PHASE 2 EVALUATION REPORT FOR 414LIFE

Community- and Hospital-Based Violence Intervention Program to Address Firearm Violence in Milwaukee

Acknowledgements

The evaluation team would like to recognize the entire 414LIFE team, past and present, for their tireless dedication to serving the community by intervening and preventing acts of violence. The data reported in this evaluation and monthly programmatic reports would not be possible without the team's effort to document their service to violence prevention.

In similar spirit, we would also like to acknowledge and thank the many partners and stakeholders who collaborate with 414LIFE in the local and national violence prevention space. Developing local and national community violence intervention ecosystems is imperative to mitigating the on-going epidemic of firearm violence, and 414LIFE is an important facet of these efforts in Milwaukee.

With this in mind, there are a few agencies and organizations that we would like to particularly call out for their support of 414LIFE's mission. This list is non-exhaustive and multiple agencies and organizations are encompassed in various groups:

City of Milwaukee

Common Council

Mayor's Office

Office of Community Wellness & Safety

Credible Messenger Agencies

Department of Health and Human Services, Milwaukee County

Froedtert Hospital

Level 1 Trauma Center Program

Emergency Department staff

Governor's Office, State of Wisconsin

Medical College of Wisconsin

Comprehensive Injury Center

Department of Emergency Medicine

Division of Trauma & Acute Care Surgery

Milwaukee Health Care Partnership

Milwaukee Public Schools

Milwaukee Community Justice Council

Trauma Quality of Life Clinics at Froedtert Hospital and Children's Wisconsin

Violence Response Public Health and Safety Team (VR-PHAST)

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This evaluation was completed by the same team which completed the Phase 1 414LIFE evaluation. The team is based in the Division of Data Analytics and Informatics of the Comprehensive Injury Center at the Medical College of Wisconsin. The evaluation team does not have direct responsibility for the programmatic aspects of the 414LIFE program, including its implementation, operations, oversight, management, or funding but does work directly with the 414LIFE team and leadership on data reporting and evaluation of the program.

This positionality enables the evaluation team to have direct access to the necessary programmatic data and administrative records, as well as the ability to communicate with team members and program leadership to understand program operations, facilitate data access, understand the limitations of data entry and databases, and gain critical input and perspective on the evaluation process and results.

Executive Summary

This brief summary provides a high-level overview of the Phase 2 Evaluation for the 414LIFE program. Links are embedded throughout this summary to redirect to the location in the full evaluation report where a greater level of detail can be found and to some external resources. The structure of this summary mirrors that of the full report.

Background

The problem. Firearm violence continues to be a pervasive crisis nationally and in the city of Milwaukee. Although rates at both levels of geography decreased in 2024 compared to 2023, rates continue to exceed previous lows in 2019.[1-3] Young (15 – 34 years) Black men continue to be disproportionately impacted by firearm violence.[4,5] This cohort is considered at-risk or high risk for victimization and perpetration. Locally, the neighborhoods most impacted by homicides and non-fatal shootings in 2023 and 2024 included Old North Milwaukee, North Division, and Harambee[6], which are predominantly Black communities.

The strategy. 414LIFE initially launched in October 2018 with its community component, which was modeled after the Cure Violence model for violence interruption. Case management referral criteria aims to support those at high risk for future victimization or perpetration. In May 2019, the hospital component was established at the region's only adult Level 1 Trauma Center and modeled after the Hospital-based Violence Intervention Program (HVIP) model from the Health Alliance for Violence Intervention (HAVI). Hospital program referral criteria also seeks to prioritize those at highest risk for future victimization or perpetration. 414LIFE frontline staff include Violence Interrupters (VIs), Outreach Workers (OWs), and Hospital Responders (HRs). Program priority neighborhoods in 2023 included Old North Milwaukee and Walker's Point. School-based programming included in

the community component operates within participating Milwaukee Public Schools (middle and high school). The hospital component also integrated with clinical programming specifically for firearm injured patients – the Trauma Quality of Life Clinic[7] (TQoL Clinic) and Post-Discharge Care Team (PDCT).[8]

Aims and Purpose

This Phase 2 evaluation built upon the Phase 1 evaluation (2018 – 2022) of 414LIFE. Many of the metrics previously reported were re-assessed for calendar year 2023. Where available, new data were analyzed and are reported in this Phase 2 evaluation (Appendices A & B). New data includes case management participant outcome surveys, pre- versus post-participation outcomes from school-based programming, 414LIFE patient exposure to complementary clinical programming, program expenditure, program marketing, and updated evaluation of re-injury and criminal justice engagement for hospital participants.

Methods

Data sources. A variety of data sources were leveraged, including case management data from Cure Violence Global for community participants and a local REDCap database for hospital participants. A caseload participant outcome survey was administered to prior participants as identified by 414LIFE team members in order to identify behavior change and knowledge gained as a result of program (hospital or community component) participation. Clinical data was obtained from the Level 1 Trauma Center's electronic medical records, trauma registry, program databases, and a local clinical repository known as the Clinical Research Data Warehouse. Surveys for Milwaukee Public School youth participating in school-based programming were administered before and after

participation to document program outcomes. Criminal justice engagement data was obtained through DataShare from multiple criminal justice data sources. Focus groups were conducted with 414LIFE frontline staff, supervisors, and directors to learn about the implementation of actions related to Phase 1 evaluation recommendations and current program operations and challenges (Appendices E, F, G).

Data analyses. This evaluation focused on new data made available in 2023. At times, data was compared to 2022 and since the start of the program. Quantitative statistics were conducted to describe the frequencies, percentages, and averages of metrics of interest. Group comparisons were calculated to identify significant differences using independent samples t-tests and Chi-square tests. Qualitative analyses were used for focus group and survey open-ended question data and were assessed using a thematic content analysis.

Results

Program-wide. Program expenditure in 2023 was about $1.5 million. Marketing included traditional and social media, branded apparel, and printed public education materials. Case management participant outcome surveys indicated that since working with 414LIFE, participants (18 respondents) felt able to avoid violence and use non-violent means of conflict resolution through knowing they had strategies they could use and/or because they valued being non-violent. Participants reported a positive experience with 414LIFE, driven by the program's ability to connect them with services, provision of social support, and motivation to be part of the local community. However, although this sample of respondents reported a positive experience with being connected to resources, 414LIFE team focus groups revealed significant challenges and barriers to ensuring that

participants receive the resources to which they were referred. Emergency housing was the resource that was most difficult to secure for participants, largely driven by external services' capacity and eligibility criteria for subsidized or affordable housing.

Community component. In 2023, there were two new frontline leadership positions created – Team Leads for the VIs and OWs – designed to report to Team Supervisors. Staff training consisted of Cure Violence Global trainings since 2018, as well as complementary violence prevention trainings from other organizations. There were 59 violence mediations documented in 2023, bringing the program total to 316. Most mediations were successfully resolved (51%) or conditionally resolved (19%). Just over 575 hours were spent conducting violence interruptions, 67% of which time was spent in priority neighborhoods. There were 24 new community outreach activities conducted in 2023, bringing the program total to 134. Mediations and community activities both occurred citywide (Figure 12, 13). There were 46 new case management participants in 2023, and most were young (average age 18 years), Black (93%) and male (72%). The most common resources they were referred to included: employment (66 times), miscellaneous unspecified referrals (26), housing (22), educational opportunities (15), and financial support (11).

School Restoration of Consciousness workshops. A total of 260 students have participated since 2021, including 61 new pre-participant survey respondents in the 2023 – 2024 school year. The average age of participating students was 15 years, although most students were in 9th grade at the time of survey response. Before participation, students reported hoping to learn how to better themselves, safety, and generally wanting to learn something new. This evaluation compared pre-participation and post-participation survey

responses to understand any potential changes which may have occurred as a result of program participation. There were significant improvements in the assessed domains of: using non-violent conflict resolution methods, being able to be a peaceful person, and being able to be a positive influence/role model.

Hospital component. In 2023, the team grew to include a total of 4 HRs and 1 Supervisor. Training continued to include shadowing in the hospital, and cross-training with the VIs and OWs to participate in Cure Violence Global trainings and related violence prevention trainings. New changes in clinical programming included all gunshot wound patients being referred to the Trauma Quality of Life Clinic (TQoL) for outpatient care after hospital discharge, resulting in greater opportunity for engagement with 414LIFE HRs. Also, the new Post-Discharge Care Team (PDCT) for healthcare navigation between in- and out-patient settings for gunshot wound patients was operational. Of the 269 patients referred to 414LIFE in 2023, 39% attended TQoL Clinic and 28% received PDCT services. Most patients were young (average age 31 years), Black (83%) males (78%). Most patients met all program referral criteria (73%). Patients came from neighborhoods citywide. The most common needs identified for patients in 2023 included: financial concerns (154 times), mental health (99), miscellaneous (86), retaliation (72), and safe housing (61). Re-injury was low, approximately 3% for all hospital program participants since program start in May 2019. Contact with the criminal justice system within two years of the index injury was also low, with 7.2% of hospital participants being involved in a homicide or nonfatal shooting in Milwaukee and 4% of having new criminal charges in Milwaukee County during the follow-up period.

Recommendations

The two recommendations from the Phase 1 evaluation still continue to be recommended, along with two new recommendations based on the results of this Phase 2 evaluation. The recommendations from Phase 1 were:

#1 – Enhance outward communication.

E.g., Updating patient-facing materials, expanding monthly report recipients

#2 – Clarify and further document aspects of program implementation (*and operations*).*

E.g., Re-evaluate priority neighborhood focus, providing trauma informed care supports for frontline staff

Phase 2 recommendations include:

#3 – Re-evaluate expectations of frontline staff positions.

E.g., Ensuring alignment with position expectations and actual daily work

#4 – Update program services to reflect participant reported needs.

E.g., Incorporating conflict resolution skills related to handling disrespect

*(*and operations*) was added in Phase 2 to enhance clarity around the scope of the recommendation.

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1.0 Introduction

1.1 Scope of the Problem

Firearm violence continues to be a pervasive crisis nationally and in the city of Milwaukee. Although rates at both levels of geography were down in 2024 compared to 2023, rates continue to exceed previous lows from 2019.[1-3] Young (15 – 34 years) Black men continue to be disproportionately impacted.[4,5] For this reason, this cohort is considered at-risk or high risk for victimization and perpetration. Locally, the neighborhoods most impacted by homicides and non-fatal shootings were predominantly Black communities in 2023 and 2024 included Old North Milwaukee, North Division, and Harambee.[6]

1.1 Evidence-based approach: 414LIFE

1.1.1 Programming & structure

414LIFE was created in response to a 70% increase in homicides in 2015 in the city of Milwaukee.[6] The program was a Cure Violence (CV) adaptation which officially launched in October 2018 for community-based firearm violence intervention, including violence interruption and outreach activities (community component). Parallel programming in the region's only Level 1 Trauma Center modeled

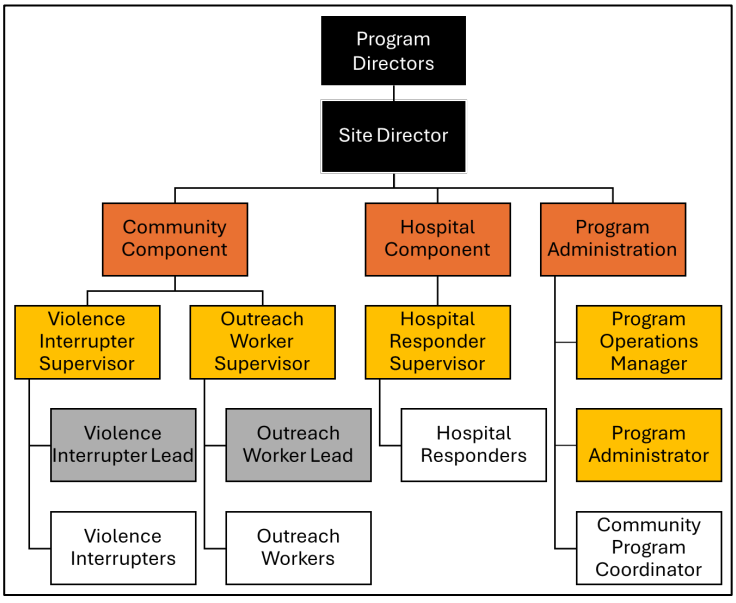

Figure 1. Hierarchical program structure of 414LIFE by component and position

after the Health Alliance for Violence Intervention's (HAVI) hospital-based violence intervention program (HVIP) model launched in May 2019 (hospital component). 414LIFE has since became a HAVI approved program in September 2023. Together, the community- and hospital-based components organize the interventions of 414LIFE (Figure 1).

As outlined in detail in the Phase I evaluation, since its inception 414LIFE has grown in organizational structure and programming.[9] Supervisor, team lead, and administrative positions have developed over time to support operations and coordinate personnel. A school-based workshop series was created and initially implemented in the 2021-2022 academic year to reach youth in Milwaukee Public Schools as part of the community component's activities. Hospital Responders (HRs) now engage with gunshot wound victims not only during their inpatient care, but also through outpatient care and in some cases refer patients directly to the community team for further support. HRs also work in tandem with complementary clinical programming specifically designed for this patient population that did not exist when 414LIFE started.

Must meet 4 of the 6 criteria:

1) Aged 15 - 35
2) Involved in street activity associated with violence
3) Personally injured by gun violence recently
4) Family or friend injured by violence recently
5) Involved in street activities
6) Easy access to a weapon

Figure 2. Community component referral criteria for case management

Community component activities are carried out by Violence Interrupters (VIs) and Outreach Workers (OWs). Individuals may be referred for case management services if they meet 4 of the 6 referral criteria (Figure 2). VIs and OWs support these participants in meeting their goals and engaging in non-violent behaviors. Conflict mediations and

violence interruptions are also conducted by VIs and OWs to prevent or intervene in violent situations. This work is informed by the CV model's approach to violence intervention. Outreach activities are conducted which include hosting a program stand at community pop-up events, canvassing priority neighborhoods with public educational material, building up community partnerships, and hosting community events (e.g., game nights). It is critical to note that while the CV model makes a distinction between VIs as conducting interventions and mediations, and maintaining participant caseloads and OWs as those conducting only outreach activities, 414LIFE does not make this distinction.[9,10]

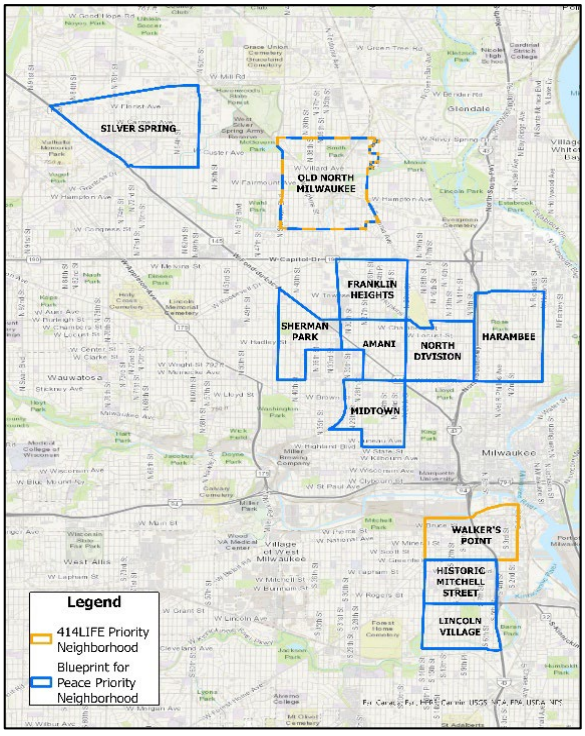

Figure 3. Map of where 414LIFE and *Blueprint for Peace* priority neighborhoods are located within the city of Milwaukee.

As previously mentioned, canvassing focuses on priority neighborhoods. Priority neighborhoods, or focus areas, are another aspect of adopting the CV model for violence interruption. They are intended to be where program activities are concentrated. This is done in part to triage resources to areas of greatest need (or highest violence risk), as well as to provide the opportunity to identify comparison areas that did not receive the

intervention to analyze violence reductions associated with program activities.[a11,12]

This evaluation assessed when and to what extent priority neighborhoods influence community component operations. Priority neighborhoods for 414LIFE have changed over time due to contractual and political priorities. At the time of this report, there were two program priority neighborhoods (Old North Milwaukee and Walker's Point) for 414LIFE (Figure 3). The city of Milwaukee also identified priority neighborhoods (Figure 3) for broader violence prevention and intervention efforts as part of the *Blueprint for Peace*, which outlined a citywide community safety agenda. The Blueprint was the impetus for the city to create 414LIFE to address residents' concerns about firearm violence.

The ***school-based programming***, known as the Restoration of Consciousness (ROC) workshops, are held in Milwaukee Public Schools with greater volumes of high-risk youth. Students are referred for participation by school administration. For the last two school years, referral criteria mirrored that of the community component of the overall program, with the addition of utilizing high suspension & referral rates due to violent incidents or significant behavior challenges. Referrals in this instance do not refer to 414LIFE program participation, but to forms used by schools to address challenging behaviors which may not always lead to a suspension. Workshops are held once a week during the school year, often during Fall or Spring semester, and are led by VIs, OWs, and/or the Community

[a] In practice there are not always true control neighborhoods/areas available implementation areas. This is due in part to ethical considerations related to utilizing a randomized controlled study design (thus creating true control areas) in which the intervention is withheld from some neighborhoods experiencing high levels of violence to allow for comparison. There are also practical considerations that most cities do not have enough high-volume areas to allow for such comparisons across similar neighborhoods. Synthetic control approaches can be considered in these cases to create simulated areas for comparison.

Program Coordinator. Curriculum includes general check-ins with participants (i.e., asking how they are doing), conversations about life known as *Circle Time*, lessons on violence as a disease, and gang violence and popular culture, viewing and discussing *The Interrupters* documentary, and Dead Prez's *Hip Hop* music video.

1) Gunshot wound mechanism of injury

2) Aged 15 - 35 years

3) Injured in, or resident of, City of Milwaukee

Figure 4. Hospital component referral criteria

Within the ***hospital component***, HRs operate as VIs within a clinical setting. HRs also conduct interruptions, conflict mediations, manage a participant caseload, and identify and address needs. Potential participants are screened from hospital patients treated at Froedtert Hospital's Level 1 Trauma Center for referral. Referral criteria aim to prioritize referral for individuals at the highest risk for re-victimization or perpetration after injury (Figure 4). There are two exceptions to note. First, hospital providers can refer a patient who does not meet all three referral criteria. For example, a patient aged 46 injured by a gunshot wound in Milwaukee could be referred. Second, there are instances where the injury severity is so great that the patient does not survive. A program referral can still be placed for the HRs to support the patient's family and/or loved ones to prevent retaliation.

It is important to highlight the two ***complementary clinical programs*** developed specifically to support gunshot wound patients, the Trauma Quality of Life (TQoL) Clinic and the Post-Discharge Care Team (PDCT). These programs were created as a result of the enhanced decision-making and care planning that came from clinical providers being able to work with 414LIFE's HRs.

The TQoL Clinic is a dedicated outpatient clinic to support post-discharge recovery for gunshot wound patients. These post-discharge appointments are considered standard of care for any traumatic injury patient. However, unlike the traditional trauma clinic appointment, gunshot wound survivors at TQoL Clinic see more than just an advanced practice provider (Figure 5). In their first visit, patients will see a trauma psychologist, trauma advanced practice provider, social worker, physical therapist, and a member of the 414LIFE team. If 414LIFE is already engaged with a patient, the clinic appointment serves as an opportunity to check-in on post-discharge recovery and resource needs. If the patient previously declined to work with 414LIFE or was not referred, the appointment serves as an opportunity to make a fresh referral to the program.

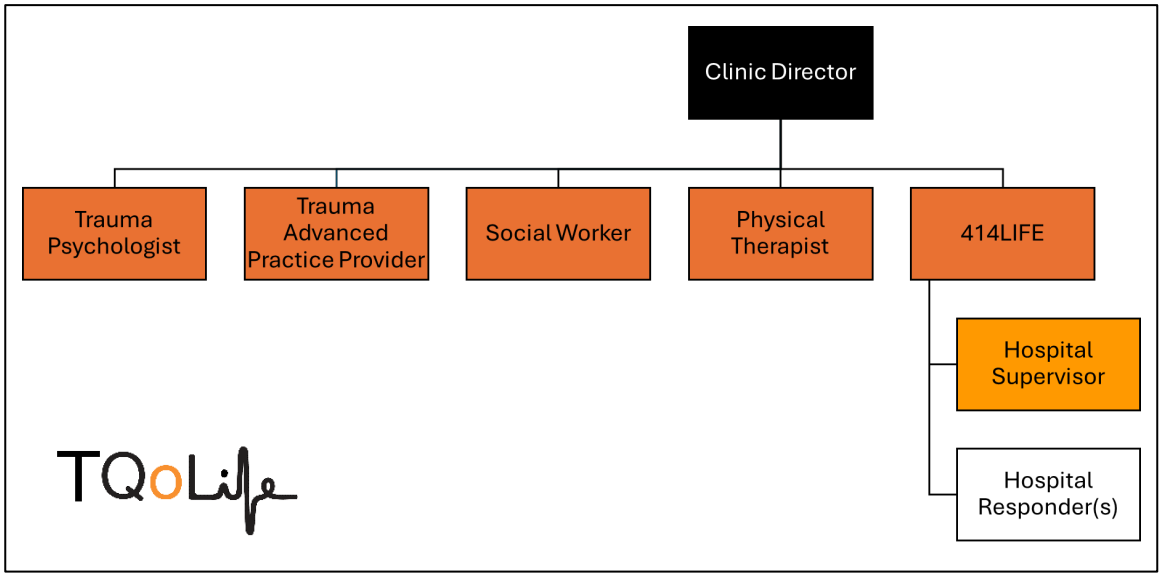

Figure 5. Trauma Quality of Life (TQoL) Clinic program structure

The PDCT is a care team created to bridge the gap between inpatient and outpatient care at the Level 1 Trauma Center. On average, there is about a week between hospital discharge and patients' first follow-up appointment in TQoL Clinic. There is no standard of care service or team which bridges this gap for traumatic injury patients. However, this

need was identified by 414LIFE HRs and clinical providers for gunshot wound injury patients due to elevated no-show rates for clinic appointments and high emergency room utilization for clinical issues which, from a resource standpoint, are more appropriately addressed and at a lower cost within a clinic setting. PDCT is a team of two dedicated providers – a trauma nurse navigator and social worker (Figure 6). These two providers are well positioned due to their professional skills and content knowledge to help triage clinical questions between inpatient and outpatient care. By working together, they are also able to help direct patients to appropriate community services. These dual functions are why the team works in tandem with 414LIFE HRs when planning resource needs and navigating healthcare utilization to support optimal recovery.

