On January 25, 2022 this report was posted as an MMWR Early Release on the MMWR website (https://www.cdc.gov/mmwr).

The B.1.1.529 (Omicron) variant of SARS-CoV-2, the virus that causes COVID-19, was first clinically identified in the United States on December 1, 2021, and spread rapidly. By late December, it became the predominant strain, and by January 15, 2022, it represented 99.5% of sequenced specimens in the United States (1). The Omicron variant has been shown to be more transmissible and less virulent than previously circulating variants (2,3). To better understand the severity of disease and health care utilization associated with the emergence of the Omicron variant in the United States, CDC examined data from three surveillance systems and a large health care database to assess multiple indicators across three high—COVID-19 transmission periods: December 1, 2020—February 28, 2021 (winter 2020–21); July 15–October 31, 2021 (SARS-CoV-2 B.1.617.2 [Delta] predominance); and December 19, 2021—January 15, 2022 (Omicron predominance). The highest daily 7-day moving average to date of cases (798,976 daily cases during January 9–15, 2022), emergency department (ED) visits (48,238), and admissions (21,586) were reported during the Omicron period, however, the highest daily 7-day moving average of deaths (1,854) was lower than during previous periods. COVID-19 disease severity appears to be lower during the Omicron period than during previous periods of high transmission, likely related to higher vaccination coverage (4), lower virulence of the Omicron variant (3,5,6), and infection-acquired immunity (3,7). Although disease severity appears lower with the Omicron variant, the high volume of ED visits and hospitalizations can strain local health care systems in the United States, and the average daily number of deaths remains substantial (5). This underscores the importance of national emergency preparedness, specifically, hospital surge capacity and the ability to adequately staff local health care systems. In addition, being up to date on vaccination and following other recommended prevention strategies are critical to preventing infections, severe illness, or death from COVID-19.

CDC used data from three surveillance systems to assess U.S. disease related to COVID-19 during December 1, 2020—January 15, 2022. COVID-19 aggregate cases and deaths reported to CDC by state and territorial health departments were tabulated by report date.** ED visits with COVID-19 diagnosis codes were obtained from the National Syndromic Surveillance System (Surveillance Network, National Syndromic Surveillance System).† The proportion of deaths due to COVID-19 is lower during the Omicron period than during previous time periods: 3.4 and 7.2 percentage points higher than during the winter 2020–21 (92, 68, and 16 respectively) and Delta (167, 78, and 13, respectively) periods. Further, among hospitalized COVID-19 patients from 199 U.S. hospitals, the mean length of stay and percentages who were admitted to an ICU, received invasive mechanical ventilation (IMV), and died while in the hospital were lower during the Omicron period than during previous periods. COVID-19 disease severity appears to be lower during the Omicron period than during previous periods of high transmission, likely related to higher vaccination coverage (4), lower virulence of the Omicron variant (3,5,6), and infection-acquired immunity (3,7). Although disease severity appears lower with the Omicron variant, the high volume of ED visits and hospitalizations can strain local health care systems in the United States, and the average daily number of deaths remains substantial (5). This underscores the importance of national emergency preparedness, specifically, hospital surge capacity and the ability to adequately staff local health care systems. In addition, being up to date on vaccination and following other recommended prevention strategies are critical to preventing infections, severe illness, or death from COVID-19.

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* Predominance defined as >50% of specimens sequenced. Proportion that was Omicron variant during the week ending December 18: 39.4%; December 25: 71.6%; January 1: 92.3%; January 8: 98.3%; and January 15: 99.5%. https://covid.cdc.gov/covid-data-tracker/#variant-proportions

** Date of report is used for consistency because most jurisdictions are not reporting case by onset or test date. The same applies to deaths, where there might be an even larger lag between date of death and date of report of death.

† https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total (Accessed January 15, 2022).

§ https://covid.cdc.gov/covid-data-tracker/#trends_dailydeaths (Accessed January 15, 2022).

