



2021 Monthly Submission Schedule

As specified in the Utah Emergency Medical Services Act (*Utah Code Title 26 Chapter 8a Section 253*), all acute care hospitals are required to regularly submit trauma data to the trauma registry. The submission schedule for calendar year **2021** is shown below. Late notices and submission status notifications are sent by the IICRC with a copy to BEMSP.

Q1 2021			Q2 2021			Q3 2021			Q4 2021		
JAN 2021 Due March 31, 2021	FEB 2021 Due April 30, 2021	MAR 2021 Due May 31, 2021	APR 2021 Due June 30, 2021	MAY 2021 Due July 31, 2021	JUNE 2021 Due Aug 31, 2021	JULY 2021 Due Sept 30, 2021	AUG 2021 Due Oct 31, 2021	SEPT 2021 Due Nov 30, 2021	OCT 2021 Due Dec 31, 2021	NOV 2021 Due Jan 31, 2022	DEC 2021 Due Feb 28, 2022
Late notice sent 4/1/21	Late notice sent 5/1/21	Late notice sent 6/1/21	Late notice sent 7/1/21	Late notice sent 8/1/21	Late notice sent 9/1/21	Late notice sent 10/1/21	Late notice sent 11/1/21	Late notice sent 12/1/21	Late notice sent 1/1/22	Late notice sent 2/1/22	Late notice sent 3/1/22

Common Null Values

These values are to be used with each of the Utah Trauma Registry Data Elements described in this document which have been defined to accept the Null Values.

<i>Utah Values</i>	<i>NTDS Values</i>	<i>Description</i>
NA	1	Not Applicable
NOT	2	Not Known/Not Recorded

Additional Information: For any collection of data to be of value and reliable, a strong commitment must be made to ensure the correct documentation of incomplete data.

- **Not Applicable:** This null value code should be utilized if at the time of patient care documentation, the information requested did not apply to the case at hand. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transport to the hospital.
- **Not Known/Not Recorded:** This null value applies if, at the time of patient care documentation, information was unknown to the patient, family, or health care provider **or** the information was not documented in the patient’s record. Use of this value documents that there was an attempt to obtain information but it was unknown by all parties involved at the time of documentation, or that the information was not supplied or documented in the patient’s record. For example, injury date and time may be documented in the hospital patient care report as “Unknown” or the patient arrived by ambulance; however, no EMS run sheet is in the patient record.