



**Wisconsin
Cancer
Collaborative**

Colorectal Cancer in Wisconsin

April 14, 2026

Agenda

- Welcome
- Wisconsin Colorectal Cancer Data Overview
- Colorectal Cancer Screening Spotlight
 - Emplify Health by Gundersen
- Questions & Discussion

Today's Speakers:



Lena Swander, MPH

Cancer Epidemiologist
Wisconsin DHS WCRS

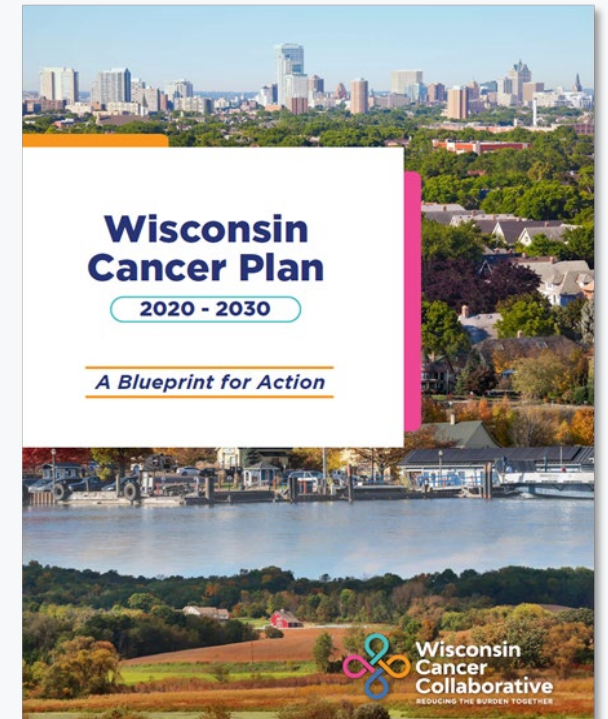


Milan Folkers, MD

Gastroenterologist
Emplify Health by Gundersen

Wisconsin Cancer Plan 2020-2030

- Serves as a ***common framework and foundation for action*** for all working on cancer prevention and control in Wisconsin
- Designed to ***provide a vision*** of what needs to be done and ***identify the resources needed*** to reduce the burden of cancer in Wisconsin



Wisconsin Cancer Plan
2020-2030

Connections to the Cancer Plan

- Colorectal cancer screening
 - Chapter 3
- Risk reduction strategies
 - Chapter 2
- Addressing data gaps
 - Chapter 7



Introduction

CHAPTER 1
Health Equity

CHAPTER 2
Risk Reduction

CHAPTER 3
Early Detection and Screening

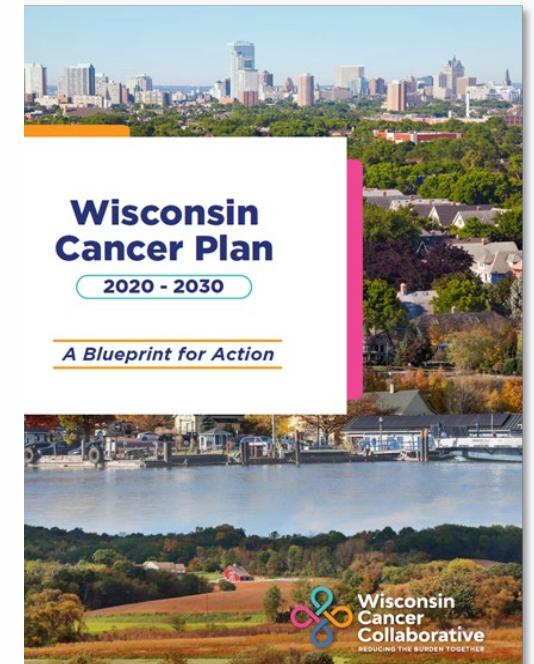
CHAPTER 4
Treatment

CHAPTER 5
Survivorship

CHAPTER 6
End of Life

CHAPTER 7
Data

Plan Measures





**Wisconsin
Cancer
Collaborative**
REDUCING THE BURDEN TOGETHER

Colorectal Cancer in Wisconsin

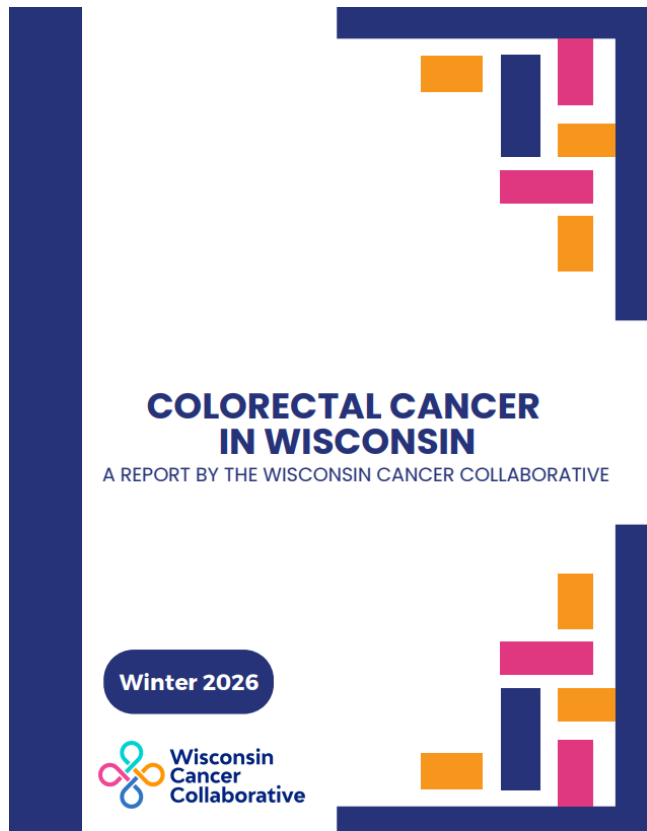


WISCONSIN DEPARTMENT
of HEALTH SERVICES

Wisconsin Cancer Reporting System

We acknowledge the CDC for its support under CDC Cooperative Agreement NU58/DP007146. Contents are solely the responsibility of DHS and WCRS, and do not necessarily represent the official views of the CDC.

Report Highlights



- Trends
- Incidence and Mortality Rates
 - Age
 - Sex
 - Race Ethnicity
 - Geography
- Screening
- Risk Reduction
- Treatment
- Survival and Stage

By the Numbers

2nd

most common cause of cancer deaths in the U.S.