¶ CDC official counts of COVID-19 cases and deaths, released daily (https://covid.cdc.gov/covid-data-tracker), are aggregate counts from reporting jurisdictions. A COVID-19 case is defined by detection of SARS-CoV-2 RNA or antigen in a respiratory specimen collected from a person with a confirmed or probable case of COVID-19 according to the Council of State and Territorial Epidemiologists’ updated case definition. https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/ps2021/21-ID-01_COVID-19.pdf

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Surveillance Program (NSSP). Hospital admissions and inpatient and ICU bed use among patients with laboratory-confirmed COVID-19 were obtained from the Unified Hospital Data Surveillance System. ED visits and hospital admissions were tabulated by admission date and stratified by the following age groups: 0–17, 18–49, and ≥50 years.

The maximum 7-day moving averages of the daily number of COVID-19 cases, ED visits, hospital admissions, and deaths during the Omicron period were compared with the peak 7-day moving averages for the winter 2020–21 and Delta periods. The maximum percentages of inpatient and ICU bed use overall and by COVID-19 patients were compared between periods. For each period analyzed, ratios of ED visits, hospital admissions, and deaths per 1,000 COVID-19 cases were calculated.

CDC used the BD Insights Research Database (BD), a U.S. health care facility database, to assess hospitalized COVID-19 patients as a percentage of total hospital admissions: the percentage of hospitalized COVID-19 patients who were admitted to an ICU, received IMV, or died while in the hospital; and the mean and median length of hospital stay. Indicators were tabulated based on discharge date and stratified by age group: 0–17, 18–50, and ≥50 years. Three-week windows were analyzed during each period to stabilize estimates. Statistical differences between the Omicron and winter 2020–21 and Delta periods were assessed using z-tests for proportions and t-tests for mean length of stay; statistical significance criterion was p<0.05.

Analyses were carried out in Python (version 3.8.6, Python Software Foundation) and Kotlin (version 1.4, Kotlin Foundation). This activity was reviewed by CDC and conducted consistent with applicable federal law and CDC policy.

The daily 7-day moving average of COVID-19 cases, ED visits, and hospital admissions rapidly increased during the Omicron period (Figure). However, during the week ending January 15, 2022, ED visits appeared to be decreasing and the rapid increase in cases and hospital admissions appeared to be slowing. As of January 15, 2022, the maximum daily 7-day moving average number of cases (798,976), ED visits (48,238), admissions (21,586), and deaths (1,854) observed during the Omicron period reflects changes of 219%, 137%, 31%, and 31%.

Hospitalized COVID-19 patients were identified by the presence of a positive SARS-CoV-2 polymerase chain reaction or antigen test result during the 14 days before or 14 days after date of admission; 43% of all admissions did not have a SARS-CoV-2 test result available (January 2021–January 2022). To identify patients admitted to an ICU, care settings were classified using the CDC National Healthcare Safety Network classification and then further classified as ICU (critical care) or non-ICU (inpatient adult wards, specialty care areas, and step-down wards); https://academic.oup.com/ofid/article/5/10/ofy241/5104818. Because of lack of timely device data to identify ventilator use, the following surrogate definition for IMV use was used: a) the patient was started on intravenous/intravenous push (IV/IP) sedation medications (propofol, lorazepam, midazolam, dexmedetomidine, or ketamine) or IV/IP opioids (fentanyl, remifentanil, sufentanil, or hydromorphone) with a duration ≥24 hours, and b) at least two arterial blood gas results were collected at least 24 hours apart (on the first day of sedation medication and a subsequent result 24 hours later) (https://academic.oup.com/ofid/article/8/6/ofab232/6285220). In-hospital death was defined by a designation of death, mortality, or presence in morgue in the admission, discharge, and transfer data feeds. A validity check of this method had been previously performed by randomly selecting 50 mortality cases and evaluating encounter-level data for clinical signs of mortality (e.g., uncorrected severe metabolic acidosis determined by pH from arterial blood gases and uncorrected electrolyte changes incompatible with life).
−46%, respectively, compared with those during the winter 2020–21 period, and 386%, 86%, 76%, and −4%, respectively, compared with those during the Delta period (Table 1). The largest relative differences in ED visits and admissions were observed among children and adolescents aged 0–17 years during the Omicron period; however, this age group represented only 14.5% of COVID-19 ED visits and 4.2% of COVID-19 admissions. During the Omicron period, a maximum of 20.6% of staffed inpatient beds were in use for COVID-19 patients, 3.4 and 7.2 percentage points higher than during the winter 2020–21 and Delta periods, respectively. However, ICU bed use did not increase to the same degree: 30.4% of staffed ICU beds were in use for COVID-19 patients during the Omicron period, 0.5 percentage points lower than during the winter 2020–21 period and 1.2 percentage points higher than during the Delta period. When comparing the indicators at their peaks during the Omicron period, event-to-case ratios for ED visits (87 visits per 1,000 cases), hospitalizations (27 hospitalizations per 1,000 cases), and deaths (nine deaths per 1,000 cases [lagged by 3 weeks]) were lower than those observed during the peak winter 2020–21 (92, 68, and 16, respectively) and Delta (167, 78, and 13, respectively) periods (Supplementary Figure, https://stacks.cdc.gov/view/cdc/113628).

