Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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health providers to guide clinical practice during this global pandemic. The primary objective of this study was to determine practice preparedness, clinical changes, compliance with ASRM recommendations, and patient/reproductive health provider reactions in response to the COVID-19 pandemic. The secondary objective was to assess whether these changes will alter the practice patterns of reproductive health providers in the future.

**DESIGN:** Survey study distributed nationally to American reproductive health providers and practice staff between April 13th to May 19th, 2020.

**MATERIALS AND METHODS:** The survey was distributed using social media platforms and subcategory specific listservs utilized by reproductive health providers. To ensure survey question face validity, expert review and interim analysis of the responses was conducted. Statistical analysis was performed with Chi squared tests using R software.

**RESULTS:** A total of 134 responses were received of 612 surveys distributed. There was a significant difference in the method by which reproductive health practices received the ASRM recommendations, with e-mail being the most common for private practice, and word-of-mouth for academic practice (p=0.02). Once distributed, the academic providers were significantly more likely to follow guidelines compared to those in private practice (p=0.006). Most practices implemented guidelines, regardless of specialty and location, within one week of publication (March 16-20th), however academic providers implemented them earlier (March 9-13th) (p=0.002). The majority of practices completed their last embryo transfer within one to two weeks (March 16-27th). Continued unmonitored ovulation induction was more commonly offered to the Midwest population compared to the rest of America (72%) vs. 56%), regardless of practice type (p=0.07). Overall, the patients’ responses to practice changes were well received. Nonetheless, specialists at academic practices were significantly more likely to offer their patients mental health resources (p=0.001). Provision of telehealth, whether before, during, or planning for after the COVID-19 pandemic, did not yield any statistically significant results.

**CONCLUSIONS:** Guidelines proposed by ASRM have had an obvious impact on reproductive care during the COVID-19 pandemic. Reproductive health practice changes were quickly implemented once received. Although the patient population was undoubtedly affected, patients were understanding regarding the need for delay in care.

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**UNIVERSAL SCREENING OF COVID-19 IN ASYMPTOMATIC PATIENTS SEEKING FERTILITY TREATMENT IN NEW YORK CITY.** Alex Robles, MD, Brittany Noel Robles, MD, MPH, Laura C. Gemmell, MD, Paula C. Brady, MD, Eric J. Forman, M.D., Zev Williams, M.D., PhD. Columbia University Medical Center, New York, NY; Wyckoff Heights Medical Center, Brooklyn, NY; Columbia University Fertility Center, New York, NY.

**OBJECTIVE:** To evaluate a protocol of universal symptom and viral screening prior to initiation of controlled ovarian hyperstimulation among patients seeking fertility treatment in New York City.

**DESIGN:** Prospective cohort study.

**MATERIALS AND METHODS:** Prior to initiation of controlled ovarian hyperstimulation among asymptomatic patients seeking fertility treatment in NYC is low. We have demonstrated that fertility care can safely resume in a way to limit risk to our patients, staff, and our physicians working in the epicenter of infection.

CONCLUSIONS: The incidence of COVID-19 infection among asymptomatic patients seeking fertility treatment in NYC is low. We have demonstrated that fertility care can safely resume in a way to limit risk to our patients, staff, and our physicians working in the epicenter of infection.

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**THE IMPACT OF COVID-19 ON FERTILITY CARE: AN EVALUATION OF SOCIETY FOR ASSISTED REPRODUCTION TECHNOLOGY (SART) MEMBER CLINICS’ WEBSITES.** Seth J. Barishansky, M.D., Miriam A. Andrusier, M.P.H., Elizabeth A. Dilday, M.D., Angela K. Lawson, Ph.D., Luis R. Hoyos, M.D., The George Washington University School of Medicine and Health Sciences, Washington, DC; SUNY Downstate Health Sciences University, Brooklyn, NY; Department of Obstetrics and Gynecology, Division of Reproductive Endocrinology and Infertility, University of California, Los Angeles, Los Angeles, CA; Northwestern University Feinberg School of Medicine, Department of Obstetrics and Gynecology, Division of Reproductive Endocrinology and Infertility, Chicago, IL; UC LA, Los Angeles, CA.

**OBJECTIVE:** To evaluate the available COVID-19 content in regard to fertility care on the websites of Society for Assisted Reproductive Technology (SART) member clinics.