2,530

new cases each year in Wisconsin

880

deaths annually in Wisconsin

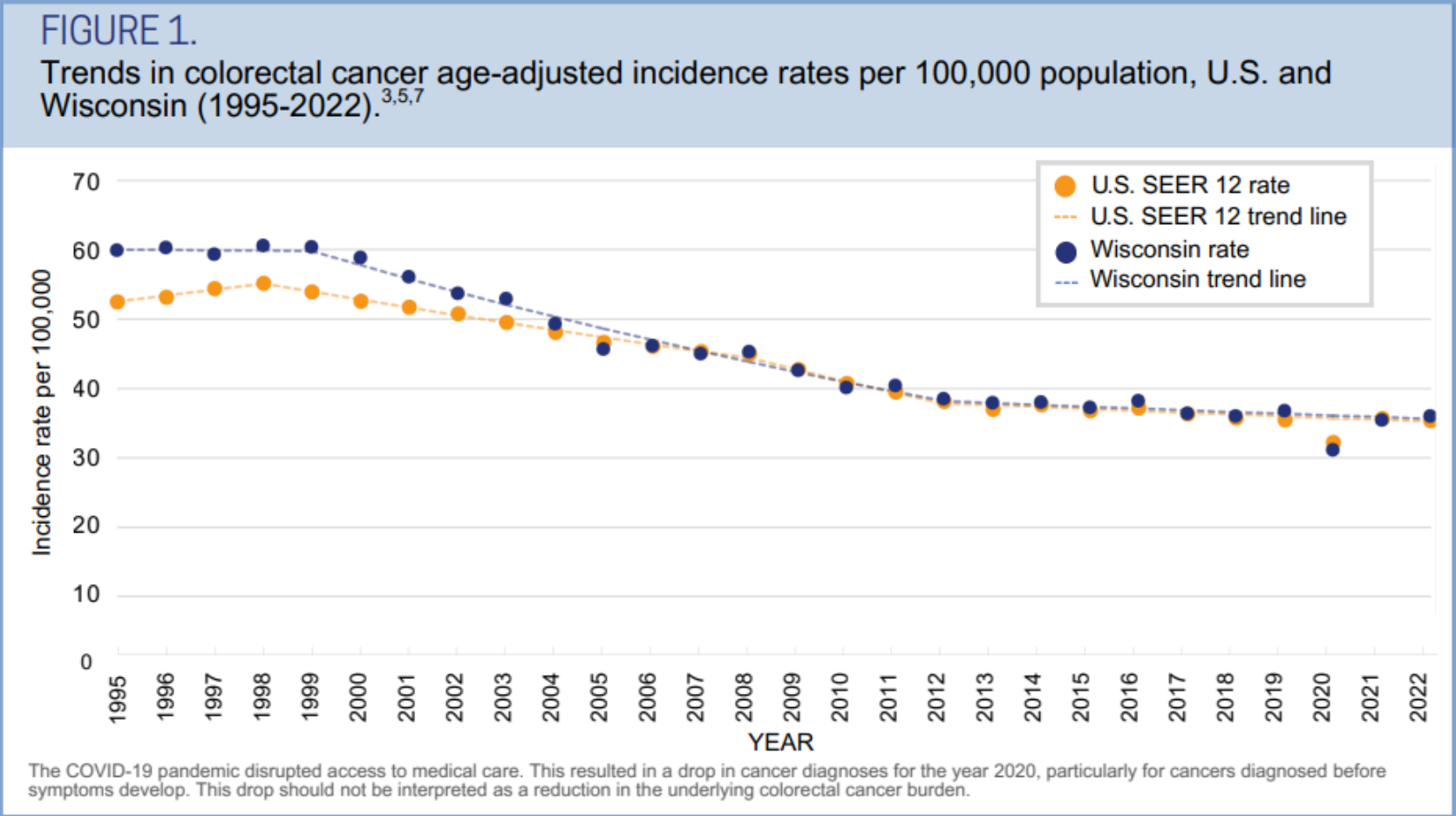
1 in 24

men will develop in their lifetime

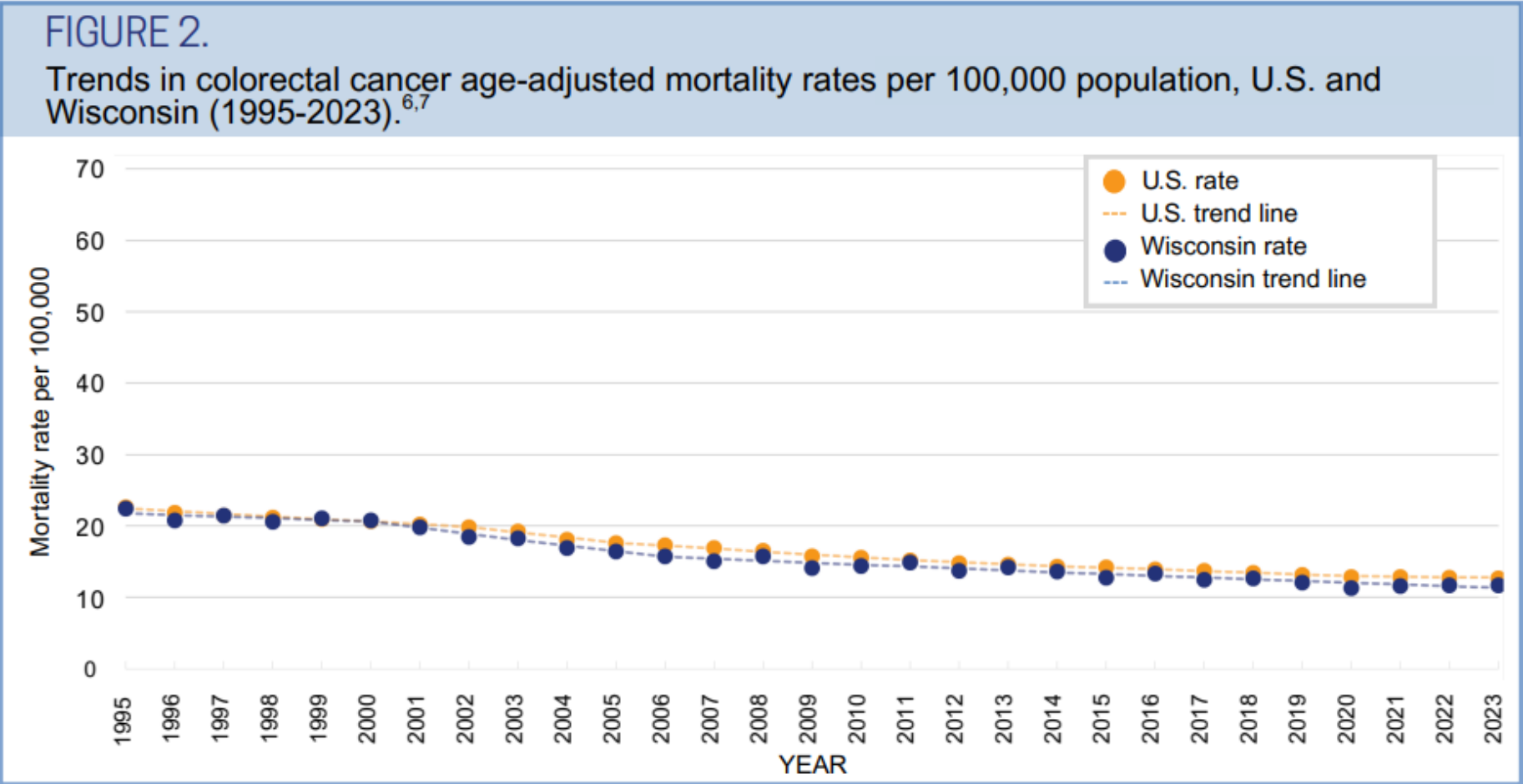
1 in 26

women will develop in their lifetime

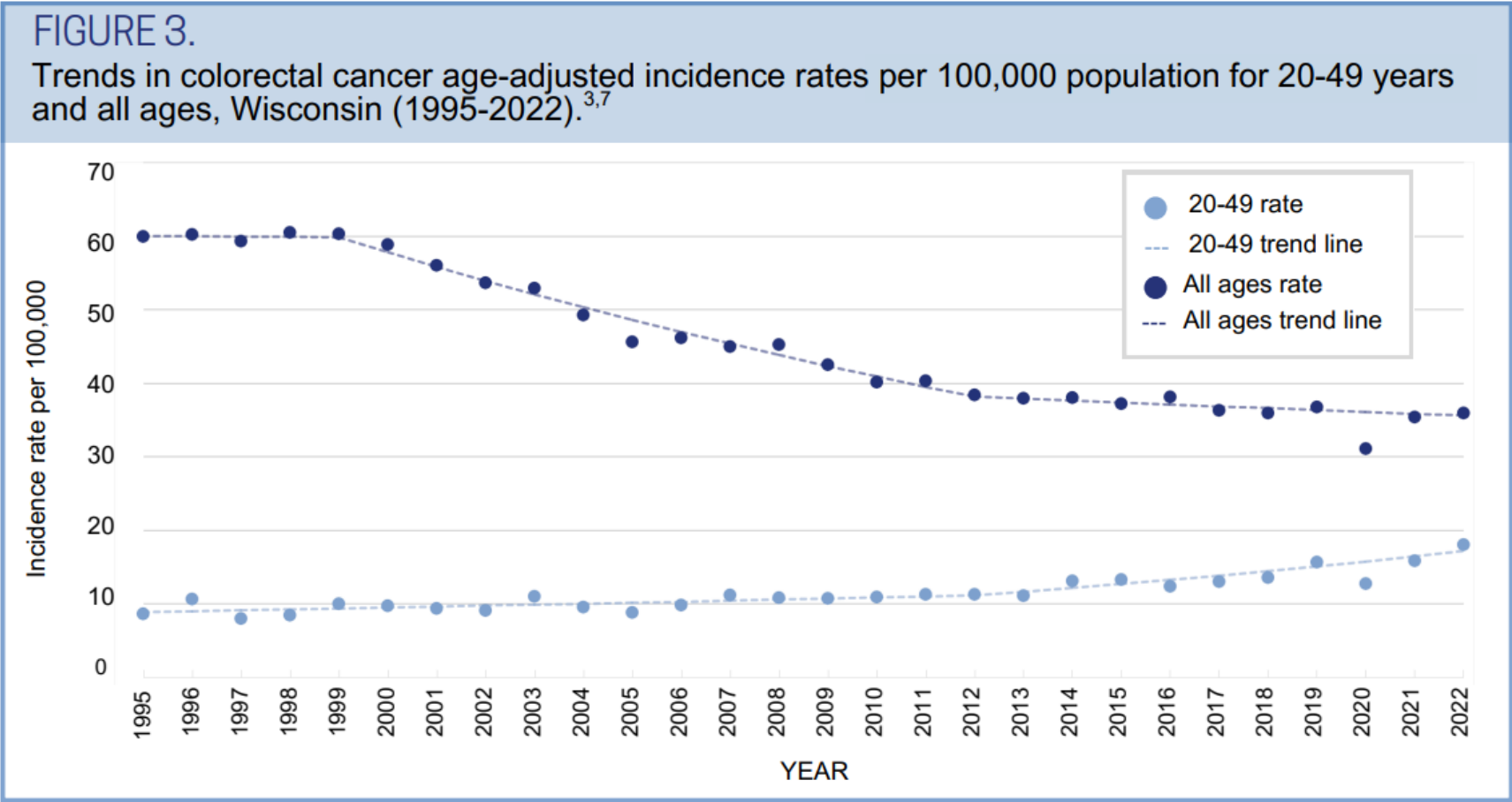
Colorectal cancer (CRC) incidence in Wisconsin continues to decline and mirrors US rates.



CRC mortality in Wisconsin continues to decline and mirrors US rates.



YO-CRC (diagnosed before age 50) incidence is increasing nationally and in Wisconsin.



CRC incidence and mortality in Wisconsin is higher for **men** than **women**.

Figure 4. Colorectal cancer age-adjusted incidence rates per 100,000 by sex and age at diagnosis, Wisconsin (2019-2023)