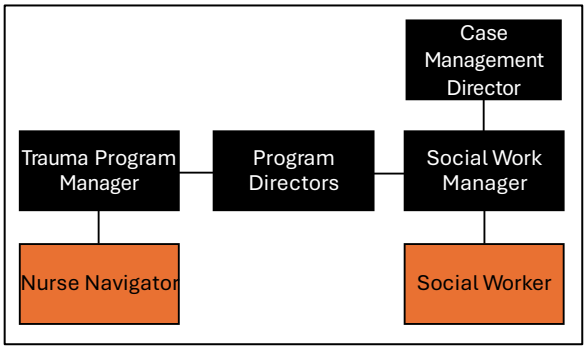

Figure 6. Post-Discharge Care Team (PDCT) program structure

1.2 Aims and objectives for the Phase 2 Evaluation

The design of this Phase 2 evaluation builds upon the program's first evaluation. Many metrics previously evaluated are re-assessed with a particular focus on 2023 as a continuation of the first evaluation which covered from the start of the program in 2018 through end of calendar year 2022. Where possible, new metrics and analyses are reported in Phase 2 due to additional available data, larger sample sizes or programmatic changes. This includes evaluating for any quality improvement programmatic changes made in response to the Phase 1 Evaluation[9] recommendations for increased outward

communication and clarification of program documentation. In addition, participant-reported outcomes were assessed with attention toward identifying changes in beliefs, norms, and violent behavior after program participation. Lastly, program marketing was reviewed in greater detail with attention toward traditional and social media presence, as well as marketing materials beyond billboard ads.

Throughout this report, results are presented by program component – full program, community component, and hospital component – and then by inputs, outputs, and outcomes (Appendices A & B). The report concludes with a brief discussion of the implications of this evaluation's results and updated program recommendations to strengthen operations to meet program goals. Additional appendices at the end of this report provide further detail related to data collection (Appendices C-J), the full evaluation analytic plan (Appendix K) and a timeline of program events that have happened in 2022-2023 to focus on major events since the publication of the Phase 1 Evaluation (Appendix L).

2.0 Methods

2.1 Evaluation Design

Similar to the Phase 1 program evaluation, this Phase 2 evaluation leverages a community-engaged, mixed methods design with data triangulation to yield a comprehensive examination of the program. These program evaluations are part of an iterative quality improvement process for the 414LIFE program, which are intended to build upon prior phases. The evaluations go into greater detail than the monthly program reports, focus on a longer time range (i.e., annual, since program start), and provide the opportunity for qualitative data and analyses of focus groups, interviews, and surveys.

The evaluations are designed to address key stakeholder questions that could be answered with existing resources and data. For instance, the program's set of evaluation questions was created in 2019 to answer questions from funders, the city of Milwaukee's Office of Community Wellness and Safety (formerly the Office of Violence Prevention) and the Common Council for the city of Milwaukee (Appendices A & B). This was done in conjunction with 414LIFE and the Comprehensive Injury Center's (CIC) Division of Data Analytics and Informatics (formerly the Division of Data Surveillance and Informatics).

For Phase 2, the evaluation questions and measures were re-visited by both the evaluation team and current 414LIFE personnel in early 2024. A survey was created and distributed to 414LIFE personnel to gather their input on which key metrics were important to measure in this evaluation phase. The team overwhelmingly agreed (60 – 93% per question) with

maintaining the original evaluation questions for Phase 2 (Appendix C).[b] In addition to majority agreement on the Phase 2 evaluation plan, the team also strongly agreed (87%) that it was important to ask 414LIFE participants directly about their experience in the program. This evaluation thus included a survey administered to participants to learn how program participation has affected their lives, as well as any changes in orientation toward non-violent behavior. This extended the work from the prior program evaluation which described 414LIFE team-reported success stories of participants.

2.2 Timeframe & data inclusion

The primary timeframe of interest for this Phase 2 report is calendar year 2023. Where indicated, results are at times compared to numbers from 2022 to provide context for the 2023 results. In addition, aggregated numbers since the start of the program are also presented throughout (October 2018 for the community component and May 2019 for the hospital component).

Events, mediations, and activities were included if they occurred between program start and December 31, 2023. Program participants from both the community and hospital components were similarly included in this evaluation if the date of referral was between program start and December 31, 2023.

Individual-level information for the community component came from participants who were screened and accepted to participate in case management. These participants could

[b] The only exceptions were a mostly neutral stance on reporting the average number of hours spent per Hospital Responder case (44% neutral vs. 38% agreed), and a slightly higher level of agreement (47% agree vs. 40% neutral) on assessing number of follow-ups per unresolved mediation.

be residents of the Milwaukee overall, not restricted to the *Blueprint for Peace* or 414LIFE's priority neighborhoods (Figure 3). For the community component's school-based ROC workshops, these students attended participating Milwaukee Public Schools who were at least present at the start or end of the workshop and submitted a completed participation survey. Hospital component individual-level information pertains to patients seen at Froedtert Hospital's Level 1 Trauma Center who were at least referred to the program in 2023 and thus had the chance to participate.

2.3 Data sources

2.3.1 Program-wide

2.3.1.1 Inputs

Program funding and expenditures for 2023 (with comparison to 2022) were obtained from administrative financial documentation. Of the overall program expenditures for 2023, expenditures related to marketing were specifically highlighted as it relates to one of the pre-identified evaluation metrics of interest for this evaluation phase.

Program operations, training, and actions taken on the quality improvement recommendations from the Phase 1 evaluation were learned from focus groups conducted with the 414LIFE team (inclusive of team members, leads, supervisors, administrators, and leadership). These focus groups were held in June 2024 to allow for as much time as possible for the implementation of any recommendations into program operations, from the time of the public release of the evaluation report (September 2023) through June 2024. More details on the focus groups and related qualitative analyses are covered later in section *7.11.6 Qualitative analyses*.

2.3.1.2 Outputs

Marketing was considered to include any materials related to advertising the program within the city of Milwaukee. This could include billboard(s), apparel with logos, and printed public educational materials for distribution during canvassing and community events. This information was obtained from the program's administrative and financial records for purchases completed in 2023.

Marketing was also considered to include media stories either about 414LIFE or that mentioned the program. Cision is a real-time online media monitoring system for traditional and digital media sources, such as news stations' online videos, printed newspapers, and online media articles.[13] The software is licensed by the Medical College of Wisconsin's (MCWs) Office of Communications which conducted this media search for "414LIFE" in 2023 and made the results available to the evaluation team. The data included the date of publication, headline, outlet, outlet type (online versus newspaper), audience reach, desktop [computer] unique views per month (UVPM), mobile device UVPM, and publicity value (in dollars). The first three metrics convey the pool of people who are *potentially* seeing coverage of the story. Audience reach indicates the total print circulation and broadcast (TV/radio) audience reach calculated per story. UVPM indicates the total number of unique individuals visiting a publication's site via a desktop computer or mobile device (e.g., cell phone) within a 30-day period. Publicity value is the estimated value of the coverage of the story.

Social media content was reviewed manually. Social media content for 414LIFE was posted through the program's own accounts, as well as the accounts for the CIC, where

the program is housed. Posts were counted if they were posted by either 414LIFE or the CIC. Posts from the CIC needed to either be about 414LIFE or mention the program. The CIC has a Facebook (https://www.facebook.com/cicatmcw) and an X (formally Twitter; @cicatmcw) account, while 414LIFE has a Facebook (https://www.facebook.com/414LIFEMKE2) and an Instagram (https://www.instagram.com/414lifemke/) account. Account posts on X in 2023 were accessed through an "Archived content" request. Once available, the data was reviewed for tweets or re-tweets that contained reference to "414LIFE" in 2023.

The themes of the traditional and social media content were qualitatively analyzed (ref. *7.11.6 Qualitative analyses*).

2.3.1.3 Outcomes

New in this evaluation was the administration of an outcome survey to participants (Appendix D). This survey was anonymous in that the IP addresses and other identifiers were not collected to protect the anonymity of those responding to the survey. The survey was designed to identify changes in behavior and knowledge related to non-violent approaches following program participation. The survey began with three basic questions related to program participation (participation with the hospital component, community component, or both; duration of participation; year program participation began) (Figure 7). The remaining questions were then administered in randomized, alternating blocks.

Block A administered the survey's two open-ended questions first followed by the 4 closed-ended questions. Block B had the opposite order of administration. Blocks alternated evenly (1:1 ratio) in which the first respondent received Block A and the next respondent received Block B, and then alternating until the survey was closed to new respondents. This was done to avoid question order bias, meaning, that it was possible that participants may have provided less detailed answers to the open-ended questions if they were presented last, as opposed to being the first questions presented. Randomizing the question types in blocks accounted for this potential bias.

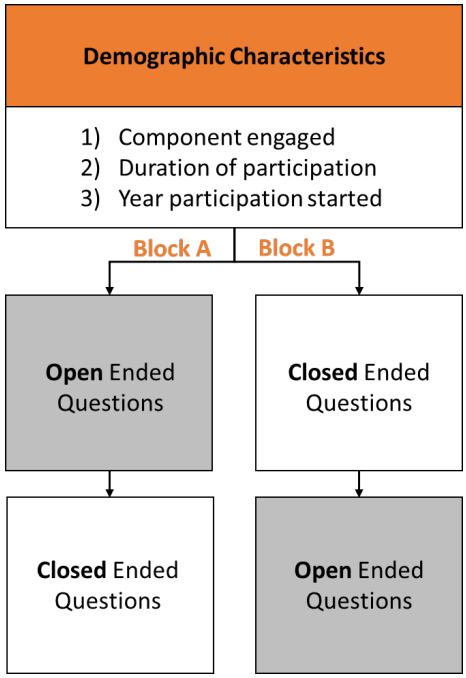

Figure 7. Participant outcome survey administration

The two open-ended questions asked respondents to 1) share their experience in working with 414LIFE and how it impacted their life, and 2) if they had suggestions for how 414LIFE could improve in its ability to address firearm violence.

The four closed-ended questions were included from the program's pre-existing, post-participation survey administered for 414LIFE's school programming (as described later in this section, *School Programming*). These questions ask the respondent to what extent they agree with each statement – *Strongly Agree, Agree, Not Sure, Disagree, Strongly Disagree*. If respondents answered positively (i.e., *Strongly Agree or Agree*), then they were given one follow-up question which asked for an example of a time in which they engaged

in a non-violent way related to the hypothetical situation. If respondents answered neutrally or negatively (i.e., *Not Sure, Disagree, Strongly Disagree*), then the follow-up question would ask why non-violence would be challenging given the hypothetical context of the preceding question.

The answers to the open-ended questions and the follow-up questions were qualitatively analyzed as outlined in the later analytic plan section (ref. *7.11.6 Qualitative analyses*).

The survey was built and maintained in Qualtrics, a software for creating, distributing, and maintaining surveys, which is licensed by MCW. Surveys were distributed to participants by 414LIFE team members by sharing a QR code generated by Qualtrics that linked directly to the survey. The team prioritized sending the QR code to participants they worked with in 2023 given the priority timeframe of this evaluation. However, due to turnover, there were team members at the time of survey administration (late April – early May 2024) who had only just joined the team in early 2024 and could only distribute the survey to participants who joined the program in 2024. Team members sent out the QR code to participants and conveyed that their participation in this survey about their experience with the program was optional. The team did not have access to individual survey responses, nor to Qualtrics to protect privacy.

2.3.2 Community component

2.3.2.1 Inputs

Community component-specific program operations and training were learned in part through focus groups and interviews conducted between June-July 2024 with program team members, administration, and leadership (See appendices E, F, G for interview

guides). Administrative records were also accessed to document program operations and team structure. These results were qualitatively analyzed and thematically reported (ref. *7.11.6 Qualitative analyses*).

2.3.2.2 Outputs

Violence mediations, outreach activities, and case management information was extracted from two data sources:

1) Archived records from the program's original database, CiviCore (program inception – July 2021).

2) Current Cure Violence Global (CVG) database implemented in August 2021 – present.

All community component team members were expected to maintain daily data entry, including the reporting of daily activities, community activities, ongoing or completed mediations, participant case management, and other areas of daily operations. The number of community events and mediations completed in the evaluation period were recorded with an added indication if the activity occurred within a priority neighborhood. Assessment of participant risk for future violence and demographic characteristics (e.g., age, sex, and race) were entered as well. No other identifying information is recorded in the database.

2.3.3 School programming

Participation surveys for the ROC workshops were collected either at the start (i.e., pre-participation) and/or end (i.e., post-participation) of the school year (Appendices H & I, pre- and post-surveys). Survey responses were recorded on paper by the students,

returned to the 414LIFE team, and then entered by the Program Evaluation Manager into a REDCap[c14] database hosted by MCW.

Surveys have been collected since workshop programming began in the 2021 – 2022 school year. The survey was typically administered by the VIs and OWs who led the workshops, and/or the community outreach coordinator. Since the person serving as the coordinator departed their role in Fall of 2022, the surveys collected in the timeframe for this evaluation were administered by 414LIFE team members. This includes surveys from participating students at the end of the 2021-2022 school year, the start and end of the 2022-2023 school year, and new to this Phase 2 evaluation, at the beginning of the 2023-2024 school year. Post-participation surveys were not collected for the 2023 – 2024 school year. In past school years the workshop was only held in high schools, in the 2023-2024 school year Andrew S. Douglas Middle School joined the roster of participating Milwaukee Public Schools. The curriculum, survey design, and questions did not change from what was previously reported in the Phase 1 Evaluation (ref. *Phase 1 evaluation*, *Methods – School Programming*, pg. 26-27).[9]

2.3.3.1 Inputs

The participating schools were documented and the number of students participating at each school was recorded. Due to the intentional anonymity of the surveys, the only additional characteristics of participating students was self-reported age, grade level, and

[c] REDCap is locally supported by CTSA grant 2UL1TR001436 awarded to the Medical College of Wisconsin's Clinical and Translational Science Institute.

whether or not the current school year was their first time participating in the ROC workshops.

2.3.3.2 Outputs

There were 8 questions pertaining to pre-post knowledge of violence and responses to violence. These 8 questions were answered on a 5-point Likert scale to indicate level of agreement: *0 – Strongly Disagree, 1 – Disagree, 2 – Not Sure, 3 – Agree, or 4 – Strongly Agree*. Survey completion rate by school year was reported, and general pre-survey responses to these questions.

2.3.3.3 Outcomes

New to this Phase 2 evaluation was a pre-post participation comparison of responses to the 8 questions about knowledge of violence and responses to violence. The purpose was to identify to what extent and where there may have been changes in knowledge or skills related to non-violence as a result of workshop participation. As already described, the surveys were anonymous which precluded the opportunity for matching pre- and post-surveys by student. Instead, all pre-participation surveys and all post-participation surveys were respectively aggregated and compared to each other. Reported is the average pre-survey response compared to the average post-survey response per question.

Another outcome was sourced from the pre-participation surveys. In this survey respondents were asked what they hoped to learn from the ROC workshops. What respondents did get out of the workshops was previously reported in the Phase 1 evaluation (ref. *Results – School Component - Outcomes*, pg. 60).[9] These responses were qualitatively analyzed (ref. *7.11.6 Qualitative analyses*).

Two outcomes were sourced from the post-participation surveys. This evaluation examined participants' likelihood to engage in violence and satisfaction with the workshop. These were assessed on a Likert scale. Students were asked whether they felt that they were less likely to be involved in violence or fights now that they have attended the workshops – *Yes, Maybe a Little, No,* and *I Don't Know*. Overall satisfaction with the workshops was rated on a scale – *Very Satisfied, Satisfied, Neither Satisfied nor Dissatisfied, Dissatisfied,* and *Very Dissatisfied*.

2.3.4 Hospital component

2.3.4.1 Inputs

Hospital component-specific program operations and training were learned in part through focus groups and interviews conducted between June – July 2024 with program team members, administration, and leadership (Appendices E, F, G for interview guides). Administrative records were also accessed in order to document program operations, training, and team structure. These results were qualitatively analyzed and thematically reported (ref. *7.11.6 Qualitative analyses*).

2.3.4.2 Outputs

Patient referral information was obtained from pages sent by hospital providers to the 414LIFE HRs and included referring provider name, identification of the patient, and any other pertinent information needed to assess the level of retaliation risk of the patient and/or circumstances of the patient's injury. This information was abstracted and then stored in an institutionally secured database managed by the evaluation team. Case management notes, including specific patient needs and resource provision, began in July

2021 in a REDCap database managed by the evaluation team, but fuller implementation of this data collection system did not begin until July 2022.

Clinical information was extracted from the electronic medical record pertaining to the admission and related follow-up care for the injury which led to the connection of the patient and/or their loved ones to program HRs (i.e., "index" hospital admission). Loved ones and/or family of patients could be referred to the program (for resource and non-retaliation support), for example, in situations where the patient requires urgent surgical intervention, or the patient passes away in the hospital due to their injury. Clinical information from the pages and medical record was supplemented with data requested from the Trauma Registry for the Level 1 Trauma Center. A Trauma Registry is a data repository of patient demographic and injury characteristics, inpatient medical care, and limited medical outcomes intended to support quality and process improvement for clinical care and injury prevention efforts. The maintenance of a Trauma Registry is mandated for accreditation as a Level 1 Trauma Center by the American College of Surgeons. This Level 1 designation indicates the highest level of care and resources for the comprehensive clinical care of traumatic injury.[15]

Information related to the engagement of 414LIFE participants in the TQoL Clinic and PDCT was requested by the respective directors of each program. The information requested was a patient list for each program for 2023. These lists were then compared to a list of program participants from 2023 from the evaluation team's hospital component database. It was then documented whether the 414LIFE participant also engaged with either the TQoL Clinic, PDCT, both, or neither.

2.3.4.3 Outcomes

The operations' outcome of interest was the type and frequency of needs identified by the HRs for referred patients. This was reported in the previous evaluation, however, new to this evaluation is the documentation of how often resources were then provided for the identified needs. This data was obtained by the REDCap case management database.

There were two clinical outcomes of interest. One was re-injury by another assaultive mechanism of injury, such as a gunshot wound, stabbing, or blunt assault, within 2 years of initial referral to 414LIFE. Another was re-referral to the program for another injury. Clinical outcome data was extracted using the electronic medical record, the Trauma Registry, the evaluation team's database of referred patients, and a clinical data repository known locally as the Clinical Research Data Warehouse.[d16] The latter data source aggregates clinical encounters from the electronic medical record across the entire enterprise of Froedtert Health. The Trauma Registry was queried for a list of comparison injury patients who were seen at the Level 1 Trauma Center before the start of the 414LIFE program, along with their basic demographic and injury characteristics. For both 414LIFE and comparison patients, follow-up visit information (e.g., readmission, emergency department visits) was requested from the Clinical Research Data Warehouse. Of note, re-injury could only be reported for patients for whom a medical record could be identified and matched between patient information extracted from the Clinical Research Data Warehouse and 414LIFE referred patients and comparison patients. These visits were then

[d] The Clinical Research Data Warehouse is supported by the National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes for Health, through grant number UL1TR001436 awarded to the Medical College of Wisconsin and Advancing a Healthier Wisconsin Endowment

manually reviewed to confirm if the reason for visit was due to a new injury or as a follow-up to the index injury. Re-referral is documented on an on-going basis by the evaluation team by checking patient name and medical record number for prior program referral.

The criminal justice outcome of interest was whether 414LIFE or comparison patients had re-engagement with the criminal justice system within 2 years of their index injury. Re-engagement with the criminal justice system included new criminal charges in Milwaukee County, the type of offense (e.g., homicide, disorderly conduct), and involvement as either a victim or perpetrator of a non-fatal shooting or homicide. This criminal justice outcome data was obtained from Milwaukee Police Department records of homicides and nonfatal shootings, as well as court-related data through the Milwaukee County District Attorney's Office and the Wisconsin Circuit Court Access (WCCA).[e] The latter two sources were referenced to identify additional incidents where individuals were either involved in violence through victimization or listed as having engagement with criminal justice system through new charges for one or more criminal offenses.

The criminal justice outcome datapoints were accessible through a data repository known as DataShare. DataShare is a secure, integrated data system that links data across multiple sectors to support research and analysis in public health, public safety, education, and related areas. The data system is hosted and managed by MCW, with permission from the contributing agencies, as well as through the WCCA. Re-engagement with the criminal justice system could only be reported for those where a record could be

[e] The Wisconsin Circuit Court Access (WCCA) data can be publicly accessed at https://wcca.wicourts.gov/

identified and matched to the various criminal justice data sources. It is important to note that findings in this evaluation from this data source represent the views of the authors and may not necessarily represent the views of DataShare and its partners.

2.4 Data limitations

There are several limitations to note for the data sources utilized in this evaluation.

2.4.1 Program wide data

There are several limitations to note with regard to the program marketing data. First, the financial data related to marketing was triangulated between institutional electronic financial administration records for the CIC and scanned copies of invoices maintained by 414LIFE administration. While there is reasonable assurance that the majority of financial transactions related to marketing were captured, it is possible that the reported dollar amounts for 2023 are slightly under-representative of actual expenditure for this expenditure type.

There are also limitations inherent to the institutionally licensed media search software, Cision. The search engine software yields a robust estimation of all possible media related to a given query. This means that while the results obtained (as described in *2.3.1.2 Outputs*) are accurate, they may represent an under-estimation through the inadvertent omission of a piece of media about 414LIFE or in which 414LIFE was mentioned. Relatedly, there may be an under- or over-estimation of audience reach. Audience reach, as quantified by estimated desktop [computer] or mobile device UVPM and estimated publicity value, is calculated on a per piece basis, meaning, stories that were viewed more

had higher estimated values. This report aggregates UVPM by media type and does not report the estimate per headline.

The last program-wide data-related limitation to note is that the Participant Outcome Survey was limited in reach due to significant frontline staff turnover. This turnover occurred in the latter part of 2023 ahead of the administration of this survey in late April – early May 2024. To address this going forward, the Evaluation Team and 414LIFE leadership are working to implement exit surveys for participants discharging from the program. In parallel, as the current frontline staff continue to build their caseloads, there will similarly be greater opportunity to survey more participants who have been engaged with current staff for a longer duration of time.

