug Agency (CDA) updated its national reimbursement recommendations to match this clinical guidance, recommending that triple therapy be funded as initial treatment for patients with moderate to severe COPD who have had at least one exacerbation in the past year, removing the previous requirement that patients first fail a step of dual therapy. [23]

The GOLD 2026 report moved in the same direction.[2] It lowered the threshold for its highest-risk group (Group E) to include people with a single moderate exacerbation in the previous year, and states that one moderate exacerbation should prompt consideration of treatment escalation. National reimbursement policy and international guidance now agree that one exacerbation is enough reason to reassess therapy.[2,23]

> POLICY UPDATE - JULY 2026
>
> **Canada's Drug Agency now recommends triple therapy as initial treatment for moderate-to-severe COPD patients with a prior-year exacerbation - putting national reimbursement policy in line with guideline-based prescribing.**

- **Single inhaler triple therapy (SITT)** delivers all three drug classes from one device. Health Canada has approved several SITT products for COPD, including Trelegy® Ellipta (approved 2018), Breztri® Aerosphere (approved 2021), and Trimbow® (approved 2026). [20]

- **Multiple inhaler triple therapy (MITT)** delivers the same three drug classes across two or more separate devices. For example, a patient may use an ICS/LABA combination inhaler plus a separate LAMA inhaler, or a LABA/LAMA combination inhaler plus a separate ICS inhaler.

The medication classes are often the same in both regimens.

What differs is the everyday burden on the patient:

- how many devices to carry
- how many inhaler techniques to master
- how many times a day to remember a dose
- how many chances there are for a step to be missed

Two different devices are also harder to teach and to check than one, which can make correct technique harder to sustain. For an older patient population often managing multiple chronic conditions, as this investigation's patient respondents overwhelmingly are, that difference in complexity is exactly the kind of friction that tends to erode adherence over time. It also affects how well the medications are used. Multiple inhaler regimens often combine different device types, each with its own inhalation technique, so patients have more to learn and care teams have more to teach and check. A single device means one technique to master and one to verify.

Adherence to COPD medication is already a challenge before that added complexity is even considered: real-world evidence puts adherence rates anywhere from 20% to 60%, meaning a substantial share of patients are not getting the full benefit of the therapy they have been prescribed regardless of device. [21] Real-world evidence suggests that SITT may offer advantages over MITT, including improved adherence and persistence and, in observational studies,[3] lower rates of moderate-to-severe exacerbations and mortality. [4]

Inside the investigation

RESPIPLUS' national investigation was designed to evaluate why SITT is prescribed less often than MITT, despite guideline support, expert recommendations and a simpler regimen for the patient. Two survey instruments were fielded in the spring of 2026, each was offered in English and French:

- **A healthcare professional (HCP) survey,** completed by 219 respondents, covering guideline familiarity, prescribing practice, device selection, and what would change prescribing behaviour.
- **A patient survey,** completed by 292 people living with COPD, covering flare-up history, current inhaler regimen, technique confidence, cost, and involvement in treatment decisions.

Both surveys used branching logic, so respondents only answered questions relevant to their situation, and both were reviewed by an expert Scientific Planning Committee of respirologists, primary care clinicians, and patient representatives before fielding. Full methodology and respondent demographics appear in the appendix.



Major findings of the investigation

This investigation revealed seven major findings:

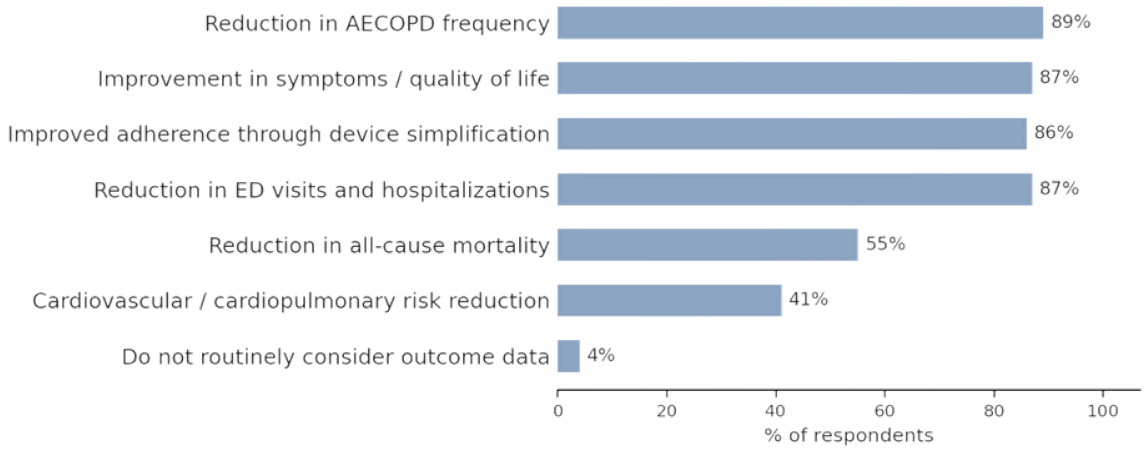
1. Clinicians support the use of SITT in COPD; the barrier is downstream of belief.
2. Perceived cost, coverage rules and administrative burden outweigh clinical hesitation.
3. Spirometry access continues to be a real bottleneck.
4. The biggest barrier clinicians face is largely invisible to patients.
5. The moment after an exacerbation at hospital or emergency department discharge is a confirmed, shared gap.
6. Patients are confident in their technique, but rarely have it checked.
7. Patients are rarely the ones who start the conversation about change.

