IMPORTANCE There is limited information describing the presenting characteristics and outcomes of US patients requiring hospitalization for coronavirus disease 2019 (COVID-19).

OBJECTIVE To describe the clinical characteristics and outcomes of patients with COVID-19 hospitalized in a US health care system.

DESIGN, SETTING, AND PARTICIPANTS Case series of patients with COVID-19 admitted to 12 hospitals in New York City, Long Island, and Westchester County, New York, within the Northwell Health system. The study included all sequentially hospitalized patients between March 1, 2020, and April 4, 2020, inclusive of these dates.

EXPOSURES Confirmed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection by positive result on polymerase chain reaction testing of a nasopharyngeal sample among patients requiring admission.

MAIN OUTCOMES AND MEASURES Clinical outcomes during hospitalization, such as invasive mechanical ventilation, kidney replacement therapy, and death. Demographics, baseline comorbidities, presenting vital signs, and test results were also collected.

RESULTS A total of 5700 patients were included (median age, 63 years [interquartile range {IQR}, 52-75; range, 0-107 years]; 39.7% female). The most common comorbidities were hypertension (3026; 56.6%), obesity (1737; 41.7%), and diabetes (1808; 33.8%). At triage, 30.7% of patients were febrile, 17.3% had a respiratory rate greater than 24 breaths/minute, and 27.8% received supplemental oxygen. The rate of respiratory virus co-infection was 2.1%.

Outcomes were assessed for 2634 patients who were discharged or had died at the study end point. During hospitalization, 373 patients (14.2%) (median age, 68 years [IQR, 56-78]; 33.5% female) were treated in the intensive care unit care, 320 (12.2%) received invasive mechanical ventilation, 81 (3.2%) were treated with kidney replacement therapy, and 553 (21%) died. Mortality for those requiring mechanical ventilation was 88.1%. The median postdischarge follow-up time was 4.4 days (IQR, 2.2-9.3). A total of 45 patients (2.2%) were readmitted during the study period. The median time to readmission was 3 days (IQR, 1.0-4.5) for readmitted patients. Among the 3066 patients who remained hospitalized at the final study follow-up date (median age, 65 years [IQR, 54-75]), the median follow-up at time of censoring was 4.5 days (IQR, 2.4-8.1).

CONCLUSIONS AND RELEVANCE This case series provides characteristics and early outcomes of sequentially hospitalized patients with confirmed COVID-19 in the New York City area.
The first confirmed case of coronavirus disease 2019 (COVID-19) in the US was reported from Washington State on January 31, 2020.1 Soon after, Washington and California reported outbreaks, and cases in the US have now exceeded total cases reported in both Italy and China.2 The rate of infections in New York, with its high population density, has exceeded every other state, and, as of April 20, 2020, it has more than 30% of all of the US cases.3

Limited information has been available to describe the presenting characteristics and outcomes of US patients requiring hospitalization with this illness. In a retrospective cohort study from China, hospitalized patients were predominantly men with a median age of 56 years; 26% required intensive care unit (ICU) care, and there was a 28% mortality rate.4 However, there are significant differences between China and the US in population demographics,5 smoking rates,6 and prevalence of comorbidities.7

This study describes the demographics, baseline comorbidities, presenting clinical tests, and outcomes of the first sequentially hospitalized patients with COVID-19 from an academic health care system in New York.

Methods

The study was conducted at hospitals in Northwell Health, the largest academic health system in New York, serving approximately 11 million persons in Long Island, Westchester County, and New York City. The Northwell Health institutional review board approved this case series as minimal-risk research using data collected for routine clinical practice and waived the requirement for informed consent. All consecutive patients who were sufficiently medically ill to require hospital admission with confirmed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection by positive result on polymerase chain reaction testing of a nasopharyngeal sample were included. Patients were admitted to any of 12 Northwell Health acute care hospitals between March 1, 2020, and April 4, 2020, inclusive of those dates. Clinical outcomes were monitored until April 4, 2020, the final date of follow-up.

Data were collected from the enterprise electronic health record (Sunrise Clinical Manager; Allscripts) reporting database, and all analyses were performed using version 3.5.2 of the R programming language (R Project for Statistical Computing; R Foundation). Patients were considered to have confirmed infection if the initial test result was positive or if it was negative but repeat testing was positive. Repeat tests were performed on inpatients during hospitalization shortly after initial test results were available if there was a high clinical pretest probability of COVID-19 or if the initial negative test result had been judged likely to be a false-negative due to poor sample collection. Transfers from one in-system hospital to another were merged and considered as a single visit. There were no transfers into or out of the system. For patients with a readmission during the study period, data from the first admission are presented.

