

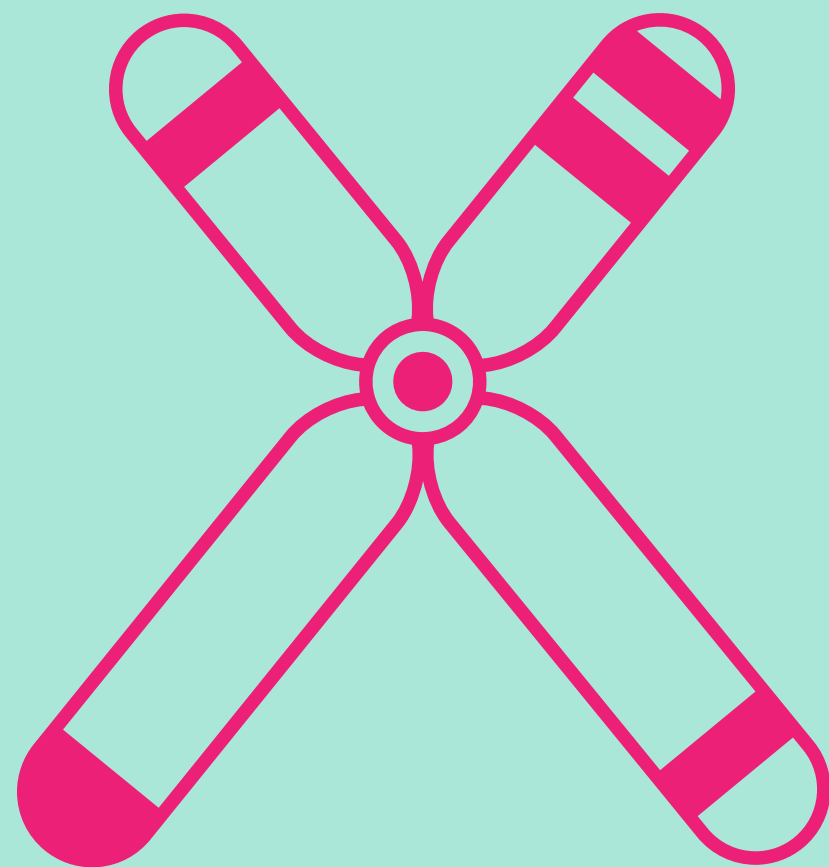
understanding variability in genomic testing across canada. a HCP survey

high level survey results.

CCRAN biomarker conference june 2025

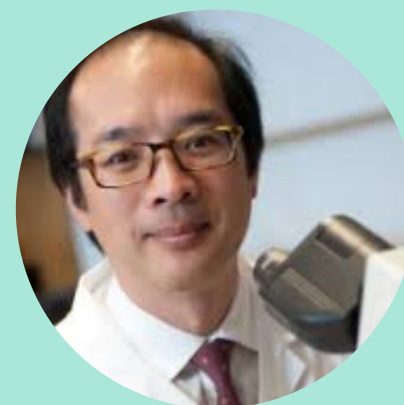


WHO BUILT THE SURVEY



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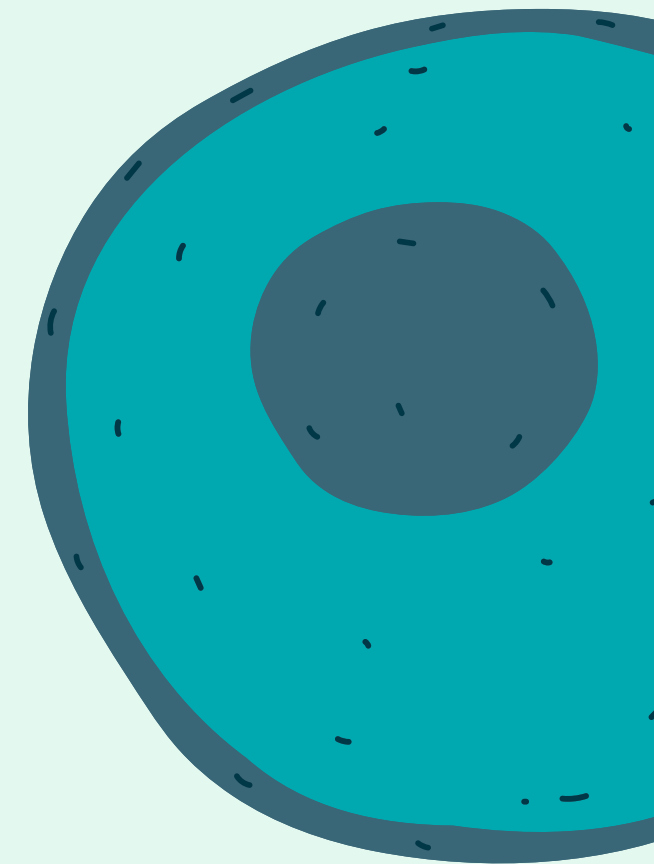
CHIEF CHANGE OFFICER,
THE CANCER COLLABORATIVE

