This memorandum is being sent to the members of the Island Health Medical Staff.
Please distribute to your colleagues as you deem appropriate.

memorandum

island health

The following has been sent on behalf of Dr. Mary-Lyn Fyfe, Chief Medical Information Officer

March 20, 2026

Subject: Heidi AI Scribe Onboarding and Support

Dear Colleagues:

As communicated on January 15, 2026, Island Health has joined the provincial BC Scribe Self-Pay program. This program enables Island Health Medial Staff the opportunity to obtain discounted subscription rates from five approved scribe vendors, see Medical Staff website for details: AI Scribe at Island Health | Medical Staff.

Heidi, one of the five approved scribe vendors, has provided further complimentary onboarding, support and support information Medical Staff may leverage. We will continue to provide this type of communication as new information is received from any of the approved BC Scribe vendors.

Complimentary Heidi Support

Live Onboarding

- Join a live onboarding session to ask questions of the HEIDI team:
- https://www.heidihealth.com/en-us/live-onboarding

Quick Resources

- For quick answers, view Heidi Resource Page. It has:
  - How to subscribe, with Scribe BC discount code
  - Session recordings on how to get started
  - Tips and tricks, including how to create and edit your templates

Template Support

- To have Heidi help to create note templates, fill out this form here. The requested template will automatically be added to your account.
- Please ensure that the templates resemble those that are Island Health approved and are in accordance with both the Medical Staff Rules, Island Health Clinical Documentation Policy and Medical Staff Bylaws (Appendix A, B, C).

Weekly Q&A availability

- Two days a week you can drop in virtually and connect with a Heidi team member to ask questions one on one. Book time here.

- If you're unable to attend those sessions or need help sooner, to reach out to us at the dedicated priority support channel for Scribe BC participants: support+scribebc@heidihealth.com

Please distribute this to your medical staff colleagues. Thank you.

Let me know if you have any questions or concerns. Alternatively, please call the Clinical Solutions Desk at 250.370.8777.
Sincerely,

Mary-Lyn

Dr. Mary-Lyn Fyfe
Chief Medical Information Officer

Appendices

Appendix A - Medical Staff Rules
Link: https://intranet.islandhealth.ca/pnp/pnpdocs/medical-staff-rules-vancouver-island-health-authority-island-health.pdf

Key sections noted and not limited to the following:
1.2.1.6 (ii)
Complete and document a full assessment for admission, including a full history, physical examination and orders for ongoing care;
1.2.4.2
A consultation is a request for a professional opinion, advice or support in the management of a patient. The consultant will provide an in-person evaluation of the patient, a review of all necessary documentation and the provision of a timely, electronically entered or dictated report. The evaluation should provide a clinical opinion, recommendations for management and/or treatment, and the basis for the advice given. The consulting Practitioner will notify the MRP on completion of the consultation in a timely and mutually
1.2.4.5 Reports (i)
All consultations and transfer-of-care documents will follow best-practice guidelines established by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians Canada (CFPC). Where the EHR is implemented in a VIHA Facility or Program, these documents must also meet or exceed the EHR documentation standards. These reports are subject to practice audits to ensure compliance with documentation standards.
1.2.5.4
Patients admitted through the ED or transferred to a higher level of care must have an initial admission note that includes the presenting problem requiring admission, the results of physical examination and ancillary investigations, as well as an initial care plan provided by the MRP or delegate. In VIHA Facilities that have implemented the EHR, the initial admission note must be entered into the EHR.
1.2.7.3

At a minimum, a transfer note, but preferably a discharge summary, completed by the sending Practitioner must accompany the patient upon transfer either as a legible, signed and dated hardcopy delivered with the patient or, where both sites have deployed the EHR, by entry into the EHR.

1.2.8.2

The MRP or delegate on-call will provide a discharge order and complete a discharge summary using a discharge template approved by HAMAC. For detailed summaries and associated templates, the HAMAC-approved templates should be referenced. The discharge summary shall conform to the EHR documentation policy in Facilities where the EHR has been deployed. Incomplete or inaccurate discharge summaries can impact the ability to extract accurate patient data for improvement purposes.

1.2.8.3

A required component of the discharge process includes provision of follow-up instructions and a specific post-discharge plan to the patient, caregivers and medical Practitioner. These instructions should include a list of all appointments made with consultants, any pending outpatient investigations, outstanding tests and any home and community care supports arranged or needing to be arranged.

