Securing Bring Your Own Application AI Scribes for Northern Health (Step-by-step)

Note: Vendors are continuously changing their applications to incorporate new features and functionality. This often results in changes to their user interfaces. The images used in this document are current as of **February 26, 2026**.

- **Audience:** Physicians and clinical staff using Bring Your Own Application (BYOA) AI scribes in NH clinical settings.

- **Goal:** Minimize privacy and access risks without compromising clinical functionality. NH provided EMR/EHR (MOIS, Cerner) are the system of record.

- **Supporting Resources:** BC Scribe Self Pay Program: Important Resources

Autochart.ai

Autochart.ai provides AI-assisted clinical documentation; onboarding includes selecting country of practice, language defaults, and EMR/EHR information.

Support and escalation

Support for this application is entirely provided by the vendor.
Please review the support links below.

- Vendor Site: [Autochart.ai | Get started in seconds. Save hours every day](#).
- Vendor Help: [Autochart.ai Help Center, https://www.youtube.com/watch?v=WU-x4YB8HxY](#)
- Provincial Toolkit: [Important Resources](#)

1. Canadian residency / in-Canada processing

Data for this application resides in Canada. There is no option to change this in the application.

2. Data retention and deletion

This application does not allow the user to determine data retention limits. It does allow the user to delete documentation created and stored within the application.

The completed encounters are under "Completed" on the left-hand menu.
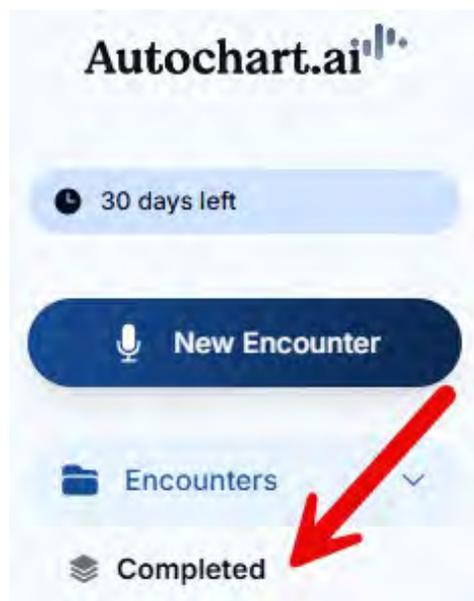
To delete the encounter, press the delete icon on the right side of the record.

[SAMPLE CHART] Osteoporosis and Anxiety Management
Thu, Feb 26, 2026 | Start: 21:00 | Finish: 21:15 | Duration: ≈ 15 m 24 s
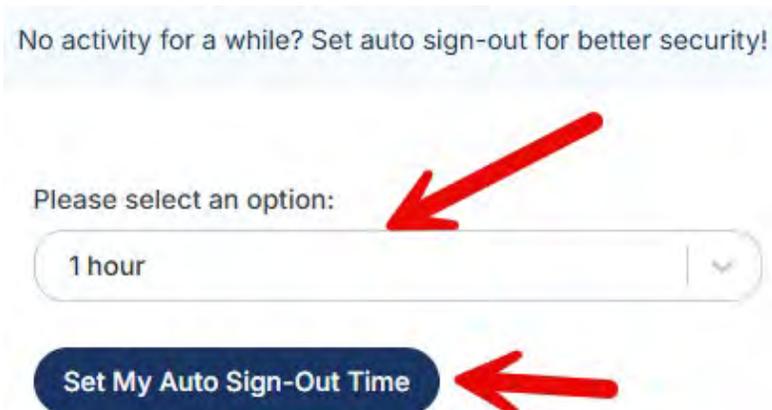
3. Auto logout / session management

The applications provides an inactivity timeout that is configurable by the user.
On the left hand bar, go into Settings -> Account.

