The reliability issue in healthcare is compounded by the fact that many leaders of hospitals have limited knowledge of human factors science and may not understand that automation, such as in electronic health records and computerized provider order entry systems, alone does not eliminate all errors. GBMC HealthCare has significantly improved reliability, but we still have work to do. Our board and senior nursing, physician, and administrative leaders are required to read John Nance's (2008) book *Why Hospitals Should Fly* to help accelerate cultural change. We developed a required course in patient safety for all of our employees to give them a basic understanding of the science of error mitigation. We created a robust error and near-miss reporting system and set annual goals for events reported and for reduction in actual incidents of harm. We use Lean daily management as a tool to drive standardized work, and we celebrate the accomplishments of local and organization-wide teams.

Vartian et al., and the other collaborators in the Safety Assurance Factors for EHR Resilience project, should be applauded for creating tools to help us implement technology such as CPOE effectively. Leaders of healthcare organizations must continue to breed a culture of humility and collaboration, which, along with curiosity about how to make things better, will create a more fertile environment for using these tools to achieve better care.

REFERENCE

Nance, J. J. (2008). *Why hospitals should fly: The ultimate flight plan to patient safety and quality care*. Bozeman, MT: Second River Healthcare Press.