New York City Annual Tuberculosis (TB) Summary **2025** | Stop TB

Mission: The New York City (NYC) Health Department aims to prevent the transmission of tuberculosis (TB) and eliminate it as a public health problem in NYC.

Goals

1 Identify all people with suspected or confirmed TB disease and ensure their appropriate treatment, ideally on directly observed therapy.

2 Ensure that people at high risk for progression from latent TB infection (LTBI) to TB disease complete treatment and do not develop disease.

Core Activities

To fulfill its mission and goals, the Health Department collaborates with health care providers, laboratories, community partners, City and state agencies, and others to ensure effective TB care and prevention in NYC through an integrated, dynamic model of core activities and services.

About This Report

This report provides TB surveillance data and summaries of core Health Department TB program activities for calendar year 2025. Unless otherwise noted, these data reflect the most complete information available as of January 21, 2026. For additional details on the use of population data and definitions in this report, see the Technical Notes (Page 39).

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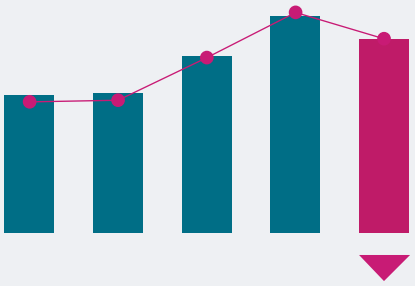
Contents

Tuberculosis in NYC

2025

743 Number of TB cases confirmed

8.4 TB rate per 100,000 people

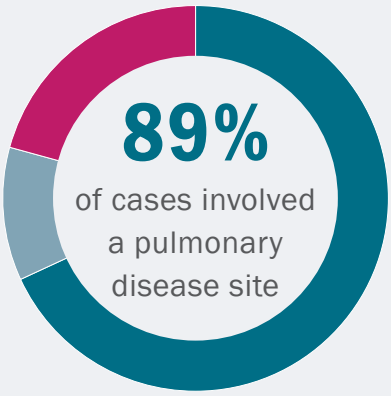


11% Decrease from 2024 to 2025

TB cases by gender identity[1]:

- Man **71%**
- Woman **29%**

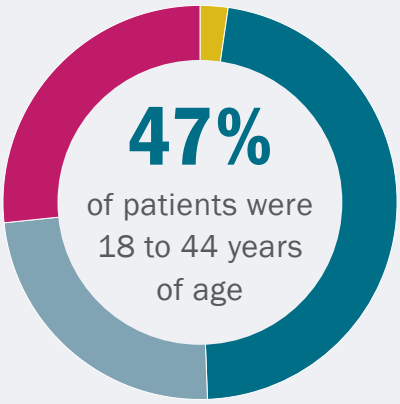
TB cases by disease site:



- Pulmonary disease only **68%**
- Extrapulmonary disease only **11%**
- Both pulmonary and extrapulmonary disease **21%**

10 Number of people newly diagnosed with a multidrug-resistant TB[2] strain

TB cases by age group:



- 17 years or younger **2%**
- 18 to 44 years **47%**
- 45 to 64 years **24%**
- 65 years or older **27%**

TB cases by birth in the U.S.[3]:

- Non-U.S.-born **90%**
- U.S.-born **10%**

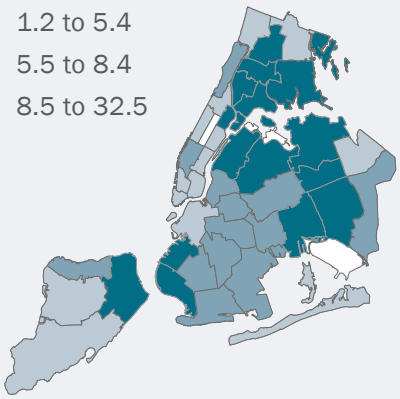
66 Number of countries of birth among people with TB

5 Median years in the U.S. at time of TB diagnosis among non-U.S.-born people

TB rates by neighborhood[4]:

Rate per 100,000

- 1.2 to 5.4
- 5.5 to 8.4
- 8.5 to 32.5



15 Number of NYC neighborhoods with a TB rate higher than the citywide rate

3% Proportion of TB patients with HIV infection

22% Proportion of TB patients with diabetes

1. Data on gender identity are not separated by cisgender or transgender. There were no TB cases among people identifying as nonbinary in 2025. 2. Defined as resistance to at least isoniazid and rifampin. 3. U.S.-born includes people born in the U.S. and U.S. territories. 4. Defined by the United Hospital Fund. Rates are per 100,000 people and are based on NYC Health Department population estimates, modified from U.S. Census Bureau interpolated intercensal population estimates, 2020-2024.

Dear Colleagues,

In the last few years, TB has had a devastating resurgence, once again becoming the leading cause of death among all infectious diseases worldwide. The number of new TB cases remains elevated since 2020, both globally and locally, reaffirming our need to continue the fight against this deadly disease. Successful efforts to reduce TB require focused strategies, significant resources, continued innovation, and strong partnerships. Throughout this past year, the NYC Health Department has continued to work closely with City and state government agencies, clinical providers, and community-based organizations to bring services to people affected by TB citywide.

In response to the recent increase in TB cases, the Health Department has taken a multipronged approach to strengthen and improve TB care and treatment. Local support ensured critical funding for TB screening, services, and staffing in 2025 and has enabled us to maintain and enhance citywide TB detection and prevention efforts. In early 2025, we began offering a new treatment regimen for latent TB infection in our Health Department chest centers. This regimen, one month of isoniazid and rifapentine (1HP), reduces the number of required clinic visits and shortens the length of preventive TB treatment from three-to-nine months to just one. Our adoption of new TB isolation guidelines from the National TB Coalition of America (NTCA) in 2025 has led to shorter hospital stays and a quicker return to school, work, and social activities for people with TB disease. The availability of mobile X-ray services continues to improve our ability to screen for TB, particularly among transient populations and other groups with substantial barriers to care.

A total of 743 TB cases were reported to the Health Department in 2025, representing an 11% decrease compared with 2024. While we are hopeful that this decline will be sustained, the overall number of cases in NYC remains high compared with recent years, and emerging challenges threaten our progress. Locally, we are concerned that some New Yorkers may be avoiding or delaying critical medical services due to fears related to cost, immigration status, or other barriers. Nationally, cuts to Medicaid and limits on eligibility for other services will make it more challenging for patients to receive the care they need. Globally, cuts to the United States Agency for International Development (USAID) and other health and social service organizations are likely to lead to a rise in the global TB burden, which will inevitably impact NYC as an international city and global tourist destination.

Together, we must continue to fight TB and to ensure access to quality care. Using our data and our collective experience, compassion, and commitment, we will continue to improve our services, support our communities, and work to eliminate TB in NYC.

Sincerely,

Joseph N. Burzynski, MD, MPH
Assistant Commissioner, Bureau of Tuberculosis Control

Core Activities

Core Activities

TB is an airborne infectious disease caused by a bacterium. TB has two stages: active TB disease and latent TB infection (LTBI). TB is treatable and preventable, but without effective treatment, TB may lead to serious illness and death.

The NYC Health Department performs a variety of integrated activities to address and prevent TB disease. These include surveillance, clinical care and treatment, medical consultation, case management, directly observed therapy, contact investigation, coordination of laboratory tests, outbreak detection and response, outreach and education, program evaluation, and research. These activities support effective, patient-centered TB care, response, and prevention in NYC.

Surveillance and Reporting

Health care providers and laboratories are required to report to the Health Department:

1. All patients with confirmed TB disease
2. Anyone suspected of having TB disease
3. Children younger than 5 years of age with a positive test for TB infection and related chest radiograph findings and treatment information
4. Results of any blood-based test for TB infection, regardless of patient age (laboratories only)

Medical providers in NYC must report these patients even though pathologists and microbiologists are also required to report findings consistent with TB. Reports must be submitted using NYC's Provider Reporting Interface and Secure Messenger (PRISM) or the Universal Reporting Form and must be received by the Health Department within 24 hours of diagnosis or clinical suspicion, whether sent electronically, by express or overnight mail, by fax, or by telephone.

For more information about TB reporting requirements in NYC and to report electronically via PRISM or to download related forms, visit **nyc.gov/health/prism.** For assistance, call **311** and ask for the Health Department Bureau of Tuberculosis Control Surveillance Unit.

The Health Department reviews all submitted reports for completeness and timeliness and determines whether patients are eligible for case management. The Health Department maintains an electronic TB surveillance registry and case management system (Maven version 6.9.7, Conduent Public Health Solutions, Florham Park, NJ) that has information for all reported patients and individuals exposed to TB. These data are used to conduct case management; ensure treatment completion; monitor trends; detect outbreaks; prepare surveillance reports; report aggregated data to the New York State Department of Health (NYSDOH) and the Centers for Disease Control and Prevention (CDC); identify reporting and data quality issues; and inform programmatic decision-making.

TB Surveillance and Reporting in 2025:

- **743** TB cases were confirmed by the Health Department.
- **3,124** people with suspected TB disease were reported to the Health Department.
- **61** children younger than 5 years of age with TB infection were reported to the Health Department.
- **104** facilities reported at least one TB case; half of all cases were reported by **13** facilities.

Figure 1: Initial reporter of confirmed TB cases verified in NYC by reporter type, 2025

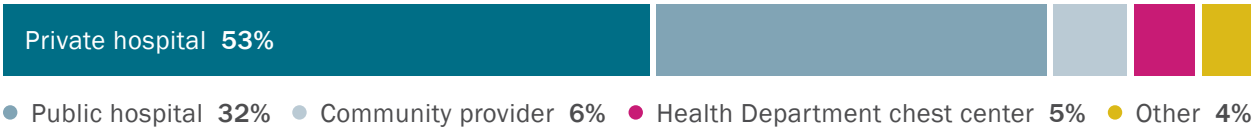


Table 1: Most common initial reporting facilities by number of NYC TB cases reported and proportion of all verified cases, 2025

Facility	n (%)
NYC Health + Hospitals/Elmhurst	63 (8)
NYC Health + Hospitals/Bellevue	38 (5)
NewYork-Presbyterian (NYP) Queens	34 (5)
Maimonides Medical Center	30 (4)
New York University (NYU) Langone Hospital — Brooklyn	28 (4)
Long Island Jewish Medical Center	28 (4)
NYU Langone Health — Tisch Hospital	28 (4)

Clinical Care and Treatment

The Health Department is a leading provider of TB care in NYC. TB services are available at three Health Department chest centers located in the Bronx, Brooklyn, and Queens. Physicians working at the chest centers are specialists in internal medicine, preventive medicine, pulmonary medicine, and infectious disease.

The Health Department provides TB diagnostic services, including testing for TB infection (using blood-based QuantiFERON-TB Gold Plus [QFT-Plus] test and tuberculin skin test [TST]); sputum induction; laboratory tests; medical evaluation; chest radiographs; treatment for TB disease and LTBI; and directly observed therapy for patients of all ages. Most patients evaluated and treated at Health Department chest centers are referred by NYC health care providers, other health departments, or social service providers. Health Department staff also conduct site-based TB testing in households and community-based settings when indicated, and refer patients to other medical professionals for further evaluation and treatment of non-TB-related conditions.

HIV testing services: Health Department staff provide opt-out rapid HIV testing services to every eligible patient at Health Department chest centers and refer patients who have HIV infection to health care providers who specialize in HIV care. The Health Department offers rapid HIV testing to contacts in household settings. Anonymous HIV testing services are available at all chest centers independent of need for TB services.

Implementation of New Short-Course LTBI Treatment Regimen in Health Department Chest Centers

Health Department chest centers have traditionally offered several options for LTBI treatment including 3 months of weekly isoniazid (INH)/rifapentine (RPT), 4 months of daily rifampin, and 6 or 9 months of daily INH. However, multi-month regimens require numerous clinic appointments and can be difficult for some patients to complete. To provide a more patient-centered preventive treatment option and improve treatment uptake and completion, Health Department chest centers began offering the new World Health Organization (WHO)-recommended one-month daily INH/RPT regimen (1HP) in February 2025. In 2025, **337** patients with LTBI were started on the 1HP regimen. Of these, **252** (75%) patients had completed treatment as of February 18, 2026.

Obtaining limited-availability medications for the treatment of multidrug-resistant TB (MDR-TB): Health Department staff can assist with obtaining certain medications that are available under limited circumstances, including pretomanid, bedaquiline, clofazimine, and delamanid. Clofazimine and delamanid require the submission of a Single Patient Investigational New Drug application to the Food and Drug Administration (FDA) and to the Health Department's Institutional Review Board for approval.