Finding 1: Clinicians support the use of SITT in COPD; the barrier is downstream of belief

For a patient at high risk of exacerbation, 87% of HCPs say SITT is always or often their first-line choice. 83% believe SITT clearly or somewhat improves adherence compared with MITT, and 87% believe patients currently stable on MITT should be proactively switched to SITT, in most cases or for selected patients. This is not a population that needs convincing.

Guideline familiarity backs this up: 71% of HCPs call themselves very familiar with the Canadian Thoracic Society's 2023 guidelines, and 53% say the same of the GOLD 2026 report, with most of the remainder somewhat familiar rather than unaware. Yet knowledge and behaviour diverge in one specific spot. 59% of HCPs say they currently have COPD patients maintained on ICS-LABA without a LAMA, a combination the current guideline generally does not recommend outside specific phenotypes. Asked how they handle these patients, only 47% actively step them up to triple therapy when clinically appropriate; the rest either consider it without always acting (30%) or maintain the current regimen unless the patient deteriorates (21%). Guideline familiarity, in other words, is not the same thing as guideline-concordant behaviour, and where the two diverge, the pattern looks like watchful waiting rather than a knowledge gap. GOLD 2026 now treats a single moderate exacerbation as enough to consider escalating therapy, rather than waiting for further deterioration.

Clinical outcomes HCPs consider when deciding whether to prescribe SITT (n=199)

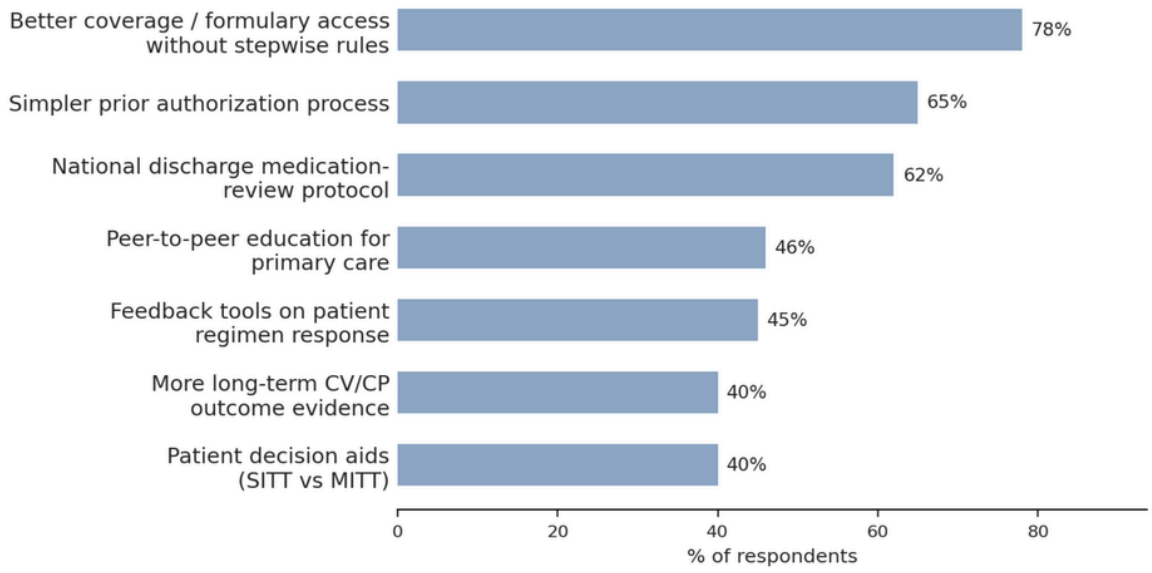


Abbreviations: AECOPD = acute exacerbation of COPD; ED = emergency department; CV/CP = cardiovascular/cardiopulmonary.

The clinical outcomes HCPs weigh when deciding whether to prescribe SITT track closely with what guidelines emphasize: reducing exacerbation frequency, improving symptoms and quality of life, and improving adherence through device simplification are each considered by well over 85% of respondents.

Cardiovascular and cardiopulmonary risk reduction is weighed less consistently (41%), suggesting an opportunity to better connect existing cardiovascular outcome evidence to prescribing decisions, but even here only 4% of HCPs say they do not consider outcome data at all when making this decision. Asked directly what would most increase their likelihood of prescribing SITT for a new patient, HCPs ranked system-level fixes well above further clinical education:

What would most increase HCP likelihood of prescribing SITT (n=154)



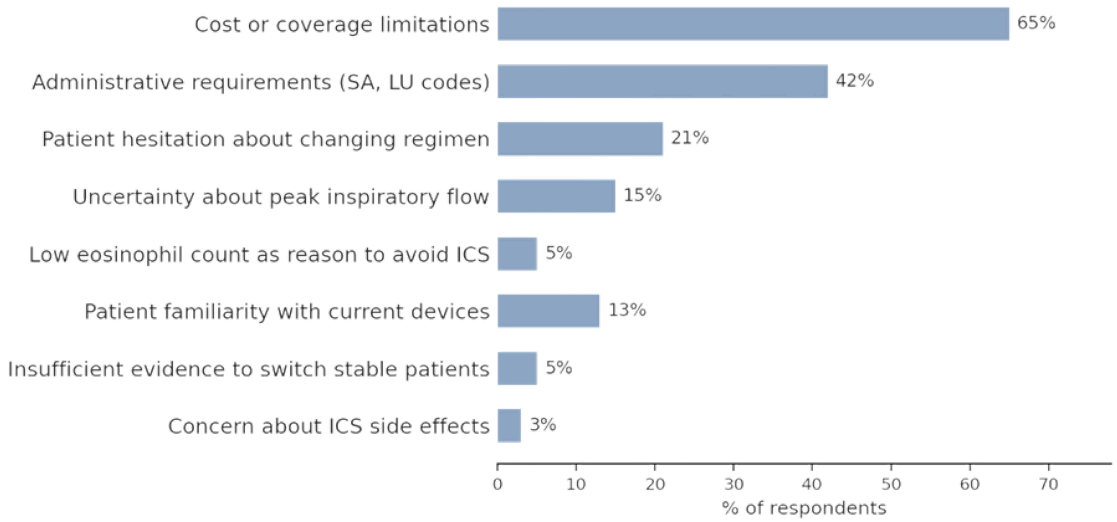
Abbreviations: CV/CP = cardiovascular/cardiopulmonary; SITT = single inhaler triple therapy; MITT = multiple inhaler triple therapy.