2.4.2 Community component data

As already described, there were differences in the database systems used for community component-related data collection and management. The CiviCore (October 2018 – July 2021) and CVG (August 2021 – present) databases did not have the same fields to allow for the exact same data points to be collected through the whole evaluation timeframe (e.g., participant risk level, type of community activity). The results reported for the community component related to the evaluation timeframe of interest (2023) and comparison year (2022) are all from CVG and are the same data points. Program totals report aggregated data from both CiviCore and CVG where possible. A further consideration for the community reporting is that there were periods where it was identified that data entry was incomplete. During the early part of the program and specifically during the use of CiviCore prior to August 2021, it was determined that not all mediations, program participants and

community events were entered into the database. In addition, due to a gap in the contract between the city of Milwaukee and CVG for use of the CVG database, there was an extended period where support of the system was limited and where new employees could not obtain login information. Therefore, it is likely that there is an undercounting at various points in the aggregated program totals. The evaluation relied on the information entered in the database and is therefore limited where the information is missing or incomplete as there is not a secondary data source available to specifically identify how many records may be missing.

Lastly, it is critical to note that data collected for the community component has not been collected in an identified fashion, which would support follow-up with participants once they leave the program. Identified information, such as name, address, or phone number would be necessary to contact former participants to determine the longer-term impact of program participation, including behavior change. The CVG database maintains data in a de-identified fashion due to confidentiality and privacy protection for both participants and team members. This continues to be an on-going area of discussion and recommendation for change that can help support more robust evaluation of outcomes for the community component in later phases.

2.4.3 School programming data

Surveys to assess pre- and post-participation program outcomes were only available for the 2022 – 2023 school year (Table 1). Only post-participation surveys were administered and collected for ROC workshops in the 2021 – 2022 school year. Only pre-participation surveys were collected for the 2023 – 2024 school year. Moreover, the surveys were

intentionally anonymized and thus exclude the opportunity for comparing pre- and post-participation surveys on an individual basis. The group comparison analytic plan proposed is designed to maximize the design of the data available (ref. *7.11.4 School programming analysis*).

Table 1. Administration of program participation surveys for the school Restoration of Consciousness workshops by school year.

School Year	Pre-Survey Completed? (Number available)	Post-Survey Completed? (Number available)
2021-2022	No	Yes (43)
2022-2023	Yes (75)	Yes (81)
2023-2024	Yes (61)	No
Total	136 surveys	124 surveys

2.4.4 Hospital component data

As previously described, the REDCap database for hospital component case management was created in July 2021. However, it was infrequently used prior to July 2022. This coincided with the expansion of the HR team from one to three HRs with the original HR being promoted to supervisor. This evaluation timeframe of interest, 2023, is the first full year of consistent and reliable data entry. The results since database creation (July 2021) and results for 2022 for the number of needs identified and how frequently resources were referred should be viewed with caution given the known limitation of data entry for those two timeframes.

Moreover, it remains a limitation that referrals are often not documented when a patient declines to participate in the program. This is because hospital providers are not required

to send a page to 414LIFE if a patient declines interest in the program. Therefore, the rate of decline is not something that is reliably documented and able to be commented on by this evaluation.

Furthermore, a referral for services does not inherently indicate that the referred patient actively engaged in the program. The hospital component of the program was hospital-wide and intended for gunshot wound survivors. If an individual was at least referred to the program, there was an assumption that there may be some impact of that connection to the program, regardless of the degree to which the individual interacted with the program. Because the program was advertised to hospital clinicians and leadership, it was anticipated that patients meeting program criteria who were referred to the program would potentially have some program effects or would be treated differently by nature of being referred, or eligible for referral, to the program, regardless of the actual level of engagement with the program.

Future evaluation phases will be better positioned to work to further disentangle the level of interaction and participation across program participants to better understand the effects of the specific dosage and types of program services offered. The analytic approach for the evaluation was chosen with this limitation in mind in order to maximize use of the available data given existing program operations and workflows. Re-injury data is only available for follow-up care received at FH, not to any hospitals. Involvement in homicide and nonfatal shooting incidents was only available for those reported to the Milwaukee Police Department, which accounts for the majority of incidents within Milwaukee County but would exclude incidents occurring in other parts of the county or

the state. As a measure of contact with the criminal justice system, criminal charges were only included for cases in Milwaukee County.

2.5 Analytic approach

The 414LIFE program was implemented as a public health approach to violence prevention, not as a research study. Therefore, this program was not implemented with a direct control group to provide a comparison with the treatment group, as would be the case in an experimental design, such as a randomized controlled trial (RCT) which is often considered a "gold standard" for research. This was an ethical decision by the founding leadership as the intent was to provide this potentially life-saving resource whenever possible to eligible participants (e.g., all gunshot patients coming into Froedtert Hospital) rather than withholding the intervention from half of potential participants to develop a control group. This aligned with prior publications of evaluations of firearm violence prevention and intervention programming.[17-20]

This evaluation utilized an analytic approach commonly utilized by RCTs and other study designs for interventions which can also be utilized for non-randomized group comparison studies. Known as the intent-to-treat (ITT) analysis,[21] the underlying assumption is that all participants are analyzed according to their original group assignment - individuals in the treatment group as if they received the intervention regardless of the level of program exposure and individuals in the control group as if they did not receive the intervention. This would mean that whichever condition a participant was assigned to, either intervention or no intervention, that they would be analyzed as such. This assignment holds even in cases where a participant did not receive the full intervention, such as in

situations where they started but did not complete the program. Those that had at least some exposure to the program, even if they did not fully complete the program, are still retained in the intervention or treatment group for purpose of the analysis.

Although 414LIFE was not implemented as an RCT, ITT for the current evaluation was chosen due to this approach's underlying assumption of participation and because it is a conservative approach to understanding the potential impact of program that underestimates program effect so that the effects that are observed are unbiased.[22,23]. The elements being controlled include non-compliance, deviations to the intervention or services, early withdrawal of participation, and, perhaps most importantly, any possible systematic differences that may result by nature of the program's existence. As previously described for the limitations of the hospital component data, this approach also accounts for differential treatment that gunshot wound patients may receive by nature of being perceived as eligible for the program. While this analytic approach is most directly applicable to the analyses conducted for the hospital component, it is still the guiding analytic approach for the whole evaluation for all aspects of the program.

The full analytic plan conducted for this evaluation can be found in Appendix K.

3.0 Results

3.1 Program-wide

3.1.1 Funding

This evaluation reports, for the first time, the programmatic expenditures.

Program expenditures were $1.2 million in 2022, and $1.5 million in 2023 (Table 2). Total program budget available during these years and future years was $6.3 million to fund program activities and staff. This includes the award of $3 million from the American Rescue Plan Act of 2021 (ARPA) in 2022 through November 2026, which were provided through the city of Milwaukee.

Year	Expenditure
2022	$ 1,199,104.14
2023	$ 1,535,675.08

Table 2. 414LIFE dollars by calendar year

Marketing expenditures in 2023 were about $10,500 and included the activities and materials described in more detail below to increase the community's awareness of the program and its services (ref. *3.1.2 Marketing* below).

There were various funder types over the years, which was also reported in the first program evaluation. Funders (direct or pass through) include the City of Milwaukee, Milwaukee County Department of Health and Human Services, the Greater Milwaukee Foundation, the Kellner Family Foundation, United Way of Milwaukee, the Milwaukee Bucks, Everytown for Gun Safety Support, and Froedtert Hospital.

3.1.2 Marketing

414LIFE has a goal of one pro-peace educational campaign per year. For 2023, there was not a billboard campaign. Instead, marketing was driven through social and traditional and social media. In addition, the program was advertised through 414 LIFE branded apparel worn by program personnel and printed public educational materials for distribution during canvassing and pop-up stands at community events.

3.1.2.1 Traditional media

Included in traditional media were newspaper stories, online stories, and broadcast media stories and/or interviews. In 2023, there were 58 instances in which there was a news story about 414LIFE or in which 414LIFE was mentioned in relation to an event or as a resource people could reach out to for support due to the content of the story.

Most stories were from online sources (46, 79%), and some through newspapers (12, 21%) Of these 58 instances, there were 39 unique headlines. The same story could be shared through multiple outlets, or even from the same outlet on different days. For example, the story, "Arrests made after 17-year-old dies in north side shooting" ran on January 2nd three times, and once on January 3rd by various online outlets including *News Break,*[26] *Milwaukee Journal Sentinel Online,*[27] and *Daily Magazine,*[28] and in the traditional newspaper format for *Milwaukee Journal Sentinel*.[29]

The majority of stories were about efforts to address firearm violence locally (25, 43%). Within this category there were stories from two points of view – questioning city government investment, commitment, and direction related to violence prevention efforts (12, 48%), and community-based calls for change and advocacy (13, 52%). Examples of

stories focused on government investment included areas such as "OVP to leave its longtime home; some question city's commitment"[30] and "Common Council presses Office of Violence Prevention on how it's using $12M to make city safer."[31] Community-based stories focused on calls for change and advocacy included stories like "Community members call for peace as New Year begins in Milwaukee"[32] and "United We Stand Against Violence Community Street Leaders Unite."[33] Many stories also focused on responses to violent incidents that occurred (18, 31%). Examples include headlines such as, "Milwaukee: Six Teens Shot,"[34] "Another child shot in cycle of senseless gun violence,"[35] and "Community laments shooting that injured six after joyful Juneteenth festival."[36] Less frequent were stories which focused on incidence rates of violence (9, 16%), such as "City's Homicides, Shootings Down in 2023"[37] and "Homicides may be down, but 'frustration' persists at level of violence in Milwaukee."[38] There were some stories about local events (6, 10%), such as the recognition of National Gun Violence Survivors Week hosted by the City of Milwaukee in which 414LIFE participated,[39] and the annual King Community Center Turkey Drive at which 414LIFE provided local resources with other local organizations.[40]

The relative publicity value of this traditional media content is approximately $225,000. The estimated audience reach was about 589,000 individuals, which includes total print and broadcast reach. Unique visitors per month (UVPM) for desktop (computer) users was about 7.6 million while for mobile users it was 15.9 million.[f]

[f] These numbers indicate the size of audience that *could* have seen this media, it does not indicate the number of individuals who actually *did* see the media.

3.1.2.2 Social media

Social media content for 414LIFE is posted through the program's own account, as well as the account for the Comprehensive Injury Center (CIC), where the program is housed. The CIC has Facebook (https://www.facebook.com/cicatmcw) and X (formally Twitter; @cicatmcw) accounts, while 414LIFE has Facebook (https://www.facebook.com/414LIFEMKE2) and Instagram (https://www.instagram.com/414lifemke/) accounts.

In 2023, the CIC had nine Facebook posts where 414LIFE was mentioned and 5 (re)tweets on X. The Facebook posts by the CIC highlighted the community-engaged work of 414LIFE, including their participation in "Healing 4 Our Youth" forum with the Milwaukee County Department of Health & Human Services (June 29, 2023), and the podcast "The Latest Word on Medicine" through the MCW's Department of Surgery to raise awareness of firearm violence (June 16, 2023). On X, there was 1 re-tweet and 4 original tweets which mentioned or were about 414LIFE in 2023. Two were posted in October, and 3 in November. Two tweets were about the research presented by the CIC at the 2023 National Research Conference for the Prevention of Firearm-Related Harms, both of which included a picture of a poster presentation of the 414LIFE Phase 1 Evaluation's

community component results. One tweet encouraged followers to watch a local news special by TMJ4 called "Beyond the Bullet"[41] which was in part about how 414LIFE fits into the local ecosystem of firearm violence prevention efforts. Another tweet similarly promoted followers to watch another TMJ4 news special about the TQoL Clinic and specifically highlighted 414LIFE's role in it (October 23, 2023; 2,999 views).[42] Lastly, one tweet was promoting the public release of the Phase 1 Evaluation on the CIC's webpage.

During the same timeframe, 414LIFE had 74 Facebook posts and 59 Instagram posts. Similar to the CIC, the Facebook posts by 414LIFE also highlighted their outreach and community-engaged work in action. Some examples of this include the team's participation on a panel discussion following a community screening of "When Claude Got Shot" (June 3, 2023), providing resources and food at the 11th Annual Heal the Hood MKE Block Party & Resource Fair (May 28, 2023), and attending national conferences, such as the GIFFORDS 2023 Community Violence Intervention Conference (June 26, 2023). Additionally, 414LIFE used their Facebook account to advertise upcoming community events, such as homicide candlelight vigils (December 28, 2023), end of Summer Bash block party (August 18, 2023), and the

"Healing 4 Our Youth" event (June 15, 2023). 414LIFE also advertised job openings in their program, such as for their community program coordinator position (June 16, 2023). On Instagram, 414LIFE similarly used the platform to highlight the team's work in action in community, as well as to advertise upcoming events and internal job openings. There was a lot of overlap in content between the program's Facebook and Instagram accounts, but each account did have unique posts/images as well. It is also important to note that these social media accounts only provide engagement metrics for the past 90 days, so unlike the Traditional Media reported in the previous section, these metrics for 2023 are not available to report at the time of writing this evaluation.

3.1.2.3 Program materials

414LIFE branded apparel worn by program personnel helps the community to identify team members and increases awareness of 414LIFE within community, at events, and at national conferences. Apparel is also handed out to community members at pop-up stands at community events. Apparel includes t-shirts, hoodies, track jackets and baseball caps with the 414LIFE logo. Slogans include "About That Life" and "Stop Shooting Start Healing" (Figure 9). Marketing expenditure for apparel in 2023 was $6,173.80.

Figure 9. Marketing program materials at community events and pop-ups.

Printed public education materials for distribution during canvassing and at pop-ups for community events included postcards, buttons, doorhangers, and handouts. The content of those materials included information about the *Blueprint for Peace,* the scope of 414LIFE's services (i.e., target areas, community services, hospital services), and information for other local resources (e.g., domestic violence, addiction, housing, legal support, etc.). The total marketing expenditure for printed materials in 2023 was $4,364.92.

3.1.3 Onboarding

This evaluation offers insight into the onboarding training process for new 414LIFE team members, which was not previously included in the Phase 1 evaluation. When new team members are hired, they interact with the Program Site Director, Program Administrator, and Program Operations Manager (ref. Figure 1). The Program Administrator is in charge of human resources-related tasks, such as ensuring the completion of MCW required employee trainings, new hire paperwork, permissions, and benefits, and training on

standard operating procedures, such as dress code and schedules. The Program Operations Manager orients new team members to the 414LIFE program-specific standard operating procedures (e.g., data entry expectations), database training, and an overview of program history, services, and operations. The Program Site Director or Program Operations Manager will also provide additional orientation to the scope of the program, meaning, how the different services and components operate together to support the program's overarching mission. More detailed job-specific trainings occur through on-the-job training and shadowing of senior team members, as well as formal trainings through organizations such as CVG and the Professional Community Intervention Training Institute, as they were able to be scheduled. More information about the CVG training is available in 3.2.1.2 *Community component, Inputs, Training*.

3.1.4 Participant outcome survey

3.1.4.1 Respondent characteristics

A total of 18 participants of 414LIFE responded to the post-participation survey. Most respondents worked with a VI or OW (10, 55.6%), two worked with a HR (11.1%), and six worked with team members from both the community and hospital components (33.3%). Most of them worked with

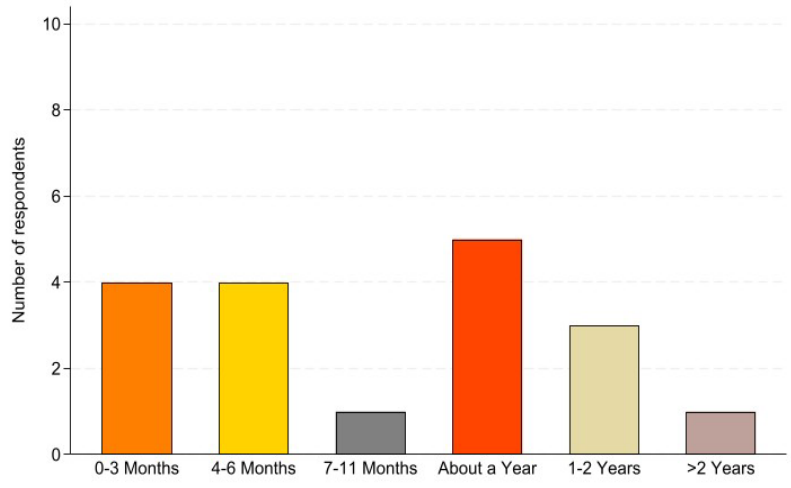

Figure 10. Duration of Respondent Participation in 414LIFE

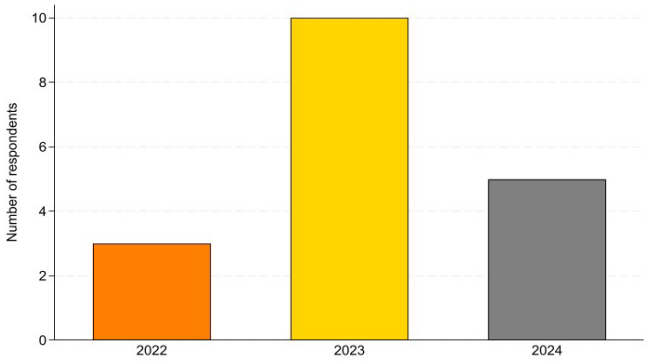

Figure 11. Year Respondents Started Engaging in 414LIFE

414LIFE for a year or less (77.8%; Figure 10). Only one respondent worked with the program for over two years. Most respondents were engaged with the program in 2023 (55.6%; Figure 11).

Since working with 414LIFE, most respondents agreed (7, 43.8%) or strongly agreed (5, 31.3%) that they could avoid getting into fights or violent confrontations (Table 3)[g]. Respondents also reported high agreement that they can use options and methods to resolve a conflict other than violence (strongly agree [5, 35.7%]; agree [8, 57.1%]) and feeling able to make a non-violent choice even when disrespected (strongly agree [4, 28.6%], agree [7, 50.0%]). Similarly, most respondents also felt able to do something different from their friends if they think it is the right thing to do (strongly agree [6, 42.9%], agree [8, 57.1%]).[h]

Table 3. Agreement with various statements of non-violence after participation in 414LIFE

Post-Participation Statements	Strength of Agreement				
	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
	#(%)	#(%)	#(%)	#(%)	#(%)
I can avoid getting into fights or violent confrontations.	1 (6.3%)	0 (0.0%)	3 (18.8%)	7 (43.8%)	5 (31.3%)
I can do something different than what all my friends are doing, if it's what I think is right.	0 (0.0%)	0 (0.0%)	0 (0.0%)	8 (57.1%)	6 (42.9%)
I can use options and methods to resolve a conflict other than violence.	0 (0.0%)	0 (0.0%)	1 (7.1%)	8 (57.1%)	5 (35.7%)
I feel that I can make a non-violent choice even if I feel disrespected.	1 (7.1%)	0 (0.0%)	2 (14.3%)	7 (50.0%)	4 (28.6%)

[g] Not every respondent responded to every question. Percentages in Table 3 are based off the total number of respondents per question.

[h] It is important to acknowledge that the high level of agreement with the statements may be related to potential selection bias where participants having a positive experience with 414LIFE may have been more likely to complete the post-participation survey. At the same time, there were both positive and negative comments offered by respondents in terms of their perception of their own change after

3.1.4.2 Areas of disagreement

Although most respondents agreed with the aforementioned statements, there were 2 noteworthy occurrences of disagreement. One respondent strongly disagreed that they could avoid getting into fights or violent confrontations. They reported that this is because "*I wasn't taught how to avoid them.*" A different respondent strongly disagreed that they could make a non-violent choice even when they feel disrespected. This is, "*because then it's like if I don't fight you then I would feel like I'm scary*." This response conveys the perpetuating normalization and necessity of appearing violent and/or being prepared to be violent in response to disrespect as a means to prevent the perception of being weak or afraid. This view is echoed by previous research on firearm carrying behavior.[43,44]

3.1.4.3 Areas of agreement

When respondents agreed with any one of these statements of non-violence, it was common that they had pre-planned, actionable strategies (mental and physical) that they could implement, or they attributed their agreement to alignment with non-violent intrinsic values. Pre-planned, actionable strategies were present regardless of whether disrespect was a factor in the hypothetical statement about a violent situation. Some

> *An example of a pre-planned, actionable strategy to avoid violence*:
>
> "I **walk away** and go and **talk to someone older** than me."
>
> - 414LIFE Participant

program participation. Future evaluations are working to incorporate feedback from a broader number of participants to better understand the range of participant experiences and perceived impact of the program.

examples provided by respondents include "*'[at] School someone walked up to me n ask to fight I took a deep breath n walked away,'*" "*Go outside or go walk around,*" and "*I walk away and go and talk to someone older than me*." These responses indicate strategies which are evidence-based and aligned the violence reduction mission of 414LIFE, such as focusing on breathing, walking away to maintain safety and time to make decisions, and seeking mentorship.[45-48]

Non-violent intrinsic values were either indicative of the standard they wanted to hold themselves to or with the goal of doing right by their community so that they can contribute toward the community being safer for everyone. For example, related to holding oneself to a certain standard in accordance with their own intrinsic values, one respondent wrote: "*My entire life I was never a person to go in start confrontation. I'm very passive in the sense of not wanting to put myself in situations that can potentially cause harm to me. If I notice a conversation is steering into a volatile environment, I simply close my mouth and walk away*." Related to a desire of contributing toward a safer community for all to live in, other respondents described their perspective that they avoided a potentially violent confrontation "B*ecause I lost a loved one and I just wanna stop the violence the shooting and killing in our city*" and "*...to help the community.*"

An example of when you have avoided a potentially violent confrontation:

"Because I lost a loved one and I just **wanna stop the violence** the shooting and **killing in our city**."

- 414LIFE Participant

Although this survey was not designed to quantify behavior change (e.g., reduction in actual participation in violence, criminal charges, re-injury, future perpetration), the results do reflect understanding of what ought to be done when confronted with a potentially violent situation for those responding 414LIFE participants. Whether or not actions align with plans should a real situation arise, the knowledge is there and aligns with the intent of 414LIFE's promotion of peaceful and non-violent behavior.

3.1.4.4 Areas of uncertainty

Although there were only two respondents who disagreed with the non-violence statements, respondents who reported being unsure were also asked follow-up questions to ascertain what prevented them from agreeing with the statements (range = 1-3 respondents per statement who answered not sure; Table 3). Some instances in which respondents reported being unsure were due to respondents feeling genuinely unable to anticipate how they might feel until they are confronted by the situations proposed in the survey. For instance, one respondent indicated that "*I don't put myself into situations where fights or violence is possible. Not sure how I would feel if that were to happen*," while another indicated "[*I'm*] *not sure. I just feel angry when someone disrespects me*." However, other responses appear to indicate a lack of skills or knowledge in being able to successfully avoid violence.