**DESIGN:** Cross-sectional study.

**MATERIALS AND METHODS:** From March 17 to March 30, 2020, following the release of the first American Society for Reproductive Medicine (ASRM) COVID-19 recommendations, SART member clinics’ websites were examined. The presence of information on COVID-19 and pregnancy implications, acknowledgement of and compliance with ASRM recommendations, description of Centers for Disease Control and Prevention (CDC) risk mitigation strategies and local health department guidelines, as well as advertisement of telehealth and available mental health resources were queried. Websites were categorized by practice size (small: <500 vs. large: ≥500 cycles/year), type (academic vs. private) and degree of statewide COVID-19 burden based on CDC data (low: 0-1000; high: ≥1000 diagnosed cases). Group differences were evaluated using χ².

**RESULTS:** Larger clinics, compared to smaller, were more likely to report COVID-19 information, acknowledge and comply with ASRM recommendations, mention CDC risk mitigation strategies and local health department guidelines, discuss pregnancy implications and advertise telehealth [88% (130/148) vs. 64% (146/227); 49% (72/148) vs. 32% (72/227); 52% (77/148) vs. 34% (75/227); 76% (112/148) vs. 53% (120/227); 50% (74/148) vs. 31% (71/227); 36% (53/148) vs. 21% (48/227) and 38% (101/148) vs. 29% (119/227), respectively, P<0.05, all values]. Academic clinics, compared to private, were more likely to report COVID-19 information and report CDC risk mitigation strategies [87% (77/89) vs. 70% (199/286); 76% (68/89) vs. 57% (164/286), respectively, P<0.05, all values]. Private clinics were also more likely to acknowledge and quote ≥2/5 ASRM key recommendations but tended to devise individualized guidelines [e.g., 120 (286) vs. 20% (18/89); 28% (80/286) vs. 12% (11/89) and 34% (97/286) vs. 4% (4/89), respectively, P<0.05, all values]. Private clinics were also more likely to advertise telehealth and discuss pregnancy implications [63% (179/286) vs. 46% (41/89) and 37% (106/286) vs. 20% (18/89), respectively, P<0.05, all values]. Only 35/375 websites offered mental health resources. Degree of statewide COVID-19 burden did not appear to impact the information available on clinic websites.

**CONCLUSIONS:** Clinic size and type of practice, rather than COVID-19 burden, influenced websites use for patient education and care during the pandemic. Telehealth advertisement as well as adherence to regulatory agencies’ and societal recommendations were more common in larger clinics. Private clinics more frequently devised individualized patient care guidelines, addressed common concerns about the effect of COVID-19 on pregnancy, and made telehealth more readily accessible. The exclusion of such information on clinic websites may be a missed opportunity to support and educate patients about fertility treatment during a uniquely vulnerable time.

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**PATIENT PERCEPTIONS AND IMPACT OF FERTILITY TREATMENT CANCELLATION RELATED TO COVID-19.** Hanna Kim, MD, Josette C. Dawkins, MD, David M. Owen, MD/Ph.D, Bruce R. Carr, MD, Ellen Wilson, MD, UT Southwestern Medical Center, Dallas, TX.
OBJECTIVE: To assess the knowledge, attitudes, and perception of burdens on patients after fertility treatment cancellations in response to the COVID-19 pandemic.

DESIGN: A web-based survey involving people who experienced cancellations to fertility treatment due to COVID-19 precautions.

MATERIALS AND METHODS: A survey link was disseminated through online infertility forums and groups in the USA. Survey data was collected and stored via REDCap and then analyzed with descriptive statistics and Chi square test.