Better coverage and formulary access without stepwise requirements topped the list, with 78% of HCPs saying it would make a significant difference, followed by simpler prior authorization processes (65%) and a national protocol for reviewing COPD medications at hospital discharge (62%). More evidence on long-term cardiovascular outcomes, patient decision aids, and peer-to-peer education from respirologists were all rated helpful, but consistently well behind the system-level items. On cardiovascular outcomes, committee members noted that the evidence is already substantial; the gap is in getting it to prescribers, not in generating more of it. The clearest reading of this data is that Canada's COPD prescribers are, for the most part, already persuaded to use SITT. The open question is whether the system around them makes it easy to act on that conviction.

Finding 2: Perceived cost, coverage rules and administrative burden outweigh clinical hesitation.

When HCPs rate eight possible barriers to choosing SITT over MITT, the ranking is unambiguous. Cost or coverage limitations are called a major barrier by 65% of HCPs, and administrative requirements, meaning Special Authorization, Limited Use codes, and stepwise criteria, are a major barrier for 42%. Every clinical concern with SITT ranked much lower: concerns about ICS-related side effects were a major barrier for only 3% of HCPs, insufficient evidence to switch a stable patient for 5%, and low blood eosinophil count for 5%.

HCP-rated "major barrier" to prescribing SITT over MITT (n=167)



Abbreviations: SA = Special Authorization; LU = Limited Use; ICS = inhaled corticosteroid.

Consistent with this, when HCPs did choose MITT over SITT for a patient needing triple therapy, the two most common reasons were patient preference for familiar devices or an established, stable routine (64%) and coverage or cost being the deciding factor (61%), well ahead of any clinical rationale (18%).

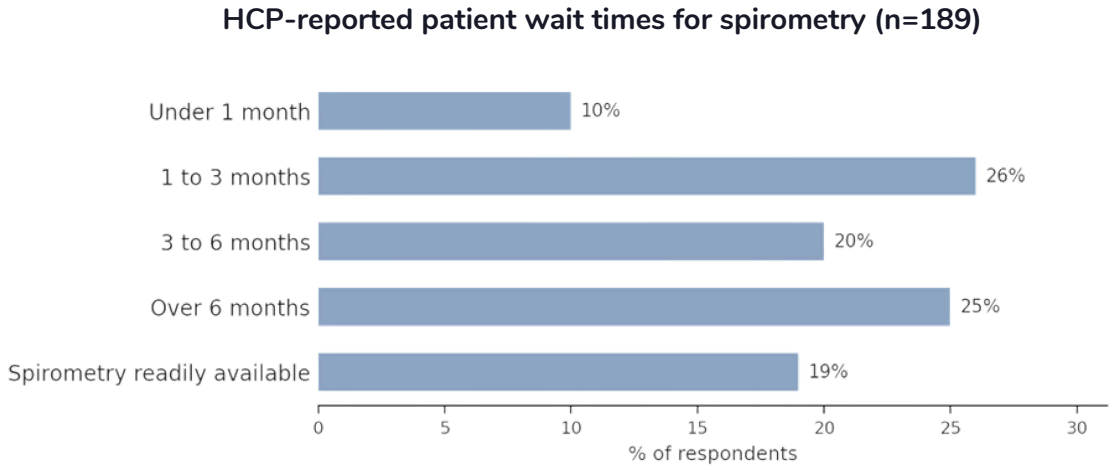
Limited Use codes or Special Authorization requirements were reported to block initiation sometimes, often, or very often for 67% of HCPs. For an intervention designer, this ordering matters: peer education, evidence summaries, and guideline updates address a barrier that, in these data, is not the one holding SITT back. Cost, coverage, and paperwork are.

Uncertainty about a patient's peak inspiratory flow (PIF) adequacy for a dry powder inhaler is the next-highest-rated barrier after cost and administrative burden, at 15% major and 42% minor. Actual measurement lags behind that stated uncertainty: only 25% of HCPs assess PIF routinely before selecting a device, 31% do so occasionally, and 25% rely on clinical judgment instead of a measured value.

As with other self-reported practice data in this investigation, these figures likely represent an upper bound; actual routine measurement in day-to-day practice may run lower than stated here. Where PIF is assessed, a dedicated device such as the In-Check DIAL is the most common method, but clinical judgment and spirometry-derived estimation are used almost as often, neither of which actually measures inspiratory flow against a specific device's resistance.

This is a second spot, alongside cost and paperwork, where closing a practical gap, in this case equipment access and routine measurement, would likely do more than further persuasion.

Finding 3: Spirometry access is a real bottleneck



59% of HCPs report that patients in their region face barriers accessing spirometry, the breathing test used to confirm a COPD diagnosis and gauge its severity. Among those reporting a barrier, 25% say the typical wait is over 6 months, while only 19% say spirometry is readily available in their own practice. A further 15% of all HCPs say they do not routinely track when their patients last had spirometry.