In BD, hospitalized COVID-19 patients represented 12.0%, 9.4%, and 12.9% of all admissions during the winter 2020–21, Delta, and Omicron periods, respectively. Disease severity among hospitalized COVID-19 patients was associated with increasing age; IMV and in-hospital deaths were rare among patients aged 0–17 years, therefore, differences between periods were not assessed. The percentage of hospitalized COVID-19 patients admitted to an ICU during Omicron (13.0%) was 28.8% lower than during the winter 2020–21 (18.2%) and 25.9% lower than during Delta (17.5%) periods overall, and for all three age groups (p<0.05) (Table 2). The percentage of hospitalized COVID-19 patients who received IMV (3.5%) or died while in the hospital (7.1%) during Omicron was lower than during the winter 2020–21 (IMV = 7.5%; deaths = 12.9%) and Delta (IMV = 6.6%; deaths = 12.3%) periods overall, and for both adult age groups (p<0.001). Mean length of hospital stay during Omicron (5.5 days) was 31.0% lower than during the winter 2020–21 (8.0 days) and 26.8% lower than during Delta (7.6 days) periods overall, and for both adult age groups (p<0.001).

**Discussion**

Emergence of the Omicron variant in December 2021 led to a substantial increase in COVID-19 cases in the United States. Although the rapid rise in cases has resulted in the highest number of COVID-19–associated ED visits and hospital admissions since the beginning of the pandemic, straining the health care system, disease severity appears to be lower than compared with previous high disease-transmission periods. In addition to...
The table presents data comparing the COVID-19 disease, hospital, and death indicators during the Omicron period (Dec 19, 2021–Jan 15, 2022) with the Delta period (Aug 1–Sep 30, 2021). The data are from the United States, December 2020–January 2022.