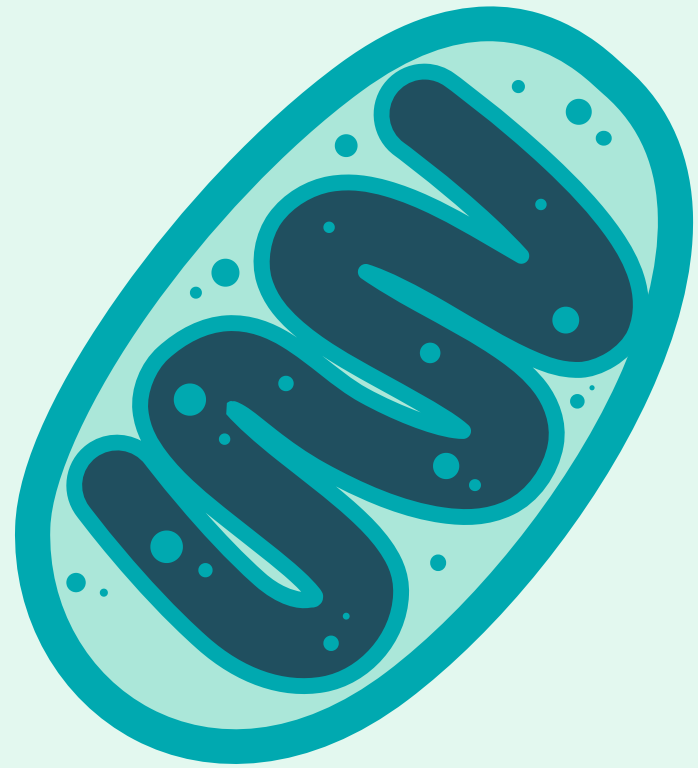
WHY?

to assess the utilization and barriers to genomic testing in cancer care across Canada

KEY AREAS OF FOCUS

- Utilization of genomic testing across different cancer types
- Barriers to testing access, especially in non-academic settings
- The role of molecular tumour boards in clinical decision making
- Educational needs for clinicians (oncologists and pathologists)
- Speaking to patients about genomic testing





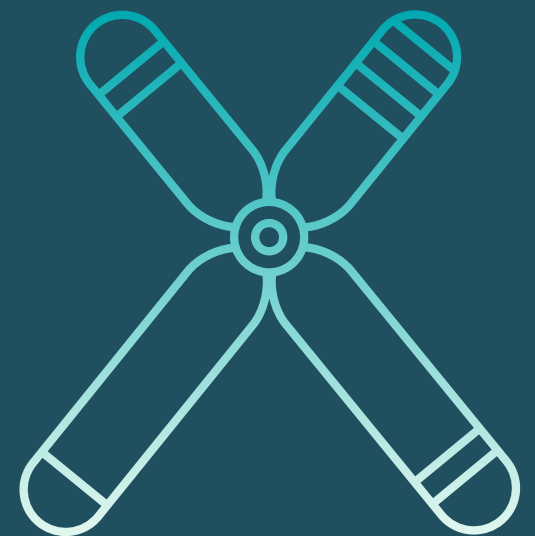
- 80% from academic centres, mostly urban.
- Oncologists (67.5%), pathologists (30%)
- Majority have 6–10+ years of experience
- 90% involved in clinical research;

