

The Lab Data Standard for Electronic Health Records

What Is ELINCS?

ELINCS is the EHR-Lab Interoperability and Connectivity Specification. It standardizes the formatting and coding of electronic messages exchanged between clinical laboratories and ambulatory electronic health record (EHR) systems.

ELINCS is an example of a clinical data standard — an agreed upon set of rules that allow information to be shared and processed uniformly, thereby providing a common language for patient care. Adopting these standards helps providers deliver the right care by making information available at the right time.

CHCF's Involvement in Developing ELINCS

In collaboration with electronic health record vendors, commercial laboratories, government agencies, professional associations and nonprofit organizations, the California HealthCare Foundation (CHCF) sponsored the development of ELINCS.

ELINCS has been adopted by HL7, the internationally recognized standards development organization for health information. HL7 is responsible for the ongoing maintenance and further development of ELINCS.

What Are the Barriers to Widespread Adoption?

Unlike other industries such as banking, health care data standards are not uniformly available or adopted. Most health information is shared in an antiquated, paper-based fashion that cannot capture important clinical information, such as reminders or other prompts to doctors. Although laboratory orders and test results are generated electronically, the lack of standards means that new agreements about how the information should be exchanged between each lab and EHR in the community needs to be brokered every time, driving more cost and inefficiency into the system.

Key Benefits of ELINCS

- **Improved practice efficiency.** Eliminates the need for physicians or office staff to send paper lab orders, enter lab data manually, scan paper lab reports, or track down missing results.
- **Easier implementation of EHRs.** Dramatically reduces the time and cost required to build electronic interfaces between lab information systems and EHRs.
- **Improved quality of care.** Allows clinicians to compare results over time, graph trends, identify patients requiring interventions, and prevent unsafe or unnecessary treatment.
- More efficient reporting between labs and multiple EHR systems. Enables reporting to all physician practices in a community instead of just a few.
- Faster delivery of test orders and results in a reliable and cost-effective method. Helps prevent errors and reducing cost.
- Achieve 'meaningful use.' Enables physicians to more easily incorporate structured lab data into their EHRs.