Data collected included patient demographic information, comorbidities, home medications, triage vitals, initial laboratory tests, initial electrocardiogram results, diagnoses during the hospital course, inpatient medications, treatments (including invasive mechanical ventilation and kidney replacement therapy), and outcomes (including length of stay, discharge, readmission, and mortality). Demographics, baseline comorbidities, and presenting clinical studies were available for all admitted patients. All clinical outcomes are presented for patients who completed their hospital course at study end (discharged alive or dead). Clinical outcomes available for those in hospital at the study end point are presented, including invasive mechanical ventilation, ICU care, kidney replacement therapy, and length of stay in hospital. Outcomes such as discharge disposition and readmission were not available for patients in hospital at study end because they had not completed their hospital course. Home medications were reported based on the admission medication reconciliation by the inpatient-accepting physician because this is the most reliable record of home medications. Final reconciliation has been delayed until discharge during the current pandemic. Home medications are therefore presented only for patients who have completed their hospital course to ensure accuracy.

Race and ethnicity data were collected by self-report in prespecified fixed categories. These data were included as study variables to characterize admitted patients. Initial laboratory testing was defined as the first test results available, typically within 24 hours of admission. For initial laboratory testing and clinical studies for which not all patients had values, percentages of total patients with completed tests are shown. The Charlson Comorbidity Index predicts 10-year survival in patients with multiple comorbidities and was used as a measure of total comorbidity burden.8 The lowest score of 0 corresponds to a 98% estimated 10-year survival rate. Increasing age in decades older than age 50 years and comorbidities, including congestive heart disease and cancer, increase the total score and decrease the estimated 10-year survival. A total of 16 comorbidities are included. A score of 7 points and above corresponds to a 0% estimated 10-year survival rate. Acute kidney injury was identified as an increase in serum creatinine by 0.3 mg/dL or more (≥26.5 μmol/L) within 48 hours or an increase in
serum creatinine to 1.5 times or more baseline within the prior 7 days compared with the preceding 1 year of data in acute care medical records. This was based on the Kidney Disease: Improving Global Outcomes (KDIGO) definition.9 Acute hepatic injury was defined as an elevation in aspartate aminotransferase or alanine aminotransferase of more than 15 times the upper limit of normal.

Results

A total of 5700 patients were included (median age, 63 years [interquartile range (IQR), 52-75; range, 0-107 years]; 39.7% female) (Table 1). The median time to obtain polymerase chain reaction testing results was 15.4 hours (IQR, 7.8-24.3). The most common comorbidities were hypertension (3026, 56.6%), obesity (1737, 41.7%), and diabetes (1808, 33.8%). The median score on the Charlson Comorbidity Index was 4 points (IQR, 2-8), which corresponds to a 53% estimated 10-year survival and reflects a significant comorbidity burden for these patients. Acute hepatic injury was defined as an elevation in aspartate aminotransferase or alanine aminotransferase of more than 15 times the upper limit of normal.

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); COVID-19, coronavirus disease 2019; IQR, interquartile range.

* Race and ethnicity data were collected by self-report in prespecified fixed categories.

1 Other insurance includes military, union, and workers’ compensation.


3 Assessed based on a diagnosis of end-stage kidney disease in medical history by ICD-10 coding.

4 Assessed based on a diagnosis of diabetes mellitus and includes diet-controlled and non-insulin-dependent diabetes.

5 Comorbidities listed here are defined as medical diagnoses included in medical history by ICD-10 coding. These include, but are not limited to, those presented in the table.