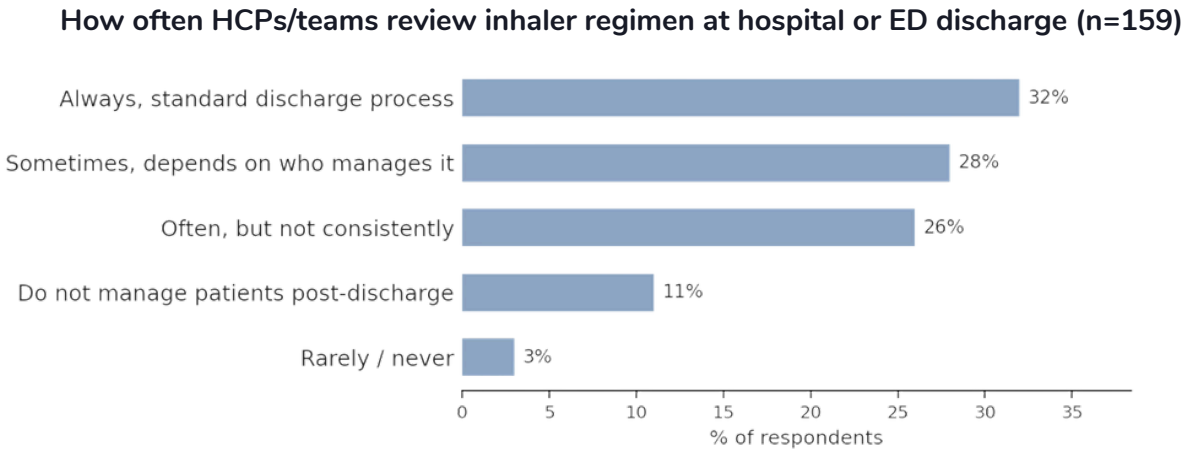
Given how significantly COPD is already underdiagnosed nationally, as the earlier context section describes, this access gap compounds an existing problem rather than sitting apart from it.

Finding 4: The biggest barrier clinicians face is largely invisible to the patients navigating around it

Finding 2 established that cost and coverage are, by a wide margin, the barrier HCPs weigh most heavily when deciding between SITT and MITT. The patient data suggests that weight rarely gets communicated. When patients who received an explanation for their current treatment were asked what reason they were given, effectiveness dominated (55%) and reducing flare-ups came second (29%); only 3% said their treatment was explained to them in terms of insurance coverage.

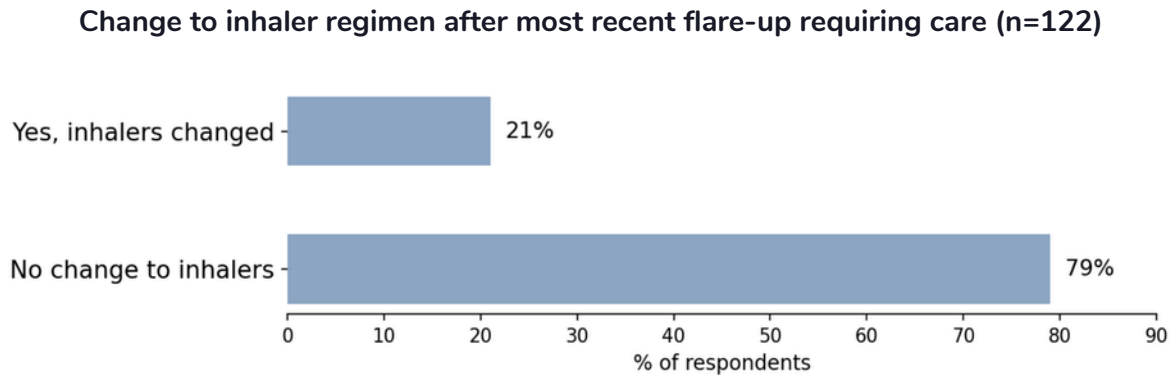
This is not a contradiction of the earlier finding, since a clinician navigating a coverage rule has little reason to frame that navigation for the patient. But it does mean the friction HCPs describe, prior authorization, Limited Use codes, stepwise criteria, remains largely a backstage problem: patients experience its downstream effects (which device they end up on, whether a switch is offered) without ever seeing the administrative logic that produced them.

Finding 5: The moment after an exacerbation at hospital or emergency department discharge is a confirmed, shared gap



Abbreviations: HCPs = healthcare professionals; ED = emergency department.

Only 32% of HCPs say reviewing and updating the maintenance inhaler regimen at hospital or emergency department discharge is always part of standard process. A further 54% say it happens often but not consistently, or sometimes depending on who manages the discharge, and 11% say they do not manage these patients post-discharge at all.



Patients confirm this gap from the other side of the same encounter. Among patients who had a flare-up serious enough to need antibiotics, steroids, an unscheduled visit, or a hospital stay, and who were actually seen or admitted for it, 79% report no change to their inhaler regimen afterward, while only 32% of HCPs say medication review at discharge is a routine, built-in part of their process (n=122; a further 20 respondents indicated they were not admitted or seen despite reporting a qualifying flare-up, and are excluded from this figure). Together these numbers point to the same gap in prescribing practice: a moment with clear clinical justification to reassess treatment is being used as a checkpoint only about a third of the time.