Encounters   >

Settings   ⌄

AI Settings

App Settings

Account
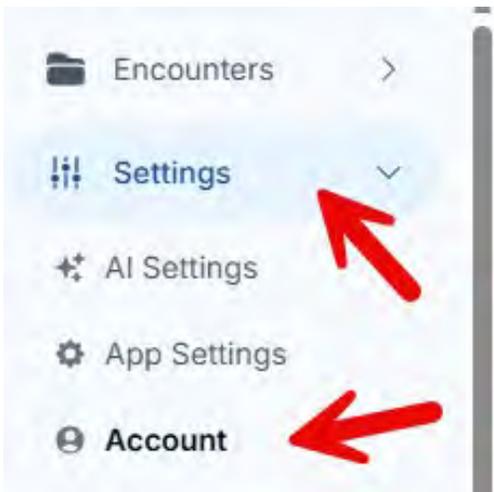
On the top of the screen choose "Auto Sign-out".

Auto Sign-Out

Set the timeout duration and press the "Set My Auto Sign-Out Time"

No activity for a while? Set auto sign-out for better security!

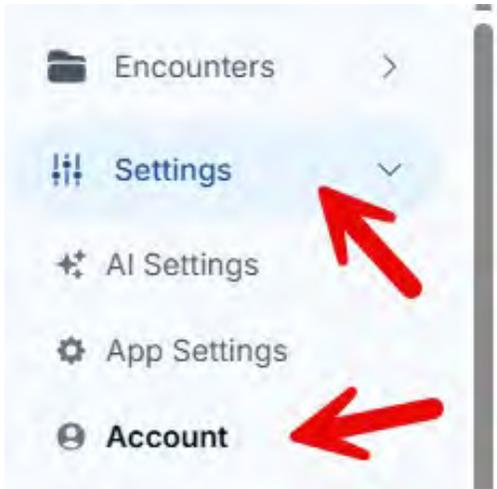Please select an option:

1 hour

Set My Auto Sign-Out Time

4. Multi-factor authentication (MFA) and access restrictions

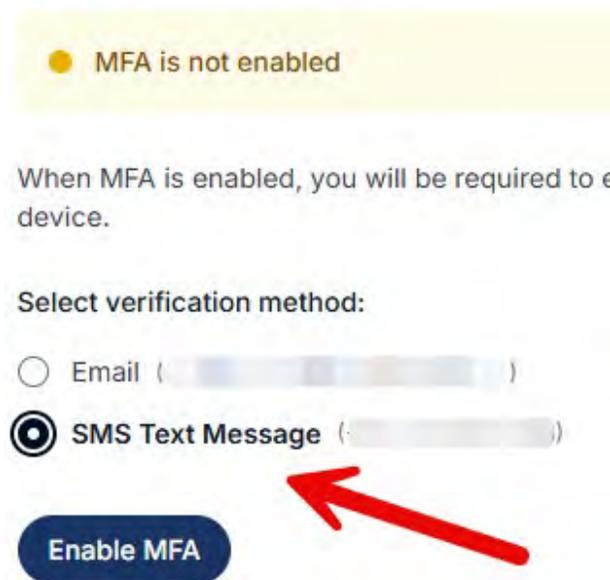Multifactor Authentication is available for this application.

Go to the settings screen and choose account.

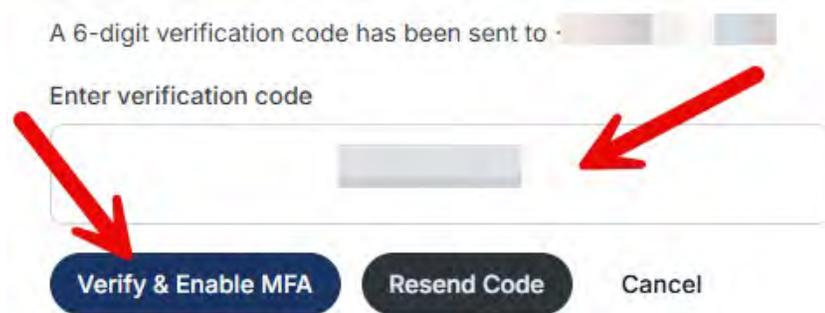At the top of the screen choose "Multi-Factor Auth"

Choose the verification method. SMS Text Message is preferred.

Press Enable MFA.

