



# Effectiveness of COVID-19 (2023-2024 Formula) vaccines

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# Agenda: effectiveness of COVID-19 (2023-2024 Formula) vaccines

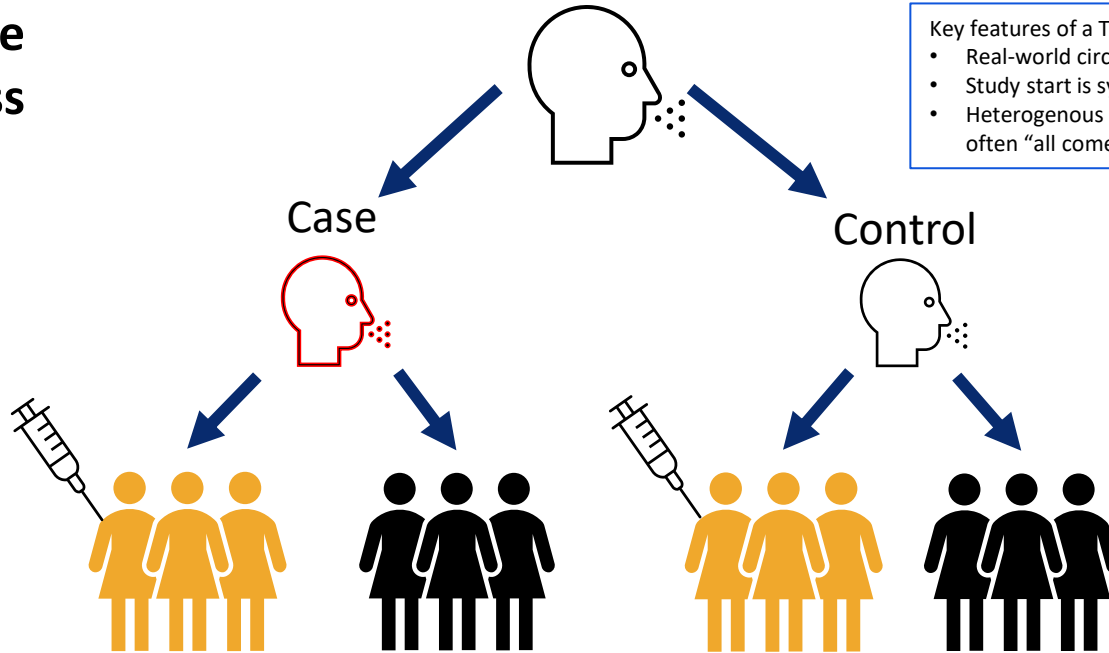
- Vaccine effectiveness (VE) methods refresher
- Context for interpretation of COVID-19 VE
- COVID-19 VE in adults, by outcome and variant:
  - Symptomatic SARS-CoV-2
  - COVID-19-associated emergency department/urgent care (ED/UC) encounters
  - COVID-19-associated hospitalizations, by immunocompromise status
  - COVID-19-associated critical outcomes
- COVID-19 VE in young children and by age group

# Observational effectiveness measured in a test-negative design (TND) study

Person with acute  
respiratory illness

Pathogen test  
(e.g., SARS-CoV-2, RSV, etc.)

Immunization  
status



Key features of a TND

- Real-world circumstances
- Study start is symptomatic medical encounter
- Heterogenous study population, often “all comers”

$$\text{Effectiveness} = 1 - (\text{odds ratio}) \times 100\% \quad \text{Odds ratio} = \frac{\text{Odds of immunization}_{\text{cases}}}{\text{Odds of immunization}_{\text{controls}}}$$

# Test-negative design methods

- **Benefits**

- Reduces bias from health-care seeking behavior by including cases and controls who presented to care and received testing (usually at the same facility).
- Efficient use of resources → allows controls to be selected from same healthcare system or testing location as cases.

- **Considerations**

- Dependent on sensitivity and specificity of diagnostic testing.
- Controls positive for another vaccine preventable disease can bias results. Sensitivity analyses excluding influenza positive controls can be helpful in assessing COVID-19 VE.

# Vaccine effectiveness is a population level estimate.

If a vaccine has an effectiveness of 80 percent:



It does not mean that the vaccine will only work 80% of the time.

It does mean that in a vaccinated population, 80% fewer people will contract the disease when they come in contact with the virus.

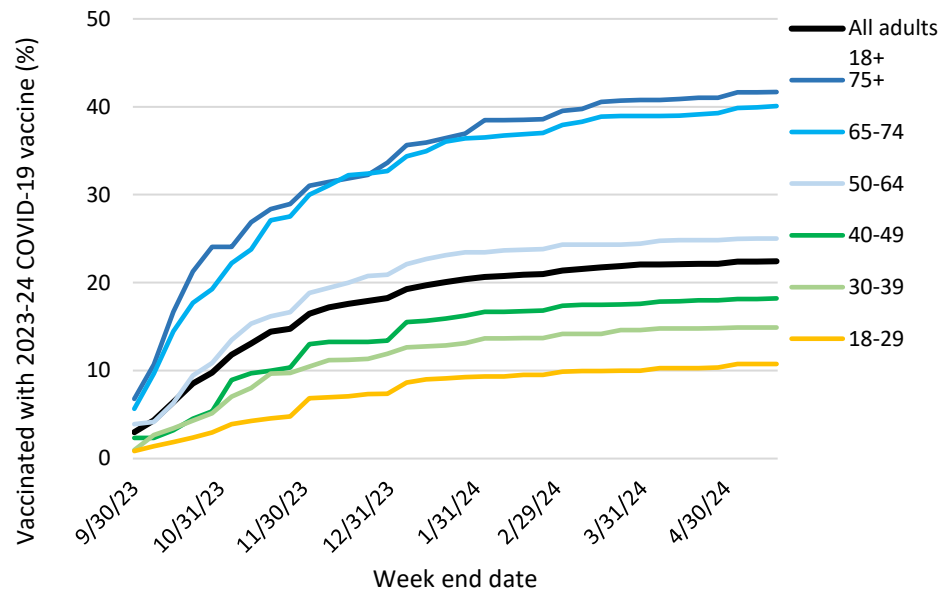


# Percent of adults and children who received 2023-24 COVID-19 vaccine

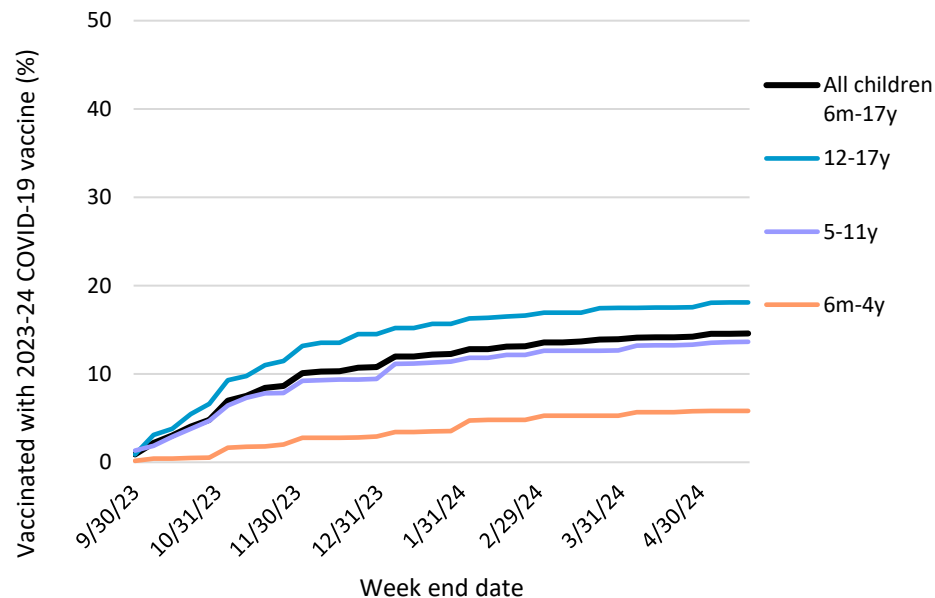
National Immunization Survey-Adult COVID Module (NIS-ACM) and -Child COVID Module (NIS-CCM)

September 2023-April 2024

COVID-19 Vaccination Coverage with 2023-24 Vaccine  
Among Adults ≥18 Years, NIS-ACM

