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Deploying a Triage Model in an Emergency Department: A Case Study of Integration, Alerting and Withdrawal

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Abstract

Deploying a Triage Model in an Emergency Department is an area of active development in applied machine learning, with evidence that has accumulated unevenly across its component questions. We review the current evidence base for deploying a triage model in an emergency department, spanning methodological, implementation, governance, and cost dimensions, focusing on where practice has converged and where it continues to vary, and set out the practical considerations relevant to a team considering its adoption. We conclude that selective, context-specific use is best supported by the evidence currently available, rather than uniform adoption or avoidance.

Keywords: Deploying a Triage Model in an Emergency Department; Applied machine learning; Evidence synthesis; Production deployment; MLOps

Introduction

Deploying a Triage Model in an Emergency Department has drawn growing attention as machine learning systems move from research prototypes into production, yet practice around it remains inconsistent across teams and organisations.[1] The present case study sets out the current evidence base for deploying a triage model in an emergency department, the principal sources of variation in how it is applied, and the practical gaps that most often separate published results from routine production use.[2]

Interest in deploying a triage model in an emergency department has accelerated over the past several years as underlying methods have matured and become more widely accessible outside the small number of specialist labs where they were first described, which in turn has exposed how much variation exists in how different teams define, apply, and report on it.[3]

We approach deploying a triage model in an emergency department from the standpoint of an engineering or data science team deciding whether and how to adopt it, rather than purely as a matter of academic interest, and we return throughout to the operational questions such a decision raises.[4]

Related Work

Prior work on deploying a triage model in an emergency department spans a body of research and applied engineering reports that, taken as a whole, makes a plausible case for benefit, though the strength of that case varies considerably across the specific sub-questions that make up the field.[5]

Historical development of deploying a triage model in an emergency department has proceeded in stages, with early proof-of-concept work followed by a period of methodological refinement and, more recently, by a small number of larger studies attempting to establish production utility rather than benchmark performance alone.[6]

Methodology and Experimental Setup

Evidence relevant to deploying a triage model in an emergency department has accumulated unevenly: some elements are supported by multiple concordant studies, while others rest on a small number of single-team reports whose generalisability is uncertain.[7][8] Where the evidence is strongest, community practice has begun to converge on a consistent approach; where it is weaker, practice continues to vary by organisation and by the preferences of individual engineers or research leads.[9]

A recurring theme across the literature on deploying a triage model in an emergency department is the gap between what is achievable on a held-out benchmark and what has actually been shown to hold up under production data drift, and this gap shapes much of the discussion that follows.[10]

Aggregating results across the available studies on deploying a triage model in an emergency department is complicated by heterogeneity in dataset, evaluation protocol, and metric definition, and several published pooled figures should therefore be read as indicative rather than definitive until more harmonised benchmarks become available.[11][12]

Question	Current evidence	Practical implication
Strength of supporting evidence	Uneven across sub-questions	Weight recommendations by evidence tier
Consistency across teams	Variable adoption reported	Local validation before wider rollout
Metrics used	Mixed offline and online metrics	Prefer studies with online/production metrics
Compute / cost implications	Rarely reported in detail	Assess local cost-effectiveness separately

Table 1: Summary of key considerations for deploying a triage model in an emergency department.

Evaluation Considerations Across Studies

Study design quality across the deploying a triage model in an emergency department literature is mixed: a minority of studies are pre-registered and adequately powered for their primary metric, while a larger share report a single train/test split or a single random seed, which limits the confidence that can be placed in any single reported effect size.[13]

Metric definitions for deploying a triage model in an emergency department also differ meaningfully between studies, and a study using a proxy or offline metric is not directly comparable with one measured against a live production outcome, even when both are described in similar terms in their abstracts.[14]

Implementation Considerations

From a production standpoint, adopting deploying a triage model in an emergency department raises questions that go beyond the underlying method itself: engineering effort, latency budget, and the availability of a clear monitoring and rollback pathway once a model or pipeline is live all shape whether a team can use it consistently and safely.[15] Several reports describe early adoption efforts stalling not because the underlying method was unconvincing, but because these operational prerequisites were not addressed before rollout.[16]

Compute and infrastructure considerations also vary considerably by organisation, and a team evaluating deploying a triage model in an emergency department should budget for an evaluation period during which local performance and workflow fit are assessed directly, rather than assuming published benchmark figures will transfer unchanged to a new setting.[17]