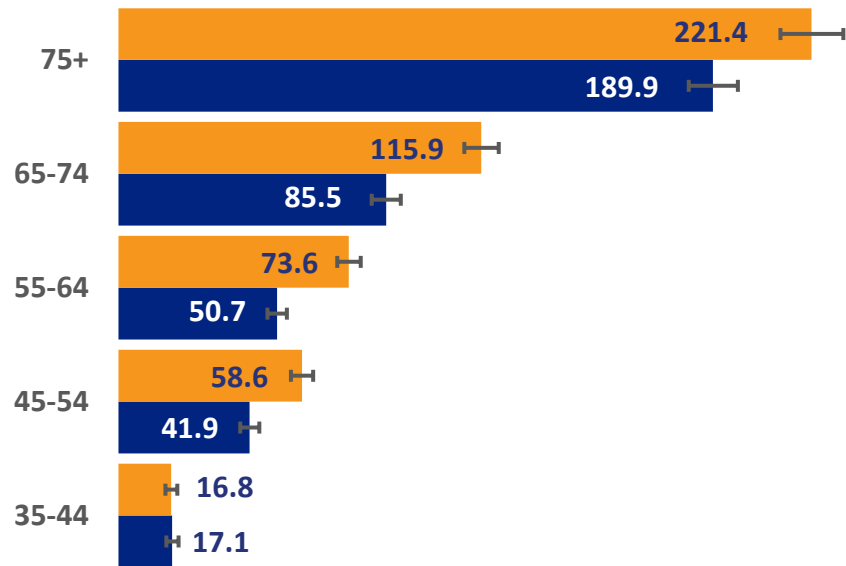
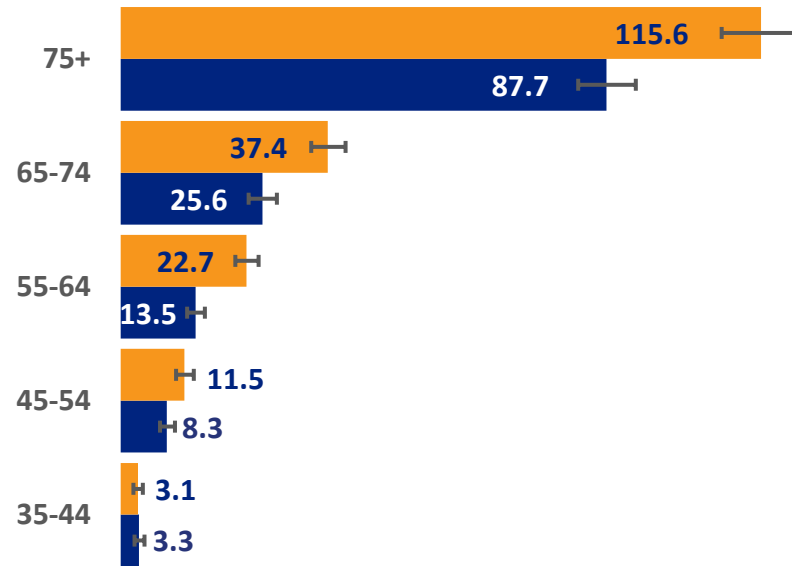


Figure 5. Colorectal cancer age-adjusted mortality rates per 100,000 by sex and age at death, Wisconsin (2019-2023)



Non-Hispanic (NH) American Indian/Alaska Native (AI/AN) and NH Black populations have the higher rates of CRC cancer compared to WI Overall.

Figure 6.

Colorectal cancer age-adjusted incidence rates per 100,000 by race, Wisconsin (2018-2022)

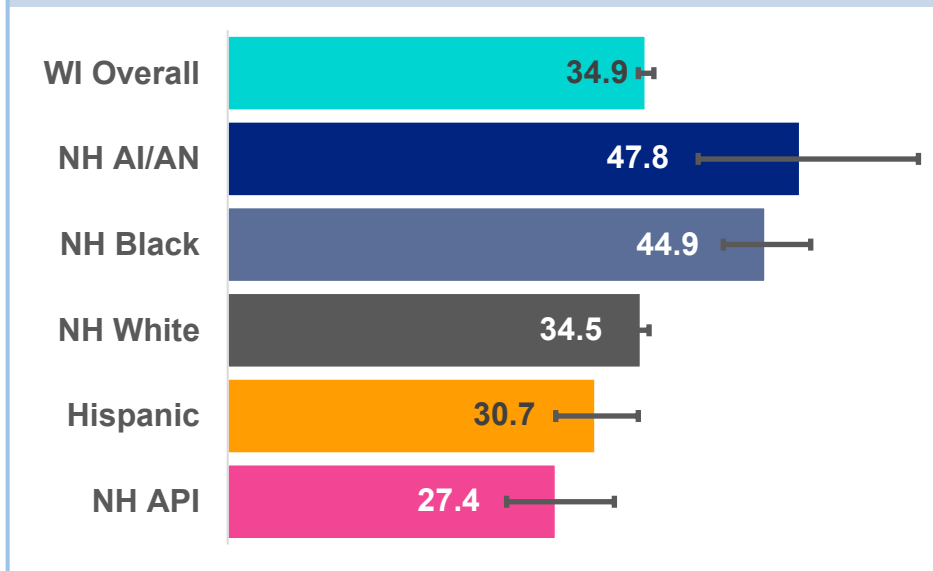
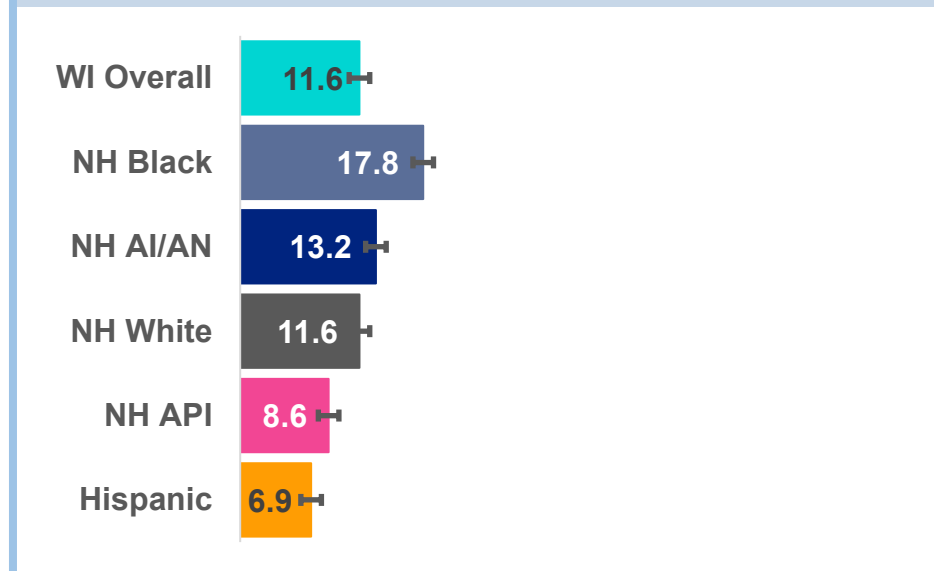
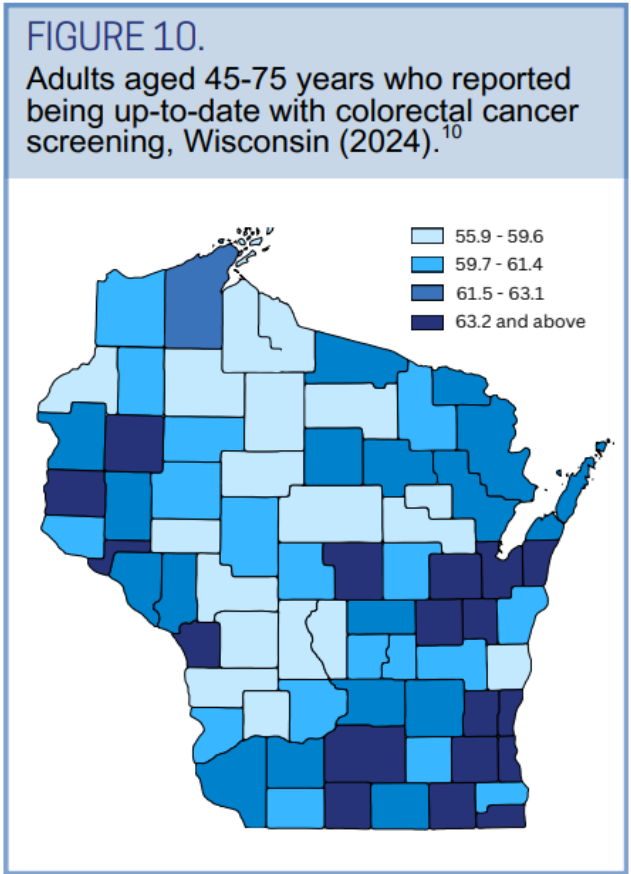
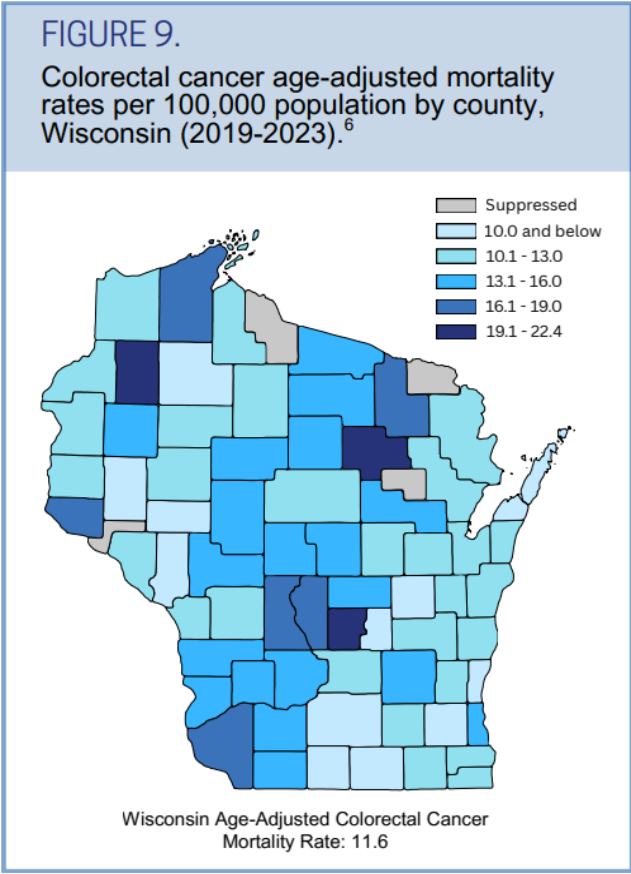
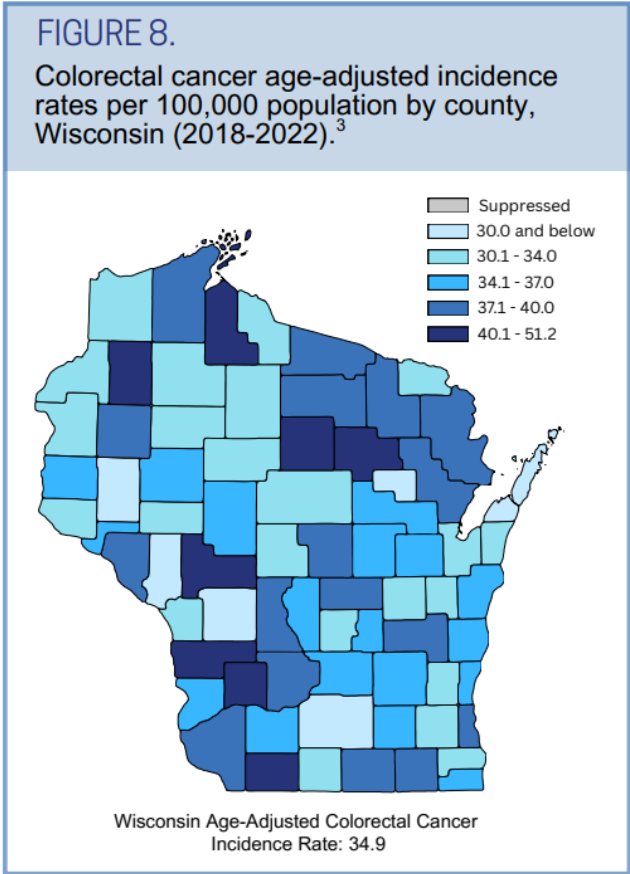


Figure 7.

