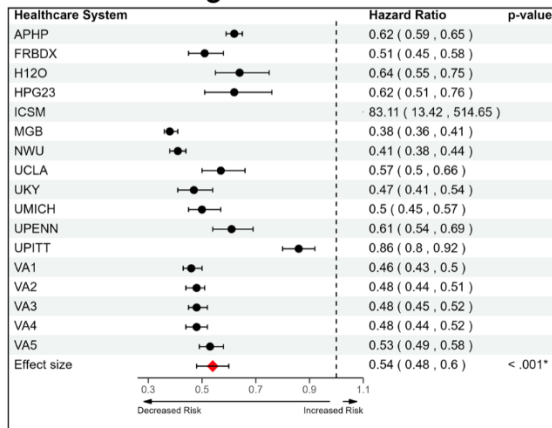
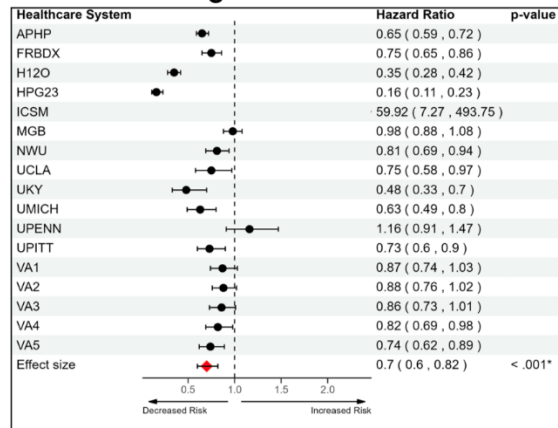


### A. CNS Discharge



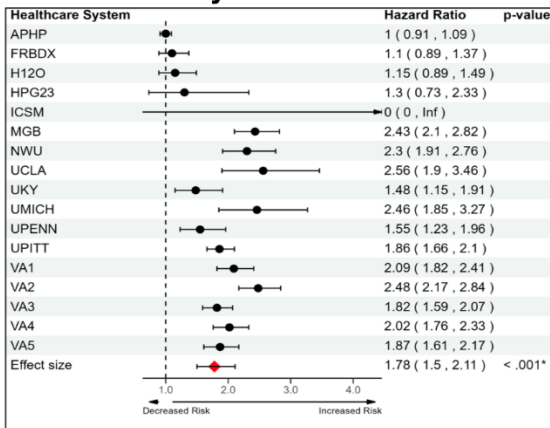
Heterogeneity:  $\tau^2=0.05$ ;  $I^2=96\%$  (95-97%)  
Prediction Interval: 0.33-0.89

### B. PNS Discharge



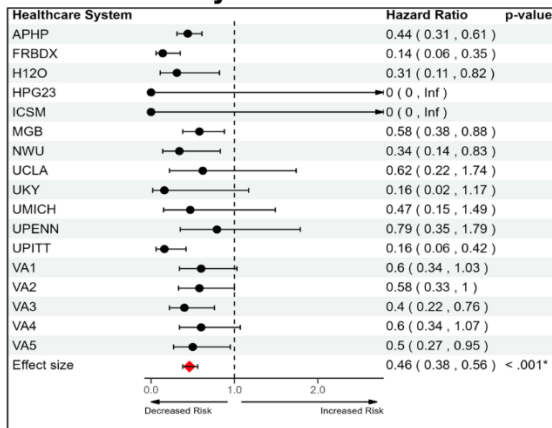
Heterogeneity:  $\tau^2=0.1$ ;  $I^2=93\%$  (90-95%)  
Prediction Interval: 0.35-1.39

### C. CNS Mortality



Heterogeneity:  $\tau^2=0.11$ ;  $I^2=94\%$  (91-95%)  
Prediction Interval: 0.86-3.68

### D. PNS Mortality



Heterogeneity:  $\tau^2=0.03$ ;  $I^2=18\%$  (0-54%)  
Prediction Interval: 0.31-0.69

**S2 Fig. Meta-analysis of the risk of adverse clinical outcomes stratified by concurrent neurological status and outcome during acute COVID-19 hospitalizations in adults.** Adverse outcomes include lower risk of hospital discharge and higher risk of mortality. Neurological status during COVID-19 hospitalization included any central nervous system (CNS) diagnosis (A, C) or any peripheral nervous system (PNS) diagnosis (B, D). Black circles indicate the local healthcare system-level hazard ratio derived from the Cox proportional hazards model. The red diamond represents the pooled effect size derived from the random-effects meta-analysis. The effect size and associated p-value derived from meta-analysis are reported in Table 2 of the main text. We also report the following metrics:  $I^2$  (95% CI), the estimated proportion of variance due to differences among healthcare systems;  $(\tau^2)$ , the between-healthcare system variance; Prediction Interval, the predicted effect size if we were to add a new healthcare system to the analysis. We excluded two adult healthcare systems (NUH and UKFR) from the meta-analysis due to low frequency of neurological diagnoses in their patient populations (< 1% of adult patients).