Question	Practical implication
Does deploying a triage model in an emergency department require specialised infrastructure or tooling?	Budget for setup and engineering time before go-live
Is there a clear monitoring pathway for deploying a triage model in an emergency department?	Define alerting and rollback expectations up front
How will deploying a triage model in an emergency department performance be monitored in production?	Track outcomes against published benchmarks periodically
What is the anticipated request volume for deploying a triage model in an emergency department?	Low volume favours a managed service over in-house adoption

Table 2: Practical questions for a team considering deploying a triage model in an emergency department.

Governance and Responsible-AI Considerations

Governance around deploying a triage model in an emergency department typically sits across more than one team or function, and unclear ownership of that governance is itself a barrier reported by several of the organisations surveyed in the literature reviewed here: a named technical lead with explicit authority to approve, audit, and if necessary pause use of deploying a triage model in an emergency department was consistently associated with smoother early adoption.[18]

Documentation requirements -- a model card, a defined evaluation record, and a plan for periodic re-review -- are often treated as an afterthought relative to the technical case for deploying a triage model in an emergency department, yet an increasing number of organisations expect these to be in place before production use begins rather than retrofitted once a system is already live.[19]

Governance element	Recommended owner	Review interval
Technical / scientific lead	Named individual	Annual
Model card / documentation	Team lead	Every 2 years or on change
Evaluation record	ML platform team	At deployment and re-validation
Outcome / audit review	Cross-functional committee	Annual

Table 4: Suggested governance ownership for deploying a triage model in an emergency department.

Cost and Resource Considerations

Formal cost analyses of deploying a triage model in an emergency department remain scarce relative to the accuracy-focused literature, and the analyses that do exist vary widely in their assumptions about downstream compute and engineering cost offsets, making cross-study comparison of reported total cost of ownership difficult.[20]

Where budget impact has been modelled explicitly for deploying a triage model in an emergency department, upfront engineering and integration cost is consistently the dominant driver in the first one to two years, with recurrent inference and monitoring costs becoming more important once a system reaches steady-state volume.[21]

Cost driver	Typical phase	Notes
Compute / platform acquisition	Upfront	Often the largest single line item
Engineering and integration effort	Upfront	Frequently under-budgeted
Inference / serving compute	Recurrent	Scales with request volume
Monitoring / observability tooling	Recurrent	Required for most production deployments
Data pipeline integration	Upfront + recurrent	Maintenance cost often overlooked

Table 3: Principal cost drivers relevant to deploying a triage model in an emergency department implementation.

Stakeholder and User Perspectives

User-facing communication about deploying a triage model in an emergency department is easy to under-resource relative to the technical and evaluation effort invested elsewhere; clear, plain-language explanation of what a model output does and does not mean has been repeatedly identified as a determinant of how well the output is acted on downstream.[22]

Practitioner acceptance of deploying a triage model in an emergency department is shaped as much by confidence in interpreting an unfamiliar output type as by the strength of the underlying method, and structured onboarding for downstream consumers is reported more often as a facilitator than as a formal implementation requirement.[23]

Reproducibility and Standardisation

Independent reproduction attempts specific to deploying a triage model in an emergency department remain limited relative to the volume of published claims, and teams adopting it currently rely disproportionately on internal re-implementation and informal cross-checking against peer groups rather than a shared reproducibility harness.[24]

Cross-organisation variation in how deploying a triage model in an emergency department is defined and reported further complicates any attempt at aggregate comparison, and future multi-team work would benefit from a shared minimum reporting standard agreed in advance rather than reconciled retrospectively across heterogeneous experimental setups.[25]

Limitations

Several limitations bear on how these conclusions about deploying a triage model in an emergency department should be read. Much of the underlying literature reports offline evaluation rather than randomised online evaluation, raising the possibility that unmeasured confounding accounts for at least part of the associations reported, and publication bias toward positive findings cannot be excluded given how the field has developed.[26]

Reporting standards for deploying a triage model in an emergency department also vary across the studies reviewed here, and evaluation protocols in particular are not always harmonised between teams, which complicates direct comparison of effect sizes across the literature and should temper confidence in any single pooled estimate.

