Antimicrobial Stewardship Honor Roll for Acute Care Setting

Acute Care Application

2025 Review Period

Thank you for your interest in the New Jersey Department of Health's (NJDOH) Antimicrobial Stewardship Honor Roll (ASHR). This is the application for healthcare entities in New Jersey that provide acute care services. A separate application should be completed for each location, even if elements of an organization's Antimicrobial Stewardship Program (ASP) are shared across a healthcare system or network. Acute care facilities will be evaluated based upon implementation of the Centers for Disease Control and Prevention (CDC) "Core Elements of Hospital Antibiotic Stewardship Programs" criteria and "Priorities for Hospital Core Element Implementation" supplements. In order for acute care facilities to achieve recognition status, they must demonstrate proficiency for all seven of the CDC Core Elements. When submitting supporting documentation to provide evidence of work within a CDC Core Element, please label the document according to the corresponding Core Element (CE) number, exactly as per the directions and guidance provided in each section and for each question on the application. Please note that this will NOT occur automatically, so title each document or file prior to uploading it in conjunction with your application. Make certain to remove all patient/resident identifying information, prior to submitting supporting documentation. Be certain to address all the components requested, both within the application and within the uploaded documents. Due to the number of applications received and reviewed, in addition to the competing priorities of staff, members of the New Jersey Department of Health will be providing limited to no feedback for cases in which recognition status was not granted.

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Requirements

- You are applying for recognition of the work completed in your facility and/or organization's ASP for the previous calendar year. If recognition is granted, it will be in the year during which you are applying, for the previous year's work. As such, ensure that the corresponding documentation you will be submitting reflects work and dates for the review period (2025), rather than the current year (2026).
- Antimicrobial stewardship (AS/AMS) is a component of infection prevention and control; answer questions from the context of an AS/AMS program and details that specifically relate to its activities.
- This application is for acute care services; the NJDOH highly recommends checking with your facility's administration to verify the licensure status of your building/organization. If an applicant proceeds with submitting an application that is not consistent with the facility's licensure status, this will preclude the application from proceeding any further, as requirements vary based on licensure. There will be no exceptions to this requirement.
- A designated individual, physically working within the licensed facility should submit the honor roll application, even if the aforementioned building is part of a larger network or organization. Proceeding in any other manner or using the same link(s) for multiple applications within a network or organization will "rewrite" and subsequently erase previously submitted applications, precluding consideration of the submitted application for recognition. There will be no special considerations or any exceptions granted for such occurrences.
- Use a desktop or laptop for completing the application, uploading the appropriately labeled documents, and submitting the application.
- Applicants should download a version of the application (PDF), review it, and compile all information and supporting documents. Applicants should review the supporting documents required of their application and ensure that the referenced supporting documents are prepared, completed, and labeled as directed, in preparation for uploading them as part of the application process. Once done, proceed with completing the application submission process in one sitting and address all aspects requested within the application and on the submitted documentation.
- In certain sections of the application, there have been numbers placed within parenthesis; these are intended to draw attention to required elements of the application and documents. Pay attention to these in order to avoid overlooking a requirement, realizing they are not entirely representative of additional requirements. There will be requirements to list a sampling of responses in text boxes and then corroborate them in conjunction with uploaded documents at times; in such cases, the information present in the documents that will be uploaded should be used as a basis for providing data requested in the text boxes, with all requested elements matching accordingly.
- An e-mail message confirming completion of the application will be sent out once it is submitted, with the option to amend or modify it, if necessary. All application editing, modification, and/or necessary actions for completion must be performed prior to the application deadline of 2/6/2026.

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Facility Data

This is an application for acute care facilities; you should confirm that you are licensed as such with your organization's administration. A failure to apply in accordance with the correct licensing status will preclude further consideration of your application and recognition status.