Colorectal cancer age-adjusted mortality rates per 100,000 by race, Wisconsin (2019-2023)



CRC incidence, mortality, and screening vary by geography.



County-level CRC data available in Appendix 4 and online platforms the public can explore for free.

APPENDIX 4: Colorectal cancer cases (total and % late stage) and age adjusted incidence rates (2018-2022), and deaths and age-adjusted mortality rates (2019-2023) by Wisconsin county.^{3,6}

County	Incidence		Mortality		Late Stage Diagnosis	
	Cases	Rate (95% CI)	Deaths	Rate (95% CI)	Cases	Late Stage Cases (%)
Adams	67	37.0 (27.5, 49.4)	36	16.5 (9.8, 26.5)	41	66.1%
Ashland	50	44.8 (32.5, 60.0)	26	15.9 (5.9, 20.5)	34	73.9%
Barron	137	39.2 (32.5, 47.5)	26	15.9 (5.9, 20.5)	90	69.8%
Bayfield	54	39.6 (28.5, 54.5)	26	15.9 (5.9, 20.5)	34	74.5%
Brown	490	32.6 (29.7, 35.5)	26	15.9 (5.9, 20.5)	34	74.5%
Buffalo	36	37.3 (29.7, 47.5)	26	15.9 (5.9, 20.5)	34	74.5%
Burnett	49	32.2 (29.7, 34.7)	26	15.9 (5.9, 20.5)	34	74.5%
Calumet	105	33.0 (29.7, 36.3)	26	15.9 (5.9, 20.5)	34	74.5%
Chippewa	158	33.0 (29.7, 36.3)	26	15.9 (5.9, 20.5)	34	74.5%



In 2024, **72%** of adults age 45–75 in Wisconsin reported being up-to-date with colorectal cancer screening.

Key Data Takeaways

- CRC incidence and mortality in Wisconsin continue to decline.
- Young-onset colorectal cancer (YO-CRC), defined as colorectal cancer diagnosed before the age of 50, is increasing in incidence in Wisconsin, across the United States, and globally.
- Non-Hispanic (NH) American Indian /Alaska Native (AI/AN) populations in Wisconsin had the highest incidence rate of CRC from 2018–2022. NH Black populations had the second highest incidence rate.

Key Data Takeaways

- CRC screening can find precancerous polyps so they can be removed before they turn into cancer. Screening tests can also find cancer at an earlier stage, when there are more treatment options.
- Adults age 45 to 75 who are at average risk should be screened. People at an increased risk of getting CRC should talk to their doctor about when to begin screening.

For questions about the
Colorectal Cancer in Wisconsin Report,
contact the Wisconsin Cancer
Collaborative at info@wicancer.org

Colon Cancer Update

Milan Folkers MD

Emplify Health

Department of Gastroenterology

4/2026

Colon Cancer

Screening (for initial test, average risk individuals):

- U.S Multi-Society Task Force recommendations update
 - JAMA, 2021; 325(19):1655-1977

Surveillance (for high risk individuals or following polypectomy)

- Am J Gastroenterol. 2020 Mar;115(3):415-434

Colon Cancer

Why Do We Care?

Colon Cancer

In US, colorectal cancer is a leading cause of cancer morbidity and mortality

- Leading cause of GI related mortality
- Without Screening, Lifetime risk of dying from colorectal cancer is 2.5%

Globally

- Third most common cancer in men and second in women

5 year survival is 90% when diagnosed early, but only 40% are diagnosed with localized disease

Colon Cancer

Incidence increases with age

- Increases sharply after age 40
- Historically, 90% of cancers are in persons over age 50, particularly over age 55
 - Cancer. 2018 Jul 15;124(14):2964-2973. doi: 10.1002/cncr.31543. Epub 2018 May 30

Colon Cancer

Why do we screen?

Colon Cancer

Why do we screen?

- Cancer Prevention
- Early Detection

Why Screen?

Colon Cancer

Symptoms do not occur until late stages:

- 70-90% of cancers are diagnosed at the onset of symptoms
 - Change in bowel habits (74%)
 - Rectal bleeding (51%)
 - Mass on exam (25 %)
 - Iron deficiency anemia (10%)
 - Abdominal pain as a single symptom (4%)

Why Screen?

Colon Cancer

- 2018 Kaiser Permanente in California published 15 year study on instituting colon cancer screening in individuals over 50
 - Primarily annual FIT and Colonoscopy
 - Increased screening rates from 38.9% in 2000 to 82.7 % in 2015
 - Reduced annual CRC incidence by 25.5% (from 95.8 to 71.4 cases/100,000)
 - Annual cancer mortality reduced by 52.4 % (from 30.9 to 14.7 deaths/100,000)

- Gastroenterology 2018; 155: 1383-1391

Why Screen?

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- Gastroenterology 2018; 155: 1383-1391

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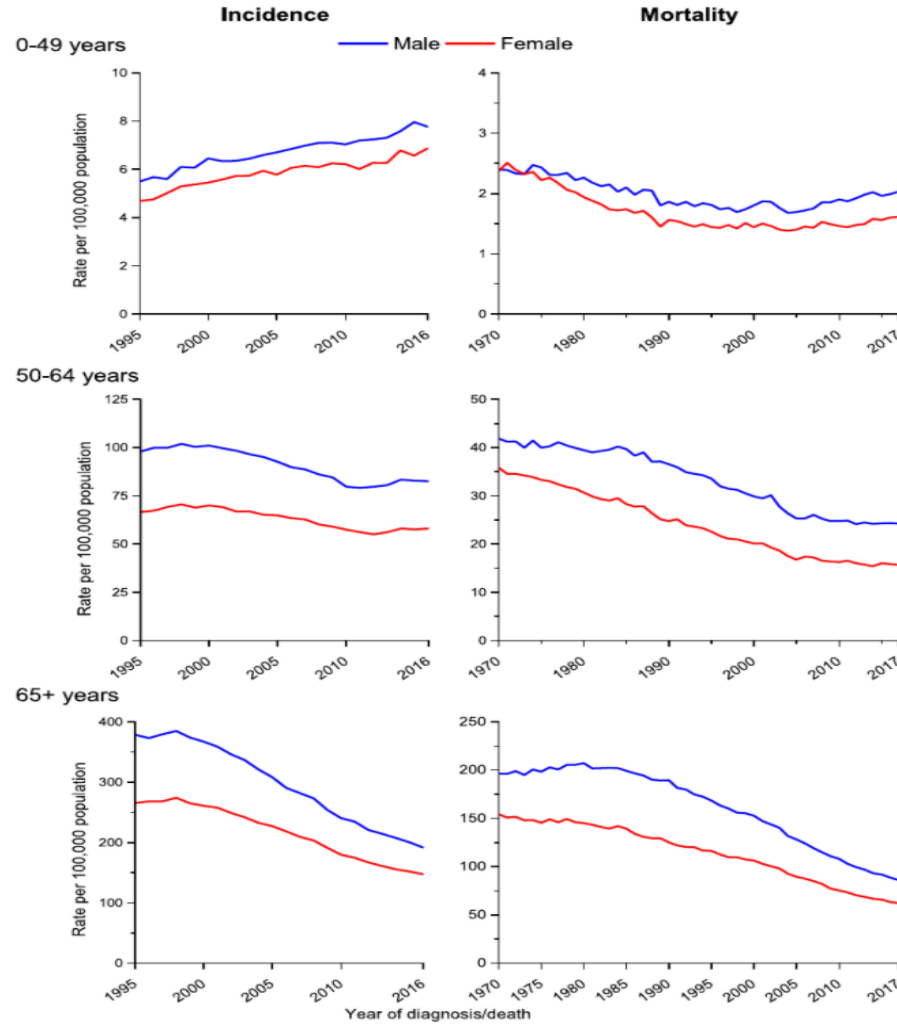
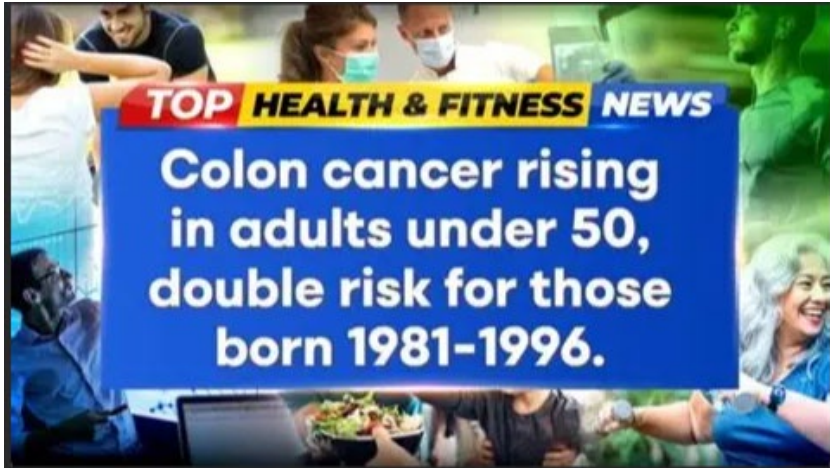
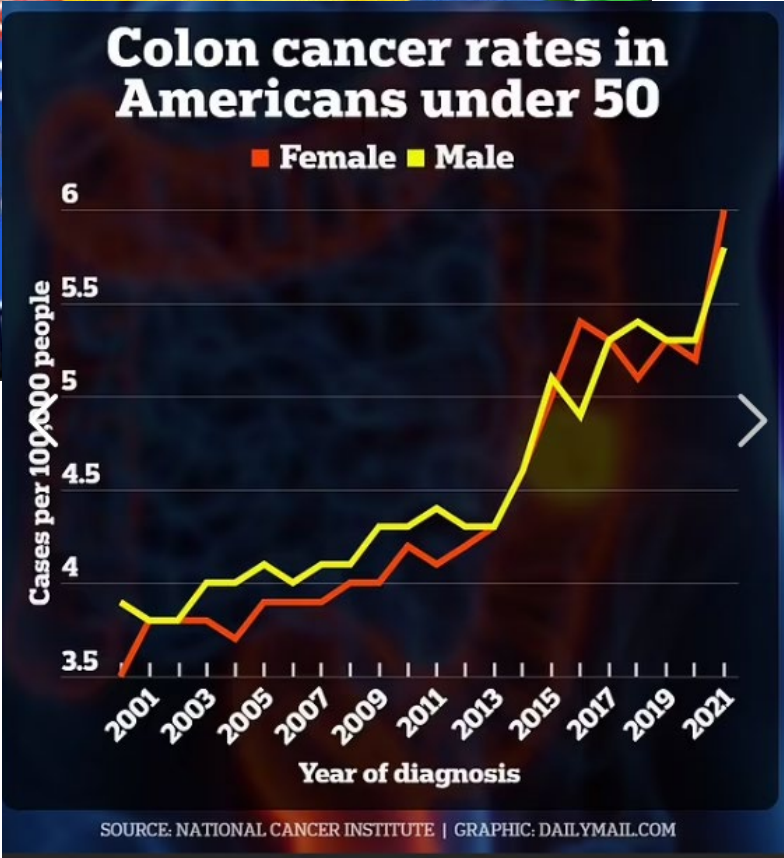
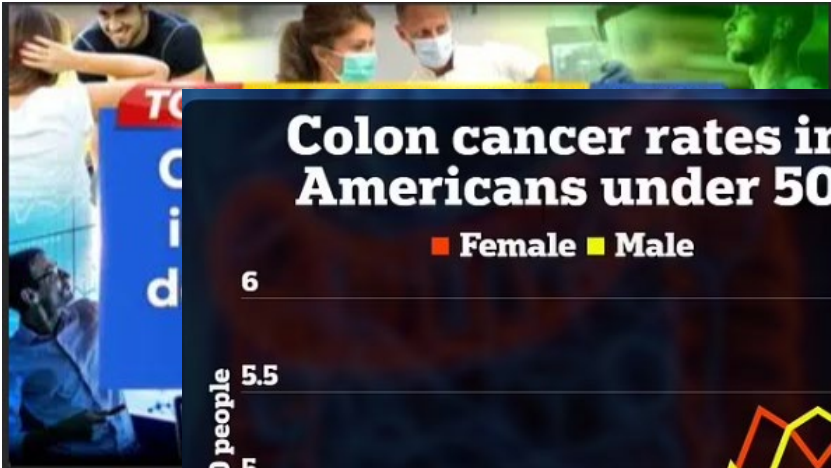