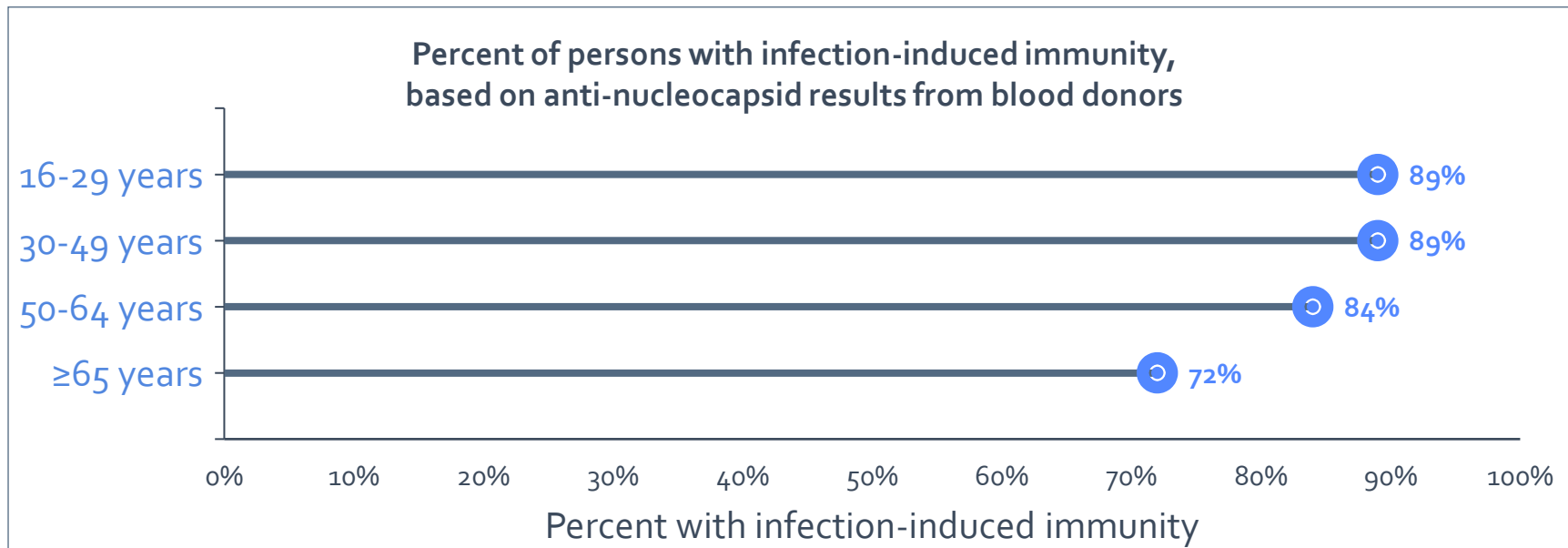


COVID-19 Vaccination Coverage with 2023-24 Vaccine  
Among Children 6 Months-17 Years, NIS-CCM



# Context for interpreting COVID-19 VE across age groups

- High rates of SARS-CoV-2 infection-induced immunity by July – August 2023.\*



VE findings should be interpreted as the incremental benefit provided by COVID-19 vaccination in a population with a high prevalence of vaccine- and infection-induced immunity.

\* Internal CDC data. Data on persons aged ≥16 years is from a longitudinal, national cohort of >35,000 blood donors.

Methods and prior data available at: <https://covid.cdc.gov/covid-data-tracker/#nationwide-blood-donor-seroprevalence-2022>

# Measuring 2023-2024 COVID-19 VE

| Measure                   | Definition  | Vaccinated group                       | Comparison group  |
|---------------------------|---|--|---|
| <b>Absolute VE</b>        | Compares frequency of health outcomes in vaccinated and unvaccinated people   | Received <b>updated (2023-24) dose</b> | Received no COVID-19 vaccines ever  |
| <b>Relative VE</b>        | Compares frequency of health outcomes in people who received one type of vaccine to people who received a different vaccine | Received <b>updated (2023-24) dose</b> | Eligible for, but did not receive, an <b>updated (2023-24) dose</b> , but received previous doses of COVID-19 vaccine |
| <b>VE presented today</b> | Compares people who received 2023-2024 COVID-19 vaccine to people who did not, regardless of past vaccination               | Received <b>updated (2023-24) dose</b> | Eligible for, but did not receive, an <b>updated (2023-24) dose</b> , regardless of past vaccination history          |



# Early Estimates of Updated 2023–2024 (Monovalent XBB.1.5) COVID-19 Vaccine Effectiveness Against Symptomatic SARS-CoV-2 Infection Attributable to Co-Circulating Omicron Variants Among Immunocompetent Adults — Increasing Community Access to Testing Program, United States, September 2023–January 2024

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MMWR Morb Mortal Wkly Rep 2024;73:77–83. DOI: <http://dx.doi.org/10.15585/mmwr.mm7304a2>

**Updates to COVID-19 VE against symptomatic infection:**  
*Increasing Community Access to Testing (ICATT) program*

# Increasing Community Access to Testing (ICATT): COVID-19 VE from national pharmacy testing data

- Nationwide community-based pharmacy SARS-CoV-2 testing
- Self-reported COVID-19 vaccination history at time of registration for SARS-CoV-2 testing\*
- **Design:** Test-negative analysis\*\*
- **Population:** Adults  $\geq 18$  years with  $\geq 1$  COVID-like symptom and nucleic acid amplification testing (NAAT) for SARS-CoV-2
- **Exclusion criteria:** Individuals with self-reported immunocompromising conditions, reported a positive SARS-CoV-2 test in preceding 90 days\*\*\*
- **Periods for analysis:**
  - Full analysis included tests from September 21, 2023 – May 22, 2024
  - Sub-analysis using S-gene target failure\*\*\*\* included tests from October 27, 2023 – April 3, 2024

\*At 5% of testing encounters, COVID-19 vaccination status is collected by clinician interview. Receipt of 2023-2024 COVID-19 vaccine formulation determined by date of most recent dose (i.e., after Sept 12, 2023).

\*\*Odds ratios were calculated using multivariable logistic regression, adjusting for single year of age, gender, race/ethnicity, SVI of the testing location ( $<0.5$  versus  $\geq 0.5$ ), pharmacy contractor, underlying conditions (presence versus absence), U.S. Department of Health and Human Services region of testing location, and date of testing

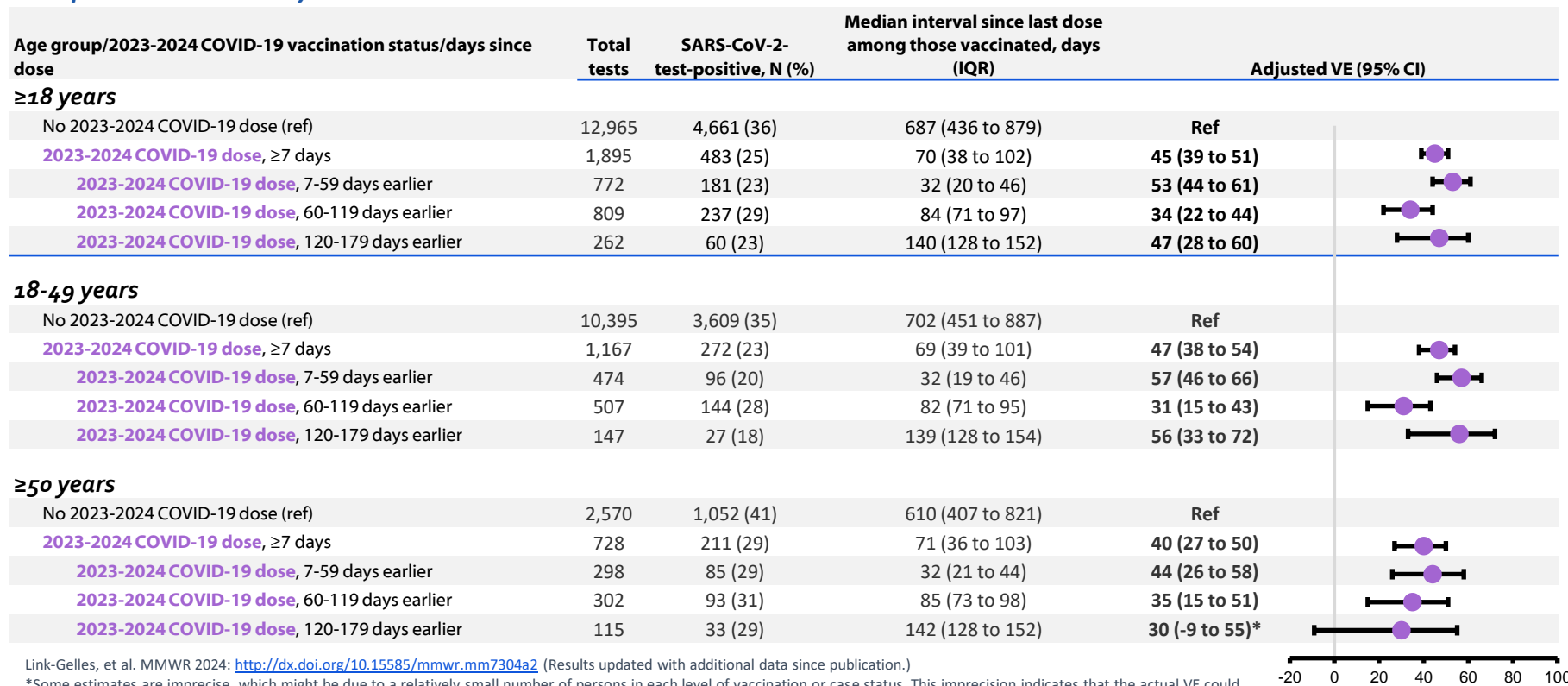
\*\*\*Additional exclusion criteria: 1) reported receiving Novavax as their most recent dose and reported receiving  $<2$  total COVID-19 vaccine doses; 2) reported receiving a Janssen (Johnson & Johnson) COVID-19 vaccine dose after May 12, 2023; 3) received most recent COVID-19 dose  $<7$  days prior to the date of testing or during September 1-12, 2023; or 4) registered for testing with a version of the questionnaire that only reported month and year of the most recent vaccine dose rather than calendar date.