An example of uncertainty in how to respond to violence:

"[I'm] not sure. I just feel angry when someone disrespects me."

- 414LIFE Participant

For instance, a respondent stated: "*I wasn't taught how to avoid them*." These respondents seemed to be self-aware of this lack of knowledge, which may infer an openness to learning the skills necessary to address this gap. In the absence of these skills, utilizing violence may still be seen as a strategy to respond to violence from others. It is important to stress though that this is a singular finding and is not representative of most respondents' experiences and the unsure responses of participants warrant further examination in future evaluation phases which aim to survey a larger sample of past participants. Again though, overall across the majority of respondents there still appears to be recognition of what they need to learn to become the person they want to be to meet their goals, such as replacing violent reactions with non-violent reactions, if only they had the skills to do so. However, it is important to note that a potential, self-acknowledged barrier to this behavior change was reported by one respondent. They described that it is challenging to avoid getting into fights or violent confrontations "because when people talk crazy I can't just look past it." This sense of overwhelming anger may override the ability to clearly choose and execute non-violent reactions to conflict, particularly in the absence of conflict avoidance skills.

3.1.4.5 Direct participation outcomes

This initial survey of program participants returned a range of agreement with hypothetical statements of how they would respond to particular situations that could involve violence. However, all respondents reported a positive outcome when asked to comment on their experience working with 414LIFE and how it has impacted their life.

The type of outcome was variable, with responses touching on a wide variety of domains. The most common outcome reported was that 414LIFE connected the participant (and possibly their family/loved ones) to resources, such as employment, health insurance, and completing an application for Crime Victim Compensation. Other types included improving outlook on life, such as improving their "*thinking strategy*" and "*look at life better,*" feeling motivated to help in and care about the community in which they live, having "*something else to do besides being* [*in*] *the house*," having "*a lot of learning experiences*," learning "*how to cope with stress*," and getting help to get out of a domestic violence incident. Social support was also indicated in a broad way. One respondent specified that they "*want to be more social with others*" and so 414LIFE "*allowed me to interact with other people outside of my family*." Another respondent reported that 414LIFE provided

comprehensive support throughout the entire inpatient admission for a firearm violence survivor. As one respondent wrote about their experience working with the HR team:

> "I've never been in surgery or anything related to a gunshot wound. Initially coming into the hospital was a scary feeling of not knowing the outcome of your livelihood. The moment [Hospital Responder] came into my hospital room was a moment of rejoice and a time that I could finally be at ease.
>
> **[They] assisted me with the next steps as far as investigation with the police department, setting me up with health insurance and any other compensation plans** that I would be eligible for due to my situation. However, **the most profound thing** about my entire experience is **their commitment to making sure that I was set up for success outside and inside of the hospital** while I was committed and making me feel comfortable about the journey to recovery while I was being discharged.
>
> People in the situation I'm in that goes through a situation very traumatic, I can see the irrationality or the guilt that people can bring upon themselves, but with [Hospital Responder] and the team **they reassured that my spirits were high and I was going to make it through** and come out of this an even stronger person. I am forever indebted to you beautiful people and the beautiful system you have put in place to help innocent people like me in these situations.
>
> - 414LIFE Participant

Due to the limited number of participants surveyed, it is likely that there are other domains which 414LIFE impacted in participants' lives. Future evaluations aim to collect more surveys in order to fully understand the breadth and depth of program outcomes.

3.1.5 Barriers for connecting participants with resources

One theme that came up prior to this evaluation during the Evaluation Team's monthly data report presentations to the 414LIFE team was the difficulty of connecting participants with particular types of resources to meet their needs. This barrier was reported by the frontline staff and supervisors of the community and hospital components. The interview

guides used in this Phase 2 evaluation sought to learn about this barrier in greater detail (Appendices E, F, G).

The barrier was more specifically the ability to actually have participants receive the resource to which they were referred by 414LIFE team members. Placing a referral for services was not the barrier. As one team member described it, it was the "follow up and follow through" of the referred service. When 414LIFE team members refer participants to a service, such as housing, and the service was either unable to or did not connect the referred participant to the resource needed, then participants perceived a lack of follow through from 414LIFE. The subsequent consequence to 414LIFE team members was distrust which then manifested in a decrease in participant engagement with 414LIFE. Decreased engagement was often experienced as lost connection with participants. This could occur as a result of changed phone numbers or technical issues (e.g., running out of minutes). However, the failure to connect with and receive the referred service had also resulted in lost communication and engagement with previously active participants.

For housing in particular, the cause of this barrier appears to be significant capacity limitations for the organizations and agencies that 414LIFE partners with. Placing the

referral is easy; the issue is obtaining the housing. Further adding to the difficulty are program eligibility criteria. For instance, it is possible to secure hotel stays for participants requiring immediate relocation. However, this is a short-term solution. Eligibility for long-term housing frequently requires financial resources the participants do not have, such as savings, credit history, or employment (including history of sufficient income, or current work due to recent firearm injury). Even if a participant is eligible for long-term housing, the wait list can be very long, so long that participants run out of time to stay at temporary shelters and have nowhere to go while they continue to wait for long-term housing to become available.

Housing was the service where the connection to resources was described as being most significant and frequent. Crime Victim Compensation and mental health resources were also mentioned, but less frequently. Domestic violence was another area of cited difficulty; however, it ultimately was also due to limitations in being able to secure immediate housing for relocation.

3.2 Community component

3.2.1 Inputs

3.2.1.1 Structure

There were at most seven filled VI positions and three filled OW positions at various points in 2023. This number fluctuated during the calendar year as new team members were hired or team members departed for external opportunities. The exception is one VI and one OW team member who were both internally promoted to new roles. These new roles were two new staff-level Team Lead roles created in October 2023; one Team Lead for VIs and

another for OWs (ref. *Introduction,* Figure 1). These roles were positioned to indicate a leadership role at the team member level. The VI Team Lead role was designed to provide direct support to the VI Supervisor in the daily execution of violence interruption efforts. This also includes modeling the knowledge, skills, and expectations of a VI through the execution of daily activities. Similarly, the OW Team Lead role was designed to provide direct support to the OW Supervisor and modeling for OW team members. This includes providing supportive services to crime victims and their family members, engaging in de-escalation for individuals who may be planning retaliatory violence, and identifying and intervening in the neighborhood most likely to instigate retaliation.

3.2.1.2 Training

Job shadowing and CVG trainings constituted the majority of specific role training for VIs and OWs.[i] Job shadowing for VIs and OWs occurred over the first several weeks of hire, and with multiple senior team members. This was done because every team member has their own unique approach to the work and thus new hires could benefit from learning from a variety of approaches. An additional benefit was allowing new hires to be able to shadow on a variety of activities, including canvassing, mediations, interruptions, participant case

[i] As previously noted, HRs were also invited to the Cure Violence Global trainings focused on how to conduct violence interruptions (as opposed to the database entry-specific trainings as the 414LIFE HRs do not use this database).

management, and community outreach events. Job shadowing and general team mentorship also facilitated data entry training. The Program Operations Manager would provide an overview of the CVG database system, however, real time assistance and learning when work occurred and need to be entered would happen between new hires and senior team members.

CVG trainings would involve about the equivalent of a work week of time (approximately 36 – 40 hours). The training topics would cover the model itself, staff roles and responsibilities, how to conduct violence interruptions and mediations, case management, and team building/sustainability. It was noted that there were contractual issues between the city and CVG which resulted in delaying when the model and data entry training could occur, which also affected when database accounts could be created for new hires. Thus, it needs to be noted that the team reported various lengths of time delay between the time they were hired and the time in which they got database access and training. The delay was at times as long as several months. This also motivated team-level mentorship and assistance with data entry because of this time delay between training and access to be able to enter data in about the work which was conducted.

3.2.2 Outputs

3.2.2.1 Violence mediations

There was a total of 316 violence mediations since the start of the program (October 2018) through end of December 2023. Of these mediations, 59 were new mediations documented in 2023. Mediations in 2023 were concentrated in 414LIFE and *Blueprint for Peace* priority neighborhoods (Figure 12). This was not new for this calendar year – a similar pattern was visualized in 2022 and in the Phase 1 evaluation (October 2018 – December 2022) (ref. *Phase 1 evaluation*, *Figure 7*, pg. 46). 414LIFE continues to have a citywide presence in their violence mediation work. Previously this pattern was considered in light of the events of 2020 which necessitated a reprioritization of community engaged

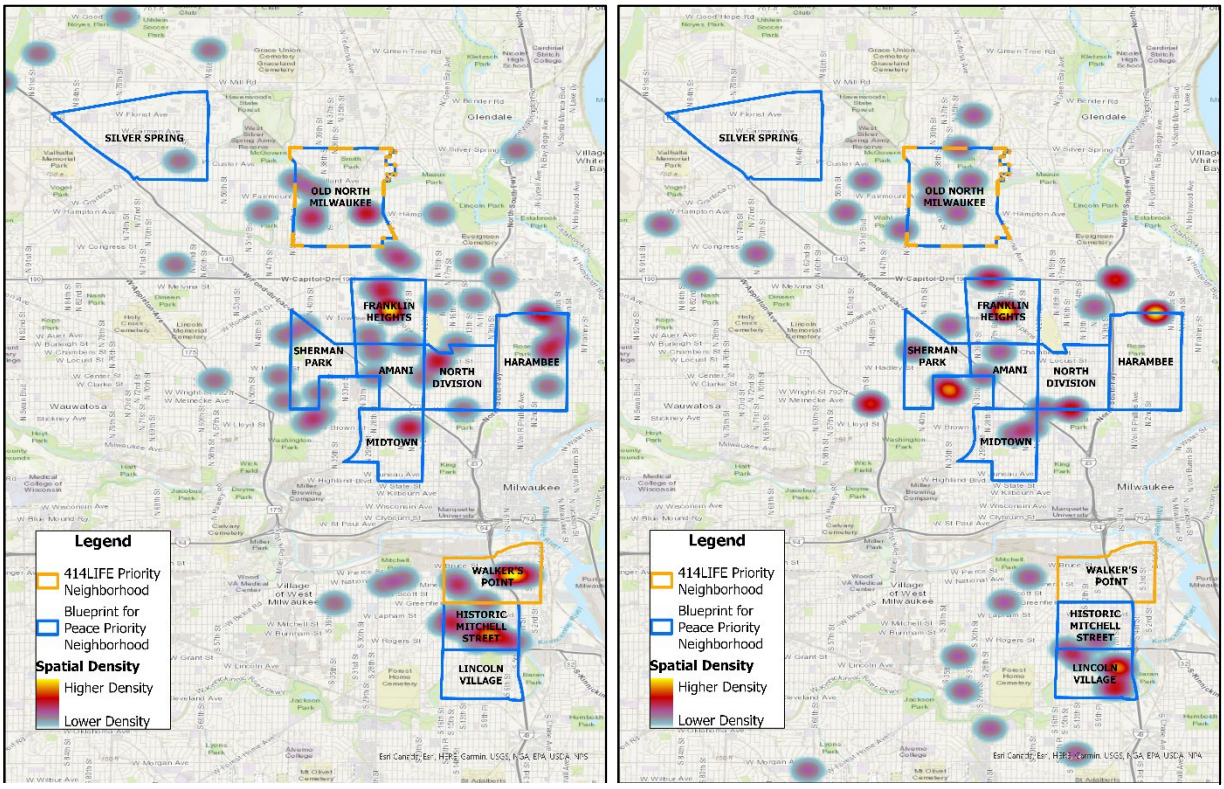

Figure 12. Spatial density of violence mediations documented in 2022 (left) compared with mediations documented in 2023 (right).

efforts. In addition, there were several changes in which neighborhoods were designated as a priority for 414LIFE from 2018 - 2022 (ref. Phase 1, Table 1, pg. 20).

3.2.2.2 Community engagement activities

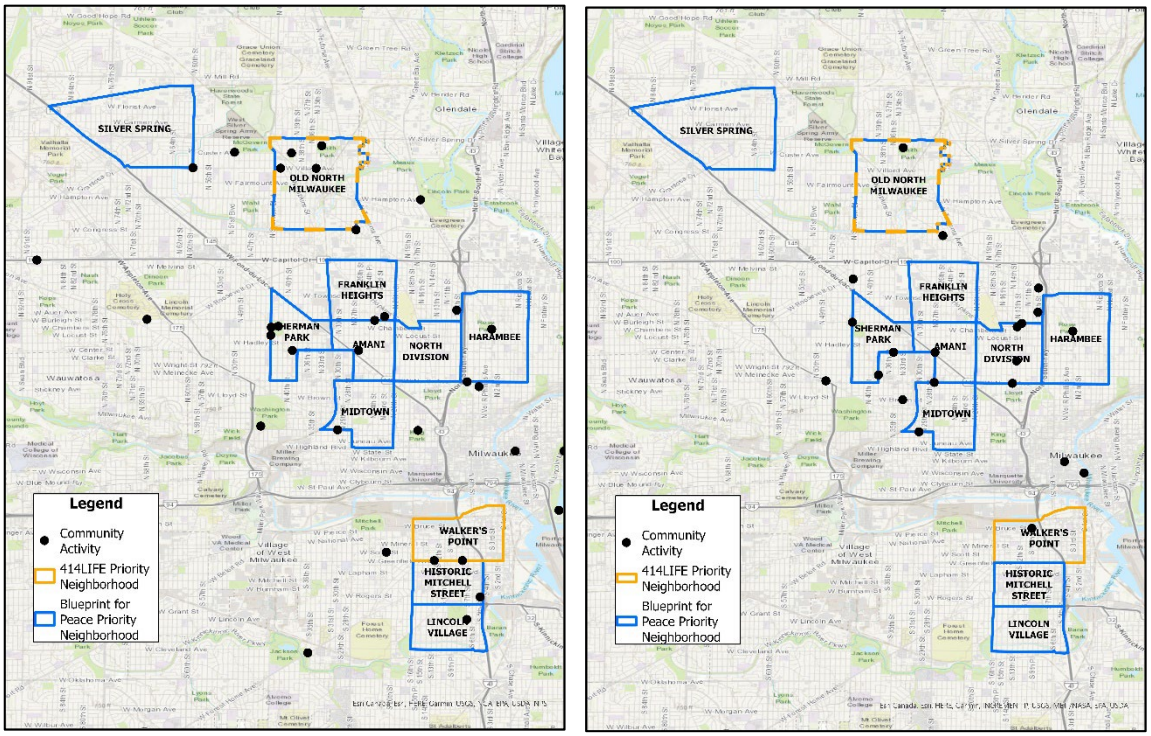

Figure 13. Location of community activities documented in 2022 (left) compared with activity locations documented in 2023 (right).

A total of 134 community events occurred since program start through December 2023. In 2023 alone, there were 24 new community events documented. Of these, 1 (4.2%) occurred within 414LIFE priority neighborhoods and 12 (50.0%) in *Blueprint for Peace* neighborhoods, and 1 occurred within Old North Milwaukee, which is both a *Blueprint for Peace* and 414LIFE priority neighborhood (Figure 13). The majority of community events (with known locations, 23 of 24; 1 virtual) occurred within North Division (4 events) and Sherman Park (4), Borchert Field (3) and Metcalfe Park (3), and Midtown (2) and Saint Joseph (2) neighborhoods. The focus of these community events was public

education/presentation (7, 29.2%) and participating in community events (17, 70.8%). Some examples of public education/presentation include the program's participation in the Healing 4 Our Youth Forum, Midwest Community Safety CVI Summit, and the Emergency Gun Violence Summit. Examples of community events included 414LIFE's participation in the Wear Orange Weekend Peace Walk, 414LIFE Community Pop-up at Smith Park, and the Juneteenth Festival in Milwaukee. The last two years, community activities have been concentrated in the summer and fall months (Figure 14).

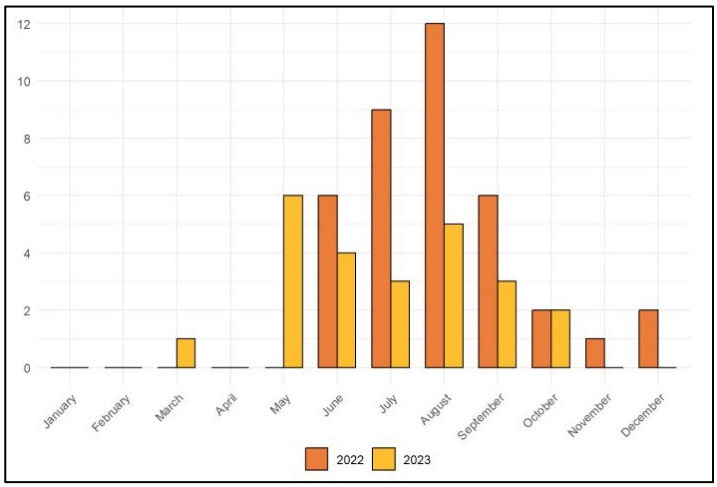

Figure 14. Frequency of community activities by month, 2022 - 2023

Community engagement through canvassing was strongly emphasized in priority neighborhoods, or in response to a recent incident in a non-priority neighborhood. This exception was described by the team member focus groups as,

> *"We're actually gonna do a pop up at 3 o'clock at Moody Park and that's not our targeted area, but a 4-year-old was killed over there not too long ago, like a couple days ago. So we just gonna make our presence known over there, and that wasn't a... a back-and-forth debate, it was told that, you know, that's what, that's what they wanted done, so that's what we're gonna do."*

In 2023, canvassing, resulted in contact with 5,914 individuals, and 11,430 pieces of public education distributed. Total time dedicated to activities related to behavior change and public accompaniment was 1,731 hours. These activities are defined by CV as those related to: working with participants, working with organizations/agencies, referring participants and/or non-participants to services, attending appointments with participants, connecting community members to the program, and more.

For both program participants and non-participants, there are several types of potential referrals that could be initiated and documented (Figure 15).[j] The most common resources

Referrals* Made for Community Members by Type

Referral Type	YTD 2022	YTD 2023
Work	9	35
Housing	5	21
Psych	4	13
Financial	1	12
Education	3	3
Social	4	2
Other	13	2
Hospital	0	1
Legal	0	0
Grand Total	39	89

Referrals* Made for Participants by Type

Referral Type	YTD 2022	YTD 2023
Work	10	66
Other	1	26
Housing	6	22
Education	1	15
Financial	3	11
Legal	0	5
Hospital	0	4
Psych	1	0
Social	5	0
Grand Total	27	149

Figure 15. Referrals* made for participants and community members by 414LIFE by type, 2022 – 2023

*Referrals indicate unique number of referrals placed, not individual counts of participants, as participants could have multiple referrals for resources placed.

[j] It is important to note that program participants are individuals that were part of the case load for the community component of the program, while non-participants refers to community members that were not direct participants in the program. This could include loved ones connected with a program participant or community members who interacted with the program but may not be eligible for the program or may not be in need of referral for case management.

participants and non-participants were referred to in 2023 included work/employment (66), housing (22), education (15), financial assistance (11), a category for other or miscellaneous referrals for specific types not listed (26). Although the types of referrals made was relatively consistent, the number of referrals recorded for participants and community members in 2023 represented a substantial increase over 2022.

3.2.2.3 Case management

Since the program start, a total of 183 individuals were recorded to be part of the program's caseload for case management. Most participants were young adults (average

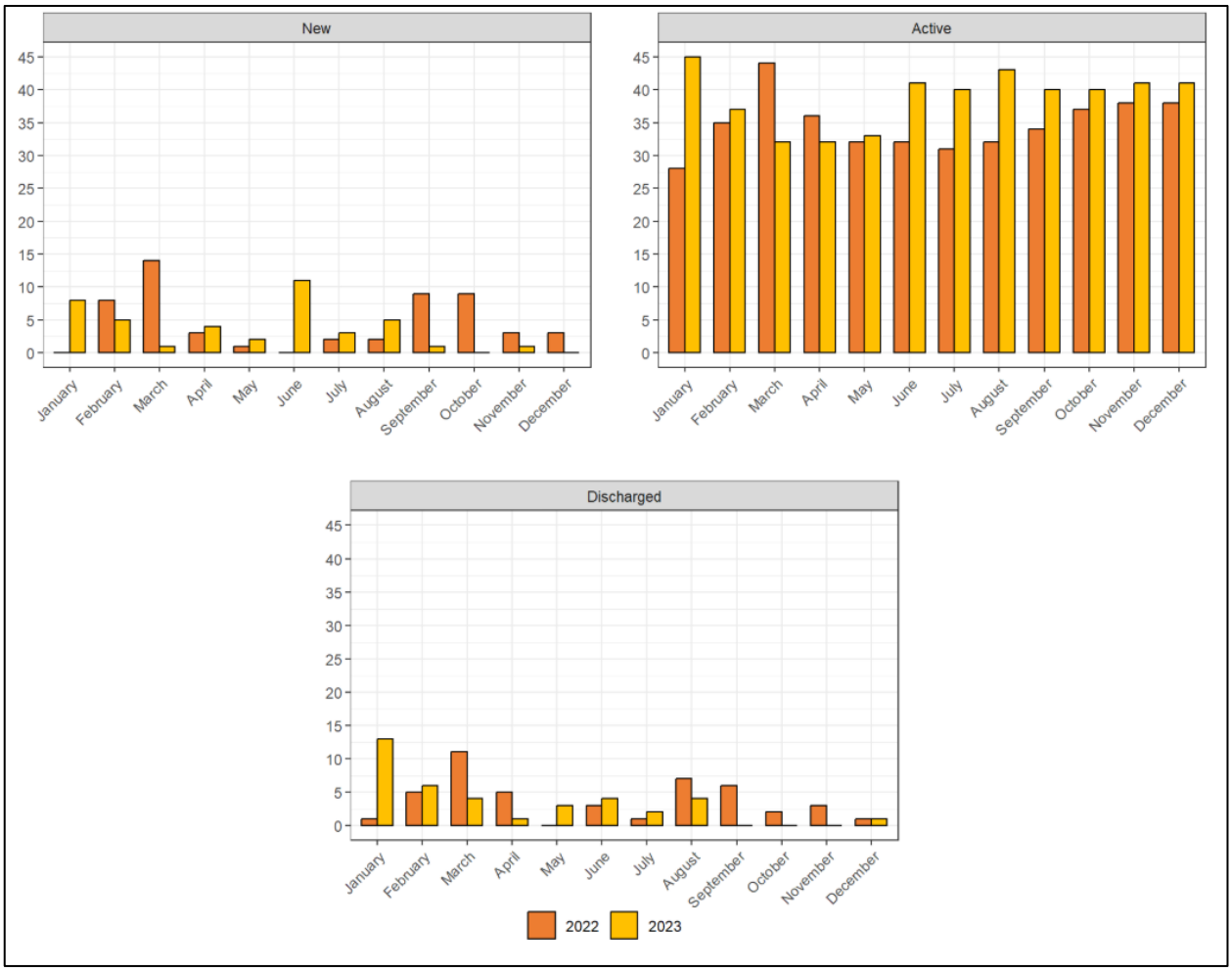

Figure 16. Case management caseload by program status, 2022 – 2023

age = 25.0 years, range 11-54), Black or African American (92.6%)[k], and male (72.1%). In 2023, there were 41 new participants added to the caseload, with an average age of 18.2 years and most were Black or African American (89.1%), and male (69.6%).

