



Monthly Submission Guidelines:

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. While hospitals are strongly encouraged to submit data monthly, they are required to submit no less frequently than quarterly. The submission schedule for calendar year **2016** is shown below. Late notices and submission status notifications are sent by the IICRC with a copy to BEMSP.

Q1 2016			Q2 2016			Q3 2016			Q4 2016		
JAN 2016 Due June 30, 2016	FEB 2016 Due July 31, 2016	MAR 2016 Due Aug 31, 2016	APR 2016 Due Sept 30, 2016	MAY 2016 Due Oct 31, 2016	JUNE 2016 Due Nov 30, 2016	JULY 2016 Due Dec 31, 2016	AUG 2016 Due Jan 31, 2017	SEPT 2016 Due Feb 28, 2017	OCT 2016 Due Mar 31, 2017	NOV 2016 Due Apr 30, 2017	DEC 2016 Due May 31, 2017
Late notice sent 7/1/16	Late notice sent 8/1/16	Late notice sent 9/1/16	Late notice sent 10/1/16	Late notice sent 11/1/16	Late notice sent 12/1/16	Late notice sent 1/1/17	Late notice sent 2/1/17	Late notice sent 3/1/17	Late notice sent 4/1/17	Late notice sent 5/1/17	Late notice sent 6/1/17

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.

Utah Values	NTDS Values	Description
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