### Indicator/Age group, yrs

| Indicator/Age group, yrs | Winter 2020–21 period | Delta period | Omicron period | Comparison of Omicron with winter 2020–21 period | Comparison of Omicron with Delta period |
|-------------------------|-----------------------|--------------|----------------|-----------------------------------------------|---------------------------------------|
| Date of maximum assessed value | Peak value (7-day moving average) | Peak value (7-day moving average) | Date of maximum assessed value | Maximum value | Number or percentage point difference | Relative % difference | Number or percentage point difference | Relative % difference |
| Disease (cases, ED visits) | | | | | | | | |
| COVID-19 cases, N | Jan 4–11, 2021 | Aug 25–Sep 1, 2021 | Jan 15, 2022 | 798,976 | 548,641 | 219.2 | 634,727 | 386.4 |
| COVID-19 ED visits, by age group, N (% of total) | Dec 29, 2020–Jan 5, 2021 | Aug 19–26, 2021 | Jan 4, 2022 | 48,238 | 27,866 | 136.8 | 22,365 | 86.4 |
| 0–17 | 901 (4.4) | 3,177 (12.3) | 6,990 (14.5) | 6,089 (10.1) | 676.1 | 3,813 (2.2) | 120.0 |
| 18–49 | 6,872 (33.7) | 11,853 (45.8) | 23,372 (48.5) | 16,500 (14.7) | 240.1 | 11,519 (2.6) | 97.2 |
| ≥50 | 12,406 (60.9) | 10,546 (40.8) | 17,471 (36.2) | 5,066 (−24.7) | 40.8 | 6,926 (−4.5) | 65.7 |
| Hospital (admissions) | Jan 2–9, 2021 | Aug 20–27, 2021 | Jan 15, 2022 | 21,586 | 5,089 | 30.8 | 9,301 | 75.7 |
| COVID-19 admissions, by age group, N (% of total) | Jan 4–11, 2021 | Aug 28–Sep 4, 2021 | Jan 15, 2022 | 142,687 | 17,587 | 14.1 | 48,184 | 51.0 |
| 0–17 | 207 (1.3) | 319 (2.6) | 914 (4.2) | 707 (3.0) | 341.9 | 595 (1.6) | 186.5 |
| 18–49 | 2,761 (16.7) | 3,559 (29.0) | 5,218 (24.2) | 2,457 (7.4) | 89.0 | 1,659 (−4.8) | 46.6 |
| ≥50 | 12,840 (77.8) | 7,828 (63.7) | 14,778 (68.4) | 1,933 (−9.4) | 15.1 | 6,945 (4.7) | 88.7 |
| Inpatient beds in use for COVID-19, N | Jan 4–11, 2021 | Aug 28–Sep 4, 2021 | Jan 15, 2022 | 142,687 | 17,587 | 14.1 | 48,184 | 51.0 |
| Staffed beds in use for COVID-19, % | 17.2 | 13.4 | 20.6 | 3.4 | 20.0 | 7.2 | 53.7 |
| Staffed beds in use for ICU, % | 74.1 | 76.8 | 79.2 | 5.1 | 6.9 | 2.4 | 3.1 |
| ICU beds in use for COVID-19, N | Jan 9–16, 2021 | Sep 6–13, 2021 | Jan 15, 2022 | 24,774 | 24,776 | 0.0 | 6,990 | 14.5 |
| Inpatient ICU beds in use for COVID-19, % | 30.9 | 30.4 | 30.4 | −0.5 | −1.7 | 1.2 | 4.2 |
| Staffed ICU beds in use, % | 78.2 | 79.6 | 82.2 | 4.0 | 5.1 | 2.6 | 3.2 |

**Sources:** CDC state-reported data (case and death totals), CDC case line-level data (cases by age), Unified Hospital data set (hospital admissions, inpatient, and ICU), and National Syndromic Surveillance Program (ED visits with COVID-19 discharge diagnoses).

**Abbreviations:** ED = emergency department; ICU = intensive care unit; N = no. of hospital admissions.

* COVID-19 hospital admissions include admissions for COVID-19 as well as patients who receive a positive test result for COVID-19 after being admitted for other reasons. National Syndromic Surveillance Program data are not inclusive of all ED visits, representing approximately 71% of all visits. The peak value and associated date are calculated independently for each indicator as the highest 7-day moving average value during Dec 1, 2020–Jan 31, 2021 (winter 2020–21 period), Aug 1–Sep 30, 2021 (Delta period), or Dec 19, 2021–Jan 15, 2022 (Omicron period). The date and value of peaks might change slightly if data are backfilled.

**†** Data were pulled on January 20, 2022.

**§** Comparison of Omicron with winter 2020–21 period is presented for the percentage of ED visits and hospital admissions by age groups and for the percentages of inpatient and ICU beds in use for COVID-19 patients.