\*\*\*\* Results of spike gene (S-gene) amplification in real-time reverse transcription–polymerase chain reaction (RT-PCR) can be used to distinguish certain SARS-CoV-2 lineages over time (2). S-gene target presence (SGTP) was detected in most lineages that circulated in 2023, including XBB lineages, whereas S-gene target failure (SGTF) is detected in JN.1 and other BA.2.86 lineages

Link-Gelles, et al. MMWR 2024: <http://dx.doi.org/10.15585/mmwr.mm7304a2> (Results updated with additional data since publication.)

# ICATT: VE of 2023-2024 COVID-19 vaccine against *symptomatic infection* among adults aged ≥18 years, by age group and time since dose

September 2023 – May 2024

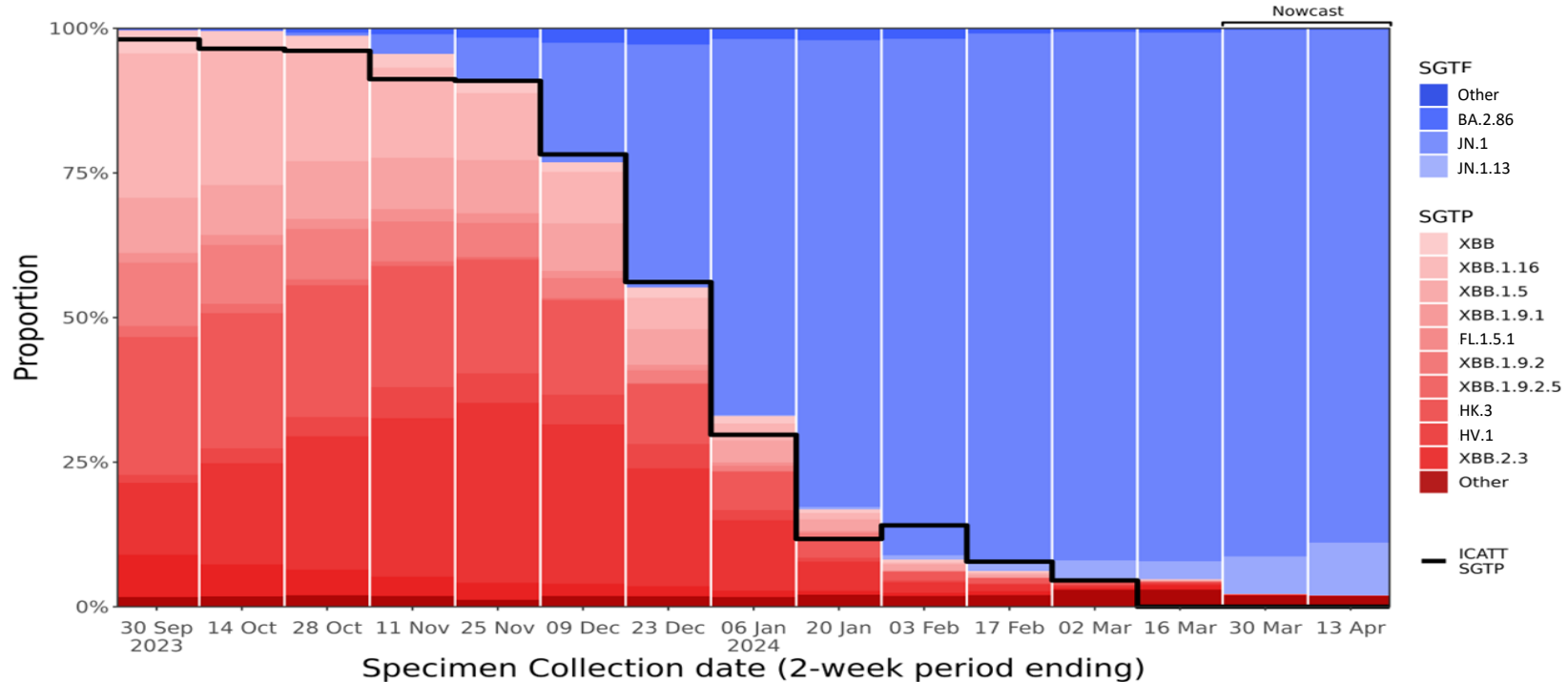


Link-Gelles, et al. MMWR 2024: <http://dx.doi.org/10.15585/mmwr.mm7304a2> (Results updated with additional data since publication.)

\*Some estimates are imprecise, which might be due to a relatively small number of persons in each level of vaccination or case status. This imprecision indicates that the actual VE could be substantially different from the point estimate shown, and estimates should therefore be interpreted with caution. Additional data accrual could increase precision and allow more precise interpretation. Ref=referent group; IQR=interquartile range; CI=confidence interval

# Trends in estimated proportions of SARS-CoV-2 S-gene target presence and variant proportions in ICATT and Nowcast projections from national genomic surveillance

September 2023-April 2024



S-gene = spike gene; SGTF = S-gene target failure; SGTP = S-gene target presence

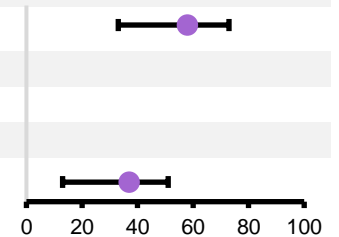
<https://covid.cdc.gov/covid-data-tracker/#variant-proportions>

# ICATT: VE of 2023-2024 COVID-19 vaccine against **symptomatic infection** among adults aged $\geq 18$ years, by S-gene target (SGT) presence or failure and time since dose

October 2023 – April 2024

| SGT status/2023-2024 COVID-19 vaccination status/days since dose | Total tests | SARS-CoV-2 negative |  | SARS-CoV-2 positive |  | Adjusted VE (95% CI) |
|--|-------------|---------------------|--|---------------------|--|----------------------|
|  |             | N (row %)           | Median interval since last dose among vaccinated, days (IQR) | N (row %)           | Median interval since last dose among vaccinated, days (IQR) |                      |
| <b>SGT presence (likely non-JN.1)</b>                            |             |                     |  |                     |  |                      |
| No 2023-2024 COVID-19 dose (ref)                                 | 2,357       | 1,934 (69)          | 668 (410 to 827)   | 423 (15)            | 670 (405 to 800)   | Ref                  |
| 2023-2024 COVID-19 dose, 60-119 days earlier                     | 307         | 282 (77)            | 85 (72 to 101)   | 25 (7)              | 73 (69 to 83)  | 58 (33 to 73)        |
|  |             |                     |  |                     |  |                      |
| <b>SGT failure (likely JN.1)</b>                                 |             |                     |  |                     |  |                      |
| No 2023-2024 COVID-19 dose (ref)                                 | 2,366       | 1,934 (69)          | 668 (410 to 827)   | 432 (15)            | 686 (426 to 829)   | Ref                  |
| 2023-2024 COVID-19 dose, 60-119 days earlier                     | 343         | 282 (77)            | 85 (72 to 101)   | 61 (17)             | 89 (75 to 101)   | 37 (13 to 51)        |

| SGT Status                     | 2023-2024 COVID-19 dose, 60-119 days earlier | Adjusted VE (95% CI) |
|--------------------------------|--|----------------------|
| SGT presence (likely non-JN.1) | 58 (33 to 73)                                |                      |
| SGT failure (likely JN.1)      | 37 (13 to 51)                                |                      |