6 Charlson Comorbidity Index predicts the 10-year mortality for a patient based on age and a number of serious comorbid conditions, such as congestive heart failure or cancer. Scores are summed to provide a total score to predict mortality. The median score of 4 corresponds to a 53% estimated 10-year survival and reflects a significant comorbidity burden for these patients.
co-infection with another respiratory virus for those tested was 2.1% (42/1996). Discharge disposition by 10-year age intervals of all 5700 study patients is included in Table 4. Length of stay for those who died, were discharged alive, and remained in hospital are presented as well. Among the 3066 patients who remained hospitalized at the final study follow-up date (median age, 65 years [IQR 54-75]), the median follow-up at time of censoring was 4.5 days (IQR, 2.4-8.1). Mortality was 0% (0/20) for male and female patients younger than 20 years. Mortality rates were higher for male compared with female patients at every 10-year age interval older than 20 years.
Among the 2634 patients who were discharged or had died at the study end point, during hospitalization, 373 (14.2%) were treated in the ICU, 320 (12.2%) received invasive mechanical ventilation, 81 (3.2%) were treated with kidney replacement therapy, and 553 (21%) died (Table 5). Mortality for those who received mechanical ventilation was 88.1% (n = 282). Mortality rates for those who received mechanical ventilation in the 18-to-65 and older-than-65 age groups were 76.4% and 97.2%, respectively. Mortality rates for those in the 18-to-65 and older-than-65 age groups who did not receive mechanical ventilation were 19.8% and 26.6%, respectively. There were no deaths in the younger-than-18 age group. The overall length of stay was 4.1 days (IQR, 2.3-6.8). The median postdischarge follow-up time was 3 days (IQR, 1.0-4.5). Of the patients who were discharged or had died at the study end point, 436 (16.6%) were younger than age 50 with a score of 0 on the Charlson Comorbidity Index, of whom 9 died.

Outcomes for Patients Who Were Discharged or Died
Among the 2634 patients who were discharged or had died at the study end point, during hospitalization, 373 (14.2%) were treated in the ICU, 320 (12.2%) received invasive mechanical ventilation, 81 (3.2%) were treated with kidney replacement therapy, and 553 (21%) died (Table 5). Mortality for those who received mechanical ventilation was 88.1% (n = 282). Mortality rates for those who received mechanical ventilation in the 18-to-65 and older-than-65 age groups were 76.4% and 97.2%, respectively. Mortality rates for those in the 18-to-65 and older-than-65 age groups who did not receive mechanical ventilation were 19.8% and 26.6%, respectively. There were no deaths in the younger-than-18 age group. The overall length of stay was 4.1 days (IQR, 2.3-6.8). The median postdischarge follow-up time was 4.4 days (IQR, 2.2-9.3). A total of 45 patients (2.2%) were readmitted during the study period. The median time to readmission was 3 days (IQR, 1.0-4.5). Of the patients who were discharged or had died at the study end point, 436 (16.6%) were younger than age 50 with a score of 0 on the Charlson Comorbidity Index, of whom 9 died.

Outcomes by Age and Risk Factors
For both patients discharged alive and those who died, the percentage of patients who were treated in the ICU or received invasive mechanical ventilation was increased for the 18-to-65 age group compared with the older-than-65 years age group (Table 5). For patients discharged alive, the lowest absolute lymphocyte count during hospital course was lower for progressively older age groups. For patients discharged alive, the readmission rates and the percentage of patients discharged to a facility (such as a nursing home or rehabilitation), as opposed to home, increased for progressively older age groups.

Table 3. Hospital Characteristics and Admission Rates

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Study admissions (N = 5700)</th>
<th>Acute beds (March occupancy), mean</th>
<th>Annual emergency department visits (% admitted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Shore University Hospital</td>
<td>1073 (18.8)</td>
<td>637 (92)</td>
<td>51 000 (34)</td>
</tr>
<tr>
<td>Long Island Jewish Medical Center</td>
<td>1151 (20.2)</td>
<td>517 (91)</td>
<td>66 000 (28)</td>
</tr>
<tr>
<td>Staten Island University Hospital</td>
<td>674 (11.9)</td>
<td>466 (85)</td>
<td>93 000 (25)</td>
</tr>
<tr>
<td>Lenox Hill Hospital</td>
<td>558 (9.8)</td>
<td>324 (75)</td>
<td>40 000 (29)</td>
</tr>
<tr>
<td>Southside Hospital</td>
<td>445 (7.8)</td>
<td>270 (86)</td>
<td>59 000 (18)</td>
</tr>
<tr>
<td>Huntington Hospital</td>
<td>359 (6.3)</td>
<td>231 (81)</td>
<td>40 000 (22)</td>
</tr>
<tr>
<td>Long Island Jewish Forest Hills</td>
<td>608 (10.7)</td>
<td>187 (86)</td>
<td>42 000 (21)</td>
</tr>
<tr>
<td>Long Island Jewish Valley Stream</td>
<td>355 (6.2)</td>
<td>180 (75)</td>
<td>31 000 (23)</td>
</tr>
<tr>
<td>Plainview Hospital</td>
<td>231 (4.1)</td>
<td>156 (70)</td>
<td>24 000 (29)</td>
</tr>
<tr>
<td>Cohen Children’s Medical Center</td>
<td>42 (0.7)</td>
<td>111 (78)</td>
<td>48 000 (14)</td>
</tr>
<tr>
<td>Glen Cove Hospital, nonteaching</td>
<td>117 (2.1)</td>
<td>66 (78)</td>
<td>15 000 (20)</td>
</tr>
<tr>
<td>Syosset Hospital</td>
<td>87 (1.5)</td>
<td>55 (70)</td>
<td>12 000 (21)</td>
</tr>
</tbody>
</table>