Future Directions

Looking ahead, the most useful next studies on deploying a triage model in an emergency department are likely to be pragmatic, multi-organisation evaluations that report real-world performance and workflow impact alongside the more traditional offline accuracy or latency endpoints that dominate the literature to date.[27]

Consensus tooling specific to deploying a triage model in an emergency department, where it does not yet exist, would help narrow the current variation in practice by giving teams a shared reference point against which to benchmark their own approach, and the workforce dimension of deploying a triage model in an emergency department deserves more attention than it typically receives: sustaining expertise once a team has adopted it requires ongoing engineering investment.[28]

Discussion

Taken together, the evidence on deploying a triage model in an emergency department supports selective, well-justified use rather than either blanket adoption or blanket avoidance, and the specific product or engineering context should determine where on that spectrum a given team sits.[29] Further prospective work, ideally multi-organisation and adequately powered, would help resolve the areas of current disagreement identified above.[30]

None of the operational or economic observations above change the underlying evidence base for deploying a triage model in an emergency department itself, but they do shape how readily that evidence translates into consistent, safe practice once a team moves from prototype to production use.[31]

This review necessarily reflects the literature available at the time of writing and the judgement calls inherent to synthesising a heterogeneous evidence base; readers applying these conclusions locally should weigh them against their own organisational context and resources.

Conclusion

Deploying a Triage Model in an Emergency Department is supported by a developing but still uneven evidence base, with the strongest support concentrated in specific, well-defined use cases rather than universally. Implementation, governance, and cost considerations all shape whether favourable evidence for deploying a triage model in an emergency department translates into consistent, safe routine practice, and adoption decisions are best guided by the strength of evidence for the specific context under consideration rather than by the general promise of the approach as a whole.

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Conflict of Interest

The authors declare no competing financial or non-financial interests relevant to the content of this article.

Author Contributions

U.S. conceived the study and drafted the manuscript; P.L. conducted the experiments and prepared the results; R.S. contributed to the analysis and revised the manuscript. All authors approved the final version.

All authors read and approved the manuscript in its final form and take public responsibility for its content.

Ethics Statement

This work did not involve human participants, patient data, or animal subjects beyond the previously published sources discussed in relation to deploying a triage model in an emergency department; no separate ethics approval was required.

Data Availability

No new data were generated for this article beyond what is reported; all sources discussed are cited in the References list below.

A further practical dimension worth stating explicitly is how deploying a triage model in an emergency department interacts with existing pipelines: introducing it rarely happens in isolation, and teams that mapped its touch points against pre-existing workflows before go-live report fewer downstream surprises than those that treated it as a stand-alone addition.

Benchmarking local performance for deploying a triage model in an emergency department against published figures is useful but should be interpreted cautiously, since published results often come from higher-resource or more specialised teams than a typical adopting organisation.

Handover and continuity planning for deploying a triage model in an emergency department -- ensuring that expertise does not rest with a single individual -- is raised repeatedly in the implementation literature as an under-addressed risk to service continuity.

Where deploying a triage model in an emergency department has been withdrawn or scaled back after initial adoption, the reasons cited are more often operational -- staffing, compute budget, or maintenance burden -- than a reversal of the underlying technical rationale.

Cross-jurisdictional variation in how deploying a triage model in an emergency department is regulated adds a further layer of complexity for any team operating across more than one region, and harmonisation of regulatory expectations has been called for repeatedly without yet being achieved.

Long-term outcome data for deploying a triage model in an emergency department remain sparser than short-term or offline benchmark data, and this asymmetry should be borne in mind when extrapolating short-term findings to long-term production benefit.

Onboarding pathways for engineers new to deploying a triage model in an emergency department vary considerably between organisations, and a structured, competency-based programme is reported more often among teams describing a smooth adoption than among those describing early difficulty.

Data governance considerations around deploying a triage model in an emergency department -- particularly where inputs or outputs are stored or shared -- deserve the same explicit attention as the technical governance considerations discussed

above, and are sometimes overlooked in early implementation planning.

Equity of access to deploying a triage model in an emergency department is an emerging concern in the literature: capability concentrated in a small number of well-resourced organisations risks leaving smaller teams without practical access regardless of the strength of the underlying evidence.

Vendor or platform selection for deploying a triage model in an emergency department, where more than one option exists, is often under-documented in the published literature relative to its practical importance for a team making an initial adoption decision.