1. Date of application *

2. Organization details *

*Please write out the **full name** of your facility. The organization/facility name will be recorded EXACTLY as written in the text box that follows. It will appear as such on the NJDOH website, should recognition be granted.*

Organization/facility name

Organization/facility street address

Town/City

Zip Code

3. Organization License *

Upload a copy of the facility's current license as registered with the New Jersey Department of Health - Licensing and Certification Division.

Label as "**Facility License**" Choose File No file selected

4. Primary contact information *

Please indicate one e-mail address, check it for accuracy, and remain consistent for all correspondence; the person submitting the application for their building should be designated as the primary contact.

First name

Last name

Credential

E-mail address

Title/Role

Telephone number

5. Secondary contact information *

*Please indicate **one** e-mail address and remain consistent for all correspondence.*

First name

Last name

Credential

E-mail address

Title/Role

Telephone number

Core Element 1: Leadership Commitment

6. Leadership Commitment *

There is administrative leadership that provides program leaders (AS physician and/or pharmacist) with dedicated time to manage ASP interventions and protocols. A physician and pharmacist are part of the organization's AS protocols.

☐ Yes, I confirm my facility fulfills this requirement.

7. Description of the ASP activities *

Provide a job description of the individual responsible for overseeing the ASP, including a description of the tasks associated with ASP activities.

8. Resources *

There is support and/or resources from leadership in the form of informational technology (IT) support.

☐ Yes, I confirm my facility fulfills this requirement.

9. Description of Support or Resources *

Please name the computer database/electronic health record software system used at your organization and describe how its use promotes principles of AS.

10. Routine Meetings and Findings *

There are routine meetings to discuss developments and findings with respect to the ASP.

☐ Yes, I confirm my facility fulfills this requirement.

11. Description of AS developments *

Please copy/paste meeting notes that reference developments, findings, outcomes, and actions taken in AS, as evidenced by meeting agendas and/or notes, including dates. The meeting notes and related activities should be reflective of the review period.

12. NHSN Procedures *

A lead team member has been established by the organization and this individual has enrolled in NHSN to report upon antimicrobial use (AU) and/or antimicrobial resistance (AR) data. This is required by the Centers for Medicare & Medicaid Services (CMS) Promoting Interoperability Program. Please note, the response to this section must be consistent with the requirement of your specific facility, in accordance with licensing status.

☐ Yes, I confirm my facility fulfills this requirement.

☐ No, my facility applied for and has been granted exemption from NHSN participation.

☐ No, my facility is ineligible to participate because it is licensed as an inpatient rehabilitation facility, inpatient psychiatric hospital, or a long-term acute care hospital (LTACH).

13. NHSN Procedure Details *

Please note if there is no lead team member/reporter, type in "NA".

Full name of NHSN Administrator

Credential of NHSN Adminstrator

Title/Role of NHSN Administrator	
Full name of Lead team member/reporter	
Credential of Lead team member/reporter	
Title/Role of Lead team member/reporter	
NHSN organizational identification number (OrgID)	

14. NHSN Exception Documentation *

Provide and upload a complete copy of evidence/documentation of the exemption status. The referenced documentation can be a letter, screenshot of an e-mail, or related document. The referenced document should clearly indicate your organization's name and exemption status. It should reference the date on which exemption was granted.

Label as **"CE1D"** Choose File No file selected

Core Element 2: Accountability

15. Accountability in Physician, Pharmacy, and Team Leadership 1 *

The ASP has a designated physician leader and a designated pharmacist co-leader; note, the second aspect (pharmacist/drug expertise) will be addressed in the next section).

☐ Yes, I confirm my facility fulfills this requirement.

16. Antimicrobial Stewardship Physician Leader Details *

Provide the details for your antimicrobial stewardship physician leader as follows:

Full name

Credential

Title/Role

17. Accountability in Physician, Pharmacy, and Team Leadership 2 *

The ASP has a designated nursing leader.

☐ Yes, I confirm my facility fulfills this requirement.

18. Antimicrobial Stewardship Nursing Leader Details *

Provide the details for your antimicrobial stewardship nursing leader as follows:

Full name

Credential

Title/Role

19. Accountability in Physician, Pharmacy, and Team Leadership 3 *

The ASP has a designated administrative leader.