**¶** Relative percent difference is calculated as the value for cases, ED visits, hospital admissions, inpatient bed use, ICU bed use, and deaths from the Omicron period minus the same indicator value from the comparison period (winter 2020–21 or Delta period) divided by the same indicator value from the comparison period.
TABLE 2. Total hospitalizations, hospitalized COVID-19 patients, and indicators of disease severity among hospitalized COVID-19 patients during the Omicron period compared with the winter 2020–21 and Delta periods,* by age group, 199 hospitals—United States, January 2021–January 2022

| Indicator/ Age group, yrs | Winter 2020–21 period | Delta period | Omicron period | Comparison of Omicron with winter 2020–21 period | Comparison of Omicron with Delta period |
|--------------------------|------------------------|--------------|----------------|-----------------------------------------------|---------------------------------------|
|                          | Jan 1–21, 2021         | Aug 22–Sep 11, 2021 | Dec 26, 2021–Jan 15, 2022 | | |
| Total hospitalizations   |                        |              |                | Percentage point or mean difference | Relative % difference | Percentage point or mean difference | Relative % difference |
| All                      | 108,360                | 110,950      | 98,920         | –1.0 † | 8.2 | 3.5 † | 37.5 |
| 0–17                     | 11,504                 | 13,946       | 11,517         | –20.3 | 3.2 | NC | |
| 18–50                    | 31,070                 | 34,537       | 28,040         | –26.8 | –23.3 | 1.6 † | 80.3 |
| >50                      | 65,786                 | 62,467       | 59,363         | –24.5 | –22.0 | 3.2 † | 28.9 |
| Hospitalized COVID-19 patients as a percentage of total hospitalizations | 12,963 (12.0) | 10,440 (9.4) | 12,800 (12.9) | −1.0 † | 8.2 | 3.5 † | 37.5 |
| 0–17                     | 147 (1.3)              | 272 (2.0)    | 405 (3.5)      | 2.2 † | 175.2 | 1.6 † | 80.3 |
| 18–50                    | 2,474 (8.0)            | 3,304 (9.6)  | 3,988 (14.2)   | 2.3 † | 78.6 | 4.7 † | 48.7 |
| >50                      | 10,342 (15.7)          | 6,864 (11.0) | 8,407 (14.2)   | –1.6 † | –9.9 | 3.2 † | 28.9 |
| ICU admission among hospitalized COVID-19 patients | 2,359 (18.2) | 1,824 (17.5) | 1,658 (13.0) | –5.2 † | –28.8 | –4.5 † | –25.9 |
| 0–17                     | 175 (7.0)              | 86 (4.8)     | 62 (4.0)       | –6.6 † | –39.0 | –8.0 † | –43.6 |
| 18–50                    | 346 (14.0)             | 438 (13.3)   | 377 (9.5)      | –4.5 † | –32.4 | –3.8 † | –28.7 |
| >50                      | 1,989 (19.2)           | 1,336 (19.5) | 1,239 (14.7)   | –4.5 † | –23.3 | –4.7 † | –24.3 |
| IMV among hospitalized COVID-19 patients§ | 764 (7.5) | 503 (6.6) | 358 (3.5) | –4.0 † | –53.4 | –3.1 † | –46.5 |
| 0–17                     | 1 (0.8)                | 1 (0.4)      | 0 (—)          | –—   | NC | NC | NC |
| 18–50                    | 122 (6.2)              | 118 (4.9)    | 73 (2.3)       | –3.9 † | –63.2 | –2.6 † | –53.2 |
| >50                      | 641 (8.0)              | 384 (7.7)    | 285 (4.3)      | –3.7 † | –46.2 | –3.4 † | –44.3 |
| In-hospital death among hospitalized COVID-19 patients** | 976 (12.9) | 803 (12.3) | 533 (7.1) | –5.8 † | –44.9 | –5.2 † | –42.3 |
| 0–17                     | 1 (1.0)                | 0 (—)        | 0 (—)          | –—   | NC | NC | NC |
| 18–50                    | 57 (4.0)               | 110 (5.4)    | 38 (1.7)       | –2.3 † | –58.3 | –3.7 † | –69.2 |
| >50                      | 918 (15.2)             | 693 (16.0)   | 495 (10.0)     | –5.2 † | –34.2 | –6.0 † | –37.5 |
| Length of stay among hospitalized COVID-19 patients, by age group, yrs | | | | | |
| Median                   | 5                      | 5            | 3              | —     | — | — | — |
| 0–17                     | 2                      | 2            | 2              | —     | — | — | — |
| 18–50                    | 3                      | 4            | 2              | —     | — | — | — |
| >50                      | 5                      | 6            | 4              | —     | — | — | — |
| Mean (SD)                | 8.0 (15.6)             | 7.6 (10.6)   | 5.5 (13.1)     | –2.5 † | –31.0 | –2.0 † | –26.8 |
| 0–17                     | 4.4 (10.1)             | 3.9 (5.3)    | 3.5 (9.7)      | –0.9  | –20.3 | –0.4  | –9.5 |
| 18–50                    | 5.8 (7.8)              | 6.1 (6.9)    | 4.3 (7.4)      | –1.5 † | –25.6 | –1.8 † | –29.9 |
| >50                      | 8.6 (17.0)             | 8.4 (12.0)   | 6.2 (15.1)     | –2.4 † | –27.7 | –2.2 † | –25.8 |

