diagnosis of depression, 36% had a positive screen with the severity of depression ranging from mild to severe. Across all visits, 45 patients were transferred into adult care following a HMV.

Conclusions: This study demonstrated that a structured HMV prior to transfer may increase transition readiness as assessed by the TRAO. In addition, new diagnosis of depression was made in a significant portion of patients screened, emphasizing the importance of regular screening for psychological issues. Future studies are needed to validate these findings and potentially move towards a standard template for transition readiness in pediatric IBD patients.

P009
FINANCIAL VOLATILITY OF INFLAMMATORY BOWEL DISEASES VS OTHER CHRONIC GASTROINTESTINAL DISEASES - USING THE BETA COEFFICIENT TO CATEGORIZE GI DISORDERS
Lawrence Kosinski, Siddharth Singh, Joel Brill, Sachin Singh, Leanne Metcalfe, Dimitrina Dimitrova
Symptomatic chronic diseases differ in their propensity for serious costly morbidity. Reliable and predictable deterioration presentations can be associated with very narrow margins between symptoms and the onset of serious complications. The inflammatory bowel diseases (IBD): Crohn's Disease and Ulcerative Colitis are examples of this. As a result, they have high cost per capita with significant variation in that cost. Reliable metrics for assessing the relative volatility of chronic diseases are lacking.

In finance, the volatility of a stock is measured using the beta coefficient, a measure of the relative volatility of an individual stock in relation to the market over time. By definition, the specific index has a beta of 1.0, and individual stocks are ranked according to how much they deviate from the market based on their beta coefficient. A stock that demonstrates more volatility than the market over time has a beta above 1.0.

We postulated that chronic gastrointestinal diseases can be profiled using a similar measurement of volatility based on cost. Using a data set of 46,523 members obtained from Health Care Service Corporation, which included professional, pharmacy and claims for calendar year 2017, we calculated an index and beta rating for the major gastrointestinal disorders: gastroesophageal reflux disease (GERD), Peptic Ulcer disease (PUD), Gastritis, Celiac disease, Pancreatitis, Iritable Bowel Syndrome (IBS), Crohn's disease (CD), Ulcerative colitis (UC), Colon Polyps and Diverticulitis:

Method:
1) The Total Disease Specific Cost (TDSC) was calculated from claims data for each condition using ICD - Codes.
2) A GI Disease index (GIDI) was created by calculating the TDSC of all of the above conditions. The GIDI TDSC was then segregated into deciles.
3) The cost/decile was then analyzed for each condition and compared against the GI Index
4) A beta rating (Beta) was calculated using Standard Deviations of the relative cost/decile (SDCD) as follows: Beta = SDCD (Illness)/SDCD (Index)

Results: Using this methodology, the GI Index and individual beta ratings are numerically and graphically shown in the figures. Whereas CD and UC have strongly positive Beta scores, the remainder of the GI illnesses do not as compared to the GI Index.

Table 1. Summary of major Gastrointestinal illnesses’ cost by decile and Beta Rating

![Table 1](https://example.com/table1.png)

Conclusions: Gastrointestinal disorders can be categorized, based on their volatility, into a beta rating. Disorders associated with high cost and high variability in cost have a high-beta rating compared to the GI disorder index. This is a critical finding as high-beta conditions are those toward which management payments should be focused as they benefit most from patient engagement, care coordination and care management programs to improve outcomes and control costs.

[ii] Kosinski L, Brill J; Clinical Gastroenterology and Hepatology Vol. 14, No. 12, P1751-1752

P010
FIRST SURVEILLANCE COLONOSCOPY FOR INFLAMMATORY BOWEL DISEASE – ARE WE GETTING IT RIGHT FROM THE START?
Rajan Patel, Louis Tapper, Holly Lynne, Saadig Moledina, Riggers Cama, Kalpesh Besherdas
Background: Surveillance for colorectal cancer (CRC) is necessary in patients with inflammatory bowel disease (IBD). Patients with ulcerative colitis (UC) have a similar CRC risk to those with Crohn’s colitis (CC). British Society of Gastroenterology (BSG) guidelines from 2010 outlined recommendations for screening including surveillance intervals and pancolonic dye spraying with targeted biopsies. We aimed to identify reasons why the first surveillance colonoscopy is not being performed as advised, including the role of poor bowel preparation and disease activity.

Methods: Retrospective study of all IBD colonoscopies over a 7 year period (2011–2018) across two sites at a tertiary London based hospital trust. 214 patients were identified and exclusion criterion was applied (not first surveillance/diagnosis prior to year 2000/PSC/inadequate data). 93 patients were included for analysis.

Results: 26 (28%) surveillance colonoscopies were performed prior to 10 years of diagnosis (ie. before BSG guideline recommendation). 22 (23.7%) surveillance colonoscopies performed after the recommended interval. Dye spray was performed in only 2 patients (2%). Reasons cited for not dying were only given in 4 (4.3%) cases, and included poor prep or active disease. No reason was given in 87 (93%) cases. Targeted biopsies were performed in 24 (25.8%) patients, with random biopsies in 56 (60.2%) patients. Conclusion: The first IBD surveillance colonoscopy is only being performed at the correct time interval in approximately 50% of cases with over a quarter being performed too soon and almost a quarter being performed too late. Pan-colonic dye spray is used in only 2% and targeted biopsies are taken in only 1 in 4 patients. Poor bowel preparation and disease activity do not appear to be limiting factors in the use of dye spray. We conclude that appropriate initial colitis surveillance is not being performed in the majority despite published guidelines. Organisational factors such as sufficient time allocated to dye spray colonoscopy, along with endoscopist skill, may be contributing factors.