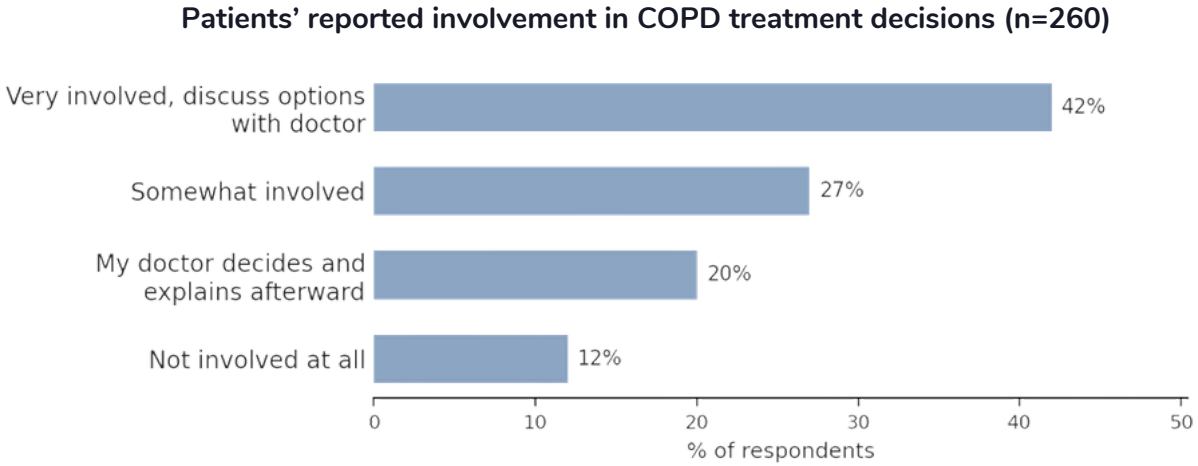
Finding 6: Patients are confident in their technique, but it is rarely checked

78% of patients say they are very comfortable and confident using their inhaler correctly. At the same time, 35% say a healthcare professional has never watched them use it, and only about a fifth are checked at every visit or at least once a year. Self-assessed competence this high, paired with verification this infrequent, is worth treating as a soft spot rather than reassurance: independent research has found that most patients believe they use their inhaler correctly, yet the large majority make at least one technique error when observed directly, and inhaler errors are consistently linked to worse symptom control and more frequent exacerbations.[22]

The professionals who do check are mostly doctors, specialists, or nurses; pharmacists check technique for only about 8% of patients, despite being the healthcare contact patients see most often, at every refill.

> *"I think it's very important that someone watch you take the inhalers. I myself use a spacer and go to pulmonary rehab. So, I've learned how to take them correctly, but no one has ever watched me do my inhaler."*
> *Patient*

Finding 7: Patients are rarely the ones who start the conversation about change



Asked who first raised the idea of changing or starting their current COPD treatment, 76% of patients say their doctor or specialist did; only 11% say they did themselves. 42% of patients feel very involved in treatment decisions, discussing options with their doctor, while a combined 32% describe low involvement, either the doctor decides and explains afterward (20%) or the patient is not involved at all (12%). Despite this, 38% say they would like more say in their treatment, so there is a real, sizeable minority for whom greater involvement is a genuine unmet preference.

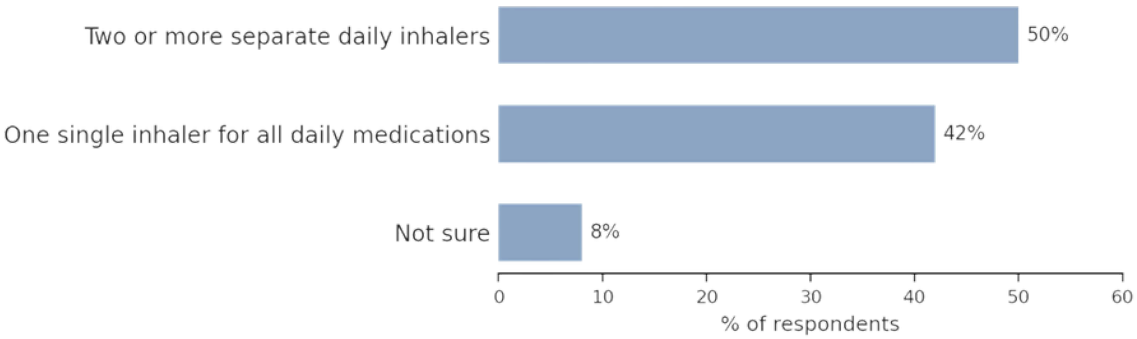
When treatment does change, it is more often reactive than planned: worsening symptoms (23%) and a severe flare-up or hospitalization (16%) together outweigh a doctor-initiated routine adjustment (15%) as the stated reason, and 15% of patients say their treatment has simply never changed.

This passivity fits a broader pattern running through the data: COPD care for these patients tends to be reactive, responding once symptoms have already worsened or a flare-up has occurred, rather than proactive, built around a plan agreed on ahead of time and aimed at disease stability.

That pattern has a practical downstream effect: only 25% of patients have a written action plan telling them what to do when symptoms worsen, a further 39% have a rescue prescription ready but no full plan, and 34% have neither.

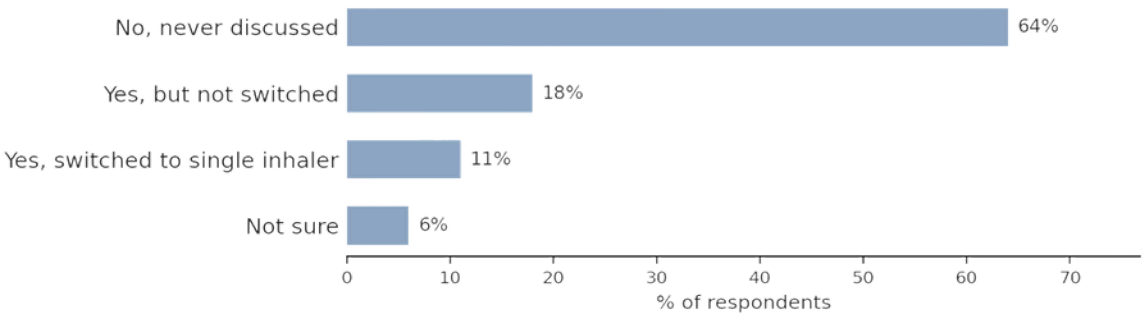
That gap shows up directly in how patients describe their own understanding of the disease:

Patients' current daily inhaler regimen (n=260)



The same pattern is also evident in single-inhaler adoption. Half of all patients (50%) are on two or more separate daily inhalers, against 42% on a single device for all daily medications.