Source: BD Insights Research Database.

Abbreviations: ICU = intensive care unit; IMV = invasive mechanical ventilation; NC = not calculated.

* The winter period was defined as January 1–21, 2021, the Delta period was defined as August 22–September 11, 2021, and the Omicron period was defined as December 26, 2021–January 15, 2022 for BD analysis.

† p<0.001.

§ Data on IMV were available from a subset of 135 hospitals. The denominators of hospitalized COVID-19 patients for IMV percentages were as follows for each period and age group: winter 2020–21 (0–17 years [132]; 18–50 years [1,964]; and >50 years [8,039]); Delta (0–17 years [258]; 18–50 years [2,415]; and >50 years [4,988]); and Omicron (0–17 years [355]; 18–50 years [3,189]; and >50 years [6,646]).

¶ Data on in-hospital deaths were available from a subset of 148 hospitals. The denominators of hospitalized COVID-19 patients for in-hospital death percentages were as follows for each period and age group: winter 2020–21 (0–17 years [87]; 18–50 years [1,437]; and >50 years [6,048]); Delta (0–17 years [142]; 18–50 years [2,415]; and >50 years [4,988]); and Omicron (0–17 years [355]; 18–50 years [3,189]; and >50 years [6,646]).

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These findings are consistent with reports from South Africa (2), England (10), and Scotland, as well as from health

[¶¶¶¶](https://www.pure.ed.ac.uk/ws/portalfiles/portal/245818096/Severity_of_Omicron_variant_of_concern_and_vaccin%20e_effectiveness_against_symptomatic_disease.pdf#%2012)

with 1.6 million persons during the Delta period; boosters were not available during winter 2020–21 (8). Other key factors for lower disease severity include infection-acquired immunity (3,7), and potential lower virulence of the Omicron variant (3,5,6).
systems in California (3) and Texas,**** where the Omicron variant was not associated with an increase in hospital or disease severity indicators among patients with Omicron infections compared with those with Delta infections. Death and in-hospital severity indicators, including in the context of vaccination status, should continue to be monitored for changes or differential effects among subpopulations throughout the Omicron period.

Among children aged <18 years, in-hospital severity indicators, including length of stay and ICU admission, were similar to and lower, respectively, during the Omicron period compared with those during previous high-transmission periods. However, high relative increases in ED visits and hospitalizations were observed among children during the Omicron period, which might be related to lower vaccination rates in children compared with those in adults, especially among children aged 0–4 years who are currently not eligible for vaccination. Children's susceptibility to the Omicron variant and the impact of changes in exposure on severity risk require additional study. Among adults aged ≥18 years, all in-hospital severity indicators assessed were lower during the Omicron period, which might be related to increased population immunity against SARS-CoV-2 because of higher vaccination coverage and booster rates and previous infection providing protection (3,4,7,9). Receipt of a third mRNA vaccine dose was found to be highly effective at preventing urgent care encounters, ED visits, and hospital admissions during both Delta and Omicron periods (9). Booster doses were also found to be effective at preventing infection during the early Omicron period, particularly among persons aged ≥50 years (4).