Most participants in 2023 fell within the target age range of 15-35 years (89.1%), and most were assessed to be at high (39.1%) or medium risk (52.2%) of future violent victimization or involvement in violence. In 2023 there were 41 participants who were newly screened for program eligibility, 78 who were active at any point in time during the calendar year, and 38 participants who were discharged (Figure 16).

3.2.3 Outcomes

3.2.3.1 Violence interruptions

The team collectively spent 575 hours conducting violence interruptions in 2023, of which most occurred within the priority neighborhoods (386 hours, 67.0%). This refers to activities related to stopping an actively violent situation.

3.2.3.2 Mediations

As previously defined (ref. *Methods* section), the outcome of a mediation can be documented as resolved, unresolved, conditional, or unknown.

Since the start of the program (October 2018 – December 2023) there have been a total of 316 mediations documented, of which 146 (46.2%) were resolved, 76 (24.1%) conditionally resolved, 76 (24.1%) unresolved, and 18 (5.7%) of unknown status. In 2023, there were 59 mediations documented, of which 30 (50.8%) were resolved, 11 (18.6%) were conditionally

[k] This percentage is based off of the number of participants with data recorded, but it should be noted that there was a lot of missingness of data in CVG (108 of 183). This has been addressed with the program team to improve the completeness of data going forward.

resolved, and 18 (30.5%) unresolved. Therefore, the majority (69.5%) of the mediations conducted in 2023 were documented as being resolved or conditionally resolved.

3.3 School programming

3.3.1 Inputs

A total of 260 students engaged in the school-based ROC workshops. Most students indicated that they were first time workshop attendees (87.0%). Most students attended Vincent High School, Howard Fuller Collegiate Academy, Marshall High School, and Andrew S. Douglas Middle School (Table 4), which is the first middle school participating in the program for the 2023-2024 school year. As a result, the average age of students was lower in this evaluation phase compared to the first evaluation (14.9 vs. 15.2 years, ±1 year; range 11-19 vs. 14-19 years). Still, most students were in 9th grade (62.5%) at the time of workshop participation, though with the addition of Andrew S. Douglas Middle School, it is important to note that there were participants from all possible grade levels (6th – 12th grade).

Table 4. ROC Workshop Attendee Characteristics from All Sessions

School	**Count** *Number (%)*	**Age** *(Average)*	**Grade** *(Average)*
Andrew S. Douglas Middle School	39 (15.0%)	12.1 years	7
Assata High School	12 (4.6%)	16.7 years	11
Howard Fuller Collegiate Academy	41 (15.8%)	15.5 years	10
Marshall High School	41 (15.8%)	14.8 years	9
Mesmer High School	7 (2.7%)	15.4 years	9
North Division High School	18 (6.9%)	14.9 years	9
Nova High School	23 (8.9%)	16.2 years	10
Obama High School	12 (4.6%)	14.8 years	9
Vincent High School	67 (25.8%)	14.9 years	9
Total/Overall	260 (100.0%)	14.9 years	9th grade

3.3.2 Outputs

Since the workshops started, there have been a total of 260 completed anonymous participation surveys; 136 were pre-participation surveys and 124 were post-participation surveys. Pre-surveys were available for school years 2022 – 2023 and 2023 – 2024. Post-surveys were available from 2021 – 2022 and 2022 – 2023. Post-surveys were not collected during the 2023 – 2024 school year. As participation surveys are anonymous, pre- and post-survey responses were not matched within school years to the same students.

Table 5. PRE-Participation Survey Responses (*N* = 136)

Before participating in these sessions…	**Strongly Agree** (%)	**Agree** (%)	**Not Sure** (%)	**Disagree** (%)	**Strongly Disagree** (%)
I understand violence as a disease.	22.0	43.2	28.8	4.6	1.5
I understand the conditions that promote violence.	18.3	51.9	24.4	3.1	2.3
I avoid getting into fights or violent confrontations.	19.7	32.6	26.5	12.1	9.1
I can do something different than what all my friends are doing, if it's what I think is right.	39.9	40.6	13.5	3.8	2.3
I think that people need to be involved in street activity if they want to survive in my neighborhood.	11.2	12.7	24.6	23.9	27.6
I feel I can be a peaceful person.	28.6	30.1	25.6	10.5	5.3
I feel that I can make a non-violent choice even if I feel disrespected.	16.5	30.8	27.8	14.3	10.5
I am a positive influence and/or a role model.	21.2	35.6	34.1	3.0	6.1
I use options and methods other than violence to resolve a conflict.	11.5	35.1	34.4	12.2	6.9
I think that using violence can sometimes solve problems.	18.2	24.2	28.0	13.6	15.9

Based on the pre- participation survey administered at the start of the ROC workshops, overall students were already predisposed towards non-violence. For instance, nearly three-fourths of students self-reported already knowing the conditions which promote violence (70.2%) and understanding violence as a disease (65.2%) (Table 5). About half of students (58.7%) indicated

that they feel that they can be a peaceful person and just under half felt they can make a non-violent choice even when encountering disrespect (47.3%). Relatedly, nearly half of students *did not* think that people need to be involved in street activity to survive in their neighborhood (51.5%). When asked how likely they are to be involved in violent arguments or physical fights, most respondents felt "a little likely" (42.9%) to be involved, followed by "not very likely" (31.1%) and responses were not significantly different by age or by grade.[l]

Post-participation survey responses only were already evaluated in Phase 1 (ref. Appendix J).

3.3.3 Outcomes

3.3.3.1 Pre- versus post-participation differences

The Phase 1 evaluation documented several post-participation outcomes. These included students' satisfaction with workshop participation (satisfied or very satisfied, 82.2%), increased preparedness to avoid or prevent violence (a little better, somewhat better, much better able, 93.5%), and decreased likelihood to engage in violence (less likely, maybe a little less likely, 82.1%). It also documented post-participation level of agreement with various statements related to their perceived impact of the program on their willingness to avoid violence.[m]

Thus, unlike the Phase 1 evaluation, this current Phase 2 evaluation reports for the first time the pre-participation agreement with statements pertaining to non-violence. Many students self-reported agreement (strongly agree or agree; 65.2%) in understanding violence as a disease (70.2%) and the conditions which promote it (Table 5). Most students also reported feeling able to do something different than what all of their friends are doing (80.5%) and feeling able to be a peaceful person (58.7%). Overall, students largely indicated having an understanding of violence,

[l] Chi-square tests yielded $\chi 2 = 25.5$ ($p = 0.38$) for age, and $\chi 2 = 25.9$ ($p = 0.10$) for grade.
[m] The post-participation results are not available for the 2023-2024 school year, which encompasses the time period of this evaluation.

choosing non-violence, and perceiving themselves positively and aligned with non-violent behavior prior to starting the program.

The present evaluation also investigated differences in pre- versus post-participation level of agreement with the various statements concerning non-violence. There were eight questions which were present on the pre- and post-participation survey in the following domains: 1) understanding violence as a disease, 2) understanding the conditions which promote violence, 3) avoidance of violent conflicts, 4) doing something different than one's friends, 5) using non-violent conflict resolution methods, 6) being able to be a peaceful person, 7) being able to make a non-violent response when disrespected, and 8) being able to be a positive influence/role model. Also, as previously described (ref. *Methods*), responses are compared in aggregate between all available pre-participation surveys responses against all available post-participation survey responses regardless of the year of data collection and the pre- and post-survey results were aggregated, as they could not be matched at the participant level.

When comparing pre- versus post-participation level of agreement, there were no differences in the domains of 1) understanding violence as a disease, 2) understanding the conditions which promote violence, 3) avoidance of violent conflicts, 4) doing something different than one's friends, and 7) being able to make a non-violent reaction when disrespected (Figure 17).[n] On average, pre- and post-participants were between being unsure and agreeing if they understand violence as a

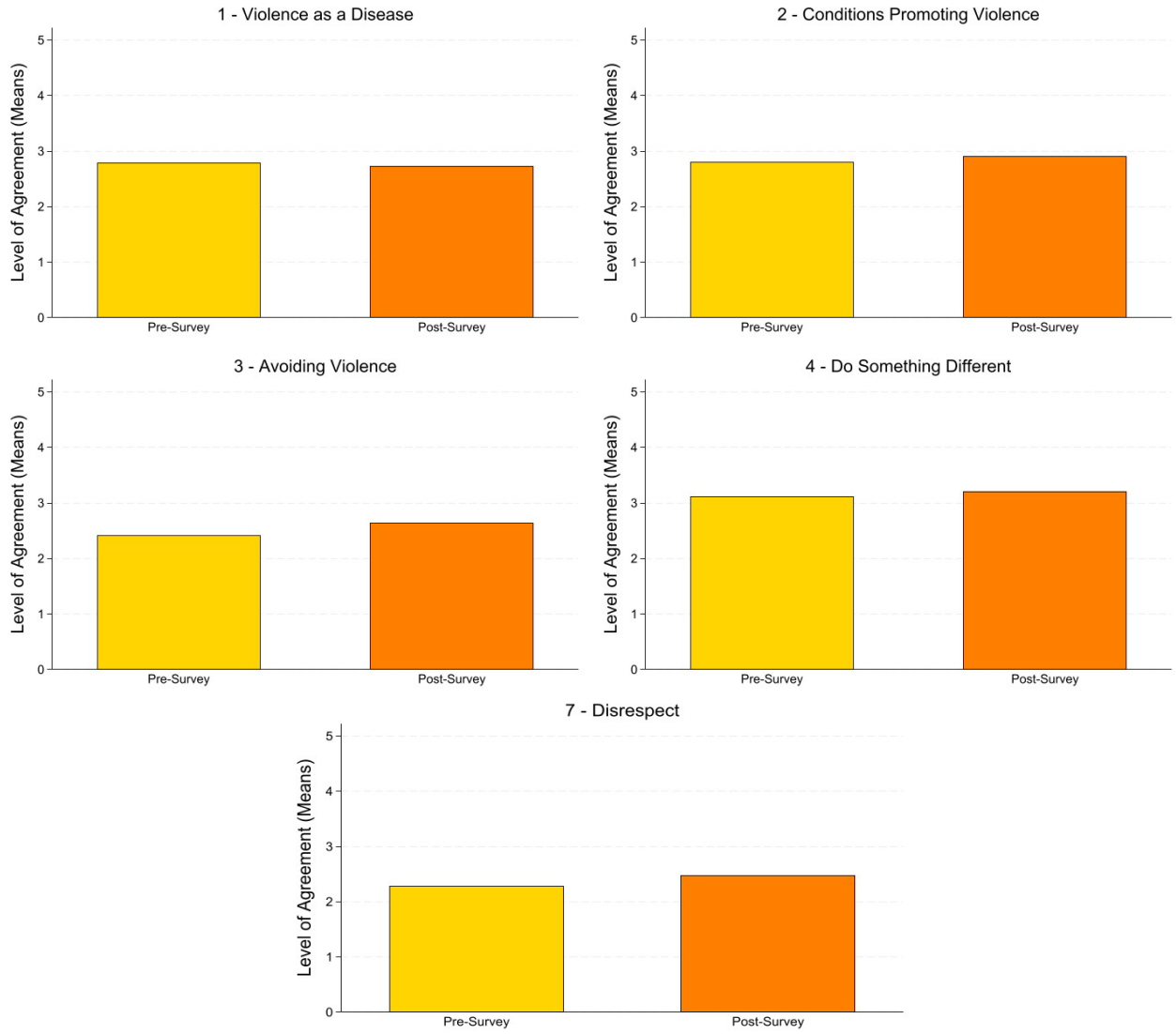

Figure 17. Average level of agreement not different between pre- and post-participation survey results for School ROC Workshops in 5 domains

Note. Questions measured on a 5-point scale, from 0 – Strongly Disagree, 1 – Disagree, 2 – Not Sure, 3 – Agree, or 4 – Strongly Agree

[n] Independent samples t-tests were conducted to evaluate if there are differences in these domains between pre- and post-survey responses. In these 5 domains (Figure 17), the differences were not statistically significant at $p < 0.05$.

disease (pre = 2.8 vs. post = 2.7), if they understand the conditions which promote violence (2.8 vs. 2.9), if they can avoid getting into fights or violent confrontations (2.4 vs. 2.6), if they can do something different than their friends if it's what they think is right (3.1 vs. 3.2), and if they can have a non-violent response even when they feel disrespected (2.3 vs. 2.5).

There were significant differences between pre- and post-participation responses in the domains of 5) using non-violent conflict resolution methods, 6) being able to be a peaceful person, and 8) being able to be a positive influence/role model (Figure 18).[o] Although the pre- and post-participation responses on these domains are also on average falling in the unsure and agree categories, the difference of the average score from pre- to post-participation responses is significant and thus indicate on average movement away from uncertainty toward agreement. Pre-

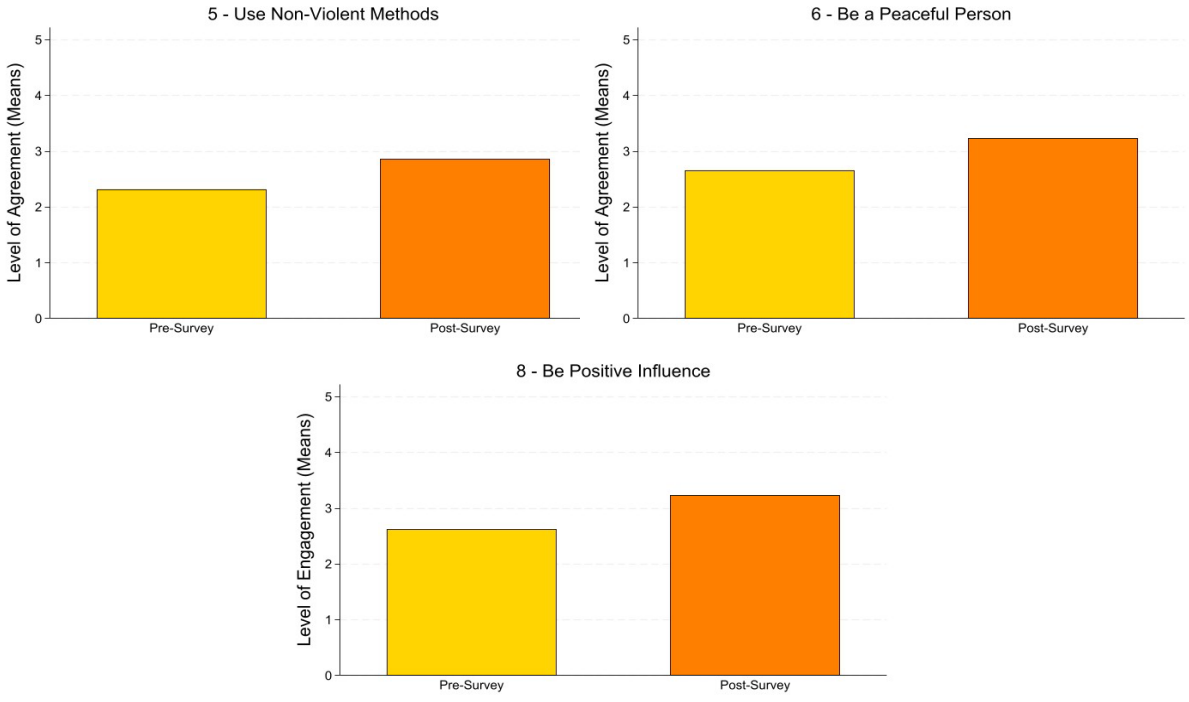

Figure 18. Average level of agreement increased from pre- to post-participation survey results for School ROC Workshops in 3 domains

Note. Questions measured on a 5-point scale, from 0 – Strongly Disagree, 1 – Disagree, 2 – Not Sure, 3 – Agree, or 4 – Strongly Agree

[o] Independent samples t-tests were statistically significant at $p < 0.05$.

survey participants were on average unsure that they could use non-violent conflict resolution methods but moved toward agreement that they could use non-violent resolution methods following participation in the ROC workshops (pre = 2.3 vs. post = 2.9). The same trend is present for reported ability to be a peaceful person (2.7 vs. 3.2), and for ability to be a positive influence/role model (2.6 vs. 3.2).[p]

3.3.3.2 Pre-participation desired outcomes

Participants were asked what they hoped to learn in the ROC workshops in the pre-participation survey. A total of 58 students provided responses in school year 2022 – 2023, while 35 students provided responses in school year 2023 - 2024. Overall, students reported wishing to learn more about how to better themselves and identified skills needed to accomplish this goal. While some responses were as general as "to be better in life," specific skills identified included learning how "to release my feelings," "how to control my anger," and "I hope to learn how to balance my emotions without violence."

> **"I hope I learn how to know my worth a little more. I hope I make it to be the person I wanna be and not what everybody wants me to be. I hope I make it far in life."**
>
> ***- ROC workshop participant***

Safety was also commonly reported. Responses about safety focused on both preventing perpetration and avoiding victimization. Some students were self-aware of the skills they needed to learn to avoid being violent, such as "how to deal with my hurt and anger in a healthy way" or "how to control myself when I feel disrespected." Conversely, some students indicated a general desire to learn "how to keep my family safe" and "how to survive" in order to avoid victimization of

[p] Future evaluations will continue to track both pre- and post-participation for students.

themselves and/or loved ones. Overall, most responses did directly concern violence prevention through the desire to learn skills/knowledge on how to stop it. For example, one student said that they hoped to learn how "to stop gun fights and other things like that," indicating that anticipated learning about intervening in violent situations overall, not only situations involving firearms.

A general open-mindedness toward learning whatever they could from their participation was also identified. Many students generally reported hoping to learn "new things" and "everything I can." These responses underscore the importance of mentioning that although (firearm) violence was not explicitly mentioned in every response, the overall positive orientation of responses indicated aspirations oriented toward growth and skill/knowledge development.

As described earlier in this section, students overall were largely pre-disposed toward having an understanding of violence, choosing non-violence, and perceiving themselves positively and aligned with non-violent behavior (Table 5). Therefore, their responses about what they hoped to learn in the ROC workshops align with many students' baseline perceptions and orientation toward violence. It is not that students perceived themselves as violent and unaware of how violence functions, it is instead what is needed is learning violence prevention and intervention skills and knowledge, and which may be changing the most from pre- to post-workshop participation.

3.4 Hospital component

3.4.1 Inputs

3.4.1.1 Structure

At the end of 2022, the hospital response team included three hospital responders (HRs) with an opening for a supervisor, which had been vacant since September 2022. The supervisor position was then filled in July 2023. As of July 2023, there were a total of five

positions within the hospital response team. The frontline team was considered fully staffed on January 9, 2024, when a fourth HR joined the team.

3.4.1.2 Training

Training continued in 2023 to primarily focus on job shadowing and in-hospital trainings and orientations. Job shadowing is the fundamental vehicle for role-specific training. Senior HRs are shadowed as they conduct their normal daily work while new hires shadow. Accompanying this training are in-hospital trainings and orientations which focus on processes, procedures, hospital units, and clinical care workflows. Pertaining to data entry, this training is provided by the program's Evaluation Team as this team created and manages the REDCap database for case management notes. Accompanying this training is also any hospital-required trainings related to electronic medical record (EMR) access. Lastly, in order to have a wholistic view of program operations as a whole, new HRs also shadow VIs and OWs in community.[q]

3.4.1.3 Referral process

In 2023, referrals were primarily made by social workers (46.0%) and an advanced practice nurse prescriber (APNP; 22.6%). With respect to where most referrals were placed, the highest percent came from the floor units (37.2%), followed by the emergency department (31.2%), and intensive care unit (ICU; 25.7%). Emergency department referrals were mostly made by social workers (90.5%), while referrals from floor units were made in similar proportions by social workers (29.0%), registered nurses (23.0%), and APNPs

[q] The reverse job shadow opportunity is not available for VIs and OWs due to HIPAA and privacy concerns.

(25.0%). Referrals placed from the ICU were mostly made by APNPs (46.4%). From the outpatient setting in the TQoL Clinic, referrals were similarly distributed amongst the Clinic's social worker (36.4%), APNP (27.3%), and trauma psychologist (36.4%). This indicates that frontline hospital staff, namely emergency department social workers, continue to routinely place referrals as early as possible in the patients' hospital course. More referrals were documented in Phase 2 as being placed in the in-patient setting. This indicates increased awareness of the program outside of the emergency department, which has created opportunity for referral after critical life-sustaining procedures have taken place in the emergency department.

Since the first program evaluation, there was a practice change in the TQoL Clinic referral process. This impacts how the proportions of referring provider types and locations are reported between the first and present evaluation. In the last evaluation period, the Clinic's Director, an APNP, was used as the provider type for any TQoL Clinic referrals and so this provider type was reported as the most common referring provider type.[r]

[r] In July 2023, a practice change in TQoL Clinic has led to a difference in the provider types listed as referral points since the last evaluation. Namely, rather than assuming that all Clinic attendees were referred to 414LIFE, the individual providers now place a referral to 414LIFE based on patient need.

3.4.1.4 Engagement with complementary clinical services

By clinical protocol all gunshot wound (GSW; medical definition) patients are referred to the Trauma Quality of Life (TQoL) Clinic at the time of hospital discharge for their follow-up medical care. The first appointment is scheduled about a week after discharge. Since the start of the TQoL Clinic in November 2020 through the end of 2023, there have been a total of 278 (22.3%) 414LIFE referred patients who attended at least one outpatient appointment in the clinic. In 2023 alone, there were 105 414LIFE referred patients (39.0% of all patients referred to 414LIFE in 2023) who attended a TQoL Clinic appointment. Separately, there were 11 (4.1%) GSW patients referred to 414LIFE from TQoL Clinic who were not previously connected with the HRs during their inpatient admission. This represents another opportunity in the healthcare continuum for patients to be referred to 414LIFE in the outpatient setting. Thus, although it is theoretically ideal to have patients referred as early as possible in their clinical care in the emergency department,[49] the local trauma center has referral opportunities at all points in patient care – the emergency department, in-patient (floor and ICU), and outpatient. This increases the opportunity for identification of patient need for the program, as needs may change over the course of patient recovery.