*WHO
RESPONDED
TO IT*

ACCESS TO GENOMIC TESTING

- Genomic testing is being used across NSCLC, mBC, CRC, prostate, ovarian, etc.—but variability exists in which genes are tested and when
- Testing more likely for standard-of-care genes; less so for exploratory or clinical trial markers
- Reflex testing by pathologists at diagnosis occurs in many centres—but not all
- Tissue testing is more common than liquid biopsy, which remains underused (most unavailable)

While genomic testing is happening across tumour types, there is significant variability in when and how it's used





HOW TESTING HAPPENS

- 2/3 of tests ordered by treating clinicians, not always reflexively initiated
- Platforms used: Oncomine, TSO500, Illumina, Ion Torrent— platform use is inconsistent
- Gene panels vary- most are using hotspot or <50 genes when used in house, 51–300+ when sent out
- Delays common: ~75% wait 2–4+ weeks for results

HOW TEST RESULTS ARE BEING USED



92% use results to guide treatment decisions

96–98% use results to access approved or funded therapies

Only 52% use testing for diagnostic or prognostic purposes

36% use for off-label treatment

20% frequently use for Cancer of Unknown Primary (CUP)

~50–60% use testing to support clinical trial enrollment

Testing is widely used for funded treatments—but less so in areas requiring interpretation, systemic support, or clinical discretion

FUNDING FOR GENOMIC TESTING

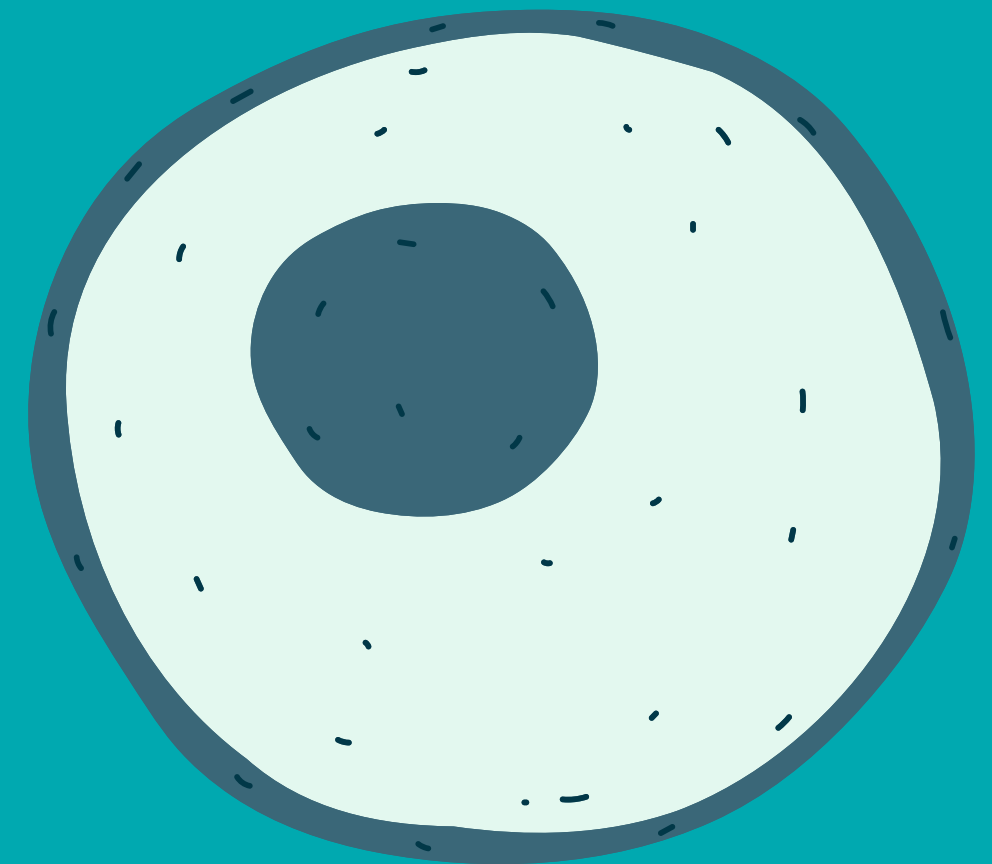
- Public funding is the most common mechanism—but not universally available
- Out-of-pocket costs are sometimes required, particularly for broader panels or private tests
- Some testing is supported through research grants or hospital foundation funding
- Funding models vary widely by province, institution, and tumour type
- Lack of consistent funding leads to inequitable access and delays in care