For more information about these drugs or for help obtaining them, call the **TB Hotline** at **844-713-0559**.

Evaluation of refugees and immigrants applying for permanent status: People who are applying for permanent U.S. immigration status or refugee status are screened for TB as part of their overseas medical examination. If the pre-immigration examination finds a clinical diagnosis of TB, a Class A designation is given and the applicant is not allowed to travel until treatment is completed or the person is no longer infectious.

The CDC notifies local jurisdictions of any immigrants and refugees who have been deemed at risk of having TB but have been cleared for travel to that U.S. jurisdiction (Class B designation). The local jurisdiction then reaches out to the individual to schedule an initial evaluation for TB in the U.S. (within 30 days, as recommended by the CDC), and the clinical team endeavors to complete domestic evaluations within 120 days. The majority of these individuals come to a Health Department chest center for evaluation after arriving in NYC.

TB Clinical Care and Treatment in 2025:

- **382** (51%) patients confirmed with TB disease in 2025 received care at a Health Department chest center.
- **18** patients with an MDR-TB strain received treatment, care, and case management through the Health Department, including **8** patients newly diagnosed with an MDR-TB strain in NYC in 2025.
    - **26** patients received bedaquiline.
- **7,419** people arriving in NYC with a Class B designation were notified to the Health Department; **2,260** (30%) were eligible for evaluation; **1,408** (62%) were evaluated as of January 23, 2026.

Medical Consultation

Health Department TB medical consultants are physicians with many years of experience treating TB disease and LTBI. They provide expert consultation to community providers and others regarding TB diagnosis, hospital discharge planning, TB treatment (including treatment of MDR-TB, management of adverse reactions to TB drugs, and treatment completion), contact investigation, infection control, and other TB-related public health concerns. Recommendations are based on professional experience and Health Department policies, which are informed by guidelines from the CDC, American Thoracic Society (ATS), Infectious Diseases Society of America (IDSA), National TB Coalition of America (NTCA), and the WHO. TB medical consultants also conduct TB rounds and give medical talks throughout NYC.

Case Management

The Health Department provides case management activities for NYC residents diagnosed with or suspected of having TB disease and their contacts, regardless of where the person receives their TB care.

Case management includes patient interviews, TB education, chart reviews, contact investigation, directly observed therapy, and coordination with community providers to ensure optimal TB treatment and care. Health Department staff conduct home assessments to identify contacts and to determine whether patients with infectious TB can be discharged from the hospital. Health Department staff also coordinate with colleagues in other jurisdictions to ensure continuity of care for patients with confirmed TB disease and contacts who work or live outside NYC. Case managers perform monthly monitoring for treatment adherence and locate patients who have significant lapses in medical appointments or medication and help them return to medical supervision.

DOT: Directly observed therapy (DOT) is the standard of care for patients with suspected or confirmed TB disease in NYC, regardless of where they receive TB care. During DOT, a health care worker observes a patient ingesting their anti-TB medications. The Health Department provides face-to-face DOT services at all chest centers and at homes, worksites, and other locations as requested by the patient. The Health Department also provides video DOT (vDOT), which facilitates continuity of DOT outside traditional business hours and when patients travel. DOT is also available through NYC Health + Hospitals Elmhurst, Kings County, and Bellevue facilities.

Contact investigation: The Health Department conducts TB contact investigations in households, congregate settings (for example, worksites and schools), and other settings where TB exposures occur. During contact investigations, Health Department staff identify, notify, and evaluate individuals who were exposed to a person with infectious TB; ensure appropriate treatment for contacts diagnosed with TB disease or LTBI; determine whether transmission occurred; and assess whether testing of additional contacts or other public health intervention is needed. When TB exposures occur in health care facilities, epidemiologists at the Health Department provide technical guidance and assist with contact investigation at the site as needed.

Social service referrals: Health Department staff identify and address obstacles to care and unmet social service needs among patients and their families whenever possible. These include concerns about finances, housing, food security, employment, school, health insurance eligibility, access to health care services, immigration status, language barriers, drug and alcohol use, and mental health issues. Patients are referred to a social worker who facilitates referrals to social service resources.

Regulatory action: The Health Department has authority under the NYC Health Code to require TB evaluation, DOT, or involuntary hospitalization for patients with infectious TB who are not adherent to evaluation, isolation, or treatment recommendations.

To get expert medical consultation about TB, call the **TB Hotline** at **844-713-0559**. To learn more about the Health Department DOT program or to enroll a patient, call **311**.

TB Case Management in 2025:

- **2,814** patients received case management services, including **734** patients with newly confirmed TB disease, **1,483** patients with suspected TB disease, **502** patients with TB diagnosed before 2025, and **95** patients with TB initially confirmed outside NYC.
- **508** eligible patients with confirmed TB disease were enrolled in DOT through the Health Department or another health care provider; **30** were enrolled exclusively in face-to-face DOT and **478** received some or all observations through vDOT.
- **4,288** contacts were identified around **594** patients who were potentially infectious; **2,406** (56%) were fully evaluated as of January 21, 2026, of whom **439** (18%) had a new positive TB test result.

Drug Susceptibility Testing and Whole Genome Sequencing

The NYC Health Code mandates that a portion of the initial isolate from all patients with culture-positive TB be sent for drug susceptibility testing (DST) and whole genome sequencing (WGS), performed at local, state, and national public health laboratories.

DST: Drug susceptibility testing identifies drug resistance in TB strains and informs clinical management and treatment for patients with TB disease and their contacts. The NYC Public Health Laboratory (PHL) performs phenotypic DST for first-line and select second-line TB drugs. Molecular-based laboratory tests are also used routinely at PHL, hospitals, commercial laboratories, and other public health reference laboratories. These tests rapidly confirm the presence of *Mycobacterium tuberculosis* (*M. tuberculosis*) complex and can provide information about the presence of mutations in specific genes that are known to predict drug resistance, enabling earlier treatment of MDR-TB and decreasing the amount of time the patient is infectious.

Universal WGS: Whole genome sequencing enables identification of the *M. tuberculosis* complex and species within it, detection of genetic mutations associated with drug resistance, and analysis of single nucleotide polymorphisms to characterize and compare TB strains. The Health Department collaborates with the NYSDOH Wadsworth Center, PHL, and the CDC to conduct WGS for all patients with a positive culture for *M. tuberculosis*.

New York State currently reports 20 mutations associated with resistance to 10 TB drugs. WGS also helps the Health Department identify false positive laboratory results, assess TB transmission, and detect outbreaks. Possible instances of contamination and potential false positive results are promptly and systematically investigated to ensure patients are not placed on anti-TB medications unnecessarily. Cases among patients with similar TB strains are investigated to identify and interrupt TB transmission.

TB Drug Susceptibility Testing and Whole Genome Sequencing in 2025:

- **574** (93%) out of **616** culture-confirmed TB cases had phenotypic DST results available; among culture-confirmed cases, molecular DST results were available for **610** (99%) cases.
- **594** (96%) culture-confirmed TB cases had WGS results available.
- **21** instances of potential false positive laboratory results were investigated; **10** (48%) investigations confirmed a false positive result.

Outreach and Education

The Health Department engages diverse stakeholders to advance efforts to detect, treat, and prevent TB throughout NYC.

Health care providers and public health professionals: The Health Department conducts outreach to and collaborates with health care providers and public health colleagues throughout NYC, particularly those serving neighborhoods with high TB burden. Health Department experts discuss TB epidemiology, screening, testing, diagnosis, and treatment through medical talks, case management conferences, webinars, and other forums. The Health Department co-sponsors an annual medical conference for health care providers and other groups in honor of World TB Day, and staff regularly meet with colleagues locally, nationally, and internationally on matters related to TB policy and practice.

Community partners and the general public: In partnership with elected officials, community-based groups, and others, the Health Department delivers culturally and linguistically tailored messaging to the public through community events, printed materials, and electronic media. Community partners support TB screening and testing efforts at health fairs and other events.

Coalition for a TB-Free NYC: The Health Department co-chairs the Coalition for a TB-Free NYC, an organization of more than 50 stakeholders from various sectors and disciplines that aims to prevent and eliminate TB in NYC through community engagement, public-private partnership, innovation, and research. The Coalition's strategic plans are guided by a patient-centered, human rights, social justice, and gender-based approach. The group meets quarterly to disseminate TB information, share resources, and provide timely updates.

In recent years, the Coalition has published materials in the areas of debunking TB myths, TB risk assessment, and TB clinical considerations; created educational materials and other resources for people with low health literacy; and developed a network of TB care model for un- or underinsured patients.

For more information about TB community events and conferences, to sign up for the Health Department's TB newsletter (**TB Action News**), or to join the **Coalition for a TB-Free NYC**, email **tboutreach@health.nyc.gov**.

Educational materials: The Health Department offers a selection of tailored TB education materials and other resources for patients, the general public, and health care providers. New TB educational materials developed in 2025 include the following:

- **Clinical Policies and Program Manual** (Sixth Edition)*:* Describes updated NYC Health Department policies, protocols, and recommendations for the prevention, treatment, and management of TB.
- **Hospital Discharge and Community Isolation of Patients With Pulmonary TB in NYC Flow Diagram:** Offers health care providers, social service providers, and public health practitioners a clear, step-by-step guide to the application of updated TB isolation guidelines in NYC.
- **Patient and Provider Handouts: One-Month Treatment Regimen for Latent Tuberculosis Infection — Isoniazid-Rifapentine (1HP)**
  - **Provider Job Aid:** Provides a concise and comprehensive overview of inclusion criteria, dosing recommendations, and physician and nursing workflows for treatment initiation and monitoring.
  - **Patient Fact Sheet:** Provides a clear overview of the 1HP regimen to support patient uptake of and adherence to treatment. Available in 15 languages.

To access these and other TB educational materials, visit **nyc.gov/health/tb,** call **311**, or email **tboutreach@health.nyc.gov**.

Outreach and Education in 2025:

- The Health Department educated **2,984** community members and **187** partner community organizations during **36** community health events throughout the city.
- The Health Department conducted **9** TB educational talks with community partners and collaborated with external stakeholders to conduct **21** Grand Rounds presentations.
- The Health Department conducted **4** cross-collaborative training events to enhance internal capacity and TB awareness among multidisciplinary Health Department staff working outside the TB program.

Expanded TB Screening in Temporary Housing Sites

Since 2022, the Health Department has collaborated with NYSDOH, NYC Health + Hospitals, NYC Department of Social Services, NYC Department of Housing Preservation and Development, the Mayor's Office of Housing Recovery Operations, and other groups to implement and enhance TB screening and related services in shelters, Humanitarian Emergency Response and Relief Centers, and other temporary housing sites in NYC.

On-site TB services include blood-based TB testing, mobile chest X-ray, care coordination, and DOT. Referral pathways were developed and enhanced to facilitate evaluation, treatment, and care at Health Department chest centers, NYC Health + Hospital facilities, and community health care providers.

This program has supported early TB case detection and timely access to TB evaluation and treatment; enhanced broader efforts to link New Yorkers to care; and strengthened capacity for rapid public health response. Between December 2022 and December 2025, more than **30,000** people received services through this initiative.

Funding and Administration

The Health Department receives City, state, and federal funding for TB care and control. These funds support all TB prevention and control activities, from hiring staff to operating Health Department chest centers. Staff ensure that funds are allocated, monitored, and utilized efficiently.

Research

Health Department staff actively participate in research, including epidemiologic studies, implementation science, and clinical research. This includes collaboration with the CDC TB Trials Consortium, which conducts national and international studies to support the development of TB treatment regimens. Health Department staff also participate in professional organizations and TB advisory groups.

Conferences: NYC TB data and staff expertise are shared at meetings locally, nationally, and internationally. In 2025, these included: the National TB Coalition of America (NTCA) Annual Conference; TB Medical Consultants Meeting; NYC Annual World TB Day Conference; Conference of The Union North America Region; Council of State and Territorial Epidemiologists (CSTE) Conference; American Public Health Association Conference; CDC TB Trials Consortium (TBTC) Meeting; and Mailman School of Public Health NYC Epi Forum.

Advisory groups: TB program staff participated in the following groups in 2025: Advisory Council for the Elimination of TB; CDC TB Education and Training Network; CDC TB Program Evaluation Network; CDC TBTC; CSTE; Maven Users Group; NTCA Board of Directors; NTCA National Society of TB Clinicians; NTCA Society for Epidemiology in TB Control; NTCA Survey Committee; International Union Against TB and Lung Disease; and TB Contact Studies Consortium.