FIGURE 6. Trends in Colorectal Cancer Incidence (1995 to 2016) and Mortality (1970 to 2017) Rates by Age and Sex, United States. Incidence rates exclude the appendix and are age adjusted to the 2000 US standard population and adjusted for reporting delays. Source: Incidence: NAACCR, 2019; Mortality: NCHS, 2019.

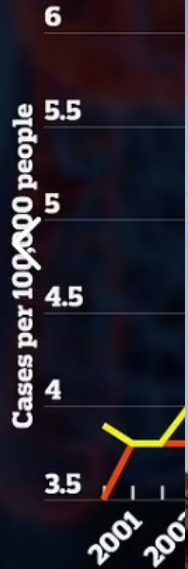
CA: Cancer J Clin 2020; 70:145-164







Colon cancer rates in Americans under 50



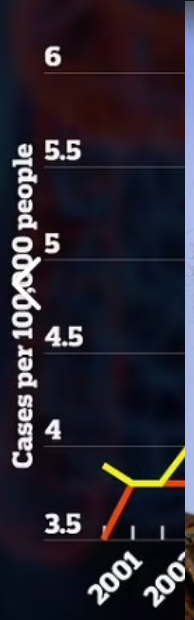
SOURCE: NA

BLACK & YOUNG ADULTS AT
**HIGHER RISK
OF COLON
CANCER**

Chadwick Boseman's diagnosis at a young age was not unusual among colon cancer patients

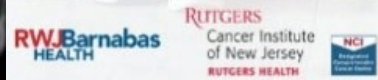


Colon cancer Americans



SOURCE: NA

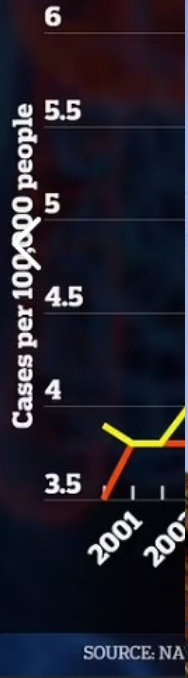
In recent years,
colorectal cancer
diagnoses among
adults younger
than 50 have more
than doubled.



Chadwick Boseman's
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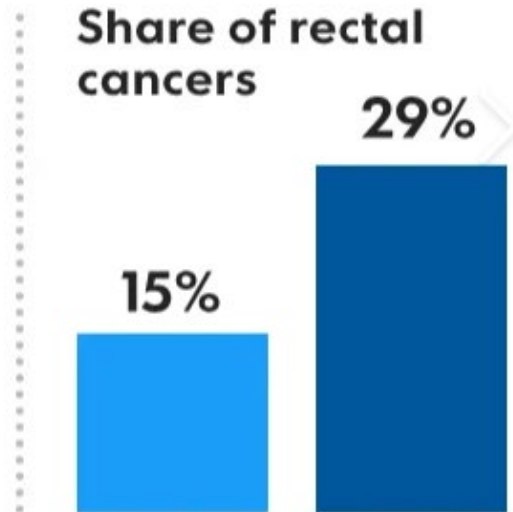
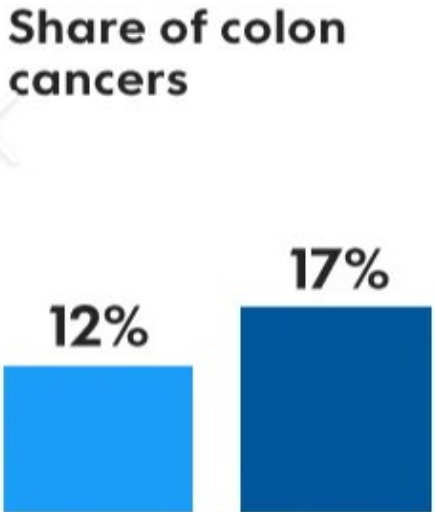
Colon cancer Americans



CANCER RATES RISE IN GEN X AND MILLENNIALS

People under age 55 make up an increasing share of colon and rectal cancer cases in the United States:

● 1990 ● 2013



SOURCE Journal of the National Cancer Institute
Karl Gelles, USA TODAY

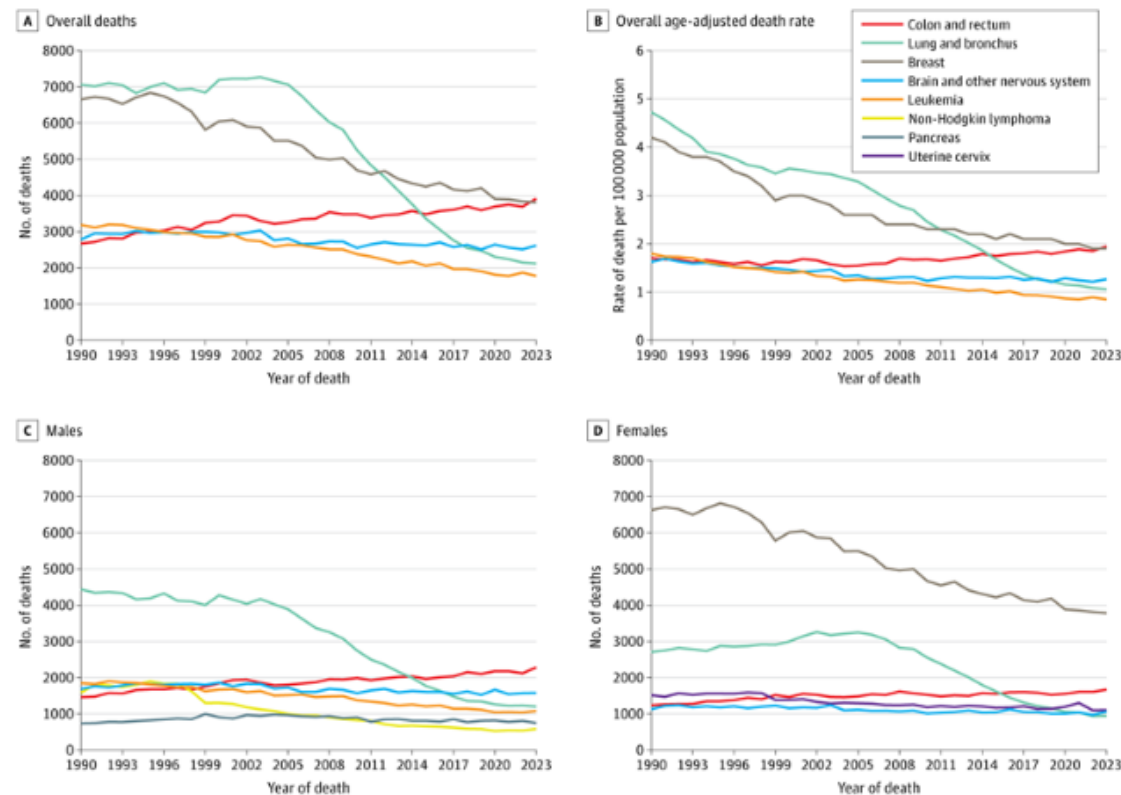


JAMA January 2026

Leading Cancer Deaths in People Younger Than 50 Years

- **Colon cancer is now # 1 cancer killer under 50 in all genders**
 - # 1 in males, #2 in females

Figure. Temporal Changes in the 5 Leading Cancer-Related Deaths in People Younger Than 50 Years in the US, 1990-2023



Panel C includes 6 cancer types instead of 5 because pancreatic cancer replaced non-Hodgkin lymphoma in the top 5 cancer deaths among males during the study period.