# Interim Effectiveness of Updated 2023–2024 (Monovalent XBB.1.5) COVID-19 Vaccines Against COVID-19–Associated Emergency Department and Urgent Care Encounters and Hospitalization Among Immunocompetent Adults Aged ≥18 Years — VISION and IVY Networks, September 2023–January 2024

Jennifer DeCuir, MD, PhD<sup>1</sup>; Amanda B. Payne, PhD<sup>1</sup>; Wesley H. Self, MD<sup>2</sup>; Elizabeth A.K. Rowley, DrPH<sup>3</sup>; Kristin Dascomb, MD, PhD<sup>4</sup>; Malini B. DeSilva, MD<sup>5</sup>; Stephanie A. Irving, MHS<sup>6</sup>; Shaun J. Grannis, MD<sup>7,8</sup>; Toan C. Ong, PhD<sup>9</sup>; Nicola P. Klein, MD, PhD<sup>10</sup>; Zachary A. Weber, PhD<sup>3</sup>; Sarah E. Reese, PhD<sup>3</sup>; Sarah W. Ball, ScD<sup>3</sup>; Michelle A. Barron<sup>9</sup>; Allison L. Naleway, PhD<sup>6</sup>; Brian E. Dixon, PhD<sup>7,8</sup>; Inih Essien, OD<sup>5</sup>; Daniel Bride, MS<sup>4</sup>; Karthik Natarajan, PhD<sup>11,12</sup>; Bruce Fireman<sup>10</sup>; Ami B. Shah, MPH<sup>1,13</sup>; Erica Okwuazi, MSc<sup>1,13</sup>; Ryan Wiegand, PhD<sup>1</sup>; Yuwei Zhu, MD<sup>2</sup>; Adam S. Luring, MD, PhD<sup>14</sup>; Emily T. Martin, PhD<sup>14</sup>; Manjusha Gaglani, MBBS<sup>15,16</sup>; Ithan D. Peltan, MD<sup>17,18</sup>; Samuel M. Brown, MD<sup>17,18</sup>; Adit A. Ginde, MD<sup>9</sup>; Nicholas M. Mohr, MD<sup>19</sup>; Kevin W. Gibbs, MD<sup>20</sup>; David N. Hager, MD, PhD<sup>21</sup>; Matthew Prekker, MD<sup>22</sup>; Amira Mohamed, MD<sup>23</sup>; Vasisht Srinivasan, MD<sup>24</sup>; Jay S. Steingrub, MD<sup>25</sup>; Akram Khan, MD<sup>26</sup>; Laurence W. Busse, MD<sup>27</sup>; Abhijit Duggal, MD<sup>28</sup>; Jennifer G. Wilson, MD<sup>29</sup>; Steven Y. Chang, MD, PhD<sup>30</sup>; Christopher Mallow, MD<sup>31</sup>; Jennie H. Kwon, DO<sup>32</sup>; Matthew C. Exline, MD<sup>33</sup>; Cristie Columbus, MD<sup>15,34</sup>; Ivana A. Vaughn, PhD<sup>35</sup>; Basmah Safdar, MD<sup>36</sup>; Jarrod M. Mosier, MD<sup>37</sup>; Estelle S. Harris, MD<sup>18</sup>; Jonathan D. Casey, MD<sup>2</sup>; James D. Chappell, MD, PhD<sup>2</sup>; Carlos G. Grijalva, MD<sup>2</sup>; Sydney A. Swan<sup>2</sup>; Cassandra Johnson, MS<sup>2</sup>; Nathaniel M. Lewis, PhD<sup>38</sup>; Sascha Ellington, PhD<sup>38</sup>; Katherine Adams, MPH<sup>38</sup>; Mark W. Tenforde, MD, PhD<sup>38</sup>; Clinton R. Paden, PhD<sup>1</sup>; Fatimah S. Dawood, MD<sup>1</sup>; Katherine E. Fleming-Dutra, MD<sup>1</sup>; Diya Surie, MD<sup>1</sup>; Ruth Link-Gelles, PhD<sup>1</sup>; CDC COVID-19 Vaccine Effectiveness Collaborators

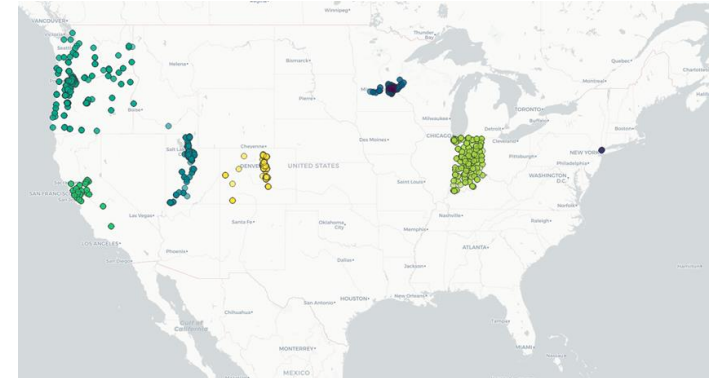
MMWR Morb Mortal Wkly Rep 2024;73:180–188. DOI: <http://dx.doi.org/10.15585/mmwr.mm7308a5>

## Updates to COVID-19 VE against COVID-19-associated ED/UC encounters: *VISION and IVY Networks*

# VISION Multi-Site Network of Electronic Health Records

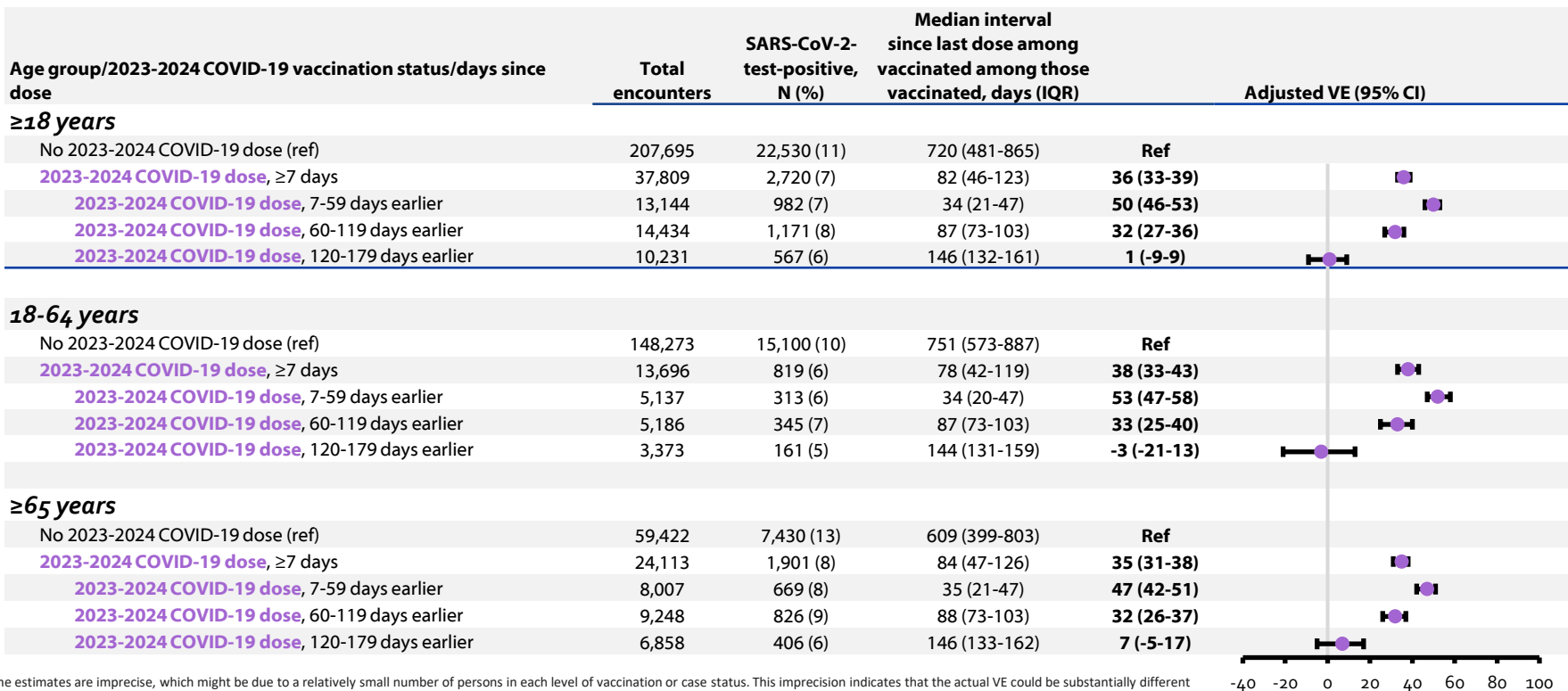
369 emergency rooms and urgent cares/229 hospitals

