



Geriatrics · Educational evidence summary

Interpreting a high burden score in an older adult

This geriatric evidence summary examines interpreting a high burden score in an older adult.

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Pause long enough to identify what “high” means

“High burden” can refer to one medication’s category, a regimen total calculated using a published instrument or an informal description of several concerning exposures. Those are different findings. Before interpreting the result, identify the method and the unit being described.

UnifiedACB shows [source-specific medication observations](#) and does not manufacture a cross-scale average. If a regimen total was calculated elsewhere, its source, version and aggregation rules need to accompany it. A number without those details is not yet a reproducible finding.

Check the inputs before reacting to the result

Verify that the medication list reflects actual use. Look for historical entries, duplicate ingredients, combination products and nonprescription medicines. Confirm the route and formulation, and clarify as-needed use during the relevant period. The [AHRO reconciliation framework](#) provides the broader context for this essential first step.

Then check the source match. A correctly transcribed category can still be attached to the wrong product. A high value for an ingredient should not silently become a precise statement about every route or formulation when the source did not specify them.

Missing entries require separate reporting. A result based on only the covered portion of a list should not be presented as a complete account of all exposure. Conversely, missing data should not be filled with invented values simply to make the total appear comprehensive.

Identify the contributors rather than staring at the total

The medication names and source observations reveal what the result is made of. Several low categories and one strongly classified medicine can produce very different clinical review questions. Arithmetic similarity does not establish equal pharmacology or equal treatment benefit.

If sources disagree, retain that disagreement. Choosing the highest available value for every medicine creates a new rule unless the chosen instrument explicitly defines it. Averaging the



categories creates another unsupported rule. The original source findings are more informative than a number assembled without a validated method.

Ask what clinical concern prompted the review

The relevant question may involve a new symptom, a fall, a change in cognition, urinary symptoms or a general review of treatment complexity. The score cannot determine which concern matters most. A symptom-specific timeline helps connect exposure to a question that can actually be assessed.

Document what changed and when. A medicine added after a symptom began cannot automatically be treated as its initiating cause. A medicine that has been stable for a long period may still deserve review, but the reasoning should be explicit rather than based only on the category.

Add the criterion that actually applies

The [AGS criteria](#) can identify a relevant geriatric context, such as a condition-specific or dose-qualified concern. The answer should name that context and retain its qualification. A general tag does not establish that every criterion applies to the individual.

If one missing detail changes applicability, ask for that detail. The needed information may be route, total daily dose, indication or a relevant condition. A focused clarification is more useful than a long undifferentiated warning list.

Balance the concern with the treatment's purpose

A high category does not describe how well the medicine is working or what might happen if it changes. The treating team needs to consider the original indication, benefit, available options and consequences of alteration. The review should not become an automatic stop order.

The [randomized medication-appropriateness intervention](#) illustrates that medication review is a defined clinical process with specific endpoints. Its existence does not make any reduction in a numerical burden measure a proven improvement in every patient outcome.

Decide what evidence would answer the question

If the concern is a symptom, follow the symptom and its functional effect. If the concern is an unclear product match, resolve the identity. If the issue is a source conflict, inspect the document and locator. These are different next steps, and the score alone does not choose among them.

After any clinically directed change, record the outcome and the retained treatment benefit. A smaller number is not a substitute for that follow-up. If uncertainty remains, document it rather than claiming that the high result explained the entire situation.



A useful high-result interpretation

The result deserves attention because it identifies a defined exposure signal. Its value is greatest when it leads to accurate inputs, a clear source explanation and a focused clinical review. It should make the next question more precise, not make the decision appear already settled.

References

1. Braithwaite E, et al. Interventions for reducing anticholinergic medication burden in older adults: a systematic review and meta-analysis. *Age Ageing*. 2023;52:afad176. [Source](#)
2. Vennard O, Stewart C, Tolia M, Soiza RL, Myint PK. Anticholinergic Medication Burden Scales: A Systematic Review. *J Am Geriatr Soc*. 2026;74(6):1771-1784. [Source](#)
3. American Geriatrics Society 2023 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc*. 2023;71:2052-2081. [Source](#)
4. American Geriatrics Society Beers Criteria Alternatives Panel. Alternative Treatments to Selected Medications in the 2023 AGS Beers Criteria. *J Am Geriatr Soc*. 2025;73:2657-2677. [Source](#)
5. Fox C, et al. Effect of medications with anti-cholinergic properties on cognitive function, delirium, physical function and mortality: a systematic review. *Age Ageing*. 2014;43:604-615. [Source](#)
6. Ruxton K, Woodman RJ, Mangoni AA. Drugs with anticholinergic effects and cognitive impairment, falls and all-cause mortality in older adults: a systematic review and meta-analysis. *Br J Clin Pharmacol*. 2015;80(2):209-220. doi:10.1111/bcp.12617. [Source](#)
7. UnifiedACB. Preserved public source-observation dataset, v3.0 RC12 final; inspected for this editorial revision. [Source](#)
8. Agency for Healthcare Research and Quality. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. [Source](#)
9. Moga DC, et al. Optimizing medication appropriateness in older adults: a randomized clinical interventional trial to decrease anticholinergic burden. *Alzheimers Res Ther*. 2017;9:36. [Source](#)

Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

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Educational evidence summary. This content does not provide patient-specific medical advice and does not replace clinical judgment, medication reconciliation, or prescribing guidance.