2022 New Colon Cancer Screening Guidelines: USPSTF

Average Risk:

- **CRC screening begins at age 45**
 - Estimates suggest that individuals born in 1990 have 2 x the risk of colon cancer and 4 x risk of rectal cancer compared to individuals born in 1950 (birth cohort effect)
 - Multifactorial but affected by obesity, diet, and alcohol consumption

Screening 50 year olds is still very important

- Increasing screening rate in individuals 50-75 from 60% to 80 % would prevent 3 x as many CRC deaths with 66% less cost than screening 45-49 year olds with colonoscopy
 - Gastroenterology 2019 Jul;157(1):137-148.

2022 New Colon Cancer Screening Guidelines

Colon cancer risk factors:

- **BIG:** Family history, Hereditary syndromes, IBD, Radiation, Cystic fibrosis (lung transplant),
- **Affects screening:** Age, Transplant History, ~~Race (African Americans)~~,
 - African Americans are still 20% more likely to get CRC and 40% more likely to die from CRC than other groups
- **Doesn't affect screening recommendations:**
 - Obesity (weight gain particularly in early adulthood and midlife)
 - Sedentary lifestyle
 - Diabetes
 - Red meat/processed meat, lack of fiber
 - Tobacco, Alcohol

Average Risk

Family Matters

Average Risk: No family history of colon cancer or advanced adenoma

- Only 1st degree relatives (or 2 generations)
 - Only cancer or **advanced adenomas** count:
 - >1 cm in size, villous histology, high grade dysplasia
 - Unknown type of adenoma: can be screened as average risk
 - Ask if histology known, surgery performed, frequency of screening in family member to help determine this
-
- **Start Screening at 45, any modality**

Increased Risk

Family Matters

Increased Risk:

- Anyone with **1st degree** family history of colon cancer/advanced adenoma any age
 - Advanced adenoma is any pre-cancerous polyp over 1 cm or with high grade or villous histology
 - 2 or more generations affected
 - Family history of polyposis syndrome
-
- **Start Screening at 40 with colonoscopy**
 - **Every 5 years if affected family member under 60**
 - **Every 10 years if affected family member over 60**

How To Screen?

Multiple options for colon cancer screening:

U.S Multi-Society Task Force recommendations update

- One step screening: colonoscopy
 - Cancer prevention
 - Early diagnosis
- Two step screening: stool cards, flex sig, CT colonography
 - Early diagnosis

How To Screen?

Guidelines for average risk *Screening*:

- Recommended
 - Colonoscopy every 10 years
 - FIT test annually
- Suggested (low quality evidence)
 - Multitarget stool DNA every 3 years (Cologuard)
 - Flex sig every 5 year or every 10 years (with annual FIT)
 - CT colonography every 5 years
 - Capsule colonoscopy every 5 years (not available many places)
- Other: Blood testing

Colon Cancer at Emplify Health

- In June 2022 Gundersen Health and Bellin Health merged to form Emplify Health
- 11 hospitals
- 100+ clinics and growing



FIGURE 10.

Adults aged 45-75 years who reported being up-to-date with colorectal cancer screening, Wisconsin (2024).¹⁰

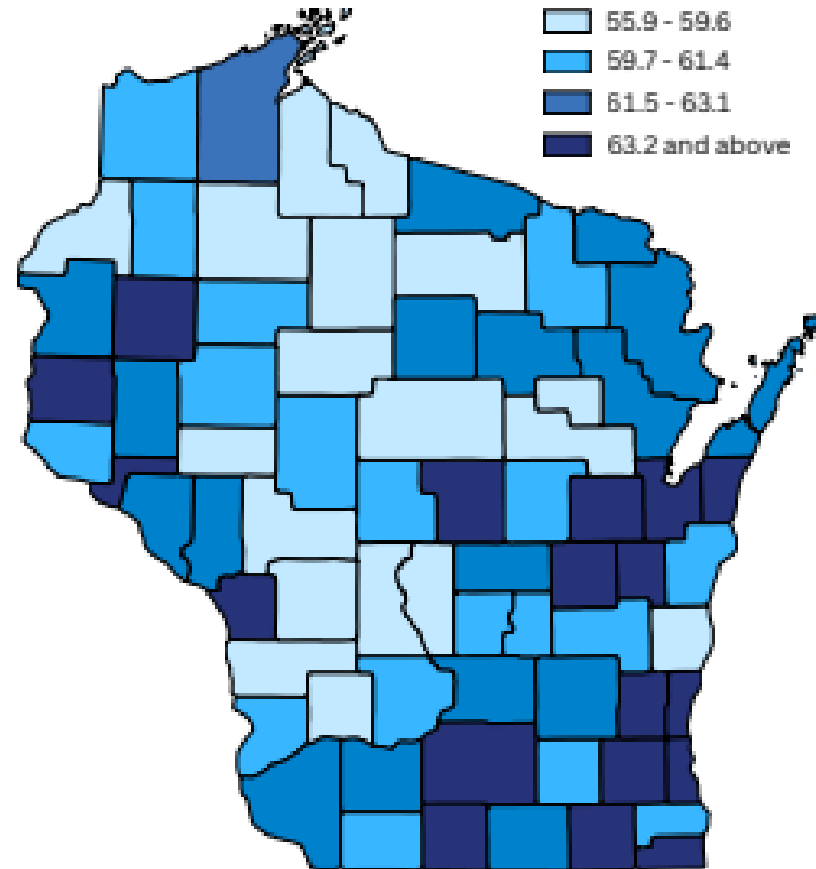


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Adults aged 45-75 years who reported being up-to-date with colorectal cancer screening, Wisconsin (2024).¹⁰

