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.

Time from first dose of misoprostol to delivery of fetus were similar between patients treated with mifepristone plus misoprostol (14.6h) vs misoprostol alone (14.1h, p=0.63) as were rates of completed abortion within 24h (84.2% vs 86.7%, p=0.53). Total complication rates were similar between treatment groups (19.6% vs 28.6% p=0.51); however, D&C for retained placenta occurred less frequently with mifepristone plus misoprostol as compared to misoprostol alone (3.8% vs 17%, p=0.0001).
Conclusions: In a cohort that includes induced abortion and intrauterine fetal demise, adding mifepristone prior to misoprostol for second trimester induction results in fewer retained placentas requiring surgical management but does not change time to complete abortion.

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P34
MATERNAL MORBIDITY AFTER EXPECTANT MANAGEMENT OF PREVIABLE PRELABOR RUPTURE OF MEMBRANES
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Objectives: Prior to 2020, pregnancy termination was not routinely offered at our institution for patients diagnosed with previable prelabor rupture of membranes (PROM), and most patients were expectantly managed. We sought to define the rate of Severe Maternal Morbidity (SMM) as defined by the Centers for Disease Control and Prevention among women with expectantly managed previable PROM. Secondary outcomes included the rates of infectious and hemorrhagic morbidity, of suction curettage for retained products of conception, and of neonatal survival.
Methods: We performed a retrospective chart review of all patients diagnosed with previable PROM at our institution from 2013 – 2019, defined as PROM at less than 22 weeks 0 days gestation. We collected data on patient demographics and maternal/fetal outcomes. Patients were excluded if they delivered within 12 hours of PROM, elected pregnancy termination, or delivered outside our institution.
Results: There were 144 pregnancies among 142 patients diagnosed with previable PROM during the study period. Of these, 105 were included for analysis. The rate of SMM was 24.8% (n=26). A large percentage of patients were diagnosed with chorioamnionitis (52.4%, n=55), experienced peripartum hemorrhage >1000 milliliters (29.5%, n=31), or underwent suction curettage for retained products of conception (23.8%, n=25). Neonatal survival to hospital discharge was 5.7% (n=6).
Conclusions: Maternal morbidity in patients with expectantly managed previable PROM is high, and the rate of neonatal survival is low. Family planning services should be available to patients diagnosed with previable PROM, which may reduce the risk of SMM.

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P35
COMPARISON OF EARLY PREGNANCY LOSS MANAGEMENT IN THE EMERGENCY DEPARTMENT VERSUS OUTPATIENT clinic
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Objectives: To characterize patients who present to the emergency department (ED) versus outpatient clinics for early pregnancy loss (EPL) and to describe their management and outcomes, using insurance claims data.
Methods: We performed a retrospective cohort study of pregnant people ages 15-49 who experienced EPL from 2015-2019 using the Truven MarketScan Database. Patients with EPL were identified by ICD-10 codes; ED and non-ED cases were determined by location of first encounter with an EPL diagnosis. Using bivariate and multivariable analyses, we identified factors associated with initial location of presentation. We used propensity-adjusted regression models to determine characteristics associated with method of EPL management, outcomes, and complications.
Results: Of 210,571 EPL patients, 21,484 (15.8%) initially presented to the ED. ED patients were younger (mean age 29 vs 32, p<0.001) and more likely to live in high poverty urban areas or rural areas (p<0.001 for both). Subsequent EPL care in the ED was more common following initial ED presentation (6% vs 3%, p<0.001). Non-ED patients were more likely than ED patients to have management with uterine aspiration (24.4% vs 14.3%, p<0.001) or medication (11.4% vs 5.8%, p<0.001).
Conclusions: Different characteristics of EPL patients managed in the ED versus those managed in the office may reflect barriers in access to routine care among patients who are younger or live in rural or economically disadvantaged areas. The significant difference in management approaches by practice setting, even among a population of privately insured patients, is suggestive that current ED practices may not reflect a patient-centered approach or shared decision-making.

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P36
THE IMPACT OF COMPREHENSIVE EARLY PREGNANCY LOSS MANAGEMENT IN THE EMERGENCY DEPARTMENT
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Objectives: To compare the outcomes of patients who present to the emergency department (ED) for early pregnancy loss (EPL) who receive comprehensive management in the ED versus referral for outpatient follow-up.
Methods: We performed a retrospective chart review of patients who presented to two EDs in our hospital system with EPL between 2014 and 2019. Patients received ED management (EDM; all counseling and/or management performed in ED) or outpatient management (OPM; discharged from ED and managed as an outpatient). We compared patients with EDM and OPM on the proportion with complete EPL within one week, EPL-related complications, and time spent in the ED. We used multivariable logistic regression adjusted for age, race/ethnicity, insurance status, and specific EPL diagnosis to obtain odds ratios (ORs) and 95% confidence intervals (CIs) for the proportion of patients with complete EPL within one week.
Results: We identified 126 patients with EDM and 37 with OPM, and 78.6% and 54.1%, respectively, had complete EPL within one week. After adjustment, the odds of complete EPL within one week was 4.5 times higher among EDM than OPM (adjusted OR 4.55, 95%CI 1.78-11.67). The mean time spent in the ED was two hours longer among patients with EDM (6.6 vs. 4.7 hours, p<0.001), but more patients with OPM had EPL-related return ED visits (37.8% vs 11.9%, p<0.001).
Conclusions: Comprehensive EPL management has a positive impact on patient outcomes and on factors unique to the ED setting. Comprehensive care should be widely implemented to improve patient-centered care for patients seen in the ED with EPL.

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P37
CONTRACEPTIVE SERVICE PROVISION DURING THE COVID-19 PANDEMIC AMONG SAFETY-NET FAMILY PLANNING CLINICS IN A SOUTHEASTERN STATE
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Objectives: This study examined contraceptive service provision at Health Department (HD) and Federally Qualified Health Center (FQHC) family planning clinics in a Southeastern state during the initial months of the COVID-19 pandemic. Assessing how contraceptive service provision was affected by COVID-19 is integral to addressing health care disparities.
Methods: A cross-sectional survey of safety-net family planning clinics in a Southeastern state was conducted in 2020. Chi-square tests and independent t-tests determined statistical significance of differences by clinic type.
Results: A total of 131 clinics responded to this survey (response rate=68%). Of clinics who previously provided IUDs and implants, 59% of HDs and 11% of FQHCs stopped providing IUD placements/removals (p<0.0001), and 61% of HDs and 11% of FQHCs stopped providing implant placements/removals (p<0.0001). Other services clinics reported stopping were cervical cancer screenings (HD=44%, FQHC=12%, p=0.0002), and provision of oral contraceptives (HD=11%, FQHC=0%, p=0.0002). Contraceptive counseling, STI testing and treatment, and provision of Depo shot, patch, ring, and male condoms all continued to be offered at 75% or more responding clinics. In terms of supply of contraceptive method, 80% of HDs and 62% of FQHCs reported no method shortages (p=0.034).
Conclusions: The COVID-19 pandemic influenced contraceptive service provision at safety-net clinics in major ways. Overall, more FQHCs continued contraceptive service provision during the pandemic. This is at least partially due to HDs reallocating resources to meet community needs for COVID-19 testing and screening. Understanding COVID-19's impact on safety-net clinics can help stakeholders assess clinic and community needs to advance equity in service provision.

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