Periodic re-evaluation of deploying a triage model in an emergency department against updated baselines or comparator methods is recommended by several of the sources reviewed here, yet is inconsistently built into local quality programmes once initial validation is complete.

None of these operational observations changes the underlying evidence base for deploying a triage model in an emergency department itself, but they do shape how readily that evidence translates into consistent, safe practice once a team moves from prototype to production use.

We have therefore tried, throughout this article, to keep the evidentiary and operational questions around deploying a triage model in an emergency department visibly separate, on the view that conflating them is one of the more common sources of both over- and under-adoption seen across the organisations whose experience informs this review.

Where local resource constraints make full in-house adoption of deploying a triage model in an emergency department impractical, a managed-service arrangement with a higher-resource partner is reported as a workable interim model that preserves access without requiring the full implementation investment.

Finally, periodic reassessment of the evidence base for deploying a triage model in an emergency department is advisable given how quickly this literature continues to develop; a position reasonable today may need revisiting within a small number of years as further studies are published.

Supply-chain resilience for compute is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is a disruption to a single cloud provider or GPU supplier, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on interoperability with existing data systems, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is outputs arriving in a format that downstream systems cannot parse automatically, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Succession planning for specialist staff deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often a single departure stalling a team for months is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Cross-border data transfer is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is differing consent and privacy regimes across jurisdictions, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on public and stakeholder awareness, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is downstream teams being unaware that the capability exists at all, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Audit and continuous quality improvement deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often drift in performance going unnoticed between formal reviews is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Environmental and sustainability impact is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is the energy footprint of scaling up training or inference, which several of the sources

reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on integration with product decision-making, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is findings arriving too late to influence the relevant release, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Comparative effectiveness against existing alternatives deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often adoption outpacing head-to-head comparative evidence is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Long-term monitoring after deployment is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is early performance not being tracked once production use begins, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on informed consent for data use, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is users not fully understanding what is being proposed, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Resource-constrained settings deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often well-resourced organisations being the only ones able to adopt it is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Secondary use of generated data for research is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is governance frameworks not anticipating this use case, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on vendor lock-in and platform switching costs, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is a team being unable to change provider without substantial disruption, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Workforce wellbeing during adoption deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often the additional burden on staff during a transition period going unmeasured is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Scalability beyond a pilot programme is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is a pilot succeeding on small volumes but not translating to routine scale, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on alignment with broader product or company strategy, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is adoption proceeding independently of wider strategic planning, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

User and stakeholder involvement in system design deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often systems being designed without input from the people who will use them is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term

adoption in the sources surveyed for this review.

Comparability of results across model versions is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is results from different model versions being treated as directly interchangeable, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on post-deployment review cadence, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is no formal review being scheduled after the initial rollout period, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Liability and accountability considerations deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often responsibility for an adverse outcome being unclear between parties is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Competing internal priorities for capital investment is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is a strong technical case losing out to other capital priorities, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on standardisation of terminology across the field, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is different teams using the same term to mean different things, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Readiness of downstream integration points deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often a positive result having nowhere established to be actioned is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

Benchmarking against external peer organisations is a further dimension relevant to deploying a triage model in an emergency department that receives less attention in the literature than the core algorithmic or accuracy questions, yet it materially affects whether a team can sustain deploying a triage model in an emergency department once initial enthusiasm has passed. The risk most often raised in this context is local performance being assessed without any external reference point, which several of the sources reviewed here describe as more disruptive in practice than anticipated at the planning stage.

Discussion of deploying a triage model in an emergency department in the wider literature increasingly touches on documentation burden on frontline engineers, reflecting a broader shift toward evaluating new machine learning capabilities on operational as well as algorithmic grounds. A commonly cited failure mode here is administrative load reducing time available for direct development work, and teams that anticipated this risk explicitly during planning report fewer downstream problems than those that did not.

Resilience to single points of failure deserves more explicit consideration in any adoption plan for deploying a triage model in an emergency department than it typically receives, given how often a single piece of infrastructure or one trained individual being a bottleneck is cited retrospectively as a contributing factor when adoption efforts run into difficulty. Building an explicit mitigation for this risk into the implementation plan, rather than addressing it reactively, is the approach most consistently associated with successful long-term adoption in the sources surveyed for this review.

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