☐ Yes, I confirm my facility fulfills this requirement.

☐ No, my ASP does not have a designated administrative leader.

20. Antimicrobial Stewardship Administrative Leader Details *

Provide the details for your antimicrobial stewardship administrator leader as follows:

Full name

Credential/Degree type

Title/Role

Core Element 3: Pharmacy Expertise

21. Drug Expertise in Pharmacy Leadership *

The ASP has a designated pharmacist leader.

☐ Yes, I confirm my facility fulfills this requirement.

22. Drug Expertise in Pharmacy Leadership Details 1 *

Please provide the details for your antimicrobial stewardship pharmacist leader as follows:

Full name	
Credential	
Title/Role	

23. Drug Expertise in Pharmaxy Leadership Details 2 *

Knowledge of drug expertise in pharmacy will be demonstrated by one of the following, choosing the option that is most applicable to the team member acting as the AS/AMS lead for your facility:

☐ I have participated in continuing education credit(s) (CEUS(s)) in antimicrobial stewardship (AS/AMS). The referenced activity has occurred during the review period or the preceding 2 years.

☐ I have participated in training through a certification program in antimicrobial stewardship (AS/AMS). The referenced activity has occurred during the review period or the preceding 2 years.

☐ I have experience in infectious disease (ID) and/or antimicrobial stewardship (AS/AMS) and serve as a subject matter expert (SME) within the organization's workplace. The referenced activity has occurred during the review period or the preceding 2 years.

24. Drug Expertise in Pharmacy Leadership Details 3 *

Provide evidence of the previous attestation to demonstrate pharmacy expertise and include all of the following: (1) Name the continuing education (CEU) course completed, certification program completed, or describe experience and activities in ID and/or AS/AMS with detail and (2) include the year that CEU(s) or certificates were completed or range of time for attainment of experience. The description in the text box that follows should describe and correspond to the chosen attestation (chosen option) preceding it.

Activity Description	
Year or time range	

Core Element 4: Action

Please note, all patient identifiers/information should be redacted for privacy.

25. Action *

Choose one of the following conditions to demonstrate how clinical staff members implement interventions and optimize the use of antimicrobials for associated treatment.

- ☐ Urinary tract infection (UTI)
- ☐ Skin/soft tissue infection (SSTI)
- ☐ Respiratory tract infections (Upper (URTI) and/or Lower (LRTI))

26. Action Documentation 1 *

Provide and upload a complete copy of a policy/procedure related to the previously chosen infection. It should include criteria and protocols used to determine the manner in which treatment will occur with the intent to optimize antimicrobial therapy. The referenced recommendations should be developed in accordance with evidence-based medicine and/or national guidelines related to antimicrobial therapy selection.

Label as "**CE4A**" Choose File No file selected

27. Action Documentation 2 *

Provide and upload a complete copy of a policy that describes interventions to (1) prevent, (2) reduce and/or eliminate the development of Clostridioides difficile, and (3) list treatment protocols to be implemented where the condition is present. All three of the referenced matters must be addressed in the document.

Label as "**CE4B**" Choose File No file selected

28. Action Documentation 3 *

Provide and upload a complete copy of a policy for antimicrobial agents that require preauthorization or a policy for timeout procedures. The provided policy should describe details of how preauthorization processes occur OR how timeout procedures are implemented. If a preauthorization process is used to meet this requirement, please include a list of the antimicrobials that require such review.

Label as "**CE4C**" Choose File No file selected

29. Action Documentation 4 *

Provide and upload a complete copy of a policy/procedure that demonstrates consistent prospective audit and feedback procedures for certain antimicrobial agents. It should include a brief description of a review process and the details of how staff will ensure the ongoing safe and appropriate use of antimicrobial regimens, once they have been initiated.

Label as "**CE4D**" Choose File No file selected

Core Element 5: Tracking

Please note, all patient identifiers/information should be redacted for privacy.