The findings in this report are subject to at least seven limitations. First, BD is not nationally representative and NSSP does not capture all ED visits across the United States; therefore, geographic and demographic differences in disease transmission and severity might bias findings. Second, the variation in vaccination coverage during the three periods assessed was not taken into account when comparing severity indicators. This limitation is most relevant when comparing the Omicron period to the winter 2020–21 period, when vaccines were just becoming available in the United States. Third, person-level vaccination status was not available to compare severity indicators based on being up to date on vaccinations. Fourth, the hospital data do not exclude incidental SARS-CoV-2 infections, which might be higher during the Omicron period because of increased transmissibility of the Omicron variant; inclusion of incidental infections could inflate hospitalization-to-case ratios and have an unknown effect on in-hospital severity indicators. Fifth, changes in testing and reporting behaviors, including the likely increase in self-administered tests, might bias comparisons; specifically, reported case counts during the Omicron period might be biased downward because of self-administered test use compared with counts during other periods.††††† Sixth, co-circulation of the Omicron and Delta variants might affect the magnitude of the severity indicators during the beginning of the Omicron period, particularly for in-hospital severity indicators based on date of hospital discharge. Finally, the findings reflect an ecologic analysis of event-based indicators; findings should not be misinterpreted as person-level indicators (e.g., case-fatality ratios).

Emergence of the Omicron variant has resulted in a rapid increase in COVID-19 cases. Concurrent increases in ED visits and hospital admissions appear to be driven by high case counts and not by increased disease severity following acute infection. Although patients hospitalized during the Omicron period have shorter stays and less frequent ICU admissions, the high volume of hospitalizations resulting from high transmission rates during a short period can strain local health care systems.

Summary
What is already known about this topic?
The SARS-CoV-2 B.1.1.529 (Omicron) variant became predominant in the United States by late December 2021, leading to a surge in COVID-19 cases and associated ED visits and hospitalizations.

What is added by this report?
Despite Omicron seeing the highest reported numbers of COVID-19 cases and hospitalizations during the pandemic, disease severity indicators, including length of stay, ICU admission, and death, were lower than during previous pandemic peaks.

What are the implications for public health practice?
Although disease severity appears lower with the Omicron variant, the high volume of hospitalizations can strain local health care systems and the average daily number of deaths remains substantial. This underscores the importance of national emergency preparedness, specifically, hospital surge capacity and the ability to adequately staff local health care systems. In addition, being up to date on vaccinations and following other recommended prevention strategies are critical to preventing infections, severe illness, or death from COVID-19.

**** https://www.medrxiv.org/content/10.1101/2021.12.30.21268560v2

††††† Case data in this report are based on data reported by states. Some states report both confirmed and probable cases, and some states report only confirmed cases. For states that include probable cases, a case based on antigen test results with symptoms might meet the case definition and be included in the probable case count. However, positive self-administered tests alone (which are also antigen tests) might not be reported to public health authorities, and do not meet the current Council of State and Territorial Epidemiologists’ case definition criteria, and thus, will likely not be included by states in probable case counts reported to CDC.
in the United States, and the average daily number of deaths remains substantial. This underscores the importance of national emergency preparedness, specifically, hospital surge capacity and the ability to adequately staff local health care systems when critical care needs arise and before the system is overwhelmed. Previous studies have identified increased risk for severe outcomes among unvaccinated persons (4,9). Thus, being up to date with COVID-19 vaccinations and following other recommended prevention strategies are critical to prevent infections, severe illness, or death from COVID-19.

Acknowledgments

Jourdan Devies, Abigail Gates, National Syndromic Surveillance Program; Jay Huang, Johns Hopkins University Applied Physics Laboratory; Heather Johnson, Marc Krawiz, Kalvin Yu, Becton, Dickinson and Company.

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All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. Vikas Gupta reports stock option holdings in Becton, Dickinson and Company, his employer. No other potential conflicts of interest were disclosed.

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