Publications in peer-reviewed journals by Health Department TB program staff, 2025: For a complete list of staff publications from 2025, scan the QR code to the left.

Program Evaluation

The Health Department uses local, state, and national performance indicators to assess program impact. These indicators inform planning and policy decisions and help identify programmatic issues and areas for improvement. Performance indicators and targets are developed in coordination with Health Department partners and funders, including the CDC, NYSDOH, and NYC Mayor's Office. Reports include the quarterly report to NYSDOH, CDC's Annual Performance Report, CDC's Aggregate Reports for TB Program Evaluation, and CDC's National Tuberculosis Indicators Project (Page 18).

Cohort review: One of the Health Department's primary tools for evaluating its TB program is the quarterly cohort review process. Staff review case management activities, treatment status, and data quality for all patients with confirmed TB disease and their contacts four to six months after TB diagnosis. Successes and challenges related to patient care and case management are used to inform programmatic changes and identify training needs.

Table 2: Select TB performance measures, national targets,[1] and NYC outcomes for the year 2024

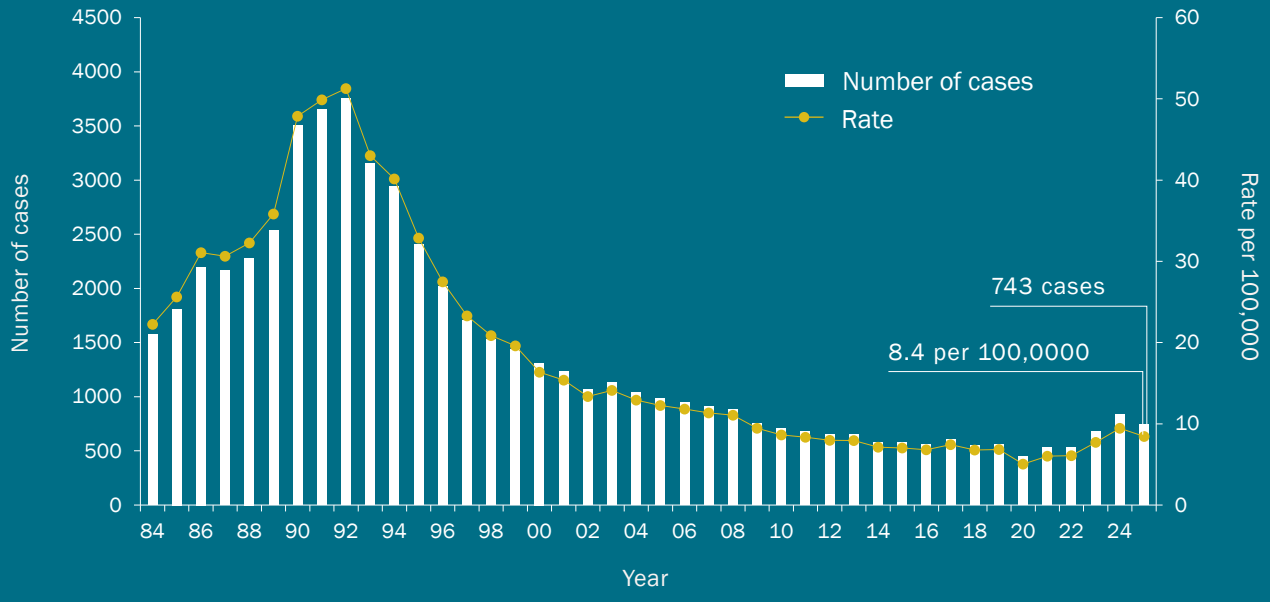
Indicator	2024	2030 target
Treatment and case management for persons with active TB		
Initiated TB treatment within 7 days of specimen collection[2]	95%	91%
Sputum culture conversion within 60 days of treatment initiation[3]	67%	80%
Completed treatment within 365 days of initiation[4]	81%	92%
Contact investigation		
Eligible cases with contacts elicited[5]	89%	100%
Eligible contacts evaluated[6]	68%	90%
Eligible contacts who initiated treatment for TB infection[7]	92%	92%
Eligible contacts who completed treatment for TB infection[8]	78%	93%

1. Definitions for performance measures and national indicators are established by the CDC; the 2030 targets were set in 2025. For details, visit https://www.cdc.gov/tb-programs/php/ntip/objectives-and-performance-targets.html. Performance measures are not reported for the current year to allow sufficient time for follow-up. 2. Of TB patients with positive acid-fast bacilli (AFB) sputum smear results who were alive at diagnosis. 3. Of TB patients with positive sputum culture results who were alive at diagnosis and have initiated treatment. Excludes patients who died within 60 days of initiating treatment. 4. Excludes patients who never started anti-TB medications, those who died or moved outside the U.S. within 365 days of treatment initiation, those with any rifampin resistance, those with meningeal TB, and children 14 years of age or younger with disseminated TB. 5. Of AFB sputum smear positive TB patients. 6. Of contacts to AFB sputum smear positive TB patients counted in the year of interest. 7. Of contacts to AFB sputum smear positive TB patients who have newly diagnosed TB infection. 8. Of contacts to AFB sputum smear positive TB patients with newly diagnosed TB infection who started treatment.

Profile of TB Cases

There were **743** confirmed cases of active TB disease identified in NYC in 2025, an 11% decrease from 2024. The 2025 TB rate was 8.4 per 100,000 people.

Figure 2: TB cases and rates,[1] NYC, 1984-2025



1984-1992

Overall increase: **139%**

Average annual increase: **12%**

1992-2004

Overall decrease: **72%**

Average annual decrease: **10%**

2004-2020

Overall decrease: **57%**

Average annual decrease: **5%**

2020-2025

Overall increase: **67%**

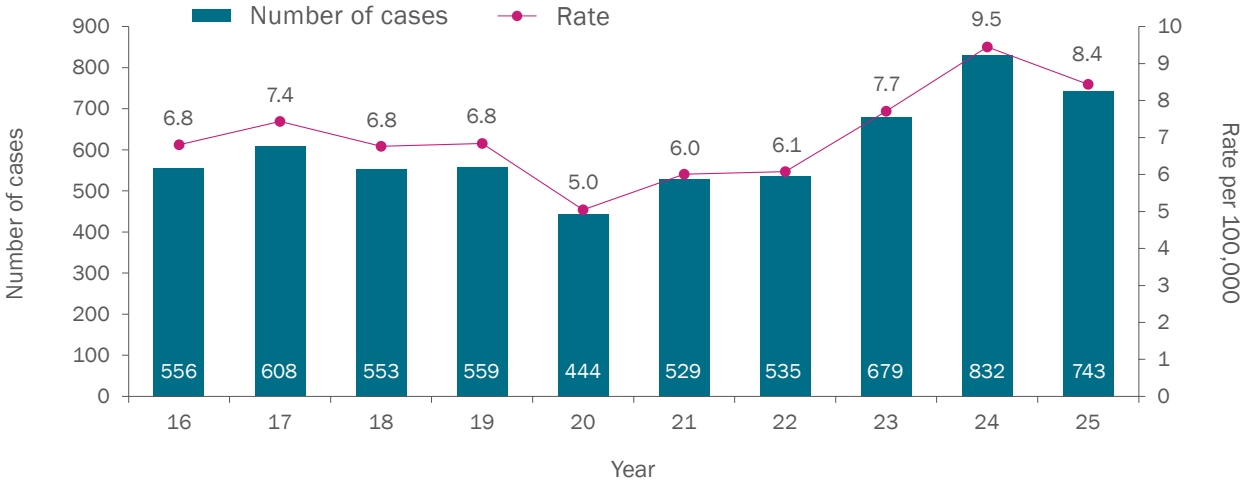
Average annual increase: **12%**

1. Rates are based on decennial census data.

Overview: TB in NYC in 2025

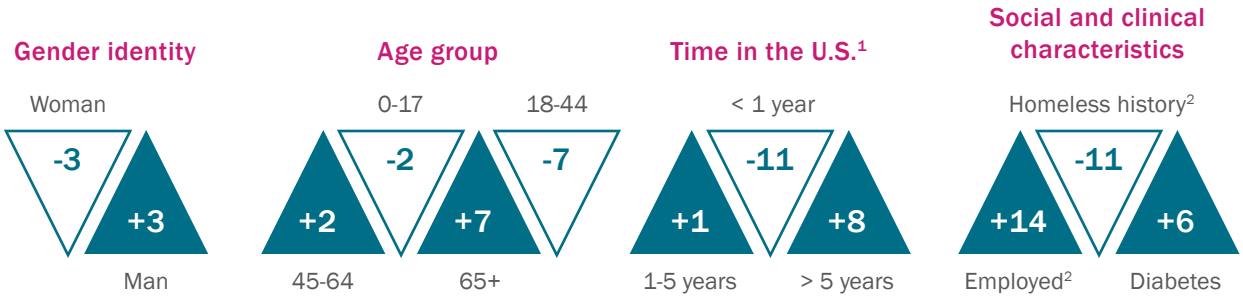
There were 743 confirmed cases of active TB disease identified in NYC in 2025, representing an 11% decrease from 2024. Decreases were seen among women, people younger than 45, people newly arrived to the U.S. at time of diagnosis, and people with history of homelessness. Despite this single-year decline, TB rates remain elevated in NYC relative to recent years. Increases between 2024 and 2025 were observed among men, people 45 and older, people with diabetes, and non-U.S.-born people living in the U.S. for more than five years at TB diagnosis. TB continues to disproportionately impact certain groups, including men, people born outside the U.S., people living in neighborhoods with high area-based poverty, and U.S.-born Black and Hispanic people.

Figure 3: TB cases and rates,[1] NYC, 2016-2025



1. Rates are based on decennial census data.

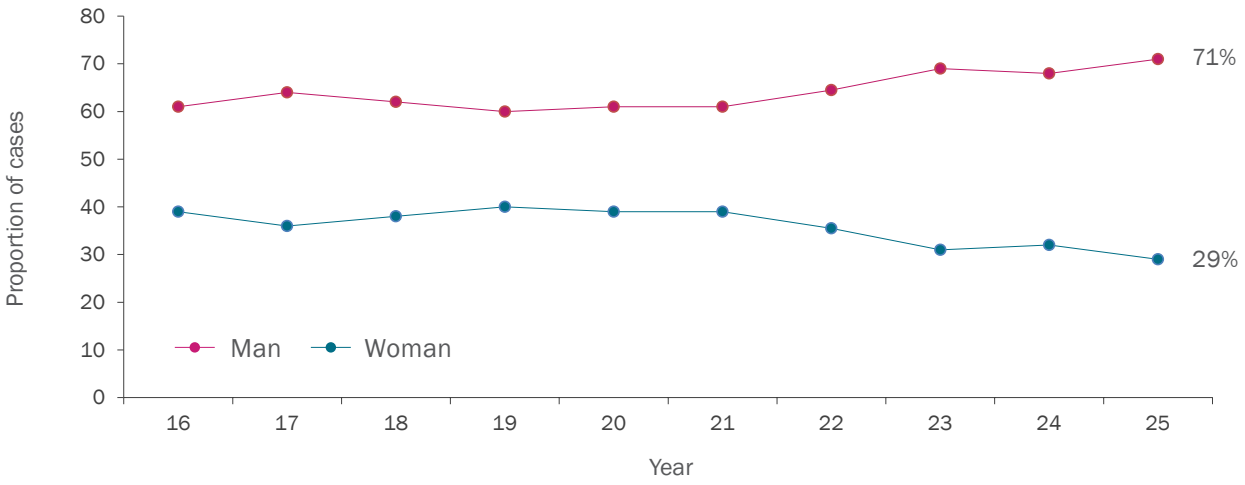
Figure 4: Percentage point change for select characteristics among patients with TB disease in 2025 compared to 2024, NYC



1. At time of TB diagnosis among individuals born outside the U.S. 2. In the 12 months before TB diagnosis.

Sociodemographic Characteristics

Figure 5: Proportion of TB cases by gender identity,[1] NYC, 2016-2025



1. Persons for whom gender identity was listed only as nonbinary or transgender are excluded from this figure. See the Technical Notes (Page 39) for more information.