1.2.9.2

The operative report must contain, at a minimum:

I. The patient's name and Health Record number;
II. The name of the primary surgeon and assistant(s);
III. The names of Practitioners who should receive a copy of the report;
IV. Date and time of admission;
V. Date of procedure;
VI. Pre-operative and post-operative diagnosis;
VII. Proposed procedure(s) and indications;
VIII. Operative procedure(s) performed;
IX. Operative complications, if any;
X. The patient s condition before, during and immediately after the operation;
XI. Estimated blood loss; and
XII. Specimens removed and their disposition (e.g., to pathology).

1.2.9.4

Operative and procedural reports will be documented in a VIHA-approved template and format. Where the EHR platform is in use, the report must be completed in the EHR.

1.4.4.3

Progress notes will document:

I. The date and time of assessment or intervention;
II. Any material change in the patient s condition;
III. Active monitoring, investigation and treatment, including the management of a problem list; and
IV. Any revision to the anticipated date of discharge, discharge plan or prognosis.

3.1.2.4

In the case of an off-site consultation at the consultant's office, documentation and communication will comply with the guidelines set forth by the College of Physicians and Surgeons of BC.

3.1.4.1

The MRP or delegate will provide a discharge order and complete the discharge summary in compliance with the EHR documentation policy, including communication about the course in the Facility or Program, medications, follow-up plans, resident disposition and any advance care plans to the community Practitioners and healthcare professionals.

Appendix B – Clinical Documentation Policy 16.1.3P

Link: https://intranet.islandhealth.ca/pnp/pnpdocs/clinical-documentation-policy.pdf

Key sections noted and not limited to the following:

1.1.1 Accuracy

- To ensure accuracy, Health Care Professionals must:
  - Enter patient information using appropriate designated data fields or forms (e.g., allergies, problem lists-as applicable, goals of care, etc.) to leverage clinical decision support tools and improve patient safety;
  - Use appropriate dropdown menu or field to capture assessment information;
  - Verify any content taken directly (i.e., verbatim) from other Health Care Professionals' documentation or notes and reference the original source.
    - Consider "tagging" which increases efficiency and identifies the original author for you.
  - Include day, month (written in letters) and year (e.g., 07 JAN 2016). Time must be captured using the 24h clock format (e.g., 0800). Exception: Systems that automatically complete the date in a system specific manner.
- EHR functionality, such as templates, macros and auto text, may be used to standardize how information is presented and increase efficiency. However, Health Care Professionals should ensure their documentation remains individualized and accurate.

1.1.3 Comprehensiveness

- All Health Care Professionals must document in the Health Record in accordance with applicable legislation, professional regulatory standards, Island Health Policies (including the Management of Health Records Policy), and Island Health Medical Staff Rules as applicable.
- Structured and Narrative documentation are complimentary and integral to ensuring a comprehensive clinical record. Narrative documentation provides context rather than replace structured documentation.
- Where applicable, documentation must include the following elements: observation, assessment findings (normal or abnormal), interventions, patient outcomes (intended or unintended), and services provided; including information or concerns reported to another Health Care Professional and their response.
- Instances where it is appropriate to document observations or care provided by others to the patient, documentation must clearly reflect who performed or observed the activity and who recorded the observation/activity.
- Communication (e.g., pages, calls, texts, etc.) to a Health Care Professional and response/lack of response, must be documented. If repeat communication attempts to the Health Care Professional (or other Health Care Professionals), are necessary to ensure timely care, these additional steps taken need to be documented.
- Advice received from another Health Care Professional must be documented.

- Advice given to a patient must be documented.
- Document types, minimum documentation requirements and frequency of documentation will be completed as outlined in Appendices A, B, C and D and in accordance with Island Health standards.

Appendix C – Medical Staff Bylaws

Link: https://intranet.islandhealth.ca/pnp/pnpdocs/medical-staff-bylaws-vancouver-island-health-authority.pdf

Key sections noted and not limited to the following:

Article 2 - Purpose of the Medical Staff Organization

2.1 General Purpose

2.1.3 To assist in providing adequate and appropriate documentation for the purpose of maintaining a health record for each patient.