- **Design:** Test-negative analysis
- **Population:** Adults visiting a participating emergency department or urgent care (ED/UC) or hospitalized with COVID-19-like illness (CLI) with a SARS-CoV-2 NAAT test result within 10 days before or 72 hours after encounter
  - **Cases:** CLI with *positive* NAAT for SARS-CoV-2 and no positive NAAT for RSV or influenza
  - **Controls:** CLI with *negative* NAAT for SARS-CoV-2 and no positive NAAT for influenza
- **Vaccination data:** Documented by electronic health records and state and city registries



# VISION: VE of 2023-2024 COVID-19 vaccine against ED/UC encounters among immunocompetent adults aged ≥18 years, by age group

September 2023 – May 2024



\*Some estimates are imprecise, which might be due to a relatively small number of persons in each level of vaccination or case status. This imprecision indicates that the actual VE could be substantially different from the point estimate shown, and estimates should therefore be interpreted with caution. Additional data accrual could increase precision and allow more precise interpretation.

<https://www.cdc.gov/mmwr/volumes/73/wr/mm7308a5.htm> (Results updated with additional data since publication.) VE was calculated as  $(1 - \text{odds ratio}) \times 100\%$ , estimated using a test-negative case-control design, with the odds ratio adjusted for age, sex, race and ethnicity, geographic region, and calendar time.



# Interim Effectiveness of Updated 2023–2024 (Monovalent XBB.1.5) COVID-19 Vaccines Against COVID-19–Associated Emergency Department and Urgent Care Encounters and Hospitalization Among Immunocompetent Adults Aged ≥18 Years — VISION and IVY Networks, September 2023–January 2024

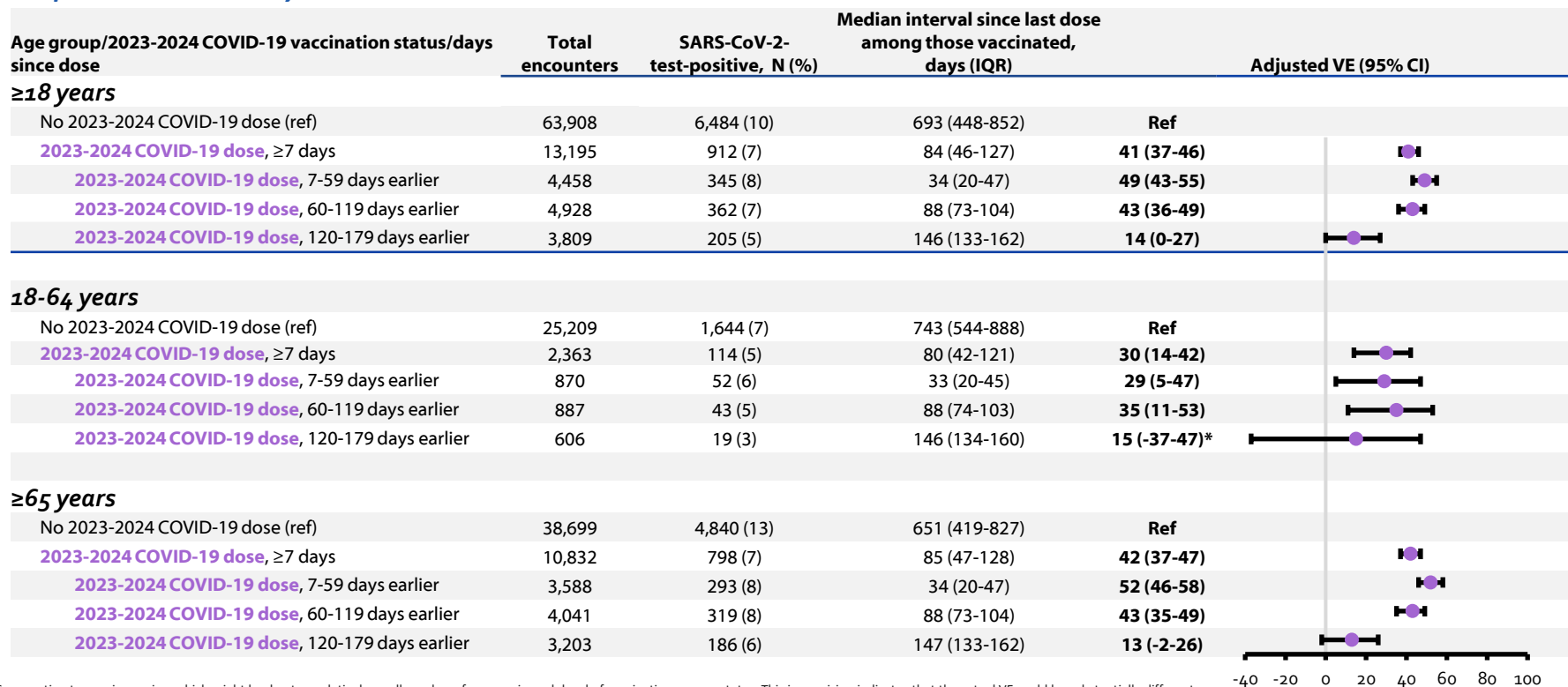
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MMWR Morb Mortal Wkly Rep 2024;73:180–188. DOI: <http://dx.doi.org/10.15585/mmwr.mm7308a5>

## Updates to COVID-19 VE against COVID-19-associated hospitalization and critical illness: *VISION and IVY Networks*

# VISION: VE of 2023-2024 COVID-19 vaccine against *hospitalization* among immunocompetent adults aged ≥18 years, by age group

September 2023 – May 2024

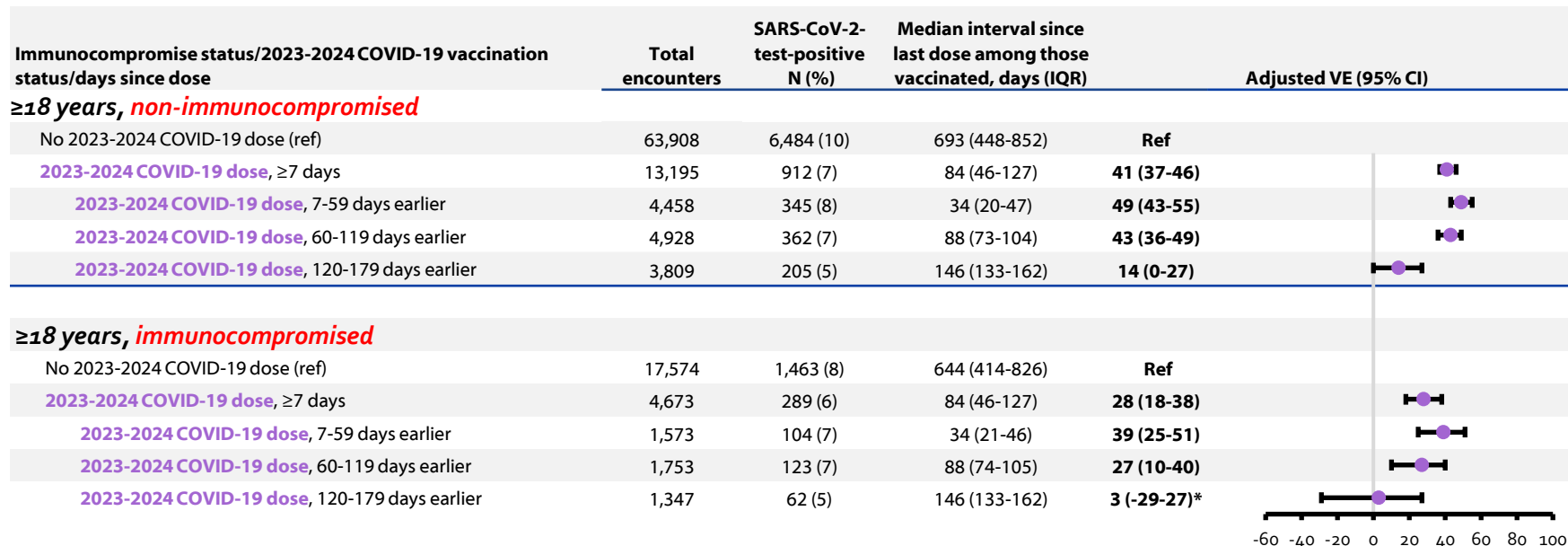


\*Some estimates are imprecise, which might be due to a relatively small number of persons in each level of vaccination or case status. This imprecision indicates that the actual VE could be substantially different from the point estimate shown, and estimates should therefore be interpreted with caution. Additional data accrual could increase precision and allow more precise interpretation.