Similarly, another program dedicated to supporting GSW patients is the Post-Discharge Care Team (PDCT). This program was initially designed as a randomized controlled trial in which GSW patients were eligible for randomization to receive PDCT's services or to receive standard of care (i.e., care as usual). Patients randomized to receive PDCT's services had a dedicated nurse navigator and social worker to support the transition from in-patient to outpatient care services necessary for recovery. Standard of care in this clinical trial meant not having a dedicated health navigator or social worker, while receiving every other routine part of clinical care as appropriate. There were 75 (27.9%) patients referred to 414LIFE in 2023 who also participated in the pilot trial for the PDCT and were randomized to receive the program's services. There were 55 (20.4%) patients referred to 414LIFE in 2023 who were part of the trial as a patient receiving standard of care services.

In 2023, there were 58 (21.6% of all 2023 referred patients) 414LIFE referred patients who were engaged with both TQoL Clinic and PDCT's clinical services.

3.4.2 Outputs

3.4.2.1 Caseload

It is important to note that like the first evaluation, not every gunshot wound (GSW) patient is referred to 414LIFE, although all GSW patients coming into Froedtert Hospital had the potential to be referred to the program if they met the eligibility criteria. Reasons for non-referral can include the patient not meeting all the program referral criteria, patient discharging prior to HR arrival, no identified risk of violent retaliation, amongst other reasons. In 2023 the program still operated only within Froedtert Hospital, southeastern

Wisconsin's only Level 1 Trauma Center, therefore the program would not have interacted with GSW patients who seek care at other local hospitals.[s]

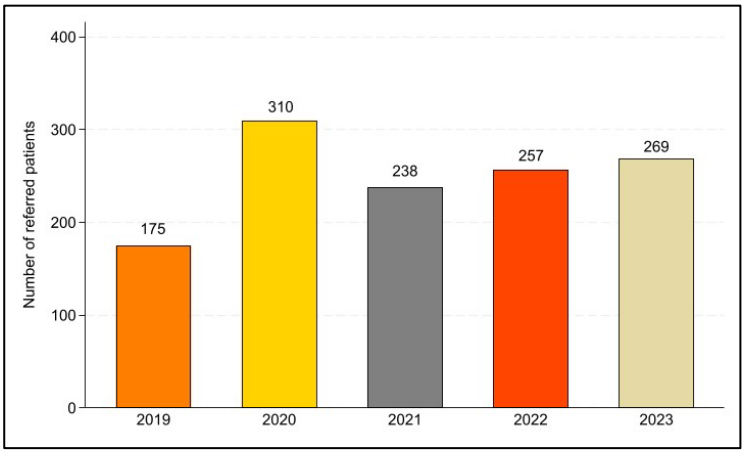

Figure 19. Referrals by Calendar Year
May 6, 2019 - December 31, 2023

During the current evaluation timeframe (i.e., calendar year 2023), there were 269 patients referred to 414LIFE. This is similar to past calendar years (Figure 19) with the exception of 2019 as the program started accepting referrals on May 6, 2019. Thus, it is evident that based on how 2023 was trending, the first year of the program's implementation saw the lowest volume of patient referrals. The year 2020 includes the start of the COVID-19 pandemic and was the same year that saw the highest volume of patient referrals.

HRs recorded approximately 276 hours working with 141 patients in 2023. This time averaged to just under 2 hours per patient recorded in 2023. However, in the early part of 2023, time spent with each patient was not recorded routinely, likely resulting in an underrepresentation of time reported for the full calendar year. However, an increased focus on data quality improvement beginning in August 2023 led to more complete recording of time spent with patients during the remainder of the year. This was supported

[s] Future evaluation phases will be able to report on the program's expansion to receive referrals from other Milwaukee hospitals as this expansion begins in 2024.

by the finding that from August through the end of 2023, the hospital response team recorded 217 hours and 55 minutes working with 114 patients which is 78.9% of all time reported for 2023. The cumulative time spent working with a single patient ranged from 15 minutes to 9 hours and 15 minutes. The average amount of time spent per patient was just under 2 hours. The average number of documented encounters per patient was about 3.

Table 6. Characteristics of patients referred to 414LIFE hospital component

Characteristics	2019 – 2023 (All 1249 patients) number, (%)	2022 (257 patients) number, (%)	2023 (269 patients) number, (%)
Sex			
Male	1006 (80.5%)	198 (77.0%)	211 (78.4%)
Female	243 (19.5%)	59 (23.0%)	58 (21.6%)
Race			
Black / African American	1063 (85.1%)	216 (84.1%)	219 (81.4%)
Other	104 (8.3%)	26 (10.1%)	27 (10.0%)
White	48 (3.8%)	9 (3.5%)	12 (4.5%)
Multi-Racial	19 (1.5%)	< 5 (-- %)	6 (2.2%)
Unknown	5 (0.4%)	0 (0.0%)	< 5 (-- %)
Asian	5 (0.4%)	< 5 (-- %)	< 5 (-- %)
American Indian or Alaskan Native	< 5 (-- %)	< 5 (-- %)	0 (0.0%)
Native Hawaiian or Other Pacific Islander	< 5 (-- %)	0 (0.0%)	0 (0.0%)
Ethnicity			
Not Hispanic or Latino	1129 (90.4%)	228 (88.7%)	240 (89.2%)
Hispanic or Latino	107 (8.6%)	27 (10.5%)	26 (9.7%)
Unknown	13 (1.0%)	< 5 (-- %)	< 5 (-- %)
Mechanism of Injury			
Gunshot Wound	1219 (97.6%)	251 (97.7%)	260 (96.7%)
Stab Wound	12 (1.0%)	< 5 (-- %)	< 5 (-- %)
Assault	11 (0.9%)	< 5 (-- %)	< 5 (-- %)
Other	5 (0.4%)	< 5 (-- %)	< 5 (-- %)
No Injury	< 5 (0.2%)	0 (0.0%)	< 5 (-- %)
Arrival Status to Hospital			
Alive	1192 (95.4%)	243 (94.6%)	254 (94.4%)
Deceased	57 (4.6%)	14 (5.5%)	15 (5.6%)

Note. Examples of "other" mechanism of injury include: suicidal-intent injury, motor vehicle crash, laceration, etc. "Other race" is a pre-set category within the electronic medical record with no further level of detail available. Values less than 5 masked to maintain anonymity, and thus percentages are not reported for these categories.

3.4.2.2 Individual reach

The patient population reached in 2023 was nearly identical to what was found in the Phase 1 evaluation (May 2019 – December 2022), which covered the first 3.5 years of the program. The age range patients referred in 2023 was 15-88 years, with an average age of 30.5 years. Most patients in 2023 were male (78.4%) and identified as Black or African American (81.4%) and not Hispanic or Latino (89.2%) (Table 6). There were an additional 15 referrals placed in 2023 for 414LIFE's services to be provided to the loved ones/family of a deceased patient, for a total of 57 referrals since the start of the program.

Table 7. 414LIFE referred patients meeting program criteria

	2019 – 2023 (All 1361 patients)	**2022** (257 patients)	**2023** (269 patients)
Criteria	number, (%)	number, (%)	number, (%)
Mets all criteria	920 (73.7%)	184 (71.6%)	196 (72.9%)
Injured in a priority neighborhood	57 (4.6%)	10 (3.9%)	9 (3.4%)
Age: *15-35 years*			
Yes	951 (76.1%)	191 (74.3%)	208 (77.3%)
No	298 (23.9%)	66 (25.7%)	61 (22.7%)
Location: *Injured in, or resident of, Milwaukee*			
Yes	1230 (98.5%)	249 (96.9%)	262 (97.4%)
No	16 (1.3%)	7 (2.7%)	5 (1.9%)
Unknown	3 (0.2%)	1 (0.4%)	2 (0.7%)
Mechanism of Injury: *Gunshot Wound*			
Yes	1219 (97.6%)	251 (97.7%)	260 (96.7%)
No	30 (2.4%)	6 (2.3%)	10 (3.3%)

The majority of referred patients met all program referral criteria (72.9%) in 2023. This is a high rate given that providers can decide on a case-by-case basis to refer patients when they met one or two of the criteria, or in rare cases with significantly high risk of violent retaliation, they refer even if there are no other criteria met. Examining how many patients met each referral criterion individually in 2023, it becomes clear that age is the referral

criterion that is more commonly not met (22.7%) (Table 7). Otherwise, nearly all patients in 2023 were injured in, or a resident of, Milwaukee (97.4%) or injured by a GSW (96.7%). A relatively small percent of patients were injured in a 414LIFE priority neighborhood (3.4%) which further reinforces why the hospital component of the program services anyone who is injured in, or a resident of, Milwaukee.

3.4.2.3 Geographic reach

For the majority patients, the location of injury was known (232 of 269, 87.1%) in 2023. The most common Milwaukee neighborhoods where GSWs occurred that required hospital care and resulted in a visit to the trauma center at Froedtert and referral to 414LIFE in 2023 were 1) Amani (18, 5.5%), 2) Washington Park and North Division (12, 3.6% each), 3) Borchert Field (10, 3.0%), 4) Metcalfe Park, Midtown, Saint Joseph, and Sherman Park, (9, 2.7% each), and 5) Dineen Park, Harambee, and Lincoln Village (8, 2.4% each).

Figure 20 displays a side-by-side comparison of the location of injuries for 2022 and 2023 referred patients. In 2023, there were 269 referrals, and 232 of them had locations of injury that were able to be mapped. Of the 37 that were not mapped, 31 had an unknown injury location (not reported), 2 patients sustained no injury, 1 incident occurred outside of Milwaukee (Kenosha), and 3 had locations provided were unable to be geocoded. For 2022, 219 injury locations out of 257 were able to be mapped. Of the 38 that were not mapped: 28 had an unknown injury location (not reported), 6 were outside of Milwaukee (Kenosha, Cudahy, Racine, Union Grove), and 4 locations provided were unable to be geocoded.

One important local event to note is that there was a mass shooting in 2022 (5/13/2022) in the area known as the Deer District. This is the entertainment district which contains the primary sporting arenas locations for the city. The map in Figure 20 includes this as a single event for 2022, as including each of these unique cases involved in this incident masks the trends present for other areas in Milwaukee. Thus, the final number of cases mapped is 207 of 257 referrals.

The spatial distribution and density of locations of injury appear very similar during this evaluation phase compared to the previous year. One perceivable difference is the spread of medium density (i.e., red) throughout the 2022 map, while the same areas in 2023 now appear to be lighter density (i.e., blue) with four centrally located clusters of high density (i.e., yellow) in/by Sherman Park, Harambee, Amani, Franklin Heights, and North Division.

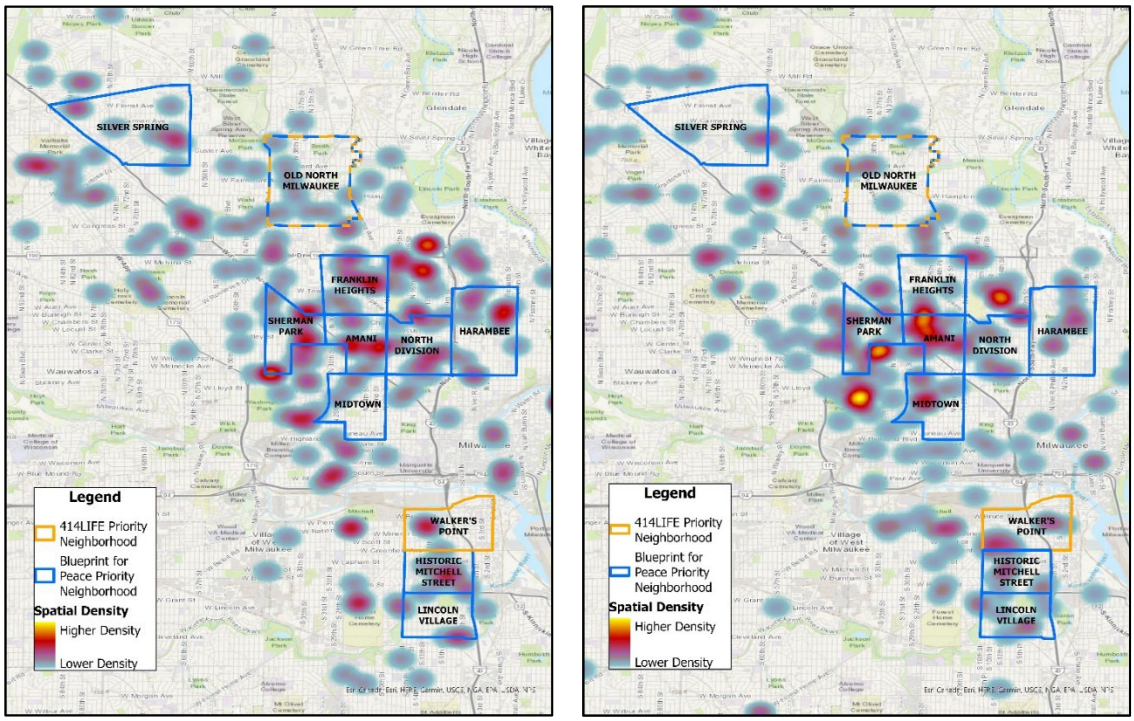

Figure 20. Spatial density of injury locations for referred hospital patients, 2022 (Left) vs. 2023 (Right)

The areas of high concentration or density do spatially show overlap between where incidents occurred and the 414LIFE and *Blueprint for Peace* neighborhoods.

3.4.3 Outcomes

3.4.3.1 Identified needs

Of the 410 referrals with detailed data in the database since its creation (Table 8), the most commonly identified patient needs for hospital responders (HRs) were financial concerns (identified 268 times), mental health (identified 214 times), other (identified 194 times), retaliation (identified 130 times), and safe housing (identified 110 times). On average, there were over three needs identified per patient, and since the start of data collection, 53% of needs were addressed overall, which increased to 63% in 2023. The needs most frequently identified also had the highest number and percent where resources were successfully referred made for patients (Table 8). For instance, financial concerns were identified 268 times and 70% of the time the participant was documented as being connected with relevant resources. Similarly, approximately 68% of the time resources were provided for mental health concerns. Although safe housing was frequently identified as a need, it had the lowest frequency of reported resource connection (45% since database creation, which did increase from 38% in 2022 to 56% in 2023), which reinforces the identification by team members of housing resources as a barrier. Further detail about barriers to successful referral connection was described in Program-wide results (ref. *3.1.4 Barriers for connecting participants with resources*).

Financial concerns included assisting patients with applying to the state's Crime Victim Compensation program, filing for unemployment, requesting FMLA of an employer, and more. Mental health concerns also included many needs, but some common examples include scheduling appointments with trauma psychology for after hospital discharge, establishing mental health services, providing mental health resources, and connecting to therapy and counseling services. The other category was intended to be a 'catch-all' for needs identified which did not belong in any of the other identified categories which may definition may be why this category also had a lower percent for resource connection

Table 8. Reported Participant Needs by Type and by Year

Need Type	Since Database Creation (Patients: 410)			2022 (Patients: 147)			2023 (Patients: 218)		
	Needs	Resources (#)	Resources (%)	Needs	Resources (#)	Resources (%)	Needs	Resources (#)	Resources (%)
Financial	268	187	70%	86	60	70%	154	120	78%
Mental health	214	145	68%	82	58	71%	99	82	83%
Other	194	69	36%	75	22	29%	86	44	51%
Retaliation	130	93	72%	41	33	80%	72	59	82%
Safe housing	110	49	45%	39	15	38%	61	34	56%
Support for family or loved ones	103	41	40%	31	14	45%	55	26	47%
Mobility	87	36	41%	19	10	53%	50	22	44%
Safe discharge	71	29	41%	29	12	41%	33	16	48%
Support for dependents	64	23	36%	23	8	35%	31	13	42%
Transportation	51	25	49%	18	10	56%	22	14	64%
Basic needs	49	20	41%	13	6	46%	27	12	44%
Substance abuse	22	9	41%	3	1	33%	14	8	57%
Spinal cord injury	18	9	50%	6	5	83%	12	4	33%
Firearm safety	8	0	0%	4	0	0%	0	0	0%
Total	**1,389**	**735**	**53%**	**469**	**254**	**54%**	**716**	**454**	**63%**
Per Patient	**3.4**	**1.8**	**53%**	**3.2**	**1.7**	**53%**	**3.3**	**2.1**	**64%**

Note. The mobility category refers to physical mobility, meaning how well one is able to move about on their own. Needs related to mobility can include obtaining a walker, becoming newly wheelchair bound, navigating insurance coverage for crutches, etc. Also, the database was more fully utilized by July 2022, which partially accounts for the differences in reporting between 2022 and 2023.

(Table 8). Some recurring themes from the "Other" category were support with funeral arrangements, legal, medical care, education, and faith-based resources.

Lastly, retaliation, was the fourth most frequently identified need. This need indicates that a mediation or violence interruption was perceived as necessary either by the HRs, or the HRs in conjunction with the community component of the program (VIs and OWs). The level of response is dictated by several factors, including if retaliation is a concern for family members/loved ones who may also be out in community, in addition to having a presence in the hospital with the patient. The retaliation concerns in some cases result in a referral from the hospital to the community component of the program for follow up.

Collectively, these top 5 most frequently identified needs underscore the biopsychosocial nature of violence prevention and the relevance of addressing needs shortly after firearm injury to support victims and their families.

3.4.3.2 Re-referral for new injury

Patients were tracked for re-referral to the program for new injur(ies). By the end of December 2023, a total of 22 patients since the start of the program were referred for the second time to Froedtert Hospital following a new injury (1.8% of all program referrals). Of these, one patient was referred for a third time, although both the second and third time were within 2022. There were 3 re-referrals placed in 2023. It is important to note this re-referral rate represents a snapshot of the program at the end of December 2023 and not all participants have had the same amount of follow-up time for capturing re-referral. Overall, re-referral to the program continues to be very low.

3.4.3.3 Re-injury

For the follow-up periods of interest there were 627 eligible historic comparison gunshot wound patients (5/6/2015 – 5/5/2017), and 429 eligible 414LIFE referred patients (5/6/2021 – 5/5/2023). Again, the historic comparison group is based on patients who were injured before 414LIFE initiated its hospital programming, but who would have met criteria for referral had the program existed at the time. Of the 429 414LIFE referred patients, 402 (93.7%) were matched to a historic match comparison patient. The 27 unmatched 414LIFE referrals consisted of 24 females of varying races, though majority were Black or African American. Not having a sufficient number of matches for female patients is unsurprising as most gunshot wound injuries treated at Froedtert Hospital are sustained by Black or African American male patients.[t] Thus it was unsurprising that we were unable to match this small sample size of female gunshot wound patients.

Given the last date of the index injury for inclusion in the 414LIFE group was 5/5/2023, 184 of the 402 referrals (45.7%) had follow-up available through 2 years as the current evaluation only considered data through 5/5/2024. Of the 402 patients referred to 414LIFE, 234 were also referred to TQoL Clinic and of those, 149 attended the Clinic appointment; only 61 who attended TQoL Clinic had a full 2-year follow-up period to evaluate. By the 2-year follow-up, there were 4 historic comparison patients and 9 414LIFE referred patients (3 of which also attended TQoL Clinic) who experienced a gunshot wound re-injury; however, this difference is not statistically significant (Table 9).[u] There was no re-injury in

[t] For comparison, in 2023, the trauma center at Froedtert Hospital saw a total of 463 gunshot wound patients, of whom 74.7% were male, and of whom 66.1% were also Black or African American.

[u] $\chi^2 = .002$, $p = 1.0$

either group by other (non-firearm) assaultive mechanisms of injury by the end of the 2-year follow-up period. Overall, the number of patients re-injured in both groups was less than 3% by the end of the 2-year follow-up period.

Table 9. Re-injury after hospital component referral at various timepoints post-index gunshot wound

	1-Month	3-Months	6-Months	1-Year	2-Years
Historic Comparison	0	1	1	1	4
414LIFE	1	2	5	7	9*

Note. Timeframe for historic comparison group patient inclusion based on injury date was 5/5/2015-5/5/2017. Timeframe for 414LIFE referral inclusion based on injury date was 5/6/2021-5/5/2023. 234 414LIFE referrals also were referred to TQoL Clinic, though 85 did not attend clinic. Of these 234 TQoL Clinic patients, only 3 were re-injured; though, of note, only 61 TQoL Clinic patients had the full 2-year follow-up period available.
*Total sample through follow-up at each timepoint was n = 402, except for the 414LIFE group at the 2-year follow-up where only 184 referrals had the full follow-up period available

As previously described, the comparison to a local group of firearm injured patients within the same trauma center prior to the start of 414LIFE was an effort to control for variability in other factors which could influence re-injury rates. For example, factors could include differences in healthcare system patient catchment area sizes, patient volume, city/county population size, urbanicity, and others. This makes comparison with other cities and other healthcare systems challenging, particularly as there is no rigorous national data source available to track re-injury rates. Current research within separate local healthcare systems indicates a wide range of re-injury rates, anywhere from 1-9%.[superscript citations for new pubs above] Therefore, a re-injury rate of <3% for 414LIFE referred patients and comparison patients is relatively low. Because Since the baseline rate is so low, analyses would require a much larger number of patients, both referred and not referred to 414LIFE, in order to detect a small, yet measurable, difference. There are also limitations given that the comparison group and follow-up period was pre-COVID

while the 414LIFE group follow-up period was during COVID, which demonstrated significantly higher rates of violence. Due to these limitations, the analytic approach for assessing re-injury is being re-assessed for the next evaluation phase.

3.4.3.4 Engagement with the criminal justice system

The analysis of specific contact points with the criminal justice system indicated that of patients referred to 414LIFE, a total of 16 of the 402 eligible patients (4.0%) were linked to new criminal charges in Milwaukee County within two years following the index injury.[v] The matched comparison group had 9 of its 402 patients (2.2%) linked to new criminal charges within the two-year follow-up period, which was similar to Phase I evaluation. As with the reinjury results, this difference between the two groups was not statistically significant.[w] For the 414LIFE patients who were charged with a new offense(s), they had an average of 1.7 charges with the most frequent charges including disorderly conduct, recklessly endangering safety, reckless injury, misdemeanor battery, misdemeanor bail jumping, and intimidation of a witness. All charge types were included for consistency with the first evaluation and to provide an overall assessment of new charges as a measure of the level of contact with the criminal justice system. However, given the focus of the program is on violence reduction it is important to note that for the majority of the 414LIFE patients who had subsequent charges, at least one of the charges was violence-related associated with

[v] Total sample was n = 402, except for the 2-year follow-up where only 184 414LIFE referrals had the full follow-up period available.