Abbreviations: COVID-19, coronavirus disease 2019; IQR, interquartile range; NA, not applicable.

Table 4. Discharge Disposition by 10-Year Age Intervals of Patients Hospitalized With COVID-19

<table>
<thead>
<tr>
<th>Age intervals, y</th>
<th>Patients discharged alive or dead at study end point</th>
<th>Length of stay among those who died, median (IQR), d</th>
<th>Discharged alive, No./No. (%)</th>
<th>Length of stay among those discharged alive, median (IQR), d</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>Died, No./No. (%) Male 0/13 Female 0/13</td>
<td>NA 13/13 (100) Male 13/13 (100)</td>
<td>2.0 (1.7-2.7)</td>
<td>7/33 (21.2) Male 4.3 (3.1-12.5)</td>
</tr>
<tr>
<td>10-19</td>
<td>Died, No./No. (%) Male 0/1 Female 0/7</td>
<td>NA 1/1 (100) Male 1/1 (100)</td>
<td>1.8 (1.0-3.1)</td>
<td>9/17 (52.9) Male 3.3 (2.8-4.3)</td>
</tr>
<tr>
<td>20-29</td>
<td>Died, No./No. (%) Male 3/4 Female 1/55</td>
<td>1/55 (1.8) Male 40/42 (92.9)</td>
<td>4.0 (0.8-7.4)</td>
<td>39/42 (92.9) Male 2.5 (1.8-4.0)</td>
</tr>
<tr>
<td>30-39</td>
<td>Died, No./No. (%) Male 6/13 Female 2/81</td>
<td>2/81 (2.5) Male 124/130 (95.4)</td>
<td>2.8 (2.4-3.6)</td>
<td>79/81 (97.5) Male 3.7 (2.0-5.8)</td>
</tr>
<tr>
<td>40-49</td>
<td>Died, No./No. (%) Male 19/233 Female 3/119</td>
<td>3/119 (2.5) Male 214/233 (91.8)</td>
<td>5.6 (3.0-8.4)</td>
<td>116/119 (97.5) Male 3.9 (2.3-6.1)</td>
</tr>
<tr>
<td>50-59</td>
<td>Died, No./No. (%) Male 40/327 Female 13/188</td>
<td>13/188 (6.9) Male 287/327 (87.8)</td>
<td>5.9 (3.1-9.5)</td>
<td>175/188 (93.1) Male 3.8 (2.5-6.7)</td>
</tr>
<tr>
<td>60-69</td>
<td>Died, No./No. (%) Male 56/300 Female 28/123</td>
<td>28/123 (22.0) Male 244/300 (81.3)</td>
<td>5.7 (2.6-8.2)</td>
<td>205/233 (88.0) Male 4.3 (2.5-6.8)</td>
</tr>
<tr>
<td>70-79</td>
<td>Died, No./No. (%) Male 70/154 Female 54/197</td>
<td>54/197 (27.4) Male 163/254 (64.2)</td>
<td>5.0 (2.7-7.8)</td>
<td>143/197 (72.6) Male 4.6 (2.8-7.8)</td>
</tr>
<tr>
<td>80-89</td>
<td>Died, No./No. (%) Male 94/155 Female 76/158</td>
<td>76/158 (48.1) Male 61/155 (39.4)</td>
<td>3.9 (2.1-6.5)</td>
<td>82/158 (51.9) Male 4.4 (2.7-7.7)</td>
</tr>
<tr>
<td>≥90</td>
<td>Died, No./No. (%) Male 28/44 Female 39/84</td>
<td>39/84 (46.4) Male 16/44 (36.4)</td>
<td>3.0 (0.7-5.5)</td>
<td>45/84 (53.6) Male 4.8 (2.8-8.4)</td>
</tr>
</tbody>
</table>

Abbreviations: COVID-19, coronavirus disease 2019; IQR, interquartile range; NA, not applicable.