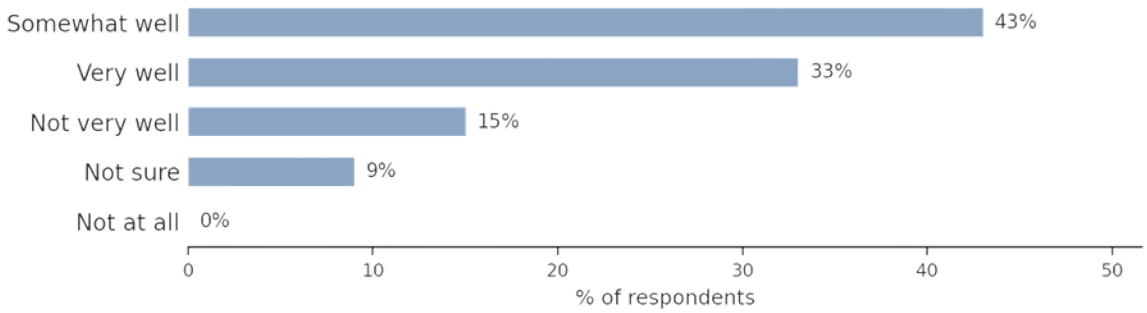
Among patients on multiple inhalers: has combining into one device been discussed? (n=131)



Among patients still on multiple inhalers, 64% say combining their medications into one device has never been discussed with their doctor or pharmacist. Only 11% report having switched. Yet among patients already using a single inhaler, the experience is strongly positive: 59% call it much simpler than what they used before, and a further 31% have always been on one inhaler. The gap here is not one of patient satisfaction once SITT is adopted; it is a gap in how often the option is raised in the first place.

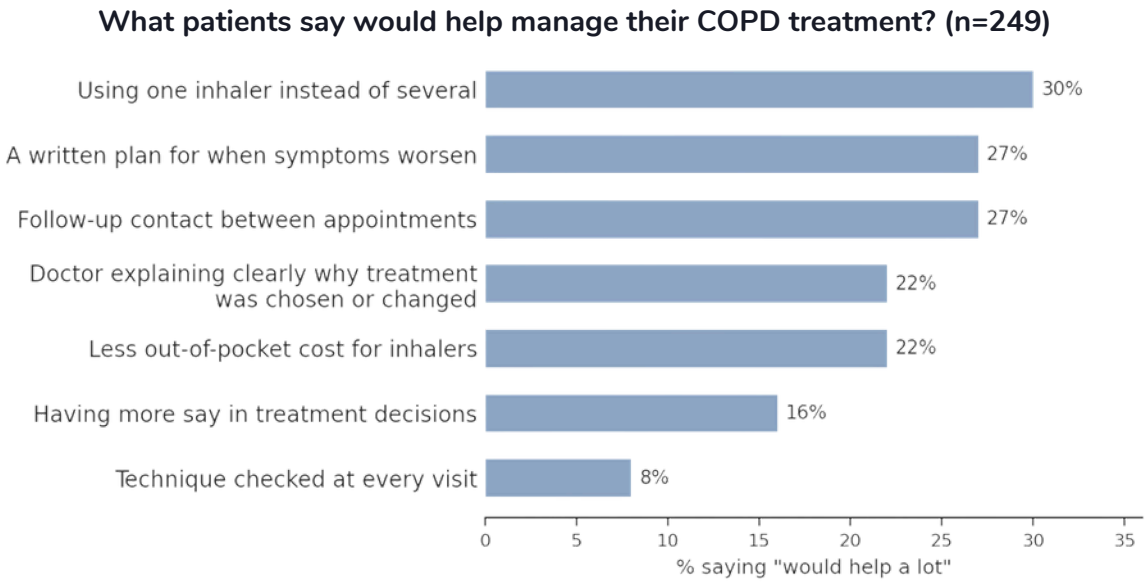
Stated intent and reported experience diverge here. Finding 1 showed that 87% of HCPs believe patients already stable on MITT should be proactively switched to SITT. Set against that, 64% of these same patients say the switch has never come up in conversation with their doctor or pharmacist. Belief in proactive switching is close to universal among clinicians; the follow-through patients describe is not. This is one of the clearer signals in the data that the barrier sits in the moment of care, not in clinical conviction.

How well current medications control symptoms and flare-ups (n=263)



It's worth noting that most patients rate their current medications as controlling symptoms very well or somewhat well (76% combined). Two caveats are worth holding alongside that figure. First, patients may not have a clear reference point for what full disease control, or "disease stability," should actually feel like, so a self-rating of "well controlled" may reflect adjusted expectations rather than the clinical target. Second, 36% of patients use their rescue inhaler daily, a pattern usually associated with poorer control, so "well controlled" and "not relying heavily on a reliever" are not always the same patients. Patients' perceptions of good control may differ from clinical targets, particularly when expectations have not been explicitly discussed.