[w] $\chi^2 = 2.022$, $p = .15$

each case. The bail jumping and disorderly conduct charges often accompanied a violence-related charge.

Those involved in one or more homicide or nonfatal shooting incidents in Milwaukee within two years of initial injury included a total of 29 patients referred to 414LIFE (7.2%) and 19 in the comparison group (4.7%), which was similar to the results from the first evaluation and there was not a measurable difference between the two groups.[x] These included individuals being involved in the incident as a victim or suspected of carrying out the incident. It was more common that individuals were listed as victims in both groups, with 21 of the 29 414LIFE patients (72.4%) and 14 of the 19 comparison patients (73.7%) being listed as having been a victim of another nonfatal shooting or homicide after the original injury. A total of four 414LIFE patients were victims of homicide within two years of the index injury that brought them into the program.

Table 10. Contact with the criminal justice system at various timepoints post-index gunshot wound

New Charges					
	1-Month	3-Months	6-Months	1-Year	2-Years
Historic Comparison	2	2	2	5	9
414LIFE	4	4	5	9	16*
Involvement in Homicide or Nonfatal Shooting Incident(s)					
	1-Month	3-Months	6-Months	1-Year	2-Years
Historic Comparison	5	6	8	12	19
414LIFE	2	3	11	18	29*

Note. Timeframe for historic comparison group patient inclusion based on injury date was 5/5/2015-5/5/2017. Timeframe for 414LIFE referral inclusion based on injury date was 5/6/2021-5/5/2023. *Total sample through follow-up at each timepoint was n = 402, except for the 2-year follow-up where only 184 414LIFE referrals had the full follow-up period available.

[x] $\chi^2 = 2.216$, $p = .136$

4.0 Discussion

The following are summaries of the results presented in this report to specifically answer questions proposed by the evaluation question sets (Appendices A & B) for Phase 2.

4.1 Community component

4.1.1 What was the reach of the community-based program, including by geographic area and target population?

Prior work has repeatedly shown that young, Black males are at high risk for perpetration or victimization.[4,5] Most participants (n = 183) in 2023 in the community component of the program fell within the target age range of 15-35 years (average age 18.2 years; 89.1%), were Black or African American (89.1%), and male (69.6%). Most individuals were assessed to be at high (39.1%) or medium risk (52.2%) of future violent victimization or perpetration. In 2023 there were 41 participants who were newly screened for program eligibility, 78 who were active at any point in time during the calendar year, and 38 participants who were discharged.

Geographically, violence mediations and community outreach events were concentrated within *Blueprint for Peace* priority neighborhoods, not necessarily the 414LIFE priority neighborhoods of Old North Milwaukee and Walker's Point. Focus group interviews revealed that the only program activity specifically concentrated within 414LIFE priority neighborhoods is canvassing. Otherwise, team members respond to referrals and conduct violence interruptions and mediations where needed throughout the city. Thus, while community component programming is reaching the target population of individuals, it is primarily concentrating only canvassing activities within 414LIFE priority neighborhoods

but other parts of the response such as mediations and interruptions, are occurring citywide. This should be considered in light of the number of community component staff, which reached a max of 10 in 2023 for Vis and OWs (not including supervisors) who are providing support citywide.

4.1.2 Did the mediation/interruption activities demonstrate successful outcomes to potentially violent or retaliatory situations?

The majority of mediation/interruption activities demonstrated successful resolution of violent situations. More specifically, there have been a total of 316 mediations conducted since the start of the program (October 2018). Of those, 59 occurred in 2023 and the majority (69.5%) were resolved either successfully (50.8%) or conditionally (18.6%), and 30.5% were unresolved. Approximately 575 hours have been documented in 2023 spent on violence interruptions, with most of that time (67.0%) occurring within priority neighborhoods.

4.1.3 Did the program reach high-risk individuals as intended and assist in addressing their goals and needs?

Overall, the community component of the program did reach individuals in the target demographic that were assessed at medium or high risk for involvement in violence (victimization or causing harm). Most participants in 2023 fell within the target age range of 15-35 years (average age 18.2 years; 89.1%), were Black or African American (89.1%), and male (72.1%) and were assessed to be at high (39.1%) or medium risk (52.2%) of future involvement in violence. Regardless of level of risk, participants in 2023 were referred to various resources based on their reported needs. The 5 most frequently referred resources included employment (66 times), housing (22 times), educational opportunities (15), and

financial assistance (11 times).[y] However, it must be noted that 414LIFE was able to refer participants to these resources, but in some cases there remains an external barrier to receiving the service/resource that the participant was referred to. Focus groups with 414LIFE team members identified capacity and program eligibility limitations when particularly trying to connect participants to safe housing, especially when participants need immediate re-location and long-term shelter.

4.1.4 Did program participants avoid situations involving violence after program participation?

Participants overall self-reported learning skills or feeling better prepared to avoid violence after program participation. Youth participants in the school-based workshops reported being significantly more able to use non-violent conflict resolution methods, to be a peaceful person, and to be a positive influence/role model (Figure 18) when compared to pre-participation surveys. Program-wide participant outcome surveys (18 respondents) similarly indicated that the majority of participants (75.1%) thought they could avoid getting into fights or violent confrontations after participation in 414LIFE (43.8% agreed, 31.3% strongly agreed). Similarly, respondents also reported high agreement (92.8%) that they can use options and methods to resolve a conflict other than violence (35.7% strongly agree, 57.1% agree) and the majority (78.6%) feel able to make a non-violent choice even when disrespected (28.6% strongly agree, 50.0% agree), as well as able to do something different from their friends if they think it is the right thing to do (100%; 42.9% strongly agree, 57.1% agree). In particular, respondents felt that they had the skills to do so, such

[y] Other is a miscellaneous category for a variety of needs not captured in other categories and was indicated 26 times in 2023.

as breath work, walking away, and seeking mentorship, as well as the intrinsic motivation to be non-violent and desire to contribute toward making their community safe.

4.2 Hospital component

4.2.1 What was the reach of the hospital-based program, including geographic area and target population?

In 2023, most patients referred to the hospital program met all program referral criteria (72.9%). This percentage is lowered by the fact that clinical providers can make a referral when a patient does not meet all three referral criteria (or even may not meet any criterion) when they are concerned for a high risk of retaliation, either further patient victimization or potential retaliation by the patient and/or their family. However, when examining program referral criteria, nearly all referred patients in 2023 were injured in, or a resident of, Milwaukee (97.4%), or injured by a gunshot wound mechanism of injury (96.7%). The age criterion was less commonly met (77.3%).

The priority geographic areas for the program, the neighborhoods of Old North Milwaukee and Walker's Point (Figure 3), were not the locations of injury for the majority of patients (Figure 20). However, the reason for this is the same as previously identified in the Phase 1 evaluation, which is that the hospital program does not triage program referral by location of injury and the Level 1 Trauma Center serves any patient that comes to the center for care. As a Level 1 Trauma Center, this hospital is equipped with the highest level of resources, care, and 24/7 in-house physician, surgeon, and staff coverage to support traumatic injury patients. Thus, Froedtert Hospital is a clinical destination for most gunshot wound injuries in the city of Milwaukee as well as the surrounding area. The maps

therefore represent the patient catchment area of the trauma center, rather than 414LIFE concentrated activities or priority areas. Overall, GSW injuries referred to the hospital program are coming from across the city of Milwaukee as intended and the vast majority of referrals are for individuals living or injured within the city.

4.2.2 Did the program reach high-risk individuals as intended and assist in addressing their goals and needs?

Hospital component programming did reach GSW patients in the intended demographic group and also assisted referred patients in addressing their identified needs or goals. In 2023, the majority of patients referred to 414LIFE were between age 15 and 35 (77.3%, average age 30.5 years), Black (82.7%), and male (77.8%). The top identified needs in 2023 included: financial concerns (154 times), mental health (99), retaliation (72), and safe housing (61).[z] HRs were able to refer 63% of participant-identified needs in 2023. These needs underscore the importance of social determinants of health in recovery from firearm injury and that HRs play a role beyond retaliation prevention. As previously noted under the same question for community component programming, there was a program-wide barrier to receiving immediate and long-term housing for participants, largely due to external capacity issues and program eligibility criteria. Successful receipt of referred resources from other service types were not as severely impacted as housing.

[z] The top categories also included other or miscellaneous (86) which is a catch-all category for items not specifically identified.

4.3 Future evaluation phases

There are a number of data elements of interest for subsequent evaluation phases. Several of these were made possible through on-going collaboration between the 414LIFE and Evaluation teams in 2023 and 2024. Examples include program exit surveys, locations of community referrals, patient data from new participating hospital sites, and identifiers for community participants to allow for outcome assessments following program participation. Other future directions were informed by the existing program evaluation question sets (Appendices A & B). These include interviewing community members to understand community norm change in priority neighborhoods (e.g., motivation toward violence reduction and involvement with related efforts). A geographically defined analysis of interest is hotspot comparisons to elucidate change over time in locations of activities, such as mediations and community activities, as well as locations of injury. In addition, of particular interest and to align with other program evaluations nationally, is the evaluation of homicide and nonfatal shooting reductions in priority neighborhoods. This analysis is being reviewed for potential inclusion in a future evaluation phase to allow sufficient time to assess change in the areas given the modification of the priority neighborhoods in 2022. In addition, as mentioned in the Phase I evaluation and described earlier, this will still be limited given that the community component of the program does not solely focus the majority of its activities within the priority neighborhoods. Indeed, only canvassing is primarily emphasized within the priority neighborhoods.

5.0 Recommendations

The Phase 1 evaluation established 2 core recommendations for program quality improvement (ref. *Recommendations, pg. 82*).[9] These recommendations were followed by potential implementation strategies based on the findings of key stakeholder interviews with 414LIFE team members, leadership and community partners. This Phase 2 evaluation leveraged its interviews with the 414LIFE team to understand how the Phase 1 recommendations may or may not have been implemented into program operations since the public release of the Phase 1 evaluation report (September 2023 – June 2024).

This evaluation found that the recommendations from Phase 1 are still relevant for program quality improvement in order to support 414LIFE's program operations and mission. Although the strategies to address those recommendations have slightly altered, the recommendations themselves are still encouraged to be implemented.

Two new recommendations were also identified and are reported here for the first time. The first new recommendation from this evaluation is to re-assess expectations of frontline staff positions. This recommendation was identified from opportunities for alignment that were shared by leadership and frontline staff related to pre-employment expectations. Better defining expectations for frontline staff positions and communicating those expectations may improve job satisfaction, reduce burnout, and reduce staff turnover. Opportunities for improved alignment of expectations include: awareness of the expectations of day-to-day responsibilities/tasks, workloads, workplace hazards, on personal vehicles, salary, and availability expectations of the roles.

The second new recommendation identified in this Phase 2 evaluation is to update program services to reflect participant reported needs. Although it is noteworthy that only two respondents from the participant impact survey (18 respondents) strongly disagreed that they could avoid making a violent choice in a hypothetical scenario, this is now the second evaluation in which the hypothetical scenario related to disrespect garnered disagreement. In the Phase 1 evaluation, the weakest point of agreement on the participation survey for the school-based restoration of consciousness programming was when students were asked if they feel that they can make a non-violent choice even if they feel disrespected. In this Phase 2 evaluation, the percentage of participants reporting "Not Sure" was less than in Phase 1 (36.6% vs. 27.8%), but still noteworthy as an opportunity to update the school programming's curriculum.

Phase 1 Recommendations

1. Enhance outward communication
2. Clarify and further document aspects of program implementation *(and operations)**

Phase 2 Recommendations

3. Re-evaluate expectations of frontline staff positions
4. Update program services to reflect participant reported needs

**italics* indicate a wording update in Phase 2 for clarity

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7.0 Appendices

7.1 Appendix A – Evaluation matrix for the community component

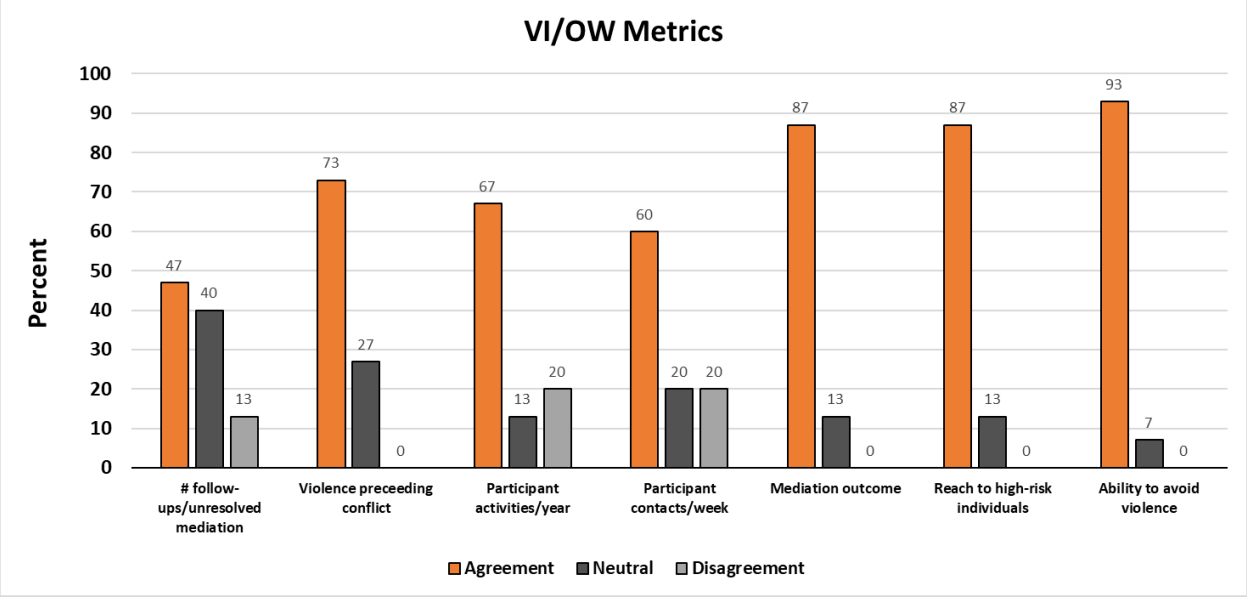
PHASE 2		
INPUTS / OUTPUTS		
Indicators		**Definition**
What was the reach of the community-based program, including by geographic area and target population?		
Conflict Mediation & Violence Interruption	Number of mediation follow-ups	Average mediation follow-ups per unresolved mediation per year
	Level of violence involved in conflict	Level of violence involved in the conflict that led to the mediation (e.g., shots fired, verbal dispute, individuals with history of violence)
	Type of conflict	Description of the type of conflict (group, individual, retaliation, other)
Community Outreach and Events	Number of participants at community events	Average estimated number of participants at community events compared to the prior year
	Number of presentations or public education	Number of presentations or public education activities completed per year
	Number of participant-only activities	Number of activities per year that only include participants
	Number of publications/educational materials dispersed	Number of publications/educational materials dispersed per year
	Number of hours spent canvassing	Number of hours OW spend on average per week canvassing
	Location of outreach or canvassing activities	Percent of total time recorded canvassing spent in the target area(s)
Participant Outreach & Case Management	Number of participants entering the program	Number of participants entering the program for case management per year
	Number of individuals eligible for the program	Number of individuals screened for eligibility and percent eligible for the program per year
	Number of contacts with participants	Average number of successful contacts VIs, OWs, and CMs have per participant per week
	Location of contacts with participants	Percent of contacts with participants that occur within the target area(s)
	Number of participants with identified needs and goals by type	Number of participants with goals set by type: violence/safety, health, legal, financial/employment, education, housing, social
	Number of participants discharging from the program	Percent of program participants discharging from the program by type and reason
Violent Incident & Shooting Response	Number of violent incident responses	Number of responses to violent incidents per year
	Location of responses	Percent of the violent incident responses occurred in the target area(s)
	Outcome of incidents	Outcome of the incident (injury, fatality, assault with no injury)
Prevention & Programming in Schools	Number of workshops offered by type	Number of workshop sessions held in schools per year
	Location of sessions offered	Percent of the workshops in schools in the priority neighborhood(s)
	Number of students attending sessions	On average number of students attending each workshop

OUTCOMES		
Did the mediation/interruption activities demonstrate successful outcomes to potentially violent or retaliatory situations?		
Mediation Outcomes	Outcome of mediations	Percent of mediations resolved or conditionally resolved after initial or follow-up contact.
Did the program reach high-risk individuals as intended and assist in addressing their goals and needs?		
Risk of Referrals & Addressing Needs	Percent of high-risk participants	Percent of participants assessed as high-risk when initially entering the program.
	Change in risk level for high-risk participants	Percent of high-risk participants assessed at a lower risk level prior to discharging from the program.
	Participant goals completed by type	Percent of participant goals completed by type: violence/safety, health, legal, financial/employment, education, housing, social
Did program participants avoid situations involving violence after program participation?		
Norm/Behavior Change (Individual-Level)	Participants are not victims of community firearm violence	Percent of participants recorded as being victims of community firearm violence after the start of program participation.
	Participants have low level of involvement with the criminal justice system for engaging for violence	Percent of participants recorded as having been arrested or charged for violent offenses or use/possession of a weapon after the start of program participation.
	Participants avoid situations that increase risk of violence	Percent of responding participants indicating that they avoided situations that had the potential for increased risk of exposure to violence
	Participants apply non-violent responses to conflict	Percent of responding participants indicating they have applied non-violent responses to conflict
	Youth express increased confidence in their ability to avoid or prevent violence	Percent of responding youth who were exposed to 414LIFE programming in schools expressing an increase in confidence in their ability to avoid or prevent violence.

7.2 Appendix B – Evaluation matrix for hospital component

PHASE 2		
INPUTS / OUTPUTS		
Indicators		**Definition**
What was the reach of the hospital-based program, including geographic area and target population?		
Hospital Response	Total time spent per case	Average hours per HR per case
	Level of engagement for participant and family/loved ones	Participants and families/loved ones demonstrate an average or high level of engagement
	Number of participants with identified issues or needs by type	Number of participants with identified issues or needs by type (retaliation, mental health, housing, transportation, etc.)
OUTCOMES		
Did the program reach high-risk individuals as intended and assist in addressing their goals and needs?		
Addressing Patient Needs	Participants indicating improvement in key Social Determinants of Health (SDoH) issues	Percent of responding participants who indicated they had improvements in identified challenges related to SDoH after program participation
	Participants engaging with treatment or resources related to substance use or mental health issues	Percent of participants with identified needs referred to substance use or mental health resources after program participation

7.3 Appendix C – 414LIFE team member agreement with measuring program evaluation metrics by role in Phase 2



Note. HR = Hospital Responders; VI/OW = Violence Interrupters/Outreach Workers

7.4 Appendix D – Participant outcome survey

Participant Outcome Survey

You have been sent this link by a 414LIFE team member because you previously worked with either hospital responder(s) through Froedtert Hospital, or with violence interrupters/outreach worker(s) in the community.

Because of your past participation, this survey is being sent to you to learn more about your experience and what impact 414LIFE may have had on your life.

Before you start answering questions, we want to assure you that your privacy is important to us. Your responses in this survey will be completely anonymous to allow you to share your thoughts openly and honestly. We ask that you do not include any identifying information in your responses.

Also, please be aware that we've designed this survey with your time in mind. It's estimated to take between 5 to 10 minutes to complete. Your time is deeply appreciated.

Lastly, participation in this survey is entirely voluntary. Your involvement is a choice, and you're free to skip any question or withdraw from the survey at any point without facing any consequences.

Your feedback is important for program improvement by helping us to understand what has worked well and where there's room for improvement. Your dedication to providing us with your insights is invaluable. With your help, we can continue to refine and enhance the 414LIFE program for the benefit of future participants. Thank you!

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1. Who did you work with from 414LIFE?

- ☐ Hospital Responders at Froedtert Hospital
- ☐ Community Violence Interrupters or Outreach Workers
- ☐ Both

2. About how long did you work with 414LIFE?

- ☐ 0 – 3 months
- ☐ 4 – 6 months
- ☐ More than 6 months, less than a year

- ☐ About a year
- ☐ 1 – 2 years
- ☐ More than 2 years

3. What year did you start working with 414LIFE?

- ☐ 2022
- ☐ 2023
- ☐ 2024

For the next two questions, we encourage you to consider using the voice-to-text feature on your phone.

4. Please tell us about your experience working with 414LIFE and how it has impacted your life?

5. Do you have any suggestions for how 414LIFE can improve in its ability to address gun violence?

For the following statements, please indicate your level of agreement with what the statement says.

6. Since working with 414LIFE, I can avoid getting into fights or violent confrontations.

- ☐ Strongly agree
- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly disagree

6a. [*If Strongly agree or Agree is selected*] – Please give us an example of when you have avoided a potentially violent confrontation.

6b. [*If any other answer choice is selected*] – Why is it challenging to avoid getting into fights or violent confrontations?

7. Since working with 414LIFE, I can do something different than what all my friends are doing, if it's what I think is right.

- ☐ Strongly agree

- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly disagree

8. Since working with 414LIFE, I can use options and methods to resolve a conflict other than violence.

- ☐ Strongly agree
- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly disagree

8a. [*If Strongly agree or Agree is selected*] – What options or methods have you been able to use to resolve conflict other than violence?

8b. [*If any other answer choice is selected*] – Why is it challenging to use non-violent methods to resolve conflicts?

9. Since working with 414LIFE, I feel that I can make a non-violent choice even if I feel disrespected.

- ☐ Strongly agree
- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly disagree

9a. [*If Strongly agree or Agree is selected*] – How do you avoid violence in situations involving disrespect?

9b. [*If any other answer choice is selected*] – From your perspective, why is it difficult to avoid violence in situations involving disrespect?

Thank you for sharing your thoughts with us!

Your feedback is incredibly valuable in helping us to learn more about the impact of 414LIFE.

7.5 Appendix E – Interview guide – Staff

Evaluation Objectives

The objectives listed below are to be used for the evaluation of the 414LIFE Program. Team members will be interviewed as part of the process to assess the extent to which the 414LIFE program has met its' goals and objectives.

Objectives

1. Was the program implemented with fidelity to the Cure Violence model?
2. How many and in what capacity were staff trained on the Cure Violence model?
3. What were the barriers and facilitators to program implementation?
4. To what extent participants have avoided involvement in violence after program participation.