<https://www.cdc.gov/mmwr/volumes/73/wr/mm7308a5.htm> (Results updated with additional data since publication.) VE was calculated as  $(1 - \text{odds ratio}) \times 100\%$ , estimated using a test-negative case-control design, adjusted for age, sex, race and ethnicity, geographic region, and calendar time.

# VISION: VE of 2023-2024 COVID-19 vaccine against *hospitalization* among adults aged ≥18 years, by immunocompromise status

September 2023 – May 2024

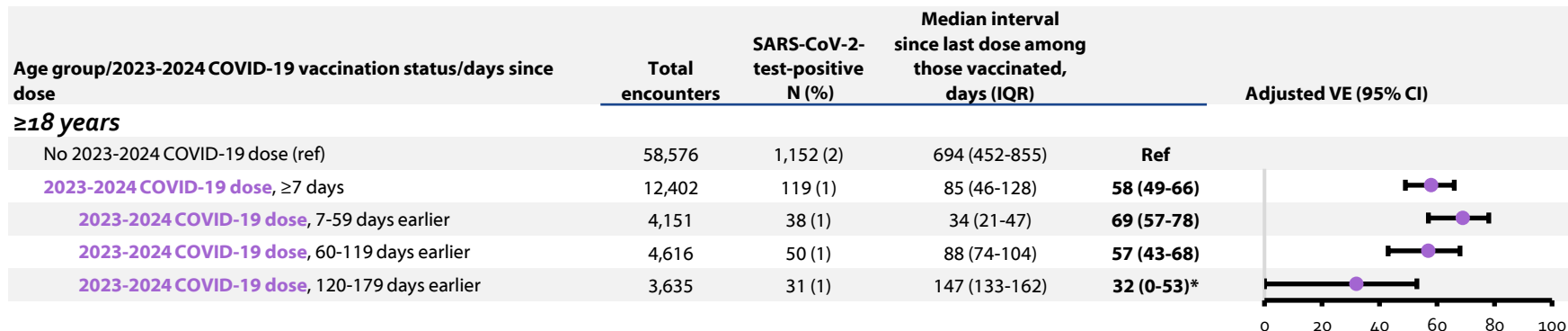


Additional methods, including definition of immunocompromised available: <https://www.cdc.gov/mmwr/volumes/73/wr/mm7308a5.htm> (Results updated with additional data since publication.) VE was calculated as  $(1 - \text{odds ratio}) \times 100\%$ , estimated using a test-negative case-control design, adjusted for age, sex, race and ethnicity, geographic region, and calendar time.

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# VISION: VE of 2023-2024 COVID-19 vaccine against *critical illness* among immunocompetent adults aged ≥18 years, by age group

September 2023 – May 2024

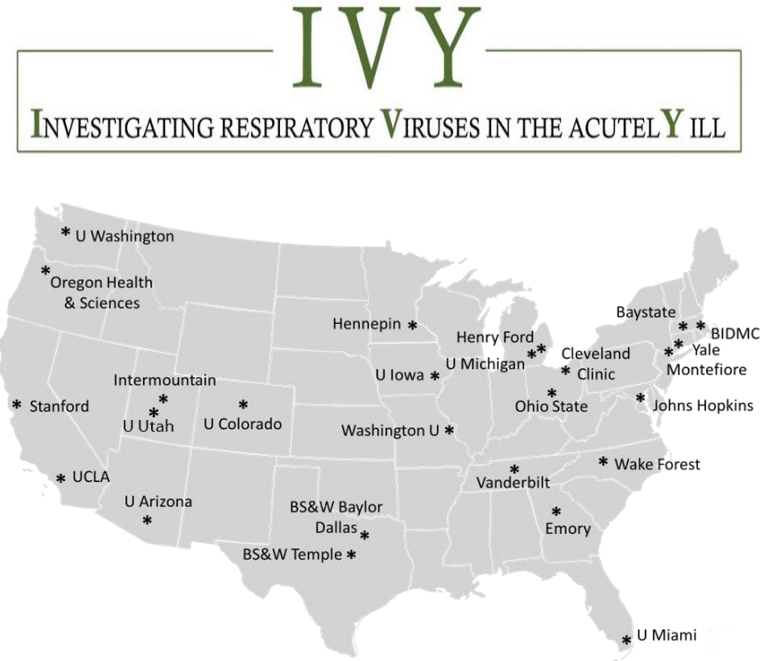


CDC unpublished data. Critical illness defined as admission to an intensive care unit (ICU) or death while hospitalized or ≤28 days after hospital admission. VE was calculated as  $(1 - \text{odds ratio}) \times 100\%$ , estimated using a test-negative case-control design, adjusted for age, sex, race and ethnicity, geographic region, and calendar time.

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# IVY Network — 26 hospitals, 20 U.S. States

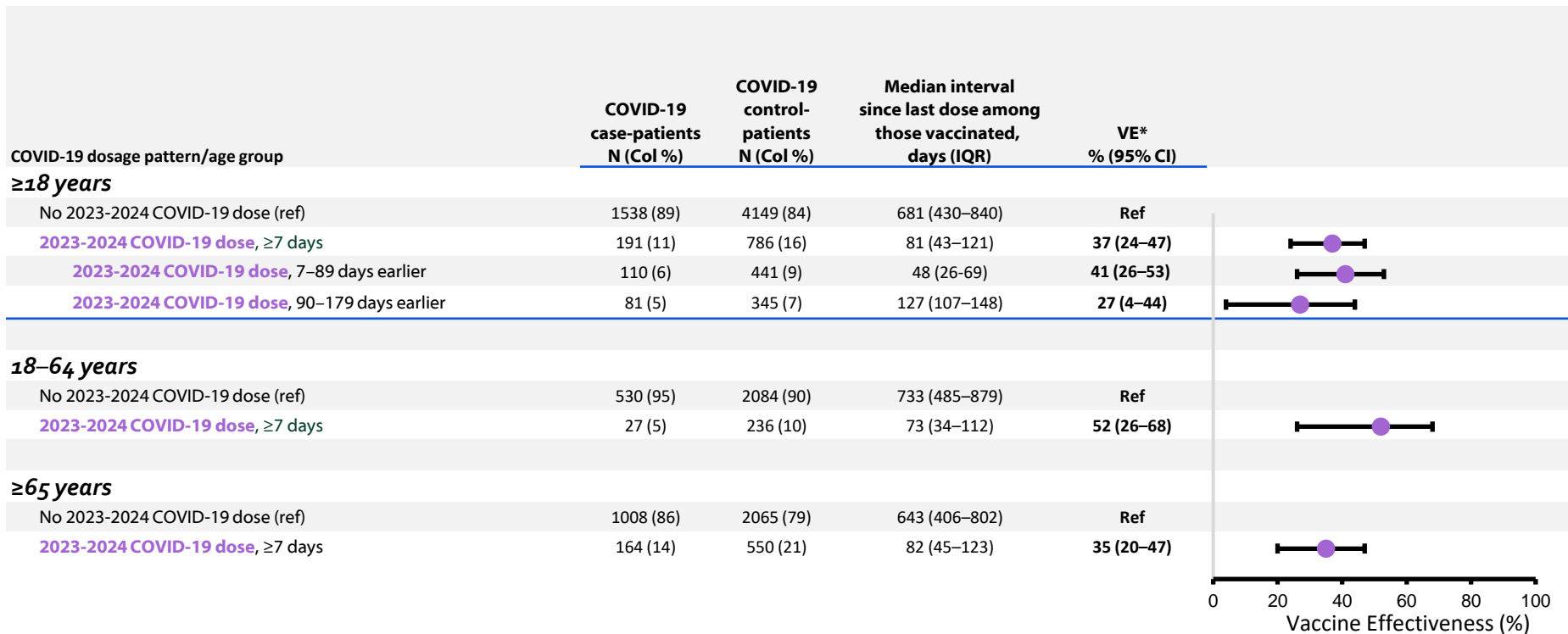
- **Design:** Test-negative, case-control design
- **Population:** Adults aged  $\geq 18$  years hospitalized with COVID-like illness (CLI)\* and SARS-CoV-2 test results within 10 days of illness onset and 3 days of admission
  - **Cases:** CLI and test *positive* for SARS-CoV-2 by NAAT or antigen
    - Co-infections with influenza and RSV are excluded
  - **Controls:** CLI and test *negative* for SARS-CoV-2 and influenza by RT-PCR
- **Vaccination data:** Electronic medical records (EMR), state and city registries, and plausible self-report
- **Specimens:** Nasal swabs obtained on all patients for central RT-PCR testing and whole genome sequencing



\*CLI is defined as presence of any one of the following: fever, cough, shortness of breath, chest imaging consistent with pneumonia, or hypoxemia

# IVY: VE of 2023–2024 vaccine against **hospitalization** among immunocompetent adults aged ≥18 years, by age group and time since dose

September 21, 2023 – April 30, 2024



\*Logistic regression models were adjusted for age, sex, race and ethnicity, geographic region, and calendar time.