Asked directly what would make managing their COPD treatment easier, patients ranked a single-inhaler regimen alongside two things care teams can offer regardless of device choice: a written action plan and follow-up contact between appointments.



Using one inhaler for all medications instead of several (30%), a written plan for when symptoms worsen (27%), and follow-up contact from the care team between appointments (27%) were all rated as something that would help a lot by roughly three in ten patients, well ahead of having more say in decisions (16%) or having technique checked at every visit (8%).

Read together with Finding 6, that last figure is worth sitting with: technique verification is something patients rate as only modestly helpful, even though the data suggests it is exactly where their confidence and their observed performance are most likely to diverge. Patients may be requesting support they already recognize as useful while underestimating the value of technique checks they may not realize they need.

It is worth noting that everything discussed above sits alongside, not instead of, the nonpharmacologic foundations of COPD care: smoking cessation, exercise and pulmonary rehabilitation, airway clearance, and vaccination. For patients who continue to have frequent exacerbations despite optimized inhaled therapy, further step-up options such as azithromycin, roflumilast, or biologic therapy may also be appropriate.

A call to action: Recommendations

These recommendations follow directly from where the data places the barrier: Coverage, process, and the discharge moment from emergency department or hospital.

For payers and formulary decision-makers

- Implement the reimbursement update by the CDA issued in July 2026, which recommends triple therapy as initial treatment for high-risk patients without a prior dual-therapy trial; the barrier this recommendation identifies is provincial adoption of a national recommendation, not a gap in the evidence or the guidance itself. [23]
- Review and, where inconsistent with the updated national reimbursement recommendation, remove Special Authorization and Limited Use code criteria, as HCP respondents identified administrative and coverage barriers among the most important system-level factors affecting SITT access.
- Provincial policies that continue to require a prior dual-therapy trial before SITT should be reassessed in light of current clinical guidelines and national reimbursement recommendations.
- Treat cost and coverage as the primary target for any intervention aimed at increasing SITT uptake; it outranks every clinical or educational factor tested in this investigation.

For hospitals, emergency departments, and discharge planning

- Build a standard medication review as part of COPD exacerbation discharge planning, given that only 32% of HCPs currently treat this as routine and 79% of patients who were actually seen or admitted report no change after a flare-up serious enough to require care.
- Clarify ownership of this review where a patient moves between hospital or rehab facility, hospitalist, family physician, and specialist, since sometimes, depending on who manages the discharge, was the second most common HCP response.

- Consider adopting a standard post-exacerbation discharge checklist:

Item	What to check
Exacerbation triggers	Review what preceded this event and whether it points to a modifiable factor.
Smoking cessation	Confirm current status and offer or reconnect to cessation support.
Medication adherence	Check actual use against the prescribed regimen, not just what is on file.
Inhalation technique	Observe the patient using their device; do not rely on self-report.
Vaccination status	Confirm influenza, pneumococcal, COVID-19, pertussis (Tdap) and RSV vaccinations are up to date.
Referral to pulmonary rehabilitation	Refer if not already enrolled or completed within the past year.
Optimization of maintenance therapy	Reassess regimen, generally toward SITT, including referral for other step-up options where appropriate.

For professional associations and continuing education

- Extend COPD education to hospital staff and emergency physicians, focused on reviewing and optimizing maintenance therapy at discharge after an exacerbation.
- Direct educational effort toward simplifying the administrative pathway and toward practice measurement of peak inspiratory flow and equipment access, rather than toward persuading HCPs that SITT works; that persuasion is largely already accomplished.

- Support pharmacists in taking a larger role in inhaler technique verification, given they currently check technique for only a small share of patients despite the most frequent patient contact at refill. In provinces where pharmacists' scope of practice includes adapting or prescribing therapy, pharmacists could also initiate a switch from MITT to SITT directly.
- Continue to package cardiovascular and cardiopulmonary outcome evidence for the majority of HCPs (59%) who do not yet weigh it when deciding whether to prescribe SITT.

For prescribers

- Where a patient is on multiple inhalers and stable, proactively raise single-inhaler consolidation explicitly rather than assuming reluctance; patients who switch overwhelmingly report the result as simpler, and most who have not switched say it was never discussed.
- Treat a moderate or severe COPD exacerbation as requiring prompt review and optimization of maintenance therapy and other aspects of chronic disease management (vaccination, airway clearance, pulmonary rehabilitation), rather than being treated as a historical event alone.
- Build routine, brief inhaler technique checks into refill or follow-up visits; patient confidence is not a reliable substitute for observation.

For patients and patient organizations

- Encourage patients to ask directly whether their current combination of inhalers could be consolidated into one device, since the data suggests this question is not always raised proactively.
- Encourage patients to ask about the other parts of COPD care alongside their inhalers, including vaccinations, pulmonary rehabilitation, airway clearance and support to stop smoking, since each can reduce flare-ups and improve daily life.
- Promote awareness of written action plans for managing flare-ups and encourage patients who want more say in their treatment decisions to say so; a sizeable minority want more involvement than they currently have.
- Promote engagement with the nonpharmacologic foundations of COPD care - vaccination, airway clearance, smoking cessation, and pulmonary rehabilitation - as complements to inhaler therapy, not substitutes for it.