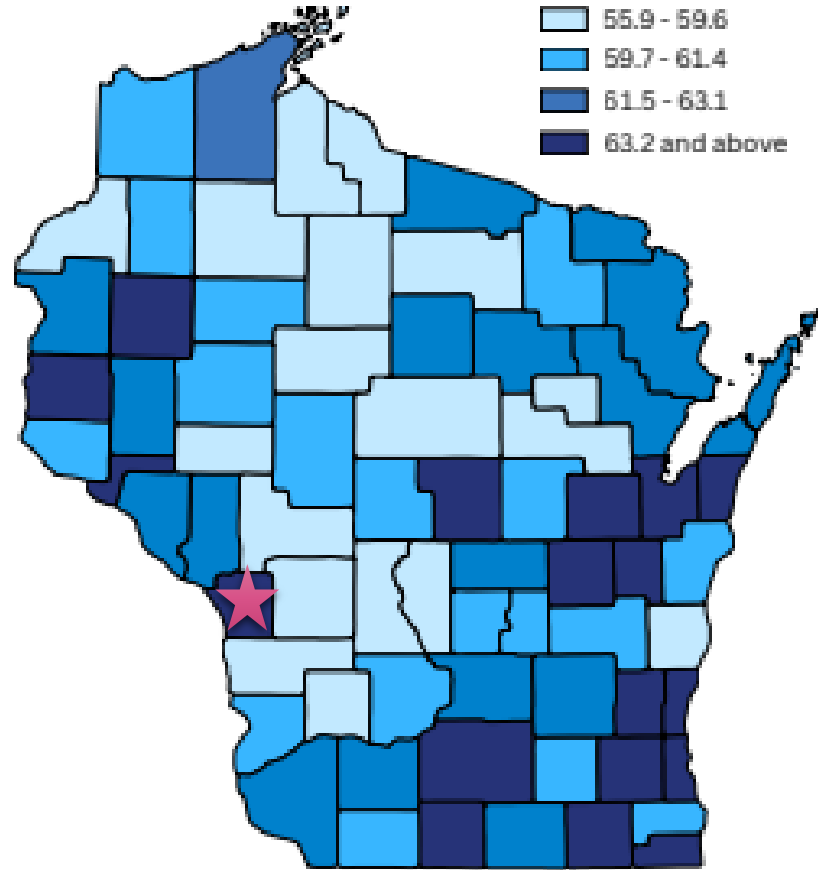
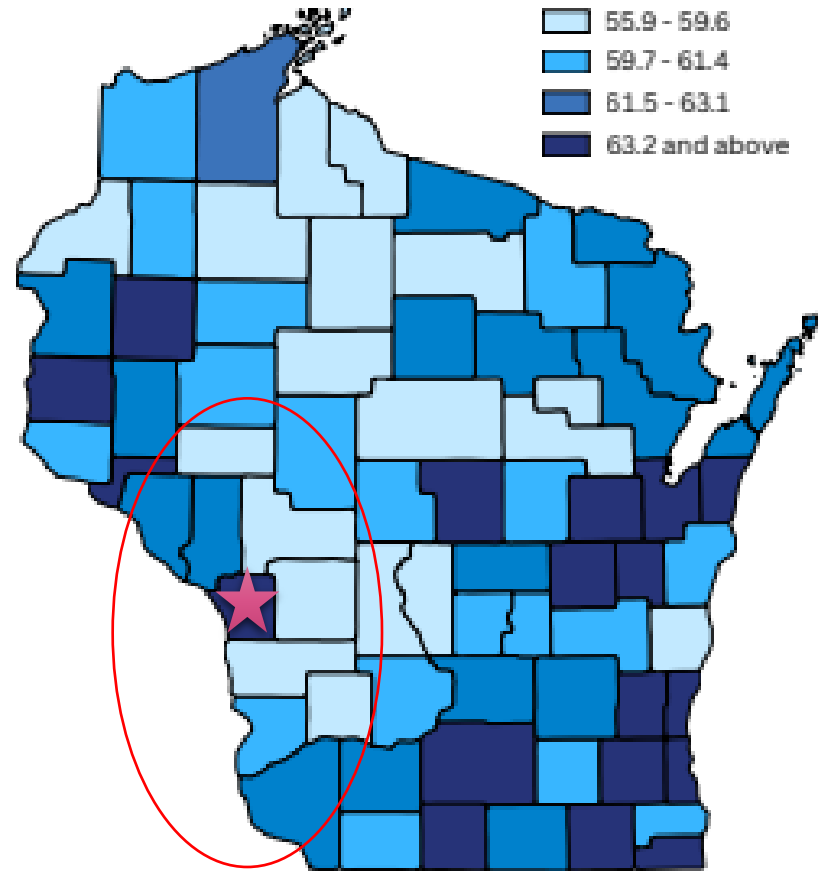
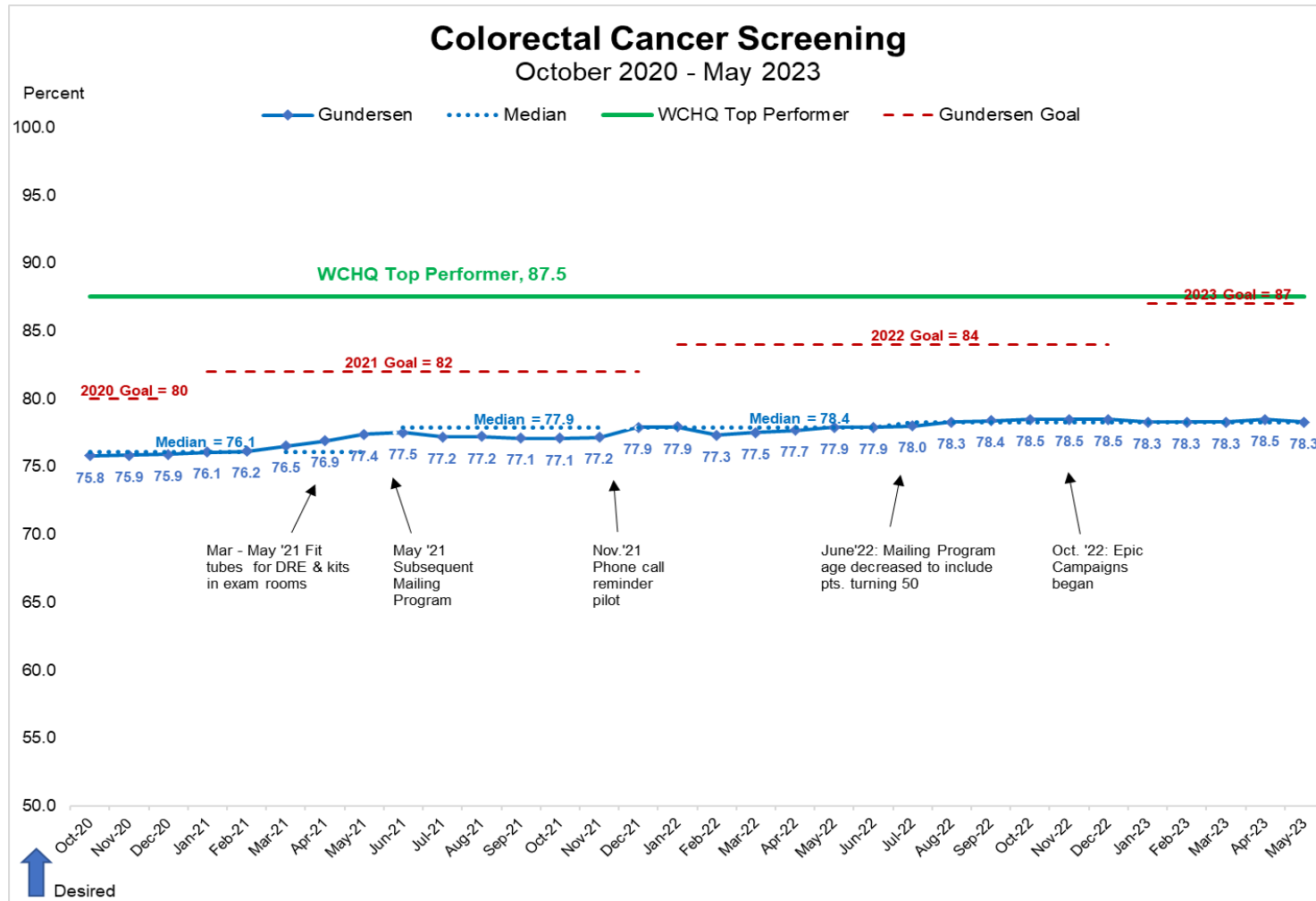


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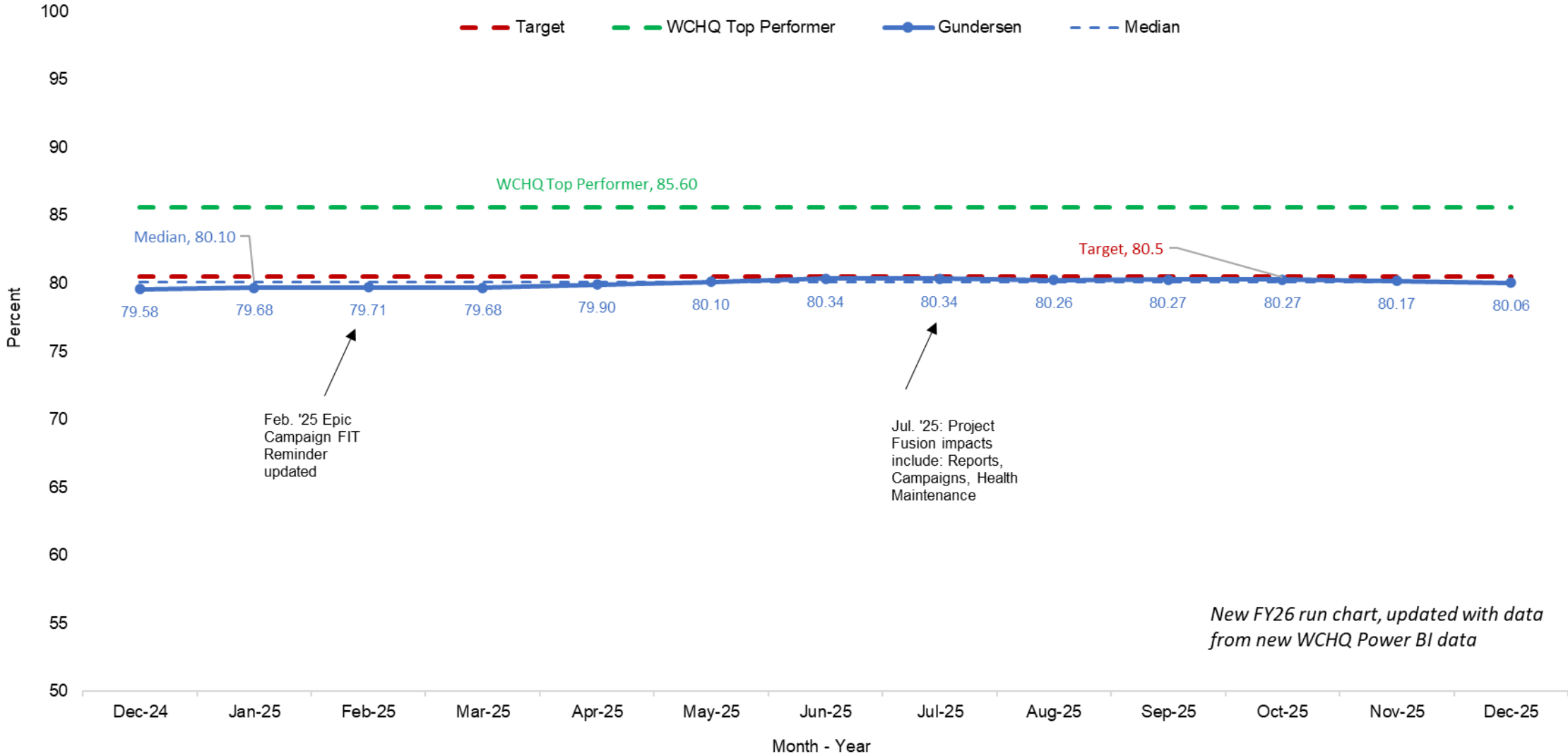


Coming out of Covid



Now

Colorectal Cancer Screening December 2024 - December 2025



What Have We Been Doing?

- In 2023 Colorectal cancer screening was identified as a priority quality measure in the organization
 - Yearly targets
 - Bonus on the department
- A dedicated multidisciplinary improvement team (MDs, RNs, manager, quality specialists, involving primary care, gastro, quality, population health) meet weekly/biweekly
- Dedicated RN and Registrar to assist Primary Care and the System

What Have We Been Doing?

- Primary Care focus
 - Multiple Systems, multiple processes
 - To guide improvements, enhance EMR and work with departments with low screening rates.
 - Took workflows from high screening departments and shared with other groups
 - MD champion shadowing, and coaching providers.
 - “Patients to target” are measured for each clinic to drive improvements
 - Best practices include:
 - PCP addressing gap in screening at wellness and acute visits
 - Staff running care gap reports and contacting patients (when staffing allows)

What Have We Been Doing?

- FIT Mailing Program:
 - Unscreened patients are sent a FIT kit to their homes for completion.
 - 90 day return rate is 15% but cost is minimal
 - For those who see PCP and have FIT ordered, return rate is 40% (our goal is 50%)
- Cologuard Care Gap campaign is in planning stages

What Have We Been Doing?