An SMS text will be sent to the number provided enter it in the verification code field and press "Verify & Enable MFA".

When you log in again after you enter your username and password you will be prompted to enter the 6 digit code texted to you. Unless you are using a dedicated device it is not recommended that you use the Trust this Device Option.
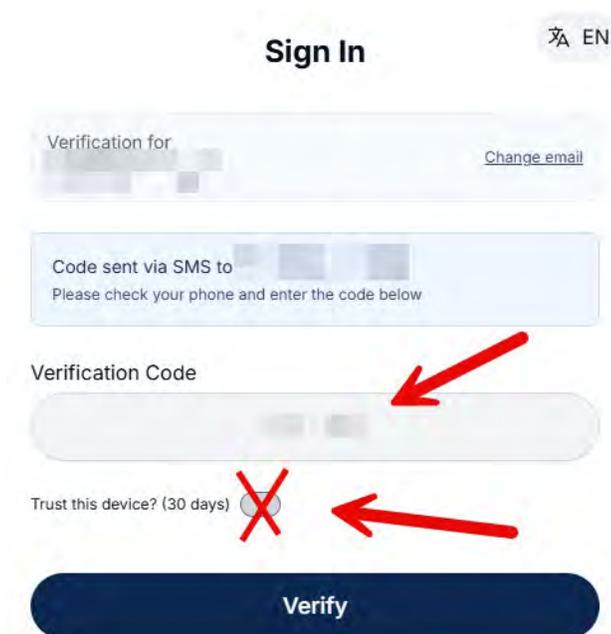
5. Transcription accuracy and clinician validation

Review and edit the generated note before submitting it to the EMR. Remove any non-medically relevant sections before saving.

6. Patient notice and consent workflow

Only begin recording with expressed consent of the patient. Use the NH Automated Transcription Notice and obtain verbal consent at the start of each encounter. If the patient declines, do not use the tool for that encounter.

The NH clinician is expected to present an NH Automated Transcription Notice to the NH client to further explain the use of 'automated transcription' for NH service improvements, and to obtain verbal consent from the client (per College and CMPA guidelines).

Automated Transcription Notice

Northern Health (NH) has adopted use of automated transcription technology to improve the delivery of health care for our clients.

The technology uses a secured and approved artificial intelligence technology to transcribe real-time conversation between an NH clinician and client during a health care session.

The medically relevant words spoken during the health care session are automatically drafted into clinical documentation, which the NH clinician reviews and confirms in advance of manually copying into the client health record.

Historically, the medically relevant content from a verbal conversation between a clinician and their client during a health care session has always been entered manually into the client's health record by the clinician.

The use of automated transcription is a modern update to this practice, to further support NH improvements to health care services.

How it works

Automated transcription uses an artificial intelligence (AI) tool called an AI scribe to assist NH clinicians with clinical documentation.

This technology translates our verbal conversation during a health care session into written words and generates a written summary. This allows us to focus more on you instead of taking notes.

The summary is used to create clinical documentation, and only medically relevant content is retained.

The documentation is reviewed and finalized by an NH clinician before adding it to your medical record. The technology does not make medical decisions–it only drafts notes.

The automated transcription solutions used at NH are subject to compliance reviews, to ensure your health information is protected as required by law.

All temporary transcription content is deleted once the final clinical documentation is saved.

If you have any questions about how it works, please ask your provider.

If you have questions about how your personal information is being managed, please contact the NH Information Privacy Office at privacy@northernhealth.ca.

7. EMR transfer and post-transfer deletion

Generate the note, review/edit, then transfer into the EMR using your local workflow (copy/paste or supported integration if configured). Confirm the note is saved in the EMR, then delete the encounter/note from the scribe app if your plan provides a deletion function.

8. NH recommended usage checklist

☐ Use the shortest-retention option available for NH encounters.

☐ Enable MFA and do not share accounts.

☐ Obtain patient consent before recording/transcribing.

☐ Clinician review is mandatory before EMR submission.

☐ Transfer to EMR promptly; delete residual data in the scribe tool where possible.

☐ Log out at the end of the session.