Appendix: Methodology and respondent profile

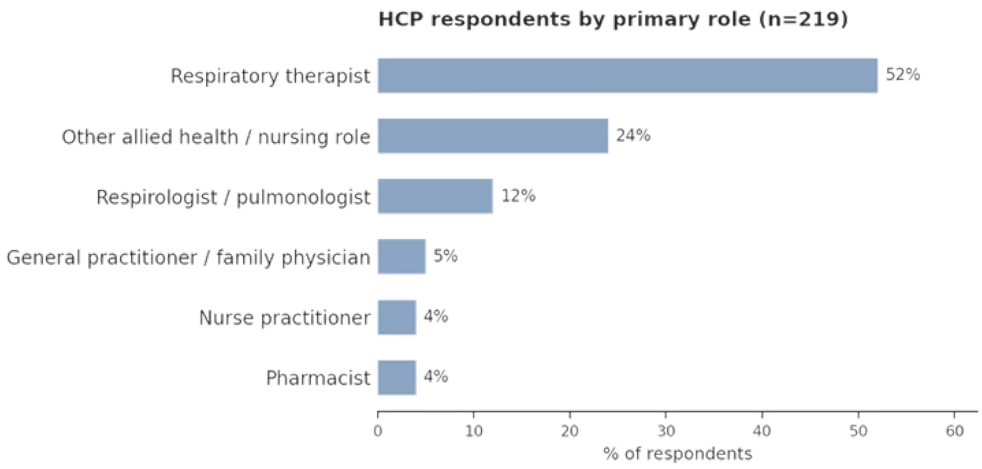
RESPIPLUS fielded two national survey instruments in the spring of 2026, each offered in English and French. Both used branching logic so respondents only saw questions relevant to their situation, and both were developed with input from a Scientific Planning Committee of respirologists, primary care physicians, pharmacists, and patient representatives.

Scientific Planning Committee

- **Dr. Jean Bourbeau**, Respirologist, McGill University Health Centre; Past President, Canadian Thoracic Society (CTS).
- **Dr. Alan Kaplan,** Family Physician; Chairperson, Family Physician Airways Group of Canada.
- **Dr. Mohit Bhutani,** Respirologist and Professor of Medicine, University of Alberta; Past President, Canadian Thoracic Society (CTS); Co-Chair, CTS COPD Clinical Assembly.
- **Michael Boivin,** Clinical Pharmacist Consultant; President, CommPharm Consulting Inc.
- **Henry Roberts,** Patient representative, Executive Committee, COPD Canada.

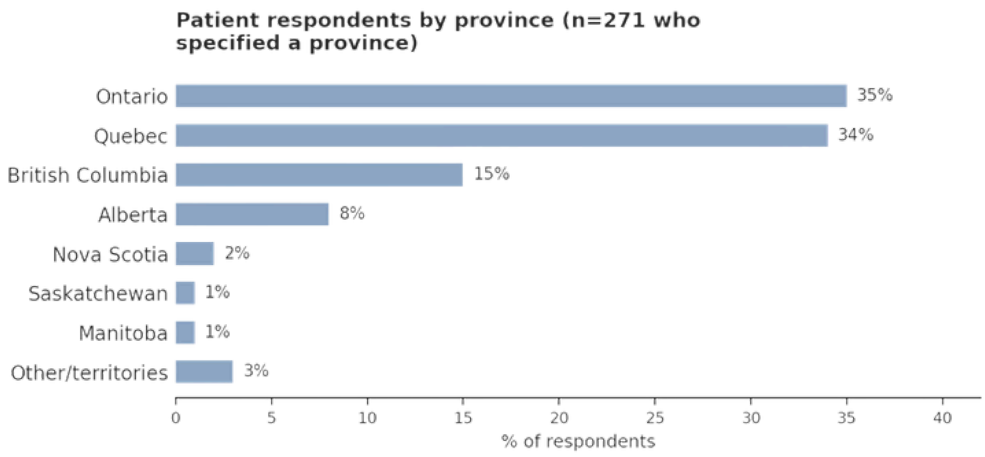
Committee members reviewed the survey instruments and contributed to this report; their participation does not imply individual endorsement of every finding or recommendation.

Healthcare professionals (n = 219)



- Primary role: respiratory therapist 52%, other allied health or nursing role 24%, respirologist or pulmonologist 12%, general practitioner or family physician 5%, nurse practitioner 4%, pharmacist 4%. This sample is weighted toward the professionals who deliver and reinforce inhaler technique day to day, more than toward the prescribers who make the initial SITT-versus-MITT decision; findings about prescribing intent should be read with that composition in mind.
- Province: Quebec 27%, Ontario 22%, Alberta 19%, British Columbia 10%, and smaller numbers from every other province and territory.
- Practice setting: community or family practice clinic 36%, community hospital 26%, academic or university-affiliated hospital 18%, and smaller numbers in private specialist offices and other settings.
- 74% of HCP respondents completed the survey in English and 26% in French.

Patients (n = 292)



- Province: Ontario 35%, Quebec 34%, British Columbia 15%, Alberta 8%, and smaller numbers from every other province and territory.
- Age: 42% are 75 to 84, 39% are 65 to 74, and the remainder are under 65 or 85 and older, reflecting the older age profile typical of COPD.
- Diagnosis duration: 43% have lived with a COPD diagnosis for more than 10 years, and a further 24% for 7 to 10 years, making this a long-standing patient population.
- 75% of patient respondents completed the survey in English and 25% in French.

Limitations

- Respondents to both surveys opted in, which may have resulted in a sample more engaged with COPD management than the broader population. As a result, reported levels of guideline awareness, technique confidence, and treatment satisfaction may differ from population-level estimates.
- Respiratory therapists outnumber respirologists and family physicians combined in the HCP sample; findings framed as HCP prescribing intent should be read with this in mind.
- All findings are self-reported and were not independently verified against clinical records or observed technique.

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We gratefully acknowledge the involvement of representatives from the Canadian Thoracic Society (CTS), the Family Physician Airways Group of Canada, and COPD Canada. Their participation and contributions do not imply organizational or individual endorsement of every finding or recommendation in this report.

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