Figure 6: TB cases by age group in years, NYC, 2025

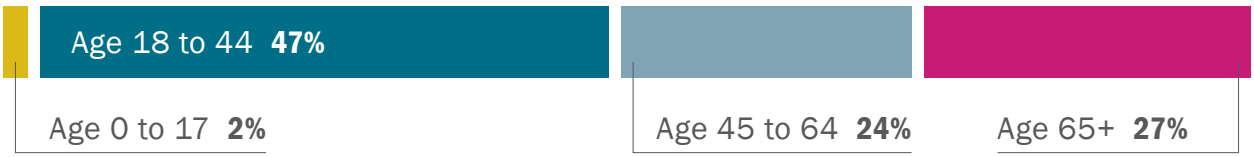
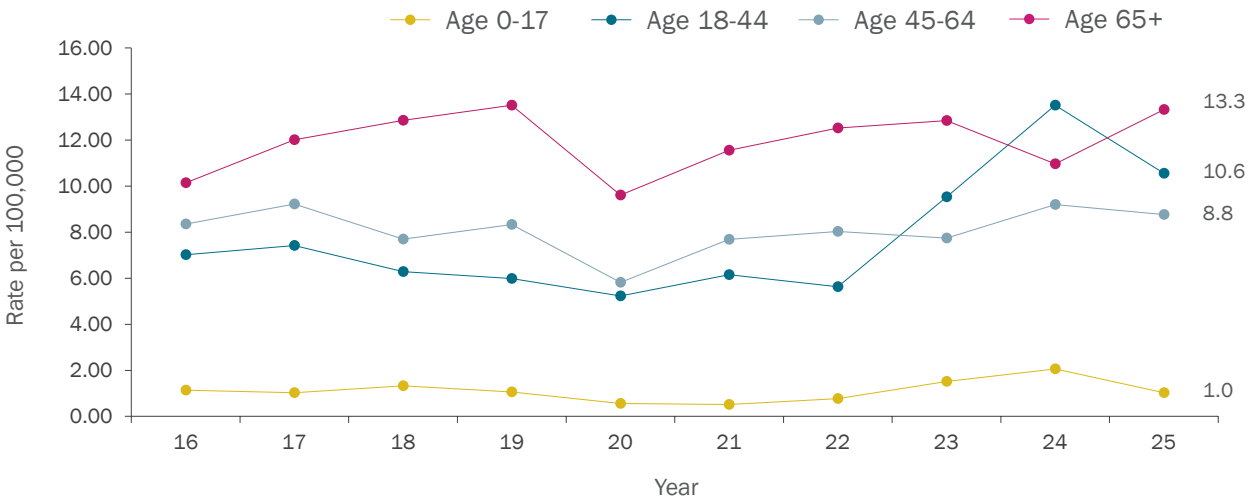
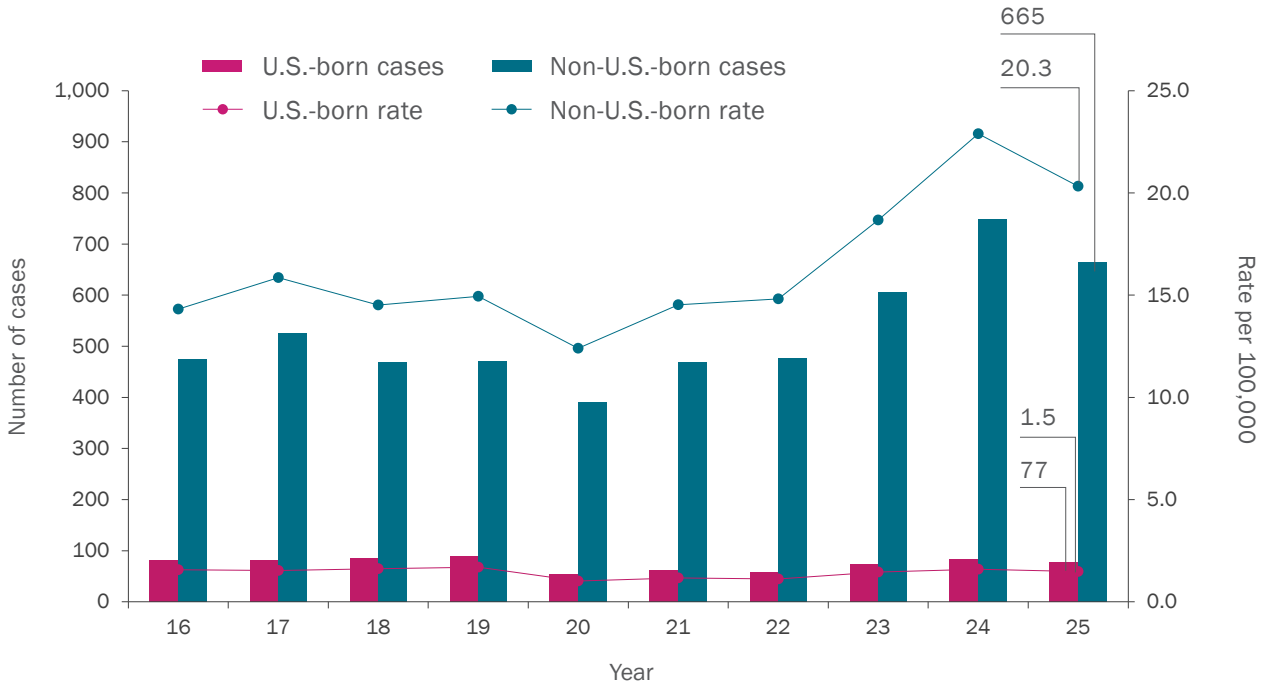


Figure 7: TB rates by age group in years,[1] NYC, 2016-2025



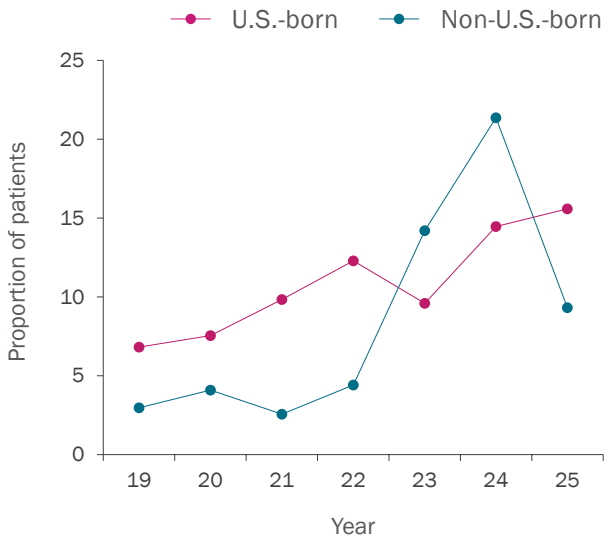
1. Rates are based on NYC Health Department population estimates, modified from U.S. Census Bureau interpolated intercensal population estimates, 2000-2024. Updated January 2026.

Figure 8: TB cases and rates[1] by birth in the U.S.,[2,3] NYC, 2016-2025



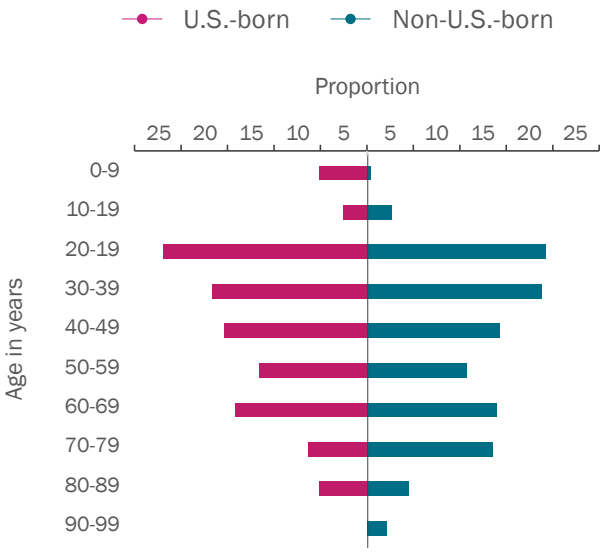
1. Rates are based on one-year American Community Survey data for the given year or the most recent available data. 2. U.S.-born includes individuals born in the U.S. and U.S. territories. 3. Excludes patients with unknown country of birth.

Figure 9: Proportion of patients with history of homelessness[1] by birth in the U.S.,[2,3] NYC, 2019-2025



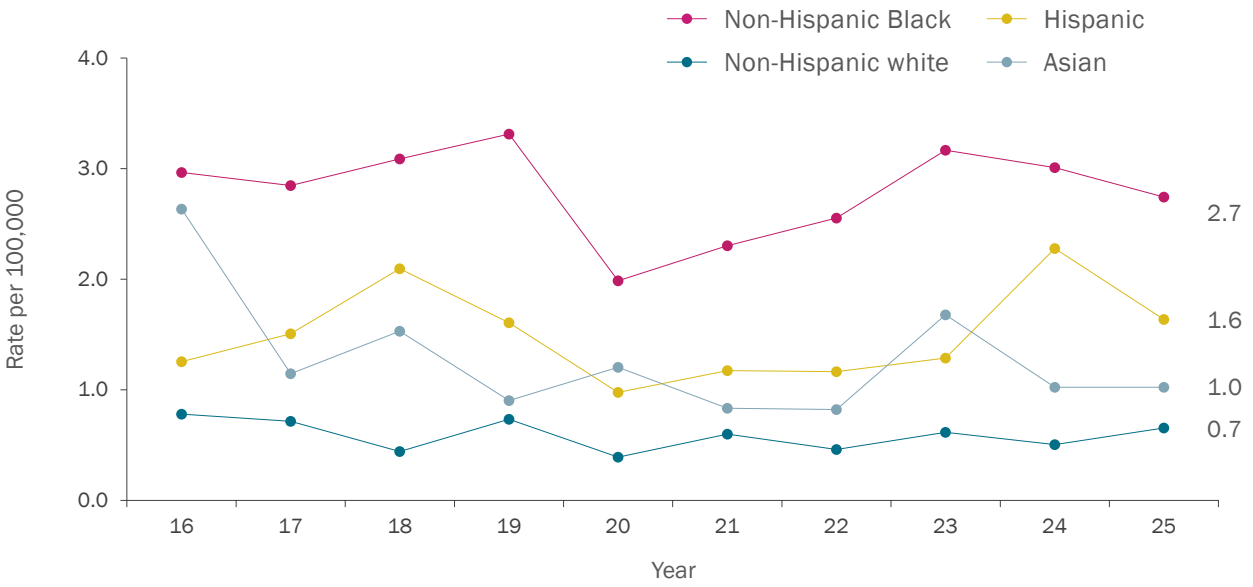
1. In the 12 months before TB diagnosis. 2. U.S.-born includes individuals born in the U.S. and U.S. territories. 3. Excludes patients with unknown country of birth.