RESULTS: A preliminary data set of 208 respondents was used. 99% of respondents were female and either married or in a relationship. The median age was 33 years (range 23-44 years) with 1-12 years of infertility (mode 2 years). Respondents included a wide range of infertility diagnoses and all common modes of treatment. In this population, 78.8% reported that they were in the middle of their treatment when cycles were cancelled while 21.1% were cancelled prior to starting. Most reported anxiety and stress (79.6%) but also understanding of the situation (68.9%). The major factors contributing to anxiety and stress were lost treatment time (50.7%), younger age (< 35 years 90.5% vs 78.8% in >35 years, p value 0.024), and desire for increased communication and emotional support. The data showed that only 20.2% of patients perceived the support from their clinics as adequate. These patients who felt supported generally reported personal phone calls from their doctors and continued outlets of communication to ask questions and receive updates. People reporting perceptions of less support were more likely to have reported getting a recorded message or email with some information that did not directly address their specific situation. 37.5% of patients perceived that the lack of communication caused them to seek out other fertility clinics to feel more supported. Additionally, 36% of patients desired more emotional support, and only 3.1% reported being provided additional resources such as mental health counseling. 57.7% of patients had positive perceptions of telemedicine as a resource for the future even though most (75%) had not tried it in the past. Finally, data showed that the type of cycle affected stress levels: ovulation induction reported most stress 89% followed by in vitro fertilization 80% then frozen embryo transfer 62.9%. Patients who felt supported generally reported personal phone calls from their doctors and continued outlets of communication to ask questions and receive updates.

CONCLUSIONS: Infertility patients suffered significant stress related to their cycle cancellation from COVID-19. Despite being most worried about lost treatment time, patients advocated for a triage system to prioritize those with poorer prognosis when planning for safe return of fertility treatment. Additionally, consensus showed that personal and ongoing communication is a primary component of support. Virtual support platforms and telemedicine may provide a valuable and supplemental outlet to improve patient communication, emotional support, and access to providers. Moving forward, incorporating this technology into standard practice will likely enhance communication, emotional support, and access to providers. Designing a system to help prioritize more urgent patients over others.

SUPPORT: None

TABLE 1. IVF Treatment Cycle Outcomes During COVID-19

| Groups                             | Positive Pregnancy Count |
|------------------------------------|--------------------------|
| Group 1: Prior to Covid-19 Pause    | 396 (75.2%)              |
| (n=526 FET Cycles)                 |                          |
| Group 2: Era of Covid-19 (n=75 FET Cycles) | 59 (76.2%)              |

* p-value = 0.75.

CONCLUSIONS: The COVID-19 pandemic has placed an unprecedented burden on patients, physicians, and the entire healthcare system. Urgent treatments, including reproductive care, were postponed, as scarce resources needed to be re-directed. Resumption of treatment required modifications in workflow, staffing, decontamination protocols, and utilization of PPE. Although the patient experience has changed, our study is first to demonstrate implantation rates were not compromised in an era of COVID-19. Importantly, our preliminary data suggests that the stress and anxiety that pervade modern COVID-era reproductive care do not alter outcomes. With an abundance of caution, a modern fertility clinic can work to “flatten the curve,” abide by guidelines, and deliver safe and effective patient care.

SUPPORT: None

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IVF TREATMENT PRE- AND POST- THE ASRM COVID-19 PAUSE. Joseph A. Lee, BA,1 Christine Briton-Jones, PhD, HCLD,1 Carlos Hernandez-Nieto, MD,2 Margaret Daneyko, RN,1 Beth McAvey, MD,1 Eric Flisser, MD,1 Daniel E. Stein, MD,1 Tammy Mukherjee, MD,1 Benjamin Sandler, MD,1 Alan B. Copperman, MD1 Reproductive Medicine Associates of New York, New York, NY;2Icahn School of Medicine at Mount Sinai, New York, NY.

OBJECTIVE: The coronavirus (COVID-19) pandemic has forever reshaped the United States health care system. However, assisted reproductive technology (ART) treatment remains an essential form of medicine. Reproductive care practitioners incorporated vigilant practices regarding social distancing, ample use of Personal Protective Equipment (PPE), and consistent decontamination protocols in order to mitigate risk of COVID-19 infection. Altogether, changes to standard operating procedures within ART treatment centers are anticipated to support patient safety without compromising quality of reproductive care. Finally, there is ample evidence of the mental health burden stemming from this pandemic with regard to anxiety and depression in both healthcare workers and patients. Given the current uncertainty, our study evaluates IVF cycle outcome in a New York City patient cohort prior to and subsequent to the ASRM COVID-19 task force’s recommended treatment pause.

DESIGN: Retrospective cohort analysis.