- **Dedicated RN and Registrar**
 - Follows up positive stool tests ensuring colonoscopy is completed by engaging patients with motivational interviewing
 - Has increased positivity stool test follow up from ~60% to 80%

	May to Dec 2024	2025
Managed by RN		
Positive stool tests	268	416
Rate of colonoscopy completion	83%	80%

- **Manages Surveillance follow up colonoscopies (ordering return surveillance/screening procedures, contacts patients as needed)**
- **Manages FIT program**
- **Helps clinicians with inquiries**

What Have We Been Doing?

- **Dedicated RN and Registrar**
 - **Care Gap Follow up (Procedure ordered, patient did not schedule)**
 - Occurs in about 160 procedure orders a month
 - 40% are contacted and scheduled
 - 15 % say they will call back
 - 5 % refuse to schedule
 - 40% we are unable to contact

What Have We Been Doing?

- **Dedicated RN and Registrar**
 - **Barriers to scheduling**
 - **No insurance, deductible concerns**
 - **Employment issues: lack of PTO, change or loss of job**
 - **Unavailable driver or transport**
 - **Lack of social support**

What Have We Been Doing?

- **Dedicated RN and Registrar**
 - **Barriers to scheduling**
 - **No insurance, deductible concerns**
 - **Social work involvement**
 - **Employment issues: lack of PTO, change or loss of job**
 - **Screening Saturdays**
 - **Unavailable driver or transport**
 - **offer vouchers for hotel/travel**
 - **Lack of social support**

Colon Cancer Screening Improvement Team

Team Name: Colon Cancer Screening

Team Sponsors: Rachel Albrecht & Dr. Bahr

Team Leaders: Dr. Zivney, Reece Rykal, Dr. Folkers, Abby Oxendine, Nada Ghandour

Team Members: Andrea Schossow, Kacee Kammel, Stephanie McNamer, Mermani Maloney-Wang, Kealie Gransee, Carolyn Bostrack, Robin Haelke (Quartz), Jennifer Laszewski (Quartz)

Region: Gundersen

GPA Measure: Screening Rate-Colon Cancer ages 45-75 (WCHQ)

Questions?

SAVE THE DATE

2026

WISCONSIN CANCER SUMMIT

October 7th & 8th

Madison Marriott West
Middleton, WI

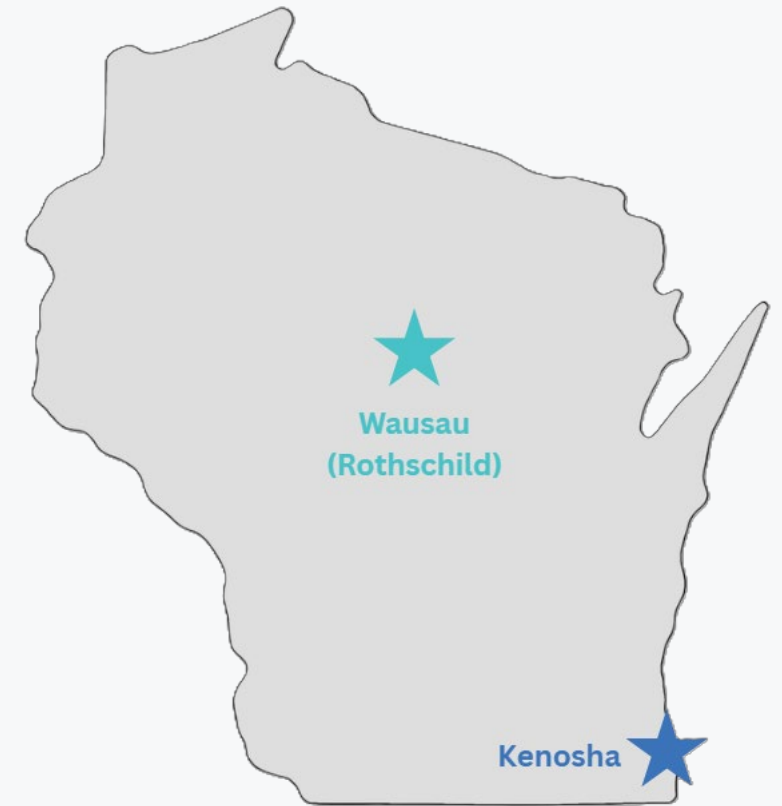


www.wicancer.org

2026 Regional Meetings

Wausau Area (Rothschild)
– Thursday, May 14

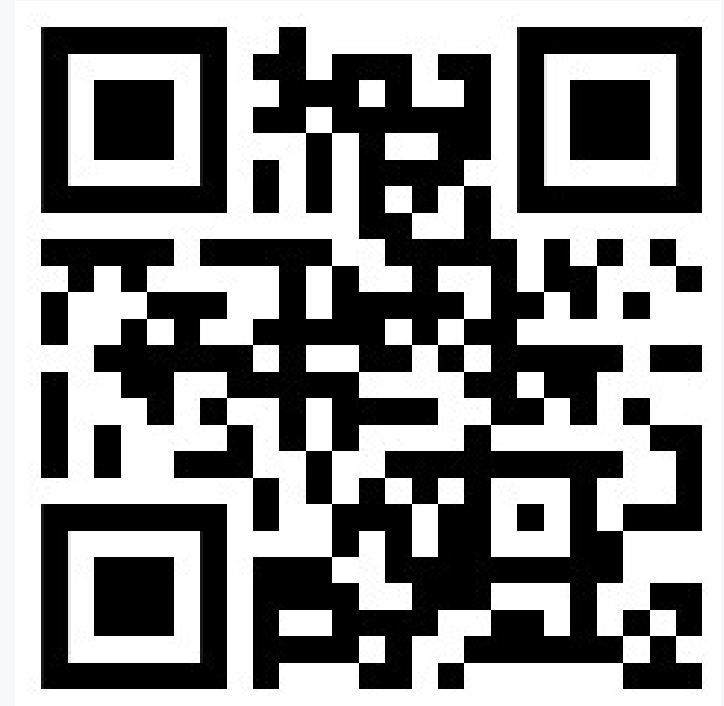
Kenosha – Monday, May 18



Join us – membership is free!

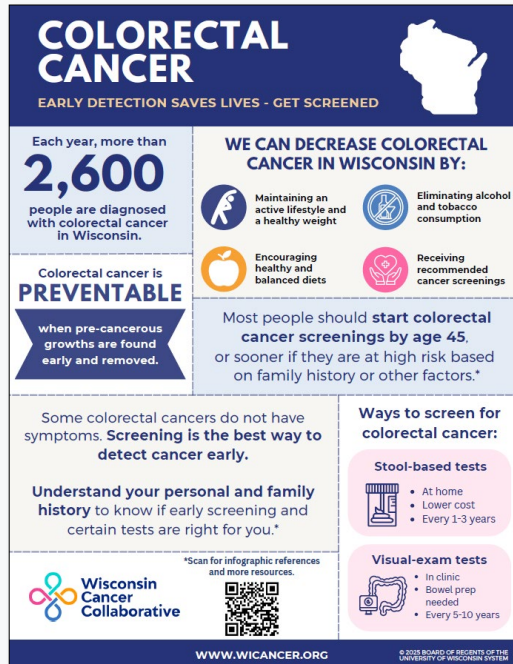
We help you take action on cancer issues that matter to you and your community.

Become part of our growing coalition of leaders, experts, and advocates working together to create a healthier Wisconsin.

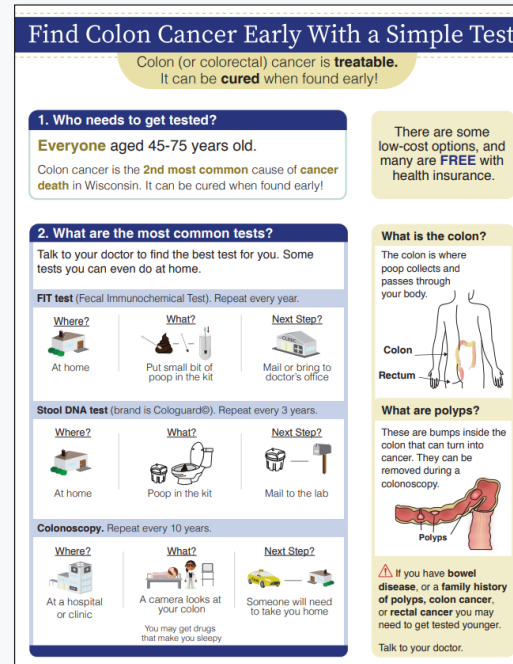


<https://wicancer.org/join/>

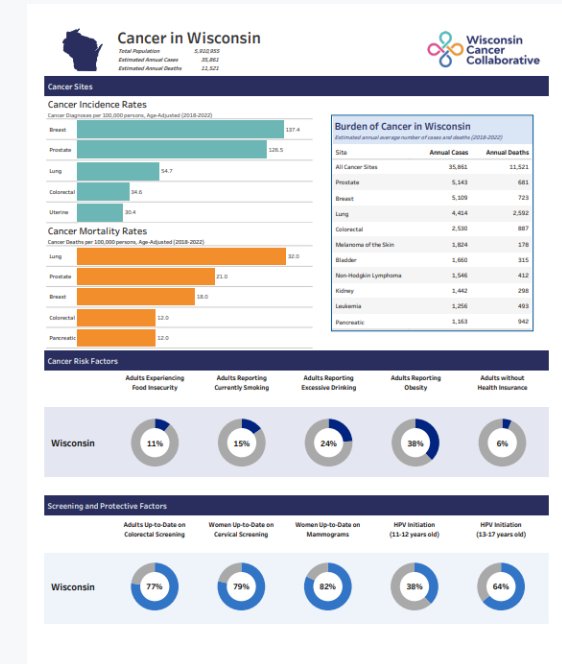
Additional WCC Resources



CRC Infographic available in English & Spanish
*Cobranding available!



CRC How-to-Sheet Developed with Covering Wisconsin



State and county-level interactive data profiles available!

Thank you!