Figure 10: Proportion of patients by age group in years and birth in the U.S.,[1,2] NYC, 2025



1. U.S.-born includes people born in the U.S. and U.S. territories. 2. Excludes patients with unknown country of birth.

Figure 11: TB rates[1] by race and ethnicity[2] among patients born in the U.S.,[3,4] NYC, 2016-2025



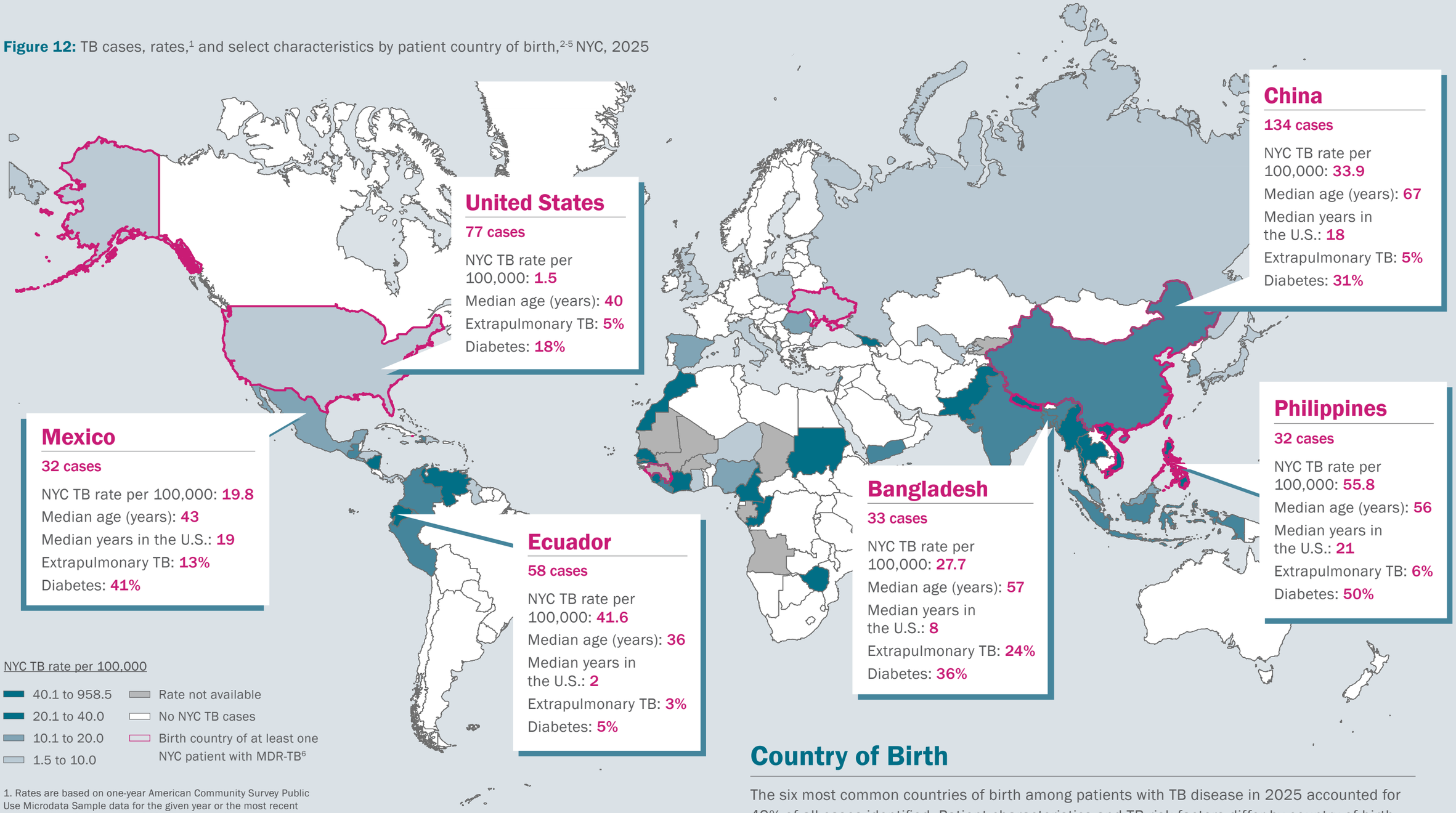
1. Rates are based on one-year American Community Survey Public Use Microdata Sample data for the given year or the most recent available data. 2. Data shown do not include patients with multiple, other, or unknown race and ethnicity. 3. U.S.-born includes individuals born in the U.S. and U.S. territories. 4. Excludes cases among patients with unknown country of birth.

Table 3: Proportion of TB cases and rates[1] by birth in the U.S.[2,3] and area-based poverty level[4] of patient residential neighborhood,[5] NYC, 2025

Area-based poverty level[4]	U.S.-born rate	% U.S.-born	Non-U.S.-born rate	% non-U.S.-born	Total NYC rate	% of all cases
Very high (30% to 100%)	3.3	31%	29.6	15%	11.6	16%
High (20% to < 30%)	1.5	21%	24.3	22%	9.9	22%
Medium (10% to < 20%)	1.3	39%	21.4	51%	9.3	50%
Low (< 10%)	0.5	9%	13.2	12%	4.5	11%

1. Rates are based on 2019-2023 American Community Survey data and use the proportion of residents within Modified ZIP Code Tabulation Areas (MODZCTA) whose family income falls below the federal poverty level. 2. U.S.-born includes people born in the U.S. and U.S. territories. 3. One patient had an unknown country of birth in 2025. 4. Area-based poverty level identifies the proportion of the population whose total family income in the 12 months prior to the survey fell below the official poverty threshold based on family size and composition. 5. Cases were assigned to a ZIP code based on patient residence at time of TB diagnosis.

Figure 12: TB cases, rates,[1] and select characteristics by patient country of birth,[2-5] NYC, 2025



United States

77 cases

NYC TB rate per 100,000: **1.5**
Median age (years): **40**
Extrapulmonary TB: **5%**
Diabetes: **18%**

China

134 cases

NYC TB rate per 100,000: **33.9**
Median age (years): **67**
Median years in the U.S.: **18**
Extrapulmonary TB: **5%**
Diabetes: **31%**

Mexico

32 cases

NYC TB rate per 100,000: **19.8**
Median age (years): **43**
Median years in the U.S.: **19**
Extrapulmonary TB: **13%**
Diabetes: **41%**

Ecuador

58 cases

NYC TB rate per 100,000: **41.6**
Median age (years): **36**
Median years in the U.S.: **2**
Extrapulmonary TB: **3%**
Diabetes: **5%**

Bangladesh

33 cases

NYC TB rate per 100,000: **27.7**
Median age (years): **57**
Median years in the U.S.: **8**
Extrapulmonary TB: **24%**
Diabetes: **36%**

Philippines

32 cases

NYC TB rate per 100,000: **55.8**
Median age (years): **56**
Median years in the U.S.: **21**
Extrapulmonary TB: **6%**
Diabetes: **50%**

NYC TB rate per 100,000

- 40.1 to 958.5
- 20.1 to 40.0
- 10.1 to 20.0
- 1.5 to 10.0
- Rate not available
- No NYC TB cases
- Birth country of at least one NYC patient with MDR-TB[6]

1. Rates are based on one-year American Community Survey Public Use Microdata Sample data for the given year or the most recent available data. 2. One case in 2025 was in a patient who had unknown country of birth. 3. There were 11 countries for which rate could not be calculated due to insufficient population data. 4. China includes individuals born in mainland China, Hong Kong, and Macau. 5. U.S.-born includes individuals born in the U.S. and U.S. territories. 6. MDR-TB is defined as resistance to at least isoniazid and rifampin.

Country of Birth

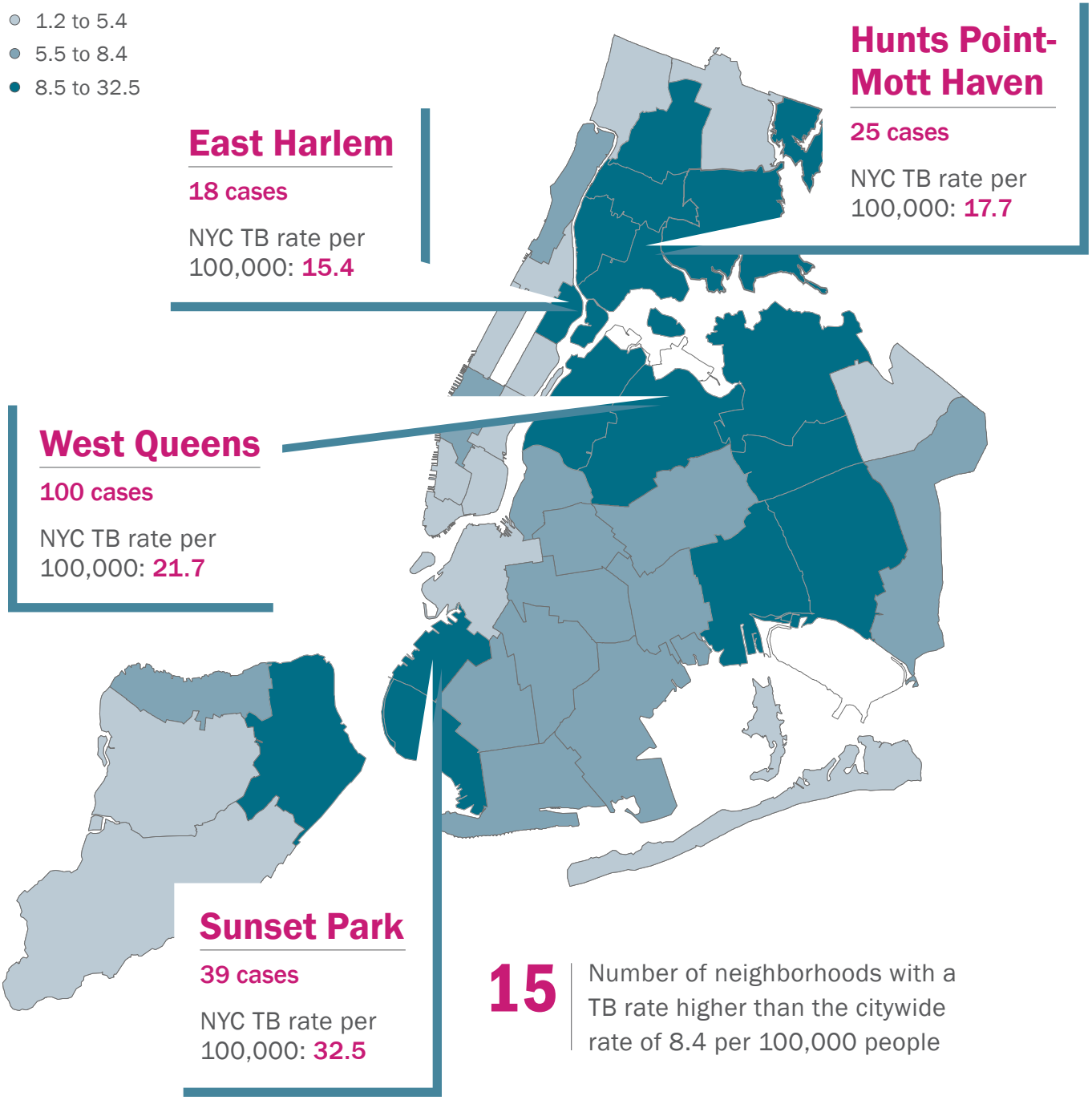
The six most common countries of birth among patients with TB disease in 2025 accounted for 49% of all cases identified. Patient characteristics and TB risk factors differ by country of birth.

66 Number of countries of birth represented among patients with TB disease in 2025

5 Median number of years in the U.S. among non-U.S.-born TB patients

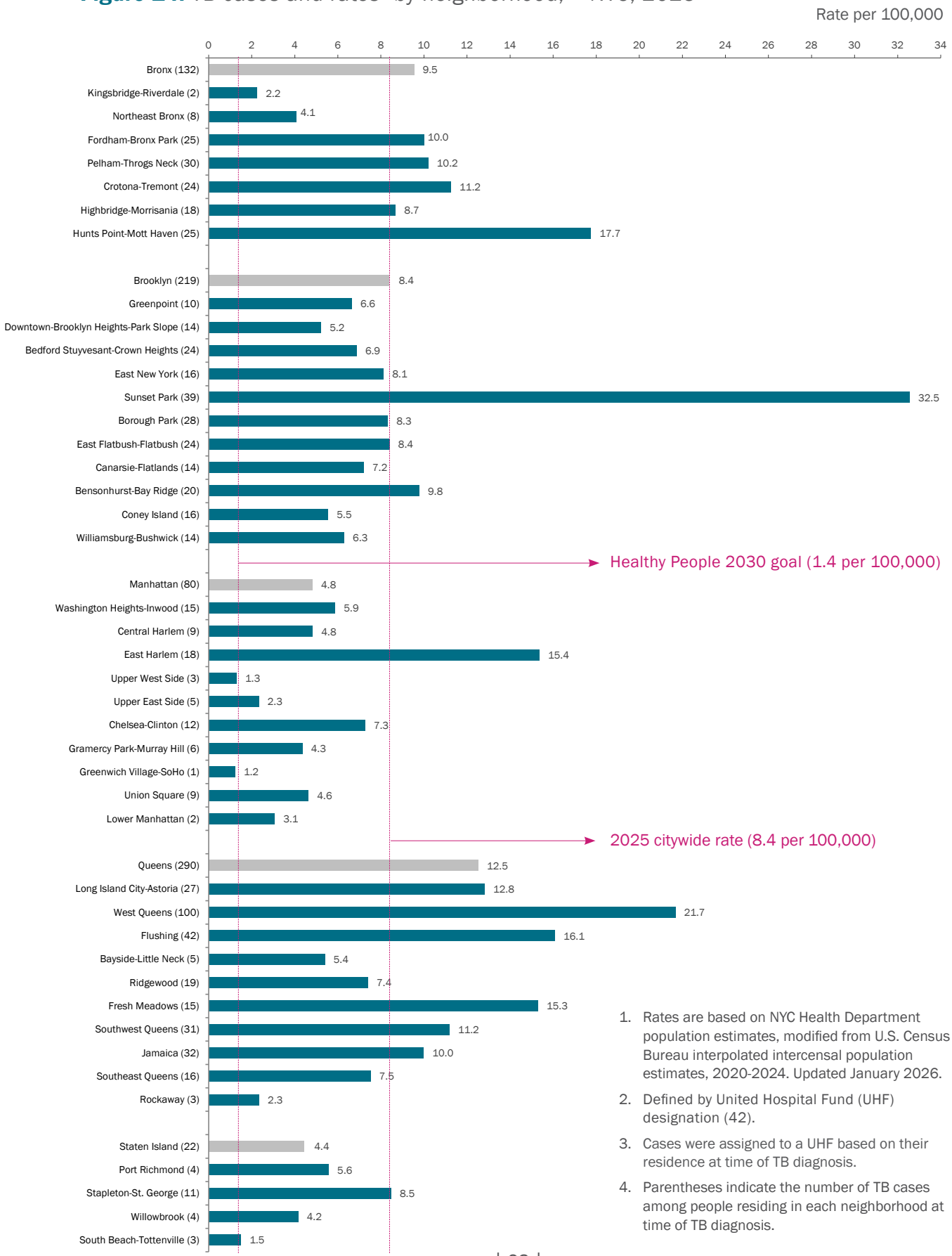
TB in NYC Neighborhoods

Figure 13: TB rates[1] by neighborhood,[2,3] NYC, 2025



1. Rates are based on NYC Health Department population estimates, modified from U.S. Census Bureau interpolated intercensal population estimates, 2020-2024. Updated January 2026. 2. Defined by United Hospital Fund (UHF) designation (42). 3. Cases were assigned to a UHF based on their residence at time of TB diagnosis.