MATERIALS AND METHODS: The study includes patients who underwent a single, euploid frozen-thawed embryo transfer (FET) from January 1st, 2020 to May 18th, 2020. Cohorts were separated into two groups based on period of IVF treatment (Group 1: Treatment prior to the COVID-19 pandemic pause; Group 2: Treatment subsequent to the COVID-19 pause). Primary outcome included early pregnancy rates. Chi squared test was used and statistically significant differences were found.

RESULTS: A total of 601 single, euploid FET cycles in which pregnancy outcomes coming prior to the COVID-19 pandemic (n=526) were compared to outcomes subsequent to COVID-19 (n=75). No differences were found in early pregnancy rates among cohorts (Table 1).

| Groups                             | Positive Pregnancy Count |
|------------------------------------|--------------------------|
| Group 1: Prior to Covid-19 Pause    | 396 (75.2%)              |
| (n=526 FET Cycles)                 |                          |
| Group 2: Era of Covid-19 (n=75 FET Cycles) | 59 (76.2%)              |

* p-value = 0.75.

CONCLUSIONS: The COVID-19 pandemic has placed an unprecedented burden on patients, physicians, and the entire healthcare system. Urgent treatments, including reproductive care, were postponed, as scarce resources needed to be re-directed. Resumption of treatment required modifications in workflow, staffing, decontamination protocols, and utilization of PPE. Although the patient experience has changed, our study is first to demonstrate implantation rates were not compromised in an era of COVID-19. Importantly, our preliminary data suggests that the stress and anxiety that pervade modern COVID-era reproductive care do not alter outcomes. With an abundance of caution, a modern fertility clinic can work to “flatten the curve,” abide by guidelines, and deliver safe and effective patient care.

SUPPORT: None

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FERTILITY PRESERVATION DURING THE COVID-19 PANDEMIC: MODIFIED BUT UNCOMPROMISED. Kara N. Goldman, M.D., Jennifer Elvikis, MSN, RN, Elmur Babayev, MD, MSc, Kristin Smith, B.S. Northwestern University, Chicago, IL.

OBJECTIVE: During the peak of the COVID-19 pandemic, our clinic remained operational for patients with cancer and other fertility-compromising medical conditions requiring urgent fertility preservation (FP). As patients with cancer are at a higher risk of death or serious illness from COVID-19, our FP approach was modified for patient safety. We sought to characterize FP care during the peak of our city’s COVID-19 shelter-in-place order and compare outcomes to historical controls.

DESIGN: Retrospective cohort study with historical controls.

MATERIALS AND METHODS: We analyzed all medically-induced FP cycles completed from March 17, 2020 (ASRM COVID-19 Task Force initial recommendation to suspend fertility treatments) until May 11, 2020 (ASRM update no. 4). Cycles performed during the same time period in 2019 were compared as historical controls. Data were analyzed using student’s T-test, Mann-Whitney-U, or Fisher’s Exact test where indicated (p<0.05).

RESULTS: Despite suspension of routine fertility care, our center managed 27 urgent FP cycles for 24 patients. 3 cycles were cancelled for acutely decompensating lymphoma, no response to gonadotropins (prior chemotherapy), and symptomatic COVID-19, respectively. 24 cycles from 21 patients were analyzed. Of 11 embryo cryopreservation cycles, 6 underwent FDA screening for future gestational carrier. More cycles were initiated in 2020 vs. 2019 (27 vs. 19), including significantly more embryo cryopreservation cycles (45.8% vs. 5.2%, p<0.005). Diagnoses were equally divided between breast cancer (29% vs 37%), leukemia/lymphoma (37.5% vs. 26.3%), and other (33.3% vs. 36.8%) (p>0.05). There was no difference in mean age (30±7 vs 28±7.4), AMH (2.9±2.0 vs. 4.2±3.1), or days of ovarian stimulation (11±1 vs 11±2) (p>0.05) but patients retrieved in 2020 utilized significantly more gonadotropin (4770±1480 vs. 3846±1438, p=0.04). Notably, patients managed during COVID-19 had significantly fewer monitoring visits (5.1±1 vs. 6.1±1, p=0.02), and 37.5% of cycles utilized a blind trigger injection (without monitoring). Despite modifications, there was no difference in number of oocytes retrieved (19±14 vs. 22±12) (p>0.05). All cycles (majority random-start) were timed to ensure anaesthesiology availability for retrieval given COVID coverage responsibilities. Extensive safety precautions were employed including appropriate personal protective