Without stable, nationwide funding, access to genomic testing remains fragmented and inconsistent.

LIMITING FACTORS FOR GENOMIC TEST USAGE

- Lack of access to therapies tied to genomic results.
- Cost and limited funding
- Difficulty interpreting results
- No guideline recommendations for some tests
- Patient hesitancy or concerns about privacy

*interpretation and access to therapies rank high, suggestsing
educational and systemic fixes are necessary*



MOLECULAR TUMOUR BOARDS (MTBS)

Majority of clinicians had access to a molecular tumour board - but many did not

Most MTBs are local or accessed via academic partnerships

Even when available, membership varies—, geneticists, bioinformaticians are not always included

Only 8% clinicians reported that MTB patients are longitudinally followed in a database

Fragmentation limits impact and continuity of care.

BARRIERS TO ADOPTION

- Lack of funding
- Delays in test turnaround—often 2+ months
- Staff shortages, especially in labs and bioinformatics
- And lack of access to therapies, even when results are actionable

There were also educational gaps: some clinicians didn't feel confident interpreting tests. Others noted poor integration of testing into EMRs, and limited access to newer biomarker tests.

EDUCATION

Every single respondent had pursued education on genomic testing—but most of it was self-taught, through CME, peer-reviewed articles, or scientific meetings.

Top priorities included:

- What NGS tests are available
- What targeted treatment options are available based on results
- Training in interpretation of the results

Most reported moderate understanding of key genomics concepts—but there's room to improve confidence, especially when communicating with patients.



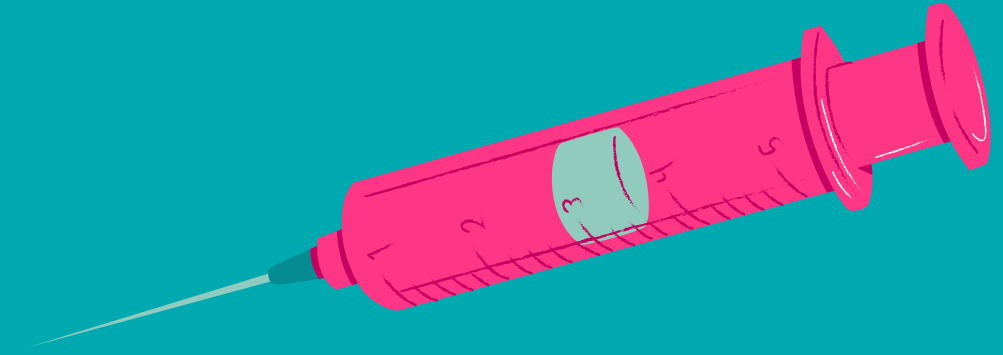
PATIENT ENGAGEMENT

More and more patients are requesting testing
89% of clinicians have had to discuss out of patient costs with patients

Top three factors that patients would refuse testing for

- cost concerns for the tests
- cost concern for the therapy
- concerns for obtaining private insurance/germline concerns for family members

KEY FINDINGS



✿ Not testing for all possible genomic mutations

Lack of clear guidelines, and lack of funding creates inconsistent and variable use of how testing is being utilized and how mutations are being tested for

✿ MTBs are underutilized

Access to MTBs are limited and uneven , where they do exist they lack structure and membership. And most MTBs are not integrated into patient tracking systems

✿ Infrastructure gaps

Most HCPs felt that their hospital did have the appropriate infrastructure to support precision medicine, they need more educational resources and tools, better access to tools for analysis and reporting (like AI), and the need to advocate for expanding access

thank you

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