Figure 14: TB cases and rates[1] by neighborhood,[2,3] NYC, 2025[4]



1. Rates are based on NYC Health Department population estimates, modified from U.S. Census Bureau interpolated intercensal population estimates, 2020-2024. Updated January 2026.
2. Defined by United Hospital Fund (UHF) designation (42).
3. Cases were assigned to a UHF based on their residence at time of TB diagnosis.
4. Parentheses indicate the number of TB cases among people residing in each neighborhood at time of TB diagnosis.

Clinical Characteristics

Figure 15: TB cases by disease site, NYC, 2025

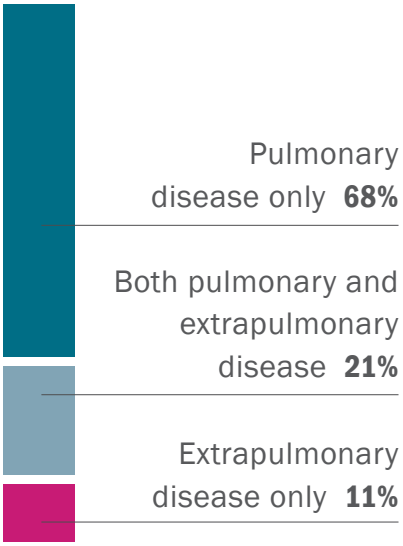


Table 4: Disease site among TB cases with an extrapulmonary disease site,[1] NYC, 2025 (237)

Disease site	# of cases	Percentage
Lymphatic	80	34%
Pleural	80	34%
Bone/joint	29	12%
Meningeal	15	6%
Genitourinary	11	5%
Peritoneal	12	5%
Laryngeal	3	1%
Other	61	26%

1. Categories are not mutually exclusive.

Figure 16: Proportion of culture-confirmed TB cases among all cases, NYC, 2025

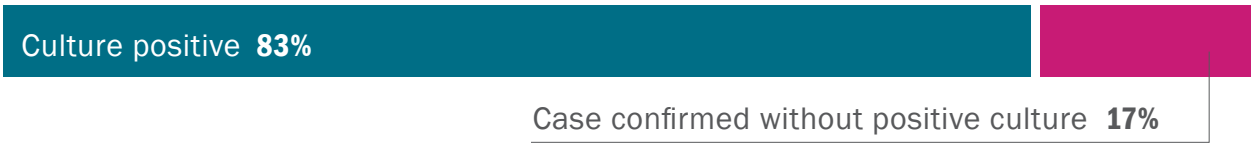
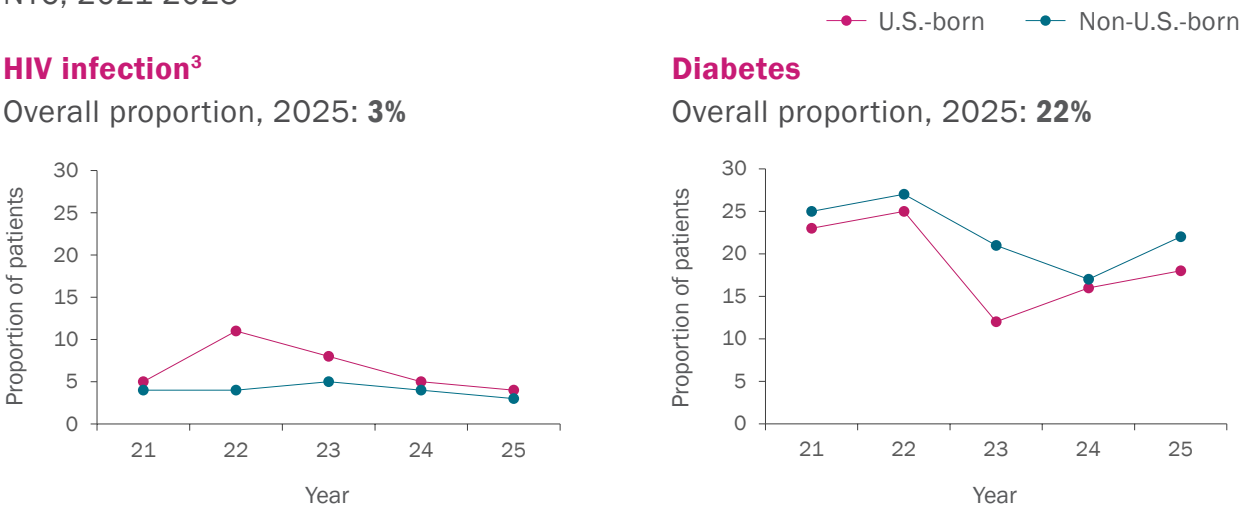


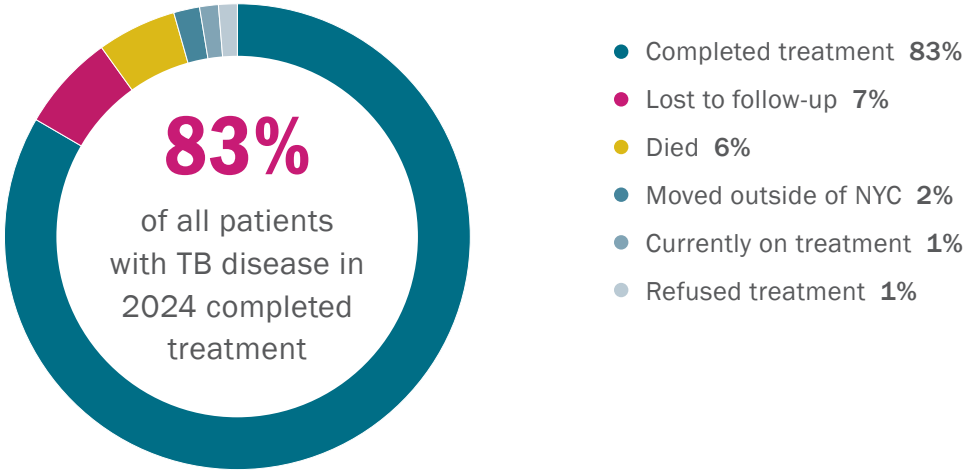
Figure 17: Select comorbidities among patients with TB disease by birth in the U.S.,[1,2] NYC, 2021-2025



1. U.S.-born includes people born in the U.S. and U.S. territories. 2. Excludes patients with unknown country of birth.
3. There were 96 (13%) patients in 2025 with an unknown HIV status.

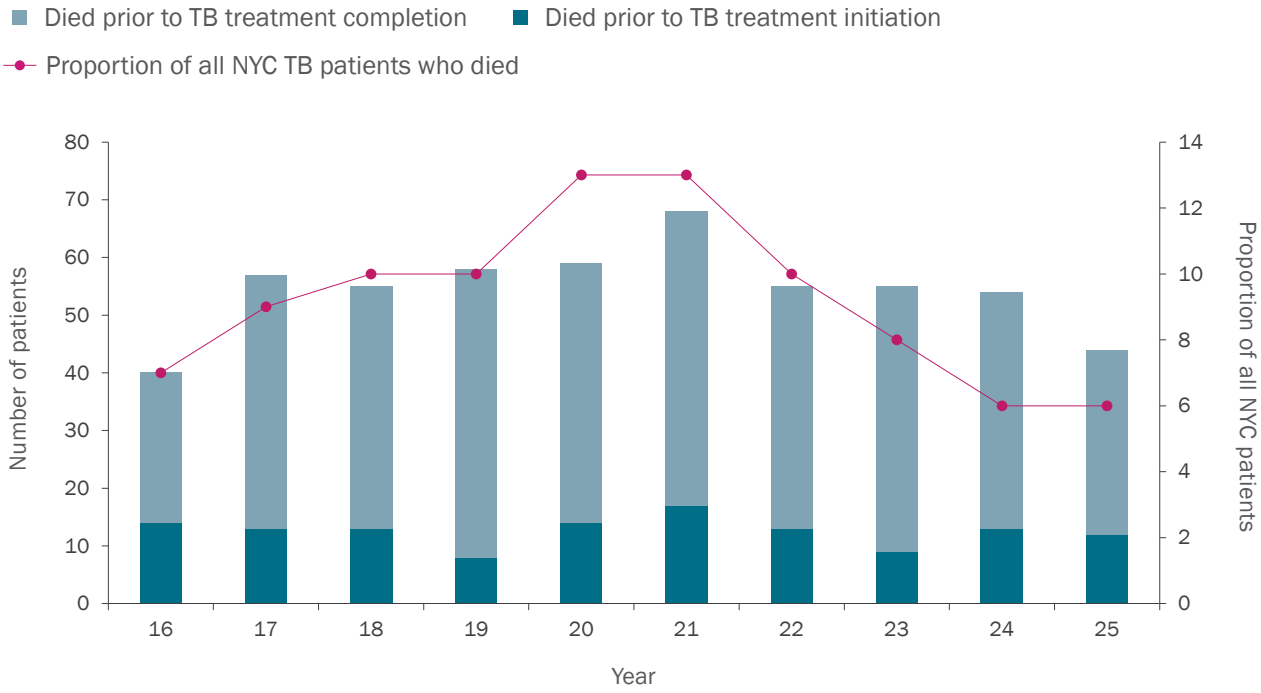
Treatment Outcomes and Mortality

Figure 18: Treatment outcomes for TB cases counted in 2024,[1,2] NYC (832)



1. Treatment outcomes are reported for 2024 instead of 2025 to allow sufficient time for follow-up. 2. A death is defined as any patient who died prior to or during TB treatment, regardless of the cause of death.

Figure 19: Number and proportion of patients with TB who died[1] before or during treatment, NYC, 2016-2025

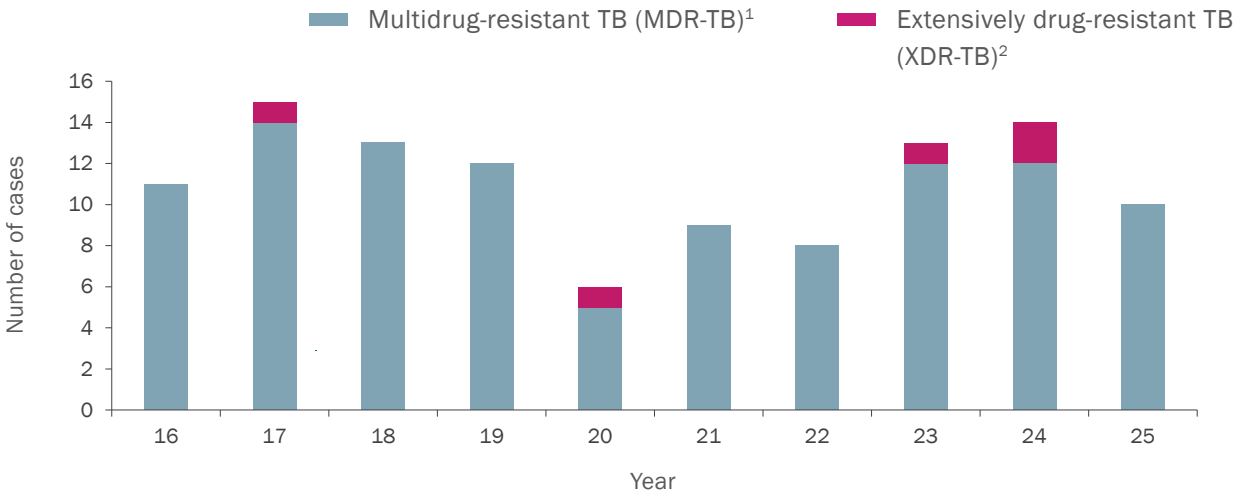


1. A death is defined as any patient who died prior to or during TB treatment, regardless of the cause of death.

Drug Resistance

Molecular-based tests that rapidly detect mutations associated with drug resistance are now being used routinely in hospitals, commercial laboratories, and public health reference laboratories in NYC. In 2025, 10 patients were newly diagnosed with MDR-TB, defined as a TB strain resistant to both isoniazid and rifampin, two of the most effective TB drugs.