* Length of stay begins with admission time and ends with discharge time, time at death, or midnight on the last day of data collection for the study. It does not include time in the emergency department.
Of the patients who died, those with diabetes were more likely to have received invasive mechanical ventilation or care in the ICU compared with those who did not have diabetes (eTable 1 in the Supplement). Of the patients who died, those with hypertension were less likely to have received invasive mechanical ventilation or care in the ICU compared with those without hypertension. The percentage of patients who developed acute kidney injury was increased in the subgroups with diabetes compared with subgroups without those conditions.

### Angiotensin-Converting Enzyme Inhibitor and Angiotensin II Receptor Blocker Use

Home medication reconciliation information was available for 2411 (92%) of the 2634 patients who were discharged or who died by the study end. Of these 2411 patients, 189 (7.8%)

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**Table 5. Clinical Measures and Outcomes for Patients Discharged Alive, Dead, and In Hospital at Study End Point by Age**

<table>
<thead>
<tr>
<th>Clinical measure</th>
<th>Total discharged alive and dead patients (N = 2634)</th>
<th>Discharged alive</th>
<th>Died</th>
<th>In hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;18 y (n = 32)</td>
<td>18-65 y (n = 1373)</td>
<td>&gt;65 y (n = 676)</td>
<td>&lt;18 y (n = 0)</td>
</tr>
<tr>
<td>Invasive mechanical ventilation</td>
<td>320 (12.2)</td>
<td>0 (0.7)</td>
<td>5 (0.7)</td>
<td>107 (79.9)</td>
</tr>
<tr>
<td>ICU care</td>
<td>373 (14.2)</td>
<td>2 (6.3)</td>
<td>62 (4.5)</td>
<td>18 (2.7)</td>
</tr>
<tr>
<td>Absolute lymphocyte count at nadir, median (IQR), x10⁹/L</td>
<td>0.8 (0.5-1.14)</td>
<td>2.3 (1.2-5.0)</td>
<td>0.9 (0.7-1.2)</td>
<td>0.8 (0.5-1.1)</td>
</tr>
</tbody>
</table>

**Note:**

- **Abbreviations:** ICU, intensive care unit; IQR, interquartile range; NA, not applicable.
- **a** Policy in the system has been not to treat patients with COVID-19 with bilevel positive airway pressure and continuous positive airway pressure out of concern for aerosolizing virus particles and therefore that information is not reported here.
- **b** Acute kidney injury was identified as an increase in serum creatinine by ≥0.3 mg/dL (≥26.5 mol/L) within 48 hours or an increase in serum creatinine to ≥1.5 times baseline within the prior 7 days compared with the preceding 1 year of data in acute care medical records. Acute kidney injury is calculated only for patients with record of baseline kidney function data available and without a diagnosis of end-stage kidney disease.
- **c** Acute hepatic injury was defined as an elevation in aspartate aminotransferase or alanine aminotransferase of ≥5 times the upper limit of normal.
- **d** Length of stay begins with admission time and ends with discharge time or time of death. It does not include time in the emergency department.
- **e** Data are presented here for readmission during the study period, March 1 to April 4, 2020.

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Of the patients who died, those with diabetes were more likely to have received invasive mechanical ventilation or care in the ICU compared with those who did not have diabetes (eTable 1 in the Supplement). Of the patients who died, those with hypertension were less likely to have received invasive mechanical ventilation or care in the ICU compared with those without hypertension. The percentage of patients who developed acute kidney injury was increased in the subgroups with diabetes compared with subgroups without those conditions.
Clinical Characteristics, Comorbidities, and Outcomes Among Patients With COVID-19 Hospitalized in the NYC Area

The Northwell COVID-19 Research Consortium

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Supervision: Narasimhan, McGinn, Becker, Chelico, Zanos.

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REFERENCES