# IVY\*: VE of 2023–2024 vaccine against *hospitalization* among adults aged ≥18 years *by SARS-CoV-2 lineage* using viral whole-genome sequencing

- **Population**
  - **Cases:** COVID-like illness (CLI) and test *positive* for SARS-CoV-2<sup>†</sup>; **restricted to patients with sequence-confirmed<sup>§</sup> JN lineage (BA.2.86 and its descendants) infection or XBB lineage (all other co-circulating lineages) infections**
  - **Controls:** CLI and test *negative* for SARS-CoV-2 and influenza viruses by RT-PCR
- **Analytic Period:** October 18, 2023–March 9, 2024
  - First date on which a patient was admitted with sequence-confirmed JN lineage infection
  - Last week during which a patient was admitted with sequence-confirmed XBB lineage infection
- VE<sup>¶</sup> against hospitalization was calculated separately using case-patients with sequence-confirmed SARS-CoV-2 JN and XBB lineage infections

\* Investigating Respiratory Viruses in the Acutely Ill (IVY) Network. <https://www.cdc.gov/flu/vaccines-work/ivy.htm>

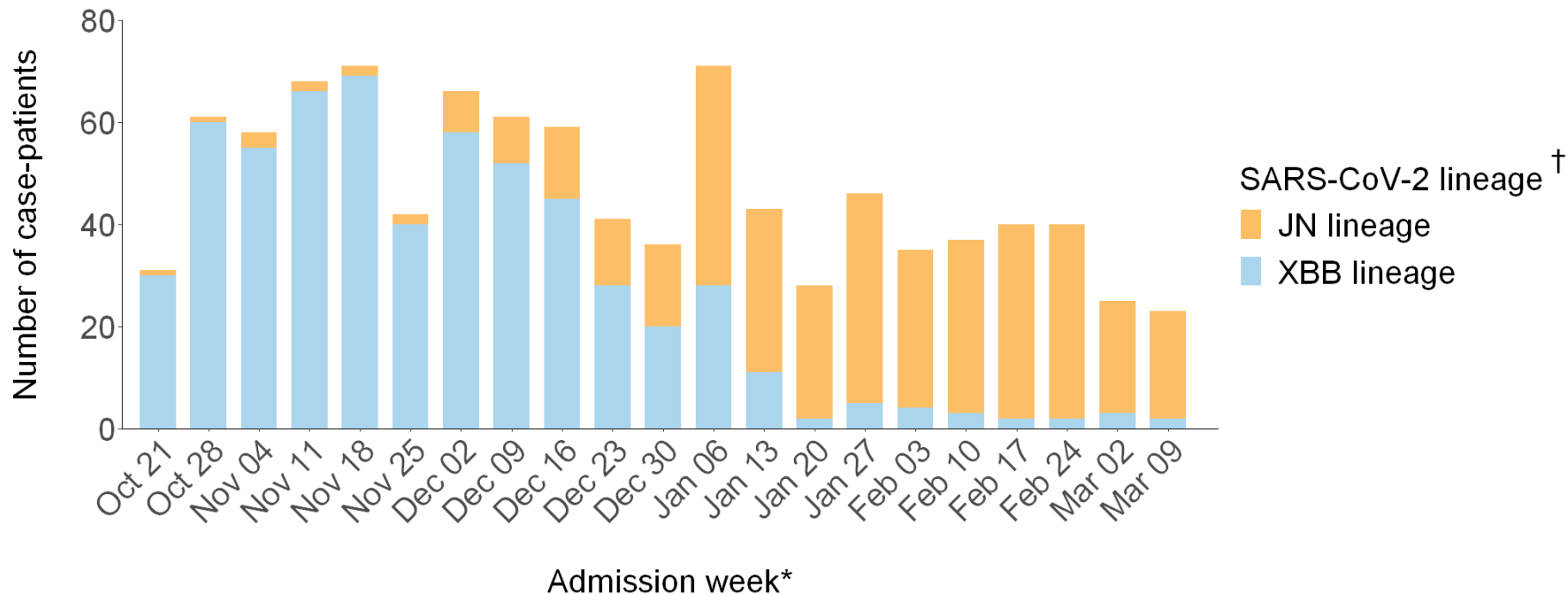
† Case patients who tested positive for influenza viruses or RSV were excluded.

§ Identification of a SARS-CoV-2 lineage through viral whole-genome sequencing was successful for 63% of case-patients during the analysis period.

¶ Odds ratios were adjusted for age, sex, race and ethnicity, geographic region, calendar time, and Charlson comorbidity index.

# IVY: Number of COVID-19 case-patients by hospital admission week and SARS-CoV-2 lineage

October 18, 2023 – March 9, 2024



\* Dates are for the end of the admission week.

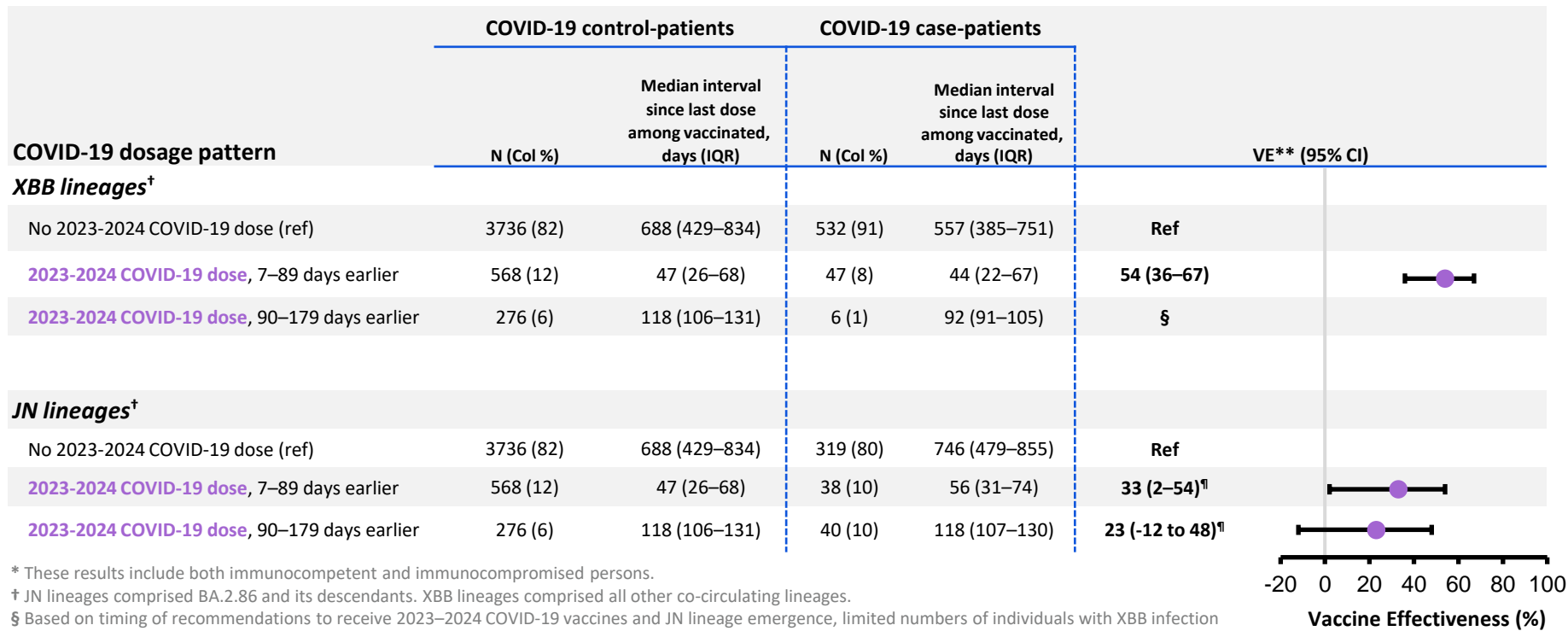
† JN lineages comprised BA.2.86 and its descendants. XBB lineages comprised all other co-circulating lineages.