Figure 20: Multidrug resistance[1] among TB cases, NYC, 2016-2025



1. MDR-TB is defined as resistance to at least isoniazid and rifampin. 2. XDR-TB is defined as resistance to at least isoniazid and rifampin plus a fluoroquinolone and either a second-line injectable anti-TB medication, bedaquiline, or linezolid.

Table 5: Detection of resistance to select TB medications by test type,[1] NYC, 2025

	INH	RIF	EMB	PZA	FLQ[2]	INJ[3]
Number of patients with a molecular test[4]	596	623	582	582	586	582
Number with mutation detected (%)	52 (9)	15 (2)	6 (1)	5 (1)	6 (1)	1 (< 1)
Number of patients with a phenotypic test	544	552	549	14	499	106
Number with resistance detected (%)	57 (10)	8 (1)	8 (1)	1 (7)	8 (2)	2 (2)
Number of patients with any drug susceptibility test conducted	612	626	603	582	604	582
Number with resistance detected (%)	63 (10)	15 (2)	9 (1)	6 (1)	9 (1)	2 (< 1)

Abbreviations: INH – isoniazid; RIF – rifampin; EMB – ethambutol; PZA – pyrazinamide; FLQ – fluoroquinolones; INJ – injectables

1. Categories are not mutually exclusive. 2. Fluoroquinolones include levofloxacin, moxifloxacin, ciprofloxacin, and ofloxacin. 3. Injectables include kanamycin, capreomycin, and amikacin. 4. Molecular tests include GeneXpert MTB/RIF, pyrosequencing, Sanger sequencing, and whole genome sequencing.

Contact Investigation in Congregate Settings

The Health Department investigates TB exposures in residential and nonresidential congregate settings in NYC to identify, notify, and evaluate contacts; ensure appropriate treatment for contacts with TB disease or LTBI; determine if transmission has occurred; and assess whether other public health interventions are warranted.

Figure 21: Contact investigations in congregate settings[1] by site type, NYC, 2025 (118)[2]

- Residential settings (for example, shelters) **35%**
- Schools **13%**
- Other **1%**

1. Excludes health care-associated investigations. 2. Data available as of March 5, 2026.

Table 6: Contact investigation outcomes in congregate settings[1] by number of exposed contacts and site type, NYC, 2025 (118)[2]

	≥ 15 exposed contacts		< 15 exposed contacts		Total	
	n	%	n	%	n	%
Number of sites	16	14%	102	86%	118	-
Total number of contacts identified	603	43%	788	57%	1,391	-
Contacts eligible for testing[3]	566	94%	758	96%	1,324	95%
Contacts tested[4]	435	77%	579	76%	1,014	77%
Contacts with a positive TB test result	17	4%	69	12%	86	8%

1. Excludes health care-associated investigations. 2. Data available as of March 5, 2026. 3. Contacts eligible for testing are defined as contacts without a known history of TB disease or documented positive test for TB infection who were alive after diagnosis of the infectious TB patient to whom they were exposed. 4. Proportion is among contacts eligible for testing.

Figure 22: Contact investigations in health care settings[1] by site type, NYC, 2025 (150)[2]

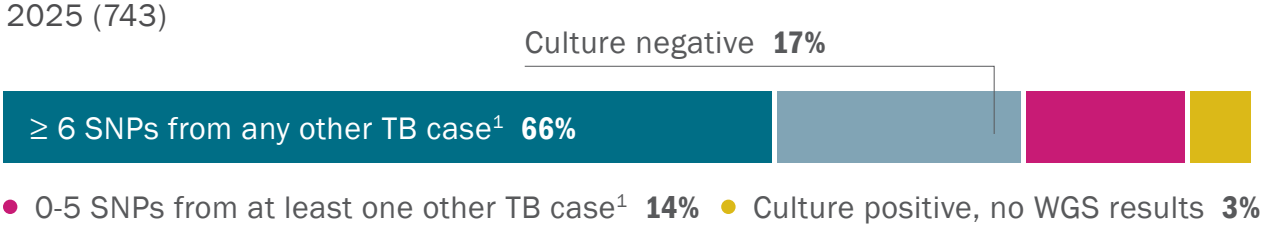
- Home health care services **13%**
- Long-term care facilities **7%**
- Other[3] **2%**

1. Includes hospitals and acute care clinics. 2. Data available as of March 5, 2026. 3. Includes dialysis centers and emergency medical services.

Whole Genome Sequencing and NYC Clusters

The Health Department uses WGS to characterize TB strains and assess transmission. Cases are reviewed, prioritized, and assigned for epidemiologic investigation. A difference of five or fewer single nucleotide polymorphisms (SNPs) between isolates is considered suggestive of possible recent transmission and prompts further investigation.

Figure 23: TB cases by WGS availability and high-quality SNP analysis results, NYC, 2025 (743)



1. Includes cases verified outside NYC with WGS results in the NYSDOH Wadsworth Center database.

Table 7: Characteristics of patients whose isolate has a difference of five or fewer SNPs from at least one other TB case,[1] NYC, 2025 (102)

Characteristic	n (%)
Male	81 (79%)
Median age in years (range)	35 (15-82)
Born in the U.S.[2]	31 (30%)
Born outside the U.S.	71 (70%)
In the U.S. for > 5 years[3]	32 (48%)
Most common countries of birth among patients born outside the U.S.	China (18%), Ecuador (17%), Venezuela (15%), Nepal (8%), Mexico (7%)
Borough of residence at diagnosis	Queens (33%), Brooklyn (31%), Bronx (21%), Manhattan (14%), Staten Island (1%)
History of homelessness[4]	17 (17%)
HIV infection	2 (2%)
Rifampin resistance[5]	4 (4%)
Pulmonary site of disease	96 (94%)
Respiratory smear positive	67 (70%)
Nearest neighbor counted by another jurisdiction	4 (4%)
Known contact to a TB case	8 (8%)

1. Includes cases verified outside of NYC with WGS results in the NYSDOH Wadsworth Center laboratory database. 2. U.S.-born includes individuals born in the U.S. and U.S. territories. 3. Percentage is among patients with available date of entry. 4. In the 12 months before TB diagnosis. 5. Percentage is among patients with susceptibility testing performed.

Table 8: Characteristics of select high-priority whole genome sequencing-identified TB clusters,[1,2] New York City, 2025

	Cluster A[3]	Cluster B	Cluster C	Cluster D	Cluster E	Cluster F
Number of cases identified between Jan. 1, 2023, and Dec. 31, 2025	26	14	8	7	5	4
Proportion of cases among males[4]	58%	57%	75%	100%	60%	100%
Proportion of patients born in the U.S.[4,5]	12%	64%	13%	86%	60%	100%
Median patient age in years (range)[4]	33 (< 1-51)	42 (< 1-69)	30 (20-69)	40 (35-55)	41 (29-51)	26 (21-34)
Most common borough of residence at time of TB diagnosis (%)[4]	Queens (54%)	Brooklyn (100%)	Queens (50%)	Brooklyn (71%)	Manhattan (100%)	Queens (50%)
Proportion of patients reporting history of homelessness[4,6]	23%	0%	88%	29%	20%	50%
Proportion of patients reporting history of drug use or excessive alcohol use[4,6]	27%	57%	13%	86%	20%	100%
Proportion of patients with pulmonary disease[4]	92%	93%	100%	100%	100%	100%
Proportion of patients with a positive sputum smear[4,7]	63%	62%	38%	100%	100%	100%
Clusters in which social network links were identified among patients[4]	●	●		●		●
Clusters in which patients were links to the same neighborhood[4,8]	●	●	●	●	●	

1. Clusters include cases whose isolates have less than or equal to five single nucleotide polymorphism (SNP) differences among them based on whole genome sequencing results, as well as clinically-counted cases with confirmed epidemiologic links to cluster cases. 2. Includes clusters with four or more cases identified in three years and evidence of recent local TB transmission. 3. Includes one case counted outside NYC. 4. Among cluster cases identified between January 1, 2023, and December 31, 2025. 5. U.S.-born includes individuals born in the U.S. and U.S. territories. 6. In the 12 months before TB diagnosis. 7. Percentage is among patients with a pulmonary site of disease. 8. Within a 10-block radius.

Appendix

Table 9: Select demographic, social, and clinical characteristics among patients with confirmed TB disease by birth in the U.S.,[1] NYC, 2024-2025

Characteristics	2024						2025					
	U.S.-born[1]		Non-U.S.-born		Total[2]		U.S.-born[1]		Non-U.S.-born		Total[2]	
	n	%	n	%	n	%	n	%	n	%	n	%
Total	**83**	-	**749**	-	**832**	-	**77**	-	**665**	-	**743**	-
Age group												
0-17	15	18	19	3	34	4	6	8	11	2	17	2
18-44	33	40	415	55	448	54	37	48	313	47	350	47
45-64	17	20	170	23	187	22	21	27	156	23	178	24
65+	18	22	145	19	163	20	13	17	185	28	198	27
Gender identity												
Woman	34	41	234	31	268	32	23	30	191	29	214	29
Man	49	59	514	69	563	68	54	70	474	71	529	71
Nonbinary	0	0	1	0	1	0	0	0	0	0	0	0
Race and ethnicity												
Non-Hispanic white	10	12	26	3	36	4	13	17	32	5	45	6
Non-Hispanic Black	34	41	188	25	222	27	31	40	127	19	158	21
Hispanic	32	39	242	32	274	33	23	30	187	28	210	28
Asian	4	5	257	34	261	31	4	5	286	43	291	39
Multiple or other	3	4	34	5	37	4	6	8	29	4	35	5
Time in the U.S. (at time of reporting)												
< 1 year	n/a	n/a	120	16	120	16	n/a	n/a	36	5	36	5
1-5 years	n/a	n/a	288	38	288	38	n/a	n/a	257	39	257	39
> 5 years	n/a	n/a	335	45	335	45	n/a	n/a	351	53	351	53
Borough of residence												
Bronx	26	31	129	17	155	19	15	19	117	18	132	18
Brooklyn	20	24	195	26	215	26	33	43	185	28	219	29
Manhattan	15	18	130	17	145	17	16	21	64	10	80	11
Queens	22	27	267	36	289	35	13	17	277	42	290	39
Staten Island	0	0	28	4	28	3	0	0	22	3	22	3
Neighborhood poverty[3]												
Low (< 10%)	11	13	99	13	110	13	7	9	77	12	84	11
Medium (10% to < 20%)	31	37	369	49	400	48	30	39	342	51	372	50
High (20% to < 30%)	17	20	150	20	167	20	16	21	148	22	165	22
Very high (30% to 100%)	23	28	125	17	148	18	24	31	98	15	122	16

Table 9 (continued): Select demographic, social, and clinical characteristics among patients with confirmed TB disease by birth in the U.S.,[1] NYC, 2024-2025