30. Tracking Documentation 1A

Provide details in each section as requested and then upload a complete copy of a tracking report to corroborate the antimicrobial orders. These must include:

(1) Drug name

(2) Drug dose

(3) Duration of drug regimen

(4) Associated diagnoses

The information provided in the grid that follows should be present in the report that will be attached in the next section, which serves as the basis for providing details in the individual text boxes. The period of time for which the referenced data was captured should be within the review period.

The intent of this requirement is to demonstrate proactive and consistent antimicrobial therapy tracking processes.

	Drug Name	Dose	Duration	Diagnosis
Antimicrobial Order 1				
Antimicrobial Order 2				
Antimicrobial Order 3				
Antimicrobial Order 4				
Antimicrobial Order 5				

31. Tracking Documentation 1B *

Provide and upload a complete copy of the corresponding tracking tool of antimicrobial orders. All of the following should be present on the attached, corresponding document (tracking tool):

(1) Drug name

(2) Drug dose

(3) Duration of drug regimen

(4) Associated diagnoses

The uploaded document should reflect the review period and indicate a date and/or time period for which the referenced antimicrobial regimens were administered to residents (e.g. month/year). The intent of this requirement is to substantiate proactive and consistent antimicrobial therapy tracking processes.

Label as "**CE5A**" Choose File No file selected

32. Tracking Documentation 2 *

Provide and upload a complete copy of a data report for quantitative tracking measures of antimicrobial agents.This requirement may be addressed by accounting for length of therapy (LOT), days of therapy (DOT) per 1,000 resident days, and/or measurement of antimicrobial use rates for a designated period of time.

The information requested here intends to capture the antimicrobial use (AU) data as a measurable quantity, for an interval of time that falls within the review period. The requested data is different and independent of infection rates. Submission of data related to infection rates will not meet the requirement.

Label as "**CE5B**" Choose File No file selected

33. Tracking Documentation 3 *

Provide and upload a complete copy of a routine report that includes the rate at which patients have been discharged on appropriate antimicrobials for the recommended duration. Include all of the following, previously referenced elements: (1) drug name, (2) drug dose, (3) duration of treatment, and (4) diagnoses, and (5) whether the

discharge therapy regimen was deemed appropriate. All data should be reflective of the review period.

Label as "**CE5C"** Choose File No file selected

Core Element 6: Reporting

Please note, all patient identifiers/information should be redacted for privacy.

34. Reporting *

The previously referenced data is compiled and shared as a report, on a routine basis, with prescribers, the interdisciplinary ASP team, and ancillary staff members for the purposes of improving AS practices within the organization.

☐ Yes, I confirm my facility fulfills this requirement.

35. Reporting Documentation 1 *

Provide complete evidence, in the form of meeting notes, that the previously tracked data (drug name, dose, duration, diagnosis, measurable tracking element, and adverse drug reaction monitoring) was shared with the interdisciplinary team. The meeting notes should include all three of the following: (1) a date, (2) names of meeting participants, and (3) a summary or notes of interventions or actionable items that may have occurred in antimicrobial stewardship, as a result of tracking and continued development of the program. The attached document should be reflective of information and actions that occurred during the review period.

Label as **"CE6A"** Choose File No file selected

36. Reporting Documentation 2 *

Provide and upload a complete copy of an antibiogram that has been distributed to prescribers and includes antimicrobial resistance patterns from the previous 24 months.

Label as **"CE6B"** Choose File No file selected

37. Reporting Documentation 3 *

Provide and upload a complete copy of a de-identified medication use evaluation (MUE) report. The referenced report should include the following: (1) review of at least one antimicrobial agent or one antimicrobial class, (2) one condition that pertains to the antimicrobial agent or class, (3) a description of the purpose/need for the review, (4) the criteria for the chosen sample of patients, (5) the compiled data and analysis, (6) the resulting interventions and/or actionable items, (7) an evaluation or conclusion that was shared with members of the team, and (8) a date or referenced time period, which should be within the review period.

