literature. Interest in frailty among cardiovascular disease investigators has flourished, yet controversy exists regarding the ascertainment of frailty syndrome among older patients. The tools to assess frailty are numerous, and some of these tools may result in misclassification of frailty status in some patients.1

Kundi et al2 used administrative claims to identify frail individuals and evaluated whether this assessment of frailty status predicted outcomes among older patients with acute myocardial infarction, heart failure, or pneumonia. The investigators used the Hospital Frailty Risk Score (HFRS), a clustering of diagnoses that were identified using Internal Statistical Classification of Diseases and Related Health Problems, Tenth Revision codes, as markers for frailty.3 While HFRS may be a useful tool when using administrative data to study older populations, the agreement between HFRS with measured frailty is quite low. Gilbert et al3 reported that the κ statistic for agreement was only 0.22 (95% CI, 0.15-0.30) when comparing the HFRS with a binary definition of frailty using the Fried frailty phenotype criteria (3 or more items present). While we believe the results of Kundi et al2 are useful for stratification and risk prediction, assessment of frailty syndrome using administrative data should use a better-validated tool.1,4

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**Editorial Note:** This letter was shown to the corresponding author of the original article, who declined to reply on behalf of the authors.


**CORRECTION**

**Changes to Author Contributions:** In the Brief Report titled “Association of Renin-Angiotensin System Inhibitors With Severity or Risk of Death in Patients With Hypertension Hospitalized for Coronavirus Disease 2019 (COVID-19) Infection in Wuhan, China,” there were changes to the Author Contributions. The sentence “Dr Li and Ms Wang contributed equally” has been deleted. This article was corrected online.


**Additional Conflict of Interest Disclosures:** In the Research Letter “Assessment of QT Intervals in a Case Series of Patients With Coronavirus Disease 2019 (COVID-19) Infection Treated With Hydroxychloroquine Alone or in Combination With Azithromycin in an Intensive Care Unit,” published online on May 1, 2020, in JAMA Cardiology, conflict of interest disclosures were omitted for 2 authors. The conflict of interest disclosure statement should have included the following: “Dr Besière reports grants and personal fees from Abbott, Boston Scientific, Medtronic, Biosense, and Volta Medical outside the submitted work. Dr Chevalier reports grants from Abbott, Boston Scientific, and Medtronic outside the submitted work. No other disclosures were reported.” The Article Information section has been corrected to include this information.


**Errors in Data in Results Section of Abstract and Text:** In the Original Investigation titled “Exercise Electrocardiography and Computed Tomography Coronary Angiography for Patients With Suspected Stable Angina Pectoris: A Post Hoc Analysis of the Randomized SCOT-HEART Trial,” published online June 3, 2020, errors appeared in the Results section of the abstract and the text. The greatest numerical difference in outcome with computed tomography angiography compared with exercise electrocardiography (ECG) alone was observed for those with inconclusive results of exercise ECG, which was 5 of 285 patients (2%) vs patients 13 of 283 (5%), not 6 of 283 patients (2%) vs patients 18 of 283 (6%). The article has been corrected online.