Characteristics	2024						2025					
	U.S.-born[1]		Non-U.S.-born		Total[2]		U.S.-born[1]		Non-U.S.-born		Total[2]	
	n	%	n	%	n	%	n	%	n	%	n	%
Total	**83**	-	**749**	-	**832**	-	**77**	-	**665**	-	**743**	-
Homeless[4]	12	14	160	21	172	21	12	16	62	9	75	10
Employed[4,5]	24	48	235	40	259	41	30	52	259	55	289	55
Health care worker[4,5]	1	4	16	7	17	6	3	9	13	5	16	5
Respiratory smear positive ever[6]	38	51	355	54	393	54	48	67	311	53	359	54
Sputum smear positive[7]	36	95	342	96	378	96	44	92	283	91	327	91
Culture positive	67	82	608	81	675	81	63	83	552	83	616	83
Pulmonary only site of disease	50	60	518	69	568	68	53	69	452	68	506	68
Extrapulmonary only site of disease	8	10	92	12	100	12	4	5	79	12	83	11
Both pulmonary and extrapulmonary disease	25	30	139	19	164	20	20	26	134	20	154	21
Cavities present on chest radiograph ever[6]	22	29	141	21	163	22	18	25	115	20	133	20
Rifampin resistance[8]	1	1	14	2	15	2	1	2	14	3	15	2
Multidrug resistance[9]	1	1	13	2	14	2	1	2	9	2	10	2
Extensive drug resistance[10]	0	0	2	0	2	0	0	0	0	0	0	0
History of TB disease	9	11	50	7	59	7	3	4	46	7	49	7
HIV infection	4	5	29	4	33	4	3	4	21	3	24	3
Diabetes	13	16	124	17	137	16	14	18	147	22	161	22

1. U.S.-born includes individuals born in the U.S. and U.S. territories. 2. Totals may not equal the sum of U.S.-born and non-U.S.-born due to missing country of birth data. 3. Area-based poverty level is based on 2019-2023 American Community Survey data on the proportion of ZIP code residents living below the federal poverty level. Cases were assigned to a ZIP code based on their residence at TB diagnosis. 4. In the 12 months before TB diagnosis. 5. Among patients 18 years of age and older. 6. Percentage is among patients with a pulmonary site of disease. 7. Percentage is among patients ever respiratory smear positive. 8. Percentage is among patients with susceptibility testing performed for rifampin. 9. MDR-TB is defined as resistance to at least isoniazid and rifampin. Percentage is among patients with susceptibility testing performed for isoniazid and rifampin. 10. XDR-TB is defined as resistance to at least isoniazid and rifampin plus a fluoroquinolone and either a second-line injectable anti-TB medication, bedaquiline, or linezolid. Percentage is among patients with susceptibility testing performed for isoniazid, rifampin, any fluoroquinolone, and any second-line injectable anti-TB medication.

Table 10: TB cases and rates[1] by select characteristics, NYC, 1900-2025

Year	Number of TB cases	Rate per 100,000	Cases with positive culture	Cases with positive sputum smear	Multidrug-resistant cases[2]	Deaths attributable to TB[3]	Death rate per 100,000
1900	11,997	349.0				9,630	280.2
1910	32,065	672.7				10,074	211.3
1920	14,035	249.7				7,915	140.8
1930	11,821	170.6				4,574	66.0
1940	9,005	120.8				3,680	49.4
1950	7,717	97.8				2,173	27.5
1960	4,699	60.4				824	10.6
1970	2,590	32.8				432	5.5
1980	1,514	21.4				143	2.0
1990	3,506	47.9	3,384			256	3.5
2000	1,311	16.4	1,043	516	24	44	0.5
2001	1,232	15.4	938	454	25	33	0.4
2002	1,071	13.4	819	436	29	30	0.4
2003	1,131	14.1	865	428	22	34	0.4
2004	1,036	12.9	793	395	19	31	0.4
2005	983	12.3	745	378	24	21	0.3
2006	947	11.8	705	354	24	18	0.2
2007	909	11.4	707	379	9	16	0.2
2008	886	11.1	685	339	11	18	0.2
2009	757	9.5	539	281	9	25	0.3
2010	705	8.6	511	265	11	26	0.3
2011	684	8.4	501	264	16	32	0.4
2012	652	8.0	495	271	18	16	0.2
2013	650	8.0	473	258	7	17	0.2
2014	582	7.1	454	243	10	31	0.3
2015	575	7.0	444	240	5	20	0.2
2016	556	6.8	448	225	11	21	0.2
2017	608	7.4	504	261	15	15	0.1
2018	553	6.8	421	230	13	20	0.2
2019	559	6.8	461	254	12	24	0.2
2020	444	5.0	366	212	6	22	0.3
2021	529	6.0	441	239	9	24	0.3
2022	535	6.1	459	241	8	27	0.3
2023	679	7.7	564	304	13	27	0.3
2024	832	9.5	675	379	14	Not available	Not available
2025	743	8.4	616	329	10	Not available	Not available

1. Rates are based on decennial census data. 2. MDR-TB is defined as resistance to at least isoniazid and rifampin. 3. Data on TB deaths are obtained from the Health Department Office of Vital Statistics; deaths recorded in a given year may include cases diagnosed in a previous year.

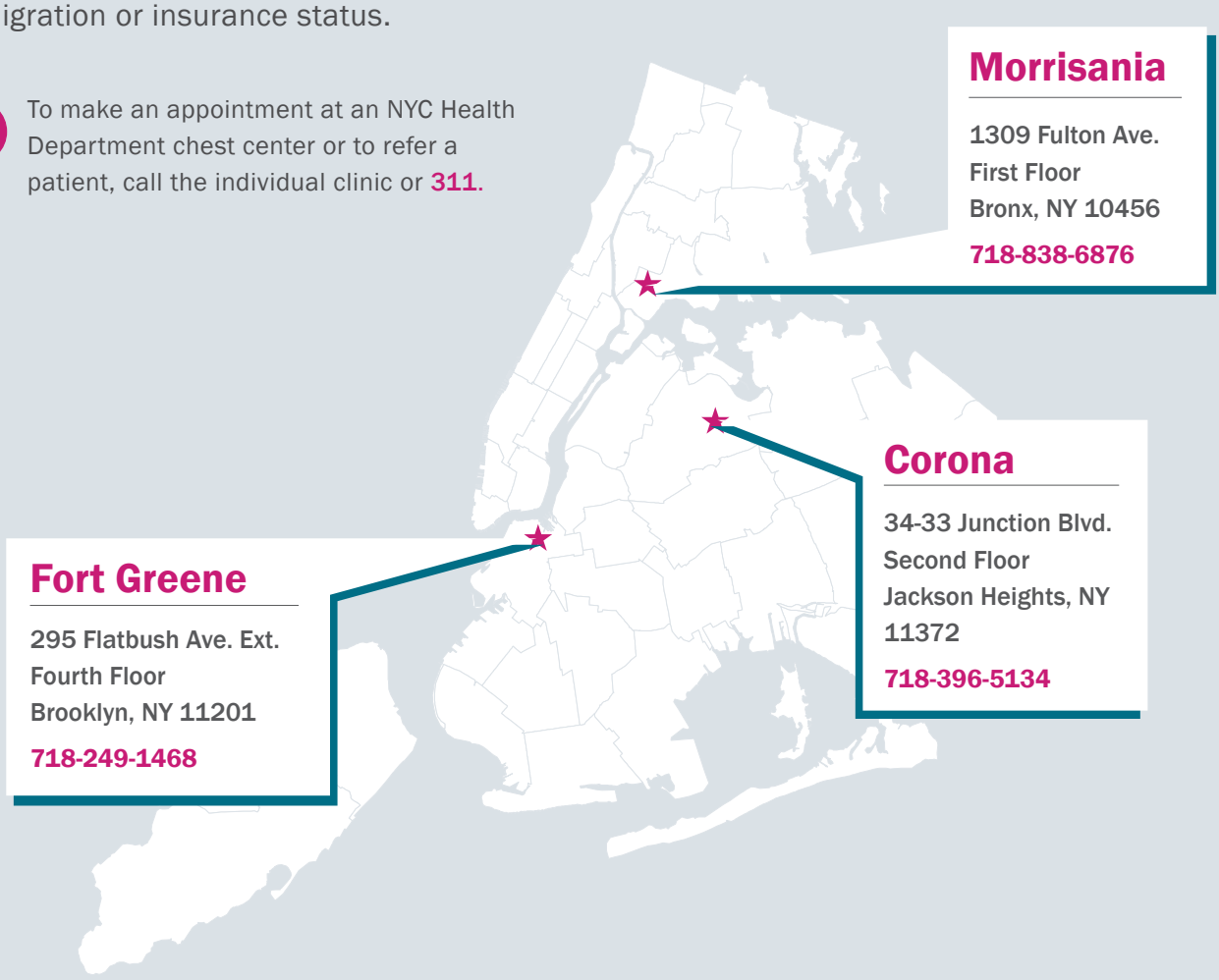
Technical Notes

- Data for 2025 are preliminary and reflect the most complete information available as of January 21, 2026, unless otherwise noted.
- Data prior to 2025 have been updated since the release of the 2023 report. Data for these years may differ from official estimates presented in previous reports.
- TB became a reportable disease on January 19, 1897. From 1920 to 1940, only cases of pulmonary TB were reportable. Beginning in 1978 the TB case definition was amended to consider people who had verified TB disease 12 or more months before their current diagnosis as incident cases of TB disease.
- Data on gender identity are not separated by cisgender or transgender and are presented as woman, man, and nonbinary.
- In all data tables, column sums may not equal applicable totals due to missing or unknown data.
- The sum of proportions do not always equal 100% due to rounding.
- All rates presented in this report are calculated per 100,000 population. Reported rates for earlier years may differ from previous reports due to corrected data and changes in the denominators used to calculate rates. The sources of denominator data are indicated throughout the report.
- The Health Department calculates population estimates based on modified U.S. Census Bureau interpolated intercensal estimates. Data are modified to account for population undercounts in northwest Queens and southern Brooklyn because of erroneously deleted housing units and housing units mislabeled as vacant. Population estimates are updated as new data become available. Therefore, rates may differ from previously reported rates.
- U.S.-born refers to patients born in the 50 states, Washington, D.C., or U.S. territories and outlying areas, including American Samoa, Baker Island, Guam, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Island, Navassa Island, Northern Mariana Islands, Palmyra Atoll, Puerto Rico, U.S. Minor Outlying Islands, U.S. Pacific Islands, U.S. Virgin Islands, and Wake Island. All others with a known country of birth are considered non-U.S.-born.
- Area-based poverty levels are based on the most recent five-year American Community Survey (ACS 5-year) data available at the time of publishing. The patient's ZIP code of residence at the time of TB diagnosis is mapped to the corresponding Modified ZIP Code Tabulation Area (MODZCTA) and subsequently to the ZIP Code Tabulation Area (ZCTA) in the ACS data. The ACS provides a measure of people living below the federal poverty level by census tract. Federal poverty level is a measure of income used by the U.S. government to determine eligibility for subsidies, programs, and benefits. The U.S. Department of Health and Human Services (DHHS) updates the poverty guidelines each January. Patients with addresses outside of NYC, addresses that were unable to be geocoded, or addresses located in ZIP codes where poverty level could not be determined were not assigned to a poverty level.
- The geographic distribution of cases is presented by the 42 United Hospital Fund (UHF) neighborhoods. These neighborhoods consist of adjoining ZIP codes that approximate NYC Community Planning Districts and contain an average of 200,000 individuals.
- Data presented on HIV status reflect information as collected by the Health Department's TB program. Misclassification of HIV status may occur if a patient refused to disclose known status or refused to be tested for HIV while under care for TB disease.
- Data on TB deaths are obtained from the Health Department Office of Vital Statistics. Deaths recorded in a given year may include cases diagnosed in a previous year.
- Product names are provided for identification purposes only; their use does not imply endorsement by the Health Department.

NYC Health Department Chest Centers

Eligible patients can be referred to one of three NYC Health Department chest centers for TB testing, radiography, sputum induction, and treatment as needed. All chest center services, including medication, are provided at no cost to the patient and regardless of immigration or insurance status.

To make an appointment at an NYC Health Department chest center or to refer a patient, call the individual clinic or **311**.



Morrisania

1309 Fulton Ave.
First Floor
Bronx, NY 10456
718-838-6876

Corona

34-33 Junction Blvd.
Second Floor
Jackson Heights, NY
11372
718-396-5134

Fort Greene

295 Flatbush Ave. Ext.
Fourth Floor
Brooklyn, NY 11201
718-249-1468

The Health Department provides a variety of TB services, including:

- Testing for TB infection using the latest-generation blood-based QFT-Plus test and TST
- Sputum induction
- Chest radiographs
- Medical evaluation
- Treatment for TB disease and LTBI
- DOT services, including vDOT

Additional clinical services provided at each chest center include:

- Outpatient medical and nursing care
- Phlebotomy services
- Social services referrals
- HIV education and testing regardless of need for TB care
- TB evaluation for newly arrived immigrants and refugees referred by the CDC