Label as **"CE6C"** Choose File No file selected

Core Element 7: Education

38. Education Documentation 1 *

Provide and upload a complete copy of annual education provided to prescribers, nurses, and ASP team members. The referenced educational material should include the (1) name, (2) credential and title/role of the educator, and (3) the date on which it was completed. The educational component should address ALL THREE of the following topics related to (4) optimal prescribing of antimicrobial agents, (5) adverse drug reactions, and (6) antimicrobial resistance.

In addition, the education should be designed and targeted towards healthcare professionals, rather than patients, recipients of care, or members of the general public. It may be a slideshow presentation, a handout with accompanied discussion, or something comparable involving an interactive opportunity that meets the intent of the requirement and conducted during the review period. The required elements are as follows:

(1) Name of presenter/educator
(2) Credential and title/role of presenter/educator
(3) Date of educational activity
(4) How optimal prescribing will occur
(5) The importance of adverse drug reactions
(6) The importance of antimicrobial resistance (AR)

Label as **"CE7A"** Choose File No file selected

39. Education Documentation 2A

Provide details in each section and then upload a corresponding copy of a sign-in sheet regarding the referenced education to include and corroborate the following:
(1) Name
(2) Credential
(3) Signature of participant (may be written or electronically time-stamped)

The participants (audience) in the educational activity should include at least one of each of the following:
(4) A prescriber
(5) A nurse
(6) A pharmacist

Any other relevant team members, deemed necessary by leadership, may be included. The representative participants and corresponding disciplines should be evident (explicitly noted) on the sign-in sheet. The (7) date and (8) title of the educational activity on the sign-in sheet should match the date and title of the antimicrobial stewardship (AS/AMS) educational activity in the previous section and reflect the review period.

	Name of Participant	Credential, Title, or Role
Physician		
Nurse		
Pharmacist		

40. Education Documentation 2B *

Provide and upload a corresponding copy of the names, credentials, titles/roles, and signatures of all AS education participants (attendees) on a sign-in sheet, completed as part of the educational component and as a confirmation of attendance.

Label as **"CE7B"** Choose File No file selected

41. Education Documentation 3 *

Provide and upload a complete copy of a document used for communication and education regarding AS and AR principles to others (e.g. a CDC handout, brochure, poster, detailed documentation of counseling provided in nursing notes, or similar materials that may be facility-specific in nature). The educational activity and/or document should raise awareness of antimicrobial stewardship concepts to patients, recipients of care, their family members, representatives, or guardians. It should be understandable by members of the general public.

Label as **"CE7C"** Choose File No file selected

Antimicrobial Stewardship Honor Roll for Acute Care Setting

Disclaimer Agreement

42. Please remember the following, as per the previous instructions: *

1. All documents must be labeled as per the application instructions; there should be documents with labels for each of the following present, as part of the completed application: Facility License, CE4A, CE4B, CE4C, CE4D, CE5A, CE5B, CE5C, CE6A, CE6B, CE6C, CE7A, CE7B, and CE7C. Applications submitted with any other document labels or titles will not be graded.

2. All documents should coincide with the date of the review period (2025); do not submit documents from the current year or any other year, since the application is assessing work completed in the previous year (review period).

3. The application must coincide with facility licensing (acute care); please check with your facility administration regarding your organization's status, before submitting an application, regardless of which setting type you may think coincides with your related work.

4. I have read all directions in their entirety and will follow all guidance in them, realizing that doing so does not imply a guarantee of any achievement and that failure to do so will preclude recognition.

5. The New Jersey Department of Health staff will provide guidance as deemed appropriate during the application submission period, but have limited contact regarding outcomes, once the application submission period ends and recognition results are posted.

6. If honor roll recognition is achieved, all recipient facilities will be acknowledged by a posting of their names on the New Jersey Department of Health website.

☐ I have read and understand all of the application instructions and related requirements.