Identification of a SARS-CoV-2 lineage through viral whole-genome sequencing was successful for 63% of case-patients during the analysis period.



# IVY: VE of 2023–2024 COVID-19 vaccine against **hospitalization** among adults aged ≥18 years\*, by SARS-CoV-2 lineage and time since dose

October 18, 2023 – March 9, 2024



\* These results include both immunocompetent and immunocompromised persons.

† JN lineages comprised BA.2.86 and its descendants. XBB lineages comprised all other co-circulating lineages.

§ Based on timing of recommendations to receive 2023–2024 COVID-19 vaccines and JN lineage emergence, limited numbers of individuals with XBB infection were 90–179 days from their updated dose, precluding estimation of VE within this stratum.

¶ Some estimates are imprecise, which might be due to a relatively small number of persons in each level of vaccination or case status. This imprecision indicates that the actual VE could be substantially different from the point estimate shown, and estimates should therefore be interpreted with caution.

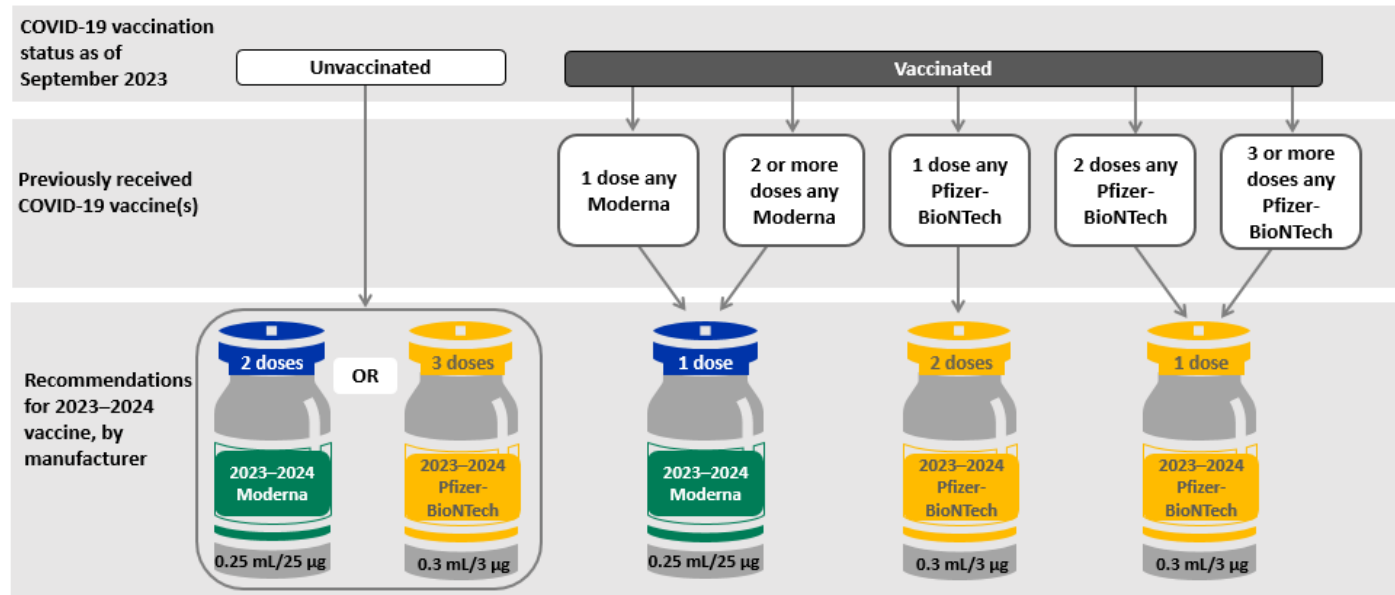
\*\* VE estimates adjusted for age, sex, race and ethnicity, geographic region, calendar time, and Charlson comorbidity index.

CDC unpublished data.

# COVID-19 VE in young children and by age group

# Reminder: children aged 6 months-4 years continue to be recommended for a complete initial series

**Recommended 2023–2024 COVID-19 mRNA vaccines for people who are NOT immunocompromised, aged 6 months–4 years\***



\*For information about administration intervals and people who transition from age 4 years to age 5 years during an mRNA vaccination series, see Table 1 in the Interim Clinical Considerations for Use of COVID-19 vaccines.

# VISION: VE of 2023–2024 COVID-19 vaccine doses against ED/UC encounters was similar across age groups

September 2023 – May 2024

| Age group   COVID-19 vaccination status              | Total encounters | SARS-CoV-2-test-positive, N (%) | Median interval since last dose among those vaccinated, days (IQR) | Adjusted VE (95% CI) |  |
|--|------------------|---------------------------------|--|----------------------|--|
| No updated 2023-2024 COVID-19 vaccine dose*          |                  |                                 |  |                      |  |
| 9 months-4 years                                     | 30,286           | 1,180 (4)                       | 349 (236-443)  | Ref                  |  |
| 5-17 years   | 37,203           | 1,449 (4)                       | 650 (449-769)  | Ref                  |  |
| 18-64 years  | 148,273          | 15,100 (10)                     | 751 (573-887)  | Ref                  |  |
| ≥65 years  | 59,422           | 7,430 (13)                      | 609 (399-803)  | Ref                  |  |
| 2023-2024 COVID-19 dose received 7-59 days earlier   |                  |                                 |  |                      |  |
| 9 months-4 years                                     | 613              | 10 (2)                          | 33 (19-46)   | 66 (36-82)           |  |
| 5-17 years   | 805              | 11 (1)                          | 33 (19-47)   | 71 (47-84)           |  |
| 18-64 years  | 5,137            | 313 (6)                         | 34 (20-47)   | 53 (47-58)           |  |
| ≥65 years  | 8,007            | 669 (8)                         | 35 (21-47)   | 47 (42-51)           |  |
| 2023-2024 COVID-19 dose received 60-179 days earlier |                  |                                 |  |                      |  |
| 9 months-4 years                                     | 706              | 14 (2)                          | 104 (80-137)   | 24 (-31-56)**        |  |
| 5-17 years   | 1,343            | 22 (2)                          | 111 (86-138)   | 50 (22-68)           |  |
| 18-64 years  | 8,559            | 506 (6)                         | 108 (82-137)   | 24 (17-31)           |  |
| ≥65 years  | 16,106           | 1,232 (8)                       | 111 (84-142)   | 25 (20-30)           |  |

-80 -60 -40 -20 0 20 40 60 80 100

-80 -60 -40 -20 0 20 40 60 80 100

\* Includes all individuals who did not receive a 2023-2024 COVID-19 vaccine. For those aged ≥5 years, this includes unvaccinated persons and persons who were vaccinated with ≥1 original monovalent or bivalent COVID-19 doses. For those aged <5 years, both those in the referent group and those in the vaccinated group were required to have completed an initial series. The 2023-2024 dose could have been part of the initial series or in addition to the initial series.

\*\* Some estimates are imprecise, which might be due to a relatively small number of persons in each level of vaccination or case status. This imprecision indicates that the actual VE could be substantially different from the point estimate shown, and estimates should therefore be interpreted with caution. Additional data accrual could increase precision and allow more precise interpretation.

# Conclusions

- 2023-2024 COVID-19 vaccination provided increased protection against symptomatic SARS-CoV-2 infection and COVID-19-associated ED/UC visits and hospitalizations compared to no 2023-2024 vaccine dose.
- Waning patterns appeared similar to previous COVID-19 vaccine formulations; most durable protection appeared to be for critical illness, though statistical power was lacking in the longest time period since vaccination
- As with previous COVID-19 vaccine formulations, effectiveness was similar across age groups
- Receipt of 2023-2024 COVID-19 vaccine provided protection against JN.1 and other circulating variants, though may be lower than protection provided against XBB sublineage variants

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