New in Phase 2

5. To what extent were Phase 1 recommendations addressed?
6. What barriers and facilitators exist related to resource referral for participants?

I. Introduction

Thank you for participating in this interview. My/our name is **<insert name(s)>**. I am/we are conducting this interview on behalf of the evaluation team to better understand the 414LIFE program as well as its impact on participants, the community, and public health in general.

It is important that you respond to all the interview questions based on your experience and perspective as a **<insert role>**. Please answer the questions honestly, your answers will be recorded but will not be attached to your name. Your participation and insight are important to the evaluation process and developing a more complete picture of the project implementation. Do you have any questions before we begin?

II. Interview Questions Related to Objectives #1, #2, and #6

1. From your perspective, what is the main purpose of **<insert role>** in the 414LIFE program?
2. Can you describe the main responsibilities of your role as a **<insert role>**?
   Prompt, as necessary:
   a. How is your role different than you expected?
3. What skills, experiences, or characteristics does one need to be an effective **<insert role>**?
4. What has training looked like for you as a member of the 414LIFE team?
   Prompt, as necessary:
   a. What kind of training did you receive as you started your role or before interacting with participants?
   b. What training would have been beneficial?
   c. What additional training have you received since joining the team?
5. How do you receive referrals?
6. What are your first steps after a referral is received?
7. How do you assess risk level of a potential participant?
8. Can you describe your approach to working with participants?
   Prompt, as necessary:

   a. Describe the procedure that you employ when engaging with a new participant.
   b. How do you establish trust with your participants?
   c. What interpersonal approach do you take when interacting with participants? *(Empathetic, tough love, etc.)*
   d. What is your main focus when interacting with a participant?
9. What, if any, barriers have you encountered in connecting participants to resources and/or services to meet their needs?
   a. If yes, with what resources/services do you experience connection difficulties?
   b. What are the barriers?
   c. What are potential solutions to address these barriers?
10. Why do you think participants choose to engage in the program?

III. Interview Questions Related to Objectives #3 and #4

11. In your role with 414LIFE, what kind of connections have you made with other people or organizations?*
    Prompt, as necessary:
    a. In what way(s) do you think your new connections with other organizations made through 414LIFE have benefitted individuals, organizations, and public health in general?
12. What do you think has contributed to the success of the 414LIFE program?
13. What, if any, challenges or barriers has 414LIFE experienced that kept the program from meeting its potential?*
    Prompt, as necessary:
    a. (e.g., competing priorities, organizational challenges, job role changes, technological challenges, funding)
14. What could 414LIFE do differently to address the challenges or barriers?*
15. In your opinion, what are the most important outcomes or benefits for participants in the 414LIFE program?*

IV. Interview Questions Related to Objectives #5 and #6

[Instructions to team members]: Part of what we're hoping to understand is what has changed in the program since last September. Please answer the following questions based on your role, time in the program, and your own experience. There are no right or wrong answers.

1.2 Close the loop on communications and referrals received

When you receive a referral from a community partner (ex., MPD, OCWS, MPS), does follow-up communication take place back to the referring agency? If so, what is communicated back to the referring agency/person?

1.3 Update written hospital component materials to be specific to gunshot wound victims

[For HRs] What printed program materials are supplied to hospital partners/providers? To patients?

2.1 Re-evaluate the level of emphasis in and the location of the priority neighborhoods

[For VIs] How does the location of a violent incident or potential mediation factor into your work? Would you respond differently knowing if the location is or is not in the priority neighborhoods?

[For OWs] How do the priority neighborhoods factor into your daily work?

2.2 Clarify expectations around engagement with participants and discharge criteria

[For VIs and HRs] What determines how often to engage with participants?

How do you know when to discharge a participant from the program?

2.3 Re-evaluate scope of team member roles

How is your **[pick one: VI/OW/HR]** role similar to the others **[read the other two: VI/OW/HRs]?** How is your role different from **[the other two: VI/OW/HR]?**

2.4 Develop centralized tracking of community component participants

[For VIs only] When you enter new participants into the CVG database, is there anywhere in or outside the system where you log identifying information about the individual? If not, how do you maintain or log their contact info for the duration of their program engagement?

2.5 Increased positive/strength focused data entry training

Please describe the data entry training you have received – what did it look like? How soon did you receive it upon starting your role? What, if anything, was missing, from the training that could have helped you in completing data entry for your role with 414LIFE?

2.6 Provide trauma-informed care for 414LIFE frontline workers

Do you feel that your mental health is supported in your role?

[**If yes**] How does 414LIFE support your mental health?

[**If no**] What could 414LIFE do to better support your mental health and well being?

V. CONCLUSION

Those are all the questions I have for you today.

16. Is there anything else that you'd like the evaluation team to know that was not already discussed?

Thank you very much for your time. Your input is appreciated and is a valuable part of the evaluation process.

<END INTERVIEW>

7.6 Appendix F – Interview guide – Supervisors

Evaluation Objectives

The objectives listed below are to be used for the evaluation of the 414LIFE Program. Leadership will be interviewed to assess the extent to which the 414LIFE program has met its' goals and objectives.

Objectives

1. Was the program implemented with fidelity to the Cure Violence model?
2. How many and in what capacity were staff trained on the Cure Violence model?
3. What were the barriers and facilitators to program implementation?
4. To what extent participants have avoided involvement in violence after program participation.

New in Phase 2

5. To what extent were Phase 1 recommendations addressed?
6. What barriers and facilitators exist related to resource referral for participants?

I. Introduction

Thank you for participating in this interview. My/our name(s) are **<insert name(s)>**. I am/we are conducting this interview on behalf of the evaluation team to better understand the 414LIFE program as well as its impact participants, the community, and public health in general.

It is important that you respond to all the interview questions based on your experience and perspective as a leader of the program. Please answer the questions honestly, your answers will be recorded but will not be attached to your name. Do you have any questions before we begin?

II. Interview Questions Related to Objectives #1, #2 and #6

17. Please describe the main responsibilities of your role as a supervisor in 414LIFE.
    Prompt, as necessary:
    a. What did you hope to achieve in working with 414LIFE?
    b. How is your role different than you expected?
18. What skills, experiences, or characteristics does one need to be an effective supervisor in the 414LIFE program?
19. What did training look like for you?
    Prompt, as necessary:
    a. What kind of training did you receive as you started your role as a supervisor?
    b. What training would have been beneficial?
    c. What additional training have you received since joining the team?
20. What does the training for team members look like?
    Prompt, as necessary:
    a. To what extent is your staff knowledgeable on the Cure Violence model?
    b. How often are staff refreshed on the Cure Violence model?
    c. How are staff trained on data collection and data entry?
21. What skills, experiences, or characteristics does one need to **do the work** of an effective hospital responder, violence interrupter, and outreach worker for 414LIFE?

22. Can you describe your approach to working with 414LIFE team members?
    Prompt, as necessary:
    a. How do you establish trust with your team?
    b. What interpersonal approach do you take when interacting with team members? *(Empathetic, tough love, etc.)*
23. Can you describe your approach to working with participants?
    a. How do you establish trust with participants?
    b. What interpersonal approach do you take when interacting with participants? (*Empathetic, tough love, etc.)*
24. What, if any, barriers have you encountered in connecting participants to resources and/or services to meet their needs?
    a. With what resources/services do you experience connection difficulties?
    b. What are the barriers?
    c. What are the potential solutions to address these barriers?
25. Why do you think participants *do* engage in the program?

III. Interview Questions Related to Objectives #3 and #4

26. What, if any, challenges or barriers has 414LIFE experienced that kept the program from meeting its potential 414LIFE?
27. What do you see as concerns for the team and leadership of 414LIFE?

IV. Interview Questions Related to Objectives #5 and #6

[Instructions to team members]: Part of what we're hoping to understand is what has changed in the program since last September. Please answer the following questions based on your role, time in the program, and your own experience. There are no right or wrong answers.

1.2 Close the loop on communications and referrals received

When you receive a referral from a community partner (ex., MPD, OCWS, MPS), does follow-up communication take place back to the referring agency? If so, what is communicated back to the referring agency/person?

1.3 Update written hospital component materials to be specific to gunshot wound victims

What printed program materials are supplied to hospital partners/providers? To patients?

2.1 Re-evaluate the level of emphasis in and the location of the priority neighborhoods

[For VIs] How does the location of a violent incident or potential mediation factor into your work? Would you or your team members respond differently knowing if the location is or is not in the priority neighborhoods?

[For OWs] How do the priority neighborhoods factor into your daily work or the work of your team members?

2.2 Clarify expectations around engagement with participants and discharge criteria

[For VIs and HRs] What determines how often to engage with participants?

How do you know when to discharge a participant from the program?

2.3 Re-evaluate scope of team member roles

How are each of the roles [VI/OW/HR, similar to each other? How are the roles different from each other?

2.4 Develop centralized tracking of community component participants

How do team members on the community side maintain or log their contact info for their participants during their program engagement? Is this information available to follow-up with participants if a team member leaves the program?

2.5 Increased positive/strength focused data entry training

Please describe the data entry training you have received – what did it look like? How soon did you receive it upon starting your role? What, if anything, was missing from the training that could have helped you in completing data entry for your role with 414LIFE?

2.6 Provide trauma-informed care for 414LIFE frontline workers

Do you feel that mental health for you and team members is supported in your role?

[**If yes**] How does 414LIFE support mental health for team members and supervisors?

[**If no**] What could 414LIFE do to better support the mental health and well being of team members and supervisors?

V. CONCLUSION

Those are all the questions I have for you today.

28. Is there anything else that you'd like the evaluation team to know that was not already discussed?

Thank you very much for your time.

<END INTERVIEW>

7.7 Appendix G – Interview guide – Leadership

Evaluation Objectives

The objectives listed below are to be used for the evaluation of the 414LIFE Program. Leadership will be interviewed to assess the extent to which the 414LIFE program has met its' goals and objectives.

Objectives

1. Was the program implemented with fidelity to the Cure Violence model?
2. How many and in what capacity were staff trained on the Cure Violence model?
3. What were the barriers and facilitators to program implementation?
4. To what extent participants have avoided involvement in violence after program participation.

New in Phase 2

5. To what extent were Phase 2 recommendations addressed? (integrated below; in orange)
6. What barriers and facilitators exist related to resource referral for participants?

I. Introduction

Thank you for participating in this interview. My/our name is **<insert name(s)>**. I am/ we are conducting this interview on behalf of the evaluation team to help us better understand the 414LIFE program.

It is important that you respond to all the interview questions based on your experience and perspective as a leader of the program. Please answer the questions honestly, your answers will be recorded but will not be attached to your name. Do you have any questions before we begin?

II. Interview Questions Related to Objectives #1, #2, and #6

Training

29. What does the training for program supervisors look like?
    Prompt, as necessary:
    a. To what extent are supervisors knowledgeable on the Cure Violence model?
    b. How often are supervisors refreshed on the Cure Violence model?
    c. How are supervisors trained on data collection and data entry?
30. What does the training for team members look like?
    Prompt, as necessary:
    a. To what extent are staff knowledgeable on the Cure Violence model? Does this apply to HRs?
    b. How often are staff refreshed on the Cure Violence model?
    c. How are staff trained on data collection and data entry?
        i. Please describe the data entry training provided to supervisors and staff – what did it look like? How soon did they receive it upon starting their roles? What, if anything, was missing from the training that could have helped them in completing data entry for their roles with 414LIFE?
    d. How do team members on the community side of the program maintain or log their contact info for their participants during the duration of their program engagement? Is this information available to you to be able to follow-up with participants if a team member leaves the program?
31. How are the team member roles (VI/ OW/ HR) roles similar to each other? How are the roles different from each other?

a. What skills, experiences, or characteristics does one need to be an effective hospital responder, violence interrupter, and outreach worker for 414LIFE?

32. **Priority neighborhoods:**
    a. **[Ref VIs]** How does the location of a violent incident or potential mediation factor into VI work? Should the VIs respond differently knowing if the location is or is not in the priority neighborhoods? What is the purpose of the priority neighborhoods?
    b. **[Ref OWs]** How do the priority neighborhoods factor into the daily work of OWs?

Referrals and participant engagement

33. What printed program materials are supplied to hospital partners/providers? To patients?
34. When the program receives a referral from a community partner (ex., MPD, OCWS, MPS), does follow-up communication take place back to the referring agency? If so, what is communicated back to the referring agency/person?
35. **Engagement with participants and discharge criteria**
    a. What determines how often VIs engage with participants? How do they know when to discharge a participant from the program?
    b. What determines how often HRs engage with participants? How do they know when to discharge a participant from the program?
36. What, if any, barriers have has the program encountered in connecting participants to resources and/or services to meet their needs?
    a. With what resources/services have there been connection difficulties?
    b. What are the barriers?
    c. What are potential solutions to address these barriers? (*Prompt – system-level change with external organizations or regulations; individual, program-level changes?)*
37. Why do you think participants engage in the program?

III. Interview Questions Related to Objectives #3 and #4

38. Were there any notable transitions that 414LIFE underwent over the past year?
    a. Can you describe how that may have impacted the program?
39. What do you see as the concerns for the staff and leadership of 414LIFE? – (re-word?)where are there growth opportunities for the program?
40. What support is available to the team to prevent burnout?
    Prompt, as necessary:
    a. How do you help to keep team members engaged?
    b. What efforts have been made to increase the retention of staff?
    c. Do you feel frontline team members' mental health is supported?
        i. [**If yes**] How does 414LIFE support mental health for team members and supervisors?
        ii. [**If no**] What could 414LIFE do to better support frontline team members' mental health and well being?

V. CONCLUSION

Those are all the questions we/I have for you today.

41. Is there anything else that you'd like the evaluation team to know that was not already discussed?

Thank you very much for your time.

<END INTERVIEW>

7.8 Appendix H – School pre-participation survey

414LIFE ROC SESSIONS

RESTORATION OF CONSCIOUSNESS (ROC)

Today's date:_____

Your school: _____ Your grade level:_____Your age: _____

Is this the first *school year* you have attended the workshops? (Check the box).

Yes, this is my first school year attending	No, I have attended in a prior school year

We are looking for your feedback before your participation in the 414LIFE sessions to better understand the impact of the program. Please answer the following questions from your perspective. There are no right or wrong answers. Please answer honestly. (Circle or check the box).

Before participating in these sessions…	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I understand violence as a disease.	1	2	3	4	5
2. I understand the conditions that promote violence.	1	2	3	4	5
3. I avoid getting into fights or violent confrontations.	1	2	3	4	5
4. I can do something different than what all my friends are doing, if it's what I think is right.	1	2	3	4	5
5. I think that people need to be involved in street activity if they want to survive in my neighborhood.	1	2	3	4	5
6. I am a peaceful person.	1	2	3	4	5
7. I feel that I can make a non-violent choice even if I feel disrespected.	1	2	3	4	5
8. I am a positive influence and/or a role model.	1	2	3	4	5
9. I use options and methods other than violence to resolve a conflict.	1	2	3	4	5
10. I think that using violence can sometimes solve problems.	1	2	3	4	5

11. How likely are you to be involved in violent arguments or physical fights? (Check the box).

Very likely	A little likely	Not very likely	Not likely

12. What do you hope to learn in these workshops?

13. Why did you decide to join these workshops?

--Thank you for your time and thoughtfulness!--

7.9 Appendix I – School post-participation survey

414LIFE ROC SESSIONS

RESTORATION OF CONSCIOUSNESS (ROC)

Today's date:_____

Your school:_____ Your grade level:_____Your age: _____

Is this the first *school year* you have attended the workshops? (**Check the box**).

Yes, this is my first school year attending	No, I have attended in a prior school year

We are looking for your feedback based on your participation in the 414LIFE sessions to better understand the impact of the program. Please answer the following questions from your perspective. There are no right or wrong answers. Please answer honestly. (**Circle or check the box**).

As a result of being part of these sessions…	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I better understand violence as a disease.	1	2	3	4	5
2. I have a better understanding of the conditions that promote violence.	1	2	3	4	5
3. I can avoid getting into fights or violent confrontations.	1	2	3	4	5
4. I can do something different than what all my friends are doing, if it's what I think is right.	1	2	3	4	5
5. I can use options and methods to resolve a conflict other than violence.	1	2	3	4	5
6. I feel I can be a peaceful person.	1	2	3	4	5
7. I feel that I can make a non-violent choice even if I feel disrespected.	1	2	3	4	5
8. I can be a positive influence and/or a role model.	1	2	3	4	5

1

9. To what extent do you feel better prepared to avoid and/or prevent violence, now that you've attended these workshops? (Check the box).

Much better	Somewhat better	A little better	Not much better	Not At All better

10. Do you think you are less likely to be involved in violence or fights now that you've attended these workshops? (Check the box).

Yes	Maybe a Little	No	I don't know

11. Please rate your overall satisfaction with these workshops (Check the box):

Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied

12. What part of the workshop sessions made the biggest impact on you, and why?

13. Please describe anything you will do differently after being involved in these workshops:

14. Was there anything that you felt was missing from the workshops that you would have liked to discuss or learn about?

*--Thank you for your time and thoughtfulness!-

7.10 Appendix J – School post-participation survey Phase 1 results

Table 5. The Extent that School ROC Workshop Participants Agree or Disagree with Statements on Violence After Participation (n = 123)

As a result of being part of these sessions…	Strongly Agree (%)	Agree (%)	Not Sure (%)	Disagree (%)	Strongly Disagree (%)
I better understand violence as a disease.	23.0	38.5	31.2	3.3	4.1
I have a better understanding of the conditions that promote violence.	23.1	52.9	17.4	5.0	1.7
I can avoid getting into fights or violent confrontations.	23.6	35.0	29.3	6.5	5.7
I can do something different than what all my friends are doing, if it's what I think is right.	50.4	32.5	8.9	4.1	4.1
I can use options and methods to resolve a conflict other than violence.	23.8	45.9	25.4	2.5	2.5
I feel I can be a peaceful person.	49.6	33.3	9.8	5.7	1.6
I feel that I can make a non-violent choice even if I feel disrespected.	18.7	30.1	36.6	9.8	4.9
I can be a positive influence and/or a role model.	48.4	36.9	9.0	1.6	4.1

7.11 Appendix K - Analytic plan

7.11.1 Statistical power of sample size

This evaluation design did not require a minimum sample size to power its analyses. The analyses were inherently descriptive in nature and focus on group comparison for program quality improvement. The historic comparison sample (for evaluating re-injury and criminal justice system involvement) was limited to the number of hospital component-referred patients for whom there was a pre-program injury patient available for matching on age, sex, race, and mechanism of injury (i.e., 402 matched pairs; 93.7% 414LIFE patients matched).

7.11.2 Financial and marketing analysis

Both financial expenditure and marketing material costs were descriptively analyzed to report total costs by year.

7.11.3 Community component analysis

The count and frequency of community activities were descriptively analyzed. This included violence mediations (and their outcomes), time spent on interruptions, outreach activities, and describing the participants in case management. Geospatial mapping of point locations for community events and locations of violence mediations, for 2023 and a comparison map provided for the same activities in 2022.

7.11.4 School programming analysis

Basic descriptive characteristics of program participants were analyzed descriptively with counts, frequencies, and averages. These characteristics were tabulated from all survey respondents (pre- and post-participation surveys) since the start of the program. This was

done to maximize survey responses available for group comparison given that there has only been one full academic year since program start that had both pre- and post-participation surveys administered (Table 1). Phase 1 reported outcomes utilizing only post-participation surveys, whereas this Phase 2 evaluation is the first to conduct group comparisons between pre-participation survey responses against post-survey responses from all school years since the beginning of the workshop. This was possible given that this was the first evaluation with a similar number of surveys available from the pre- and post-participation timepoints.

The questions compared were the closed-ended questions in which students were asked to what extent they agreed with a set of statements related to violence (10 in the pre-participation survey, 8 in the post-participation survey). There were 8 questions which were present on both the pre- and post-participation survey in the following domains: 1) understanding violence as a disease, 2) understanding the conditions which promote violence, 3) avoidance of violent conflicts, 4) doing something different than one's friends, 5) using non-violent conflict resolution methods, 6) being able to be a peaceful person, 7) being able to make a non-violent reaction when disrespected, and 8) being able to be a positive influence/role model. The answer choices for each question were: 0 – *Strongly Disagree*, 1 – *Disagree*, 2 – *Not Sure*, 3 – *Agree*, or 4 – *Strongly Agree*. These responses were first descriptively analyzed so that the average response per question is reported. For example, how many (number and percentage) students strongly disagreed, disagreed, etc. for each question.

One additional question was also evaluated that was not a hypothetical situation related to violence. This question gauged self-reported likelihood for violence prior to ROC workshop participation. Prior disposition toward violence by age and grade were compared using Chi square ($\chi 2$) tests.

Group comparisons were then conducted using independent samples tests for survey questions which were the same on the pre- and post-participation surveys (i.e., 8 questions). Each question compared aggregated pre-participation survey responses with aggregated post-participation survey responses. Thus, all surveys available since the start of workshop programming were utilized. A significant difference would be indicated by a *p*-value of ≤ 0.05. These analyses were conducted using STATA (BE version 18.5).

7.11.5 Hospital component analyses

7.11.5.1 Descriptive characteristics

Clinical characteristics among hospital component participants (e.g., mechanism of injury, arrival status) were descriptively analyzed alongside program referral information (e.g., referring provider, referring hospital unit), and participant demographic and injury characteristics (e.g., sex, age, race, ethnicity, city of residency, mechanism of injury). Also, as all the gunshot wound patients were referred to TQoL Clinic for post-discharge follow-up care, including the 414LIFE referred patients, attendance to this clinic appointment was reported to better understand if there were differences in outcomes based on whether participants interacted with the 414LIFE HR, TQoL Clinic, or both programs.

7.11.5.2 Re-injury

Since the hospital component was not implemented as a randomized control trial (RCT), a direct "control" group (i.e., gunshot wound patients who were eligible but were withheld from the program intervention and not considered for program referral) was not available (Figure 8). This meant that the efficacy of the HR intervention could not be compared within the same timeframe for those who received the treatment and those who did not, as all GSW patients meeting the criteria could be referred to the program.

Historic match comparison injury patients were statistically compared to 414LIFE participants through Chi-square tests. A historic comparison cohort was created by identifying patients with GSW from the trauma registry who were treated at the Level 1 Trauma Center between January 1, 2015 – May 5, 2017, so there was sufficient time for a two-year follow-up period prior to the start of the 414LIFE hospital component on May 6,

2019. In essence, the historic comparison cohort represents patients who would have been referred to the program if the program were in place at the time.

414LIFE participants were then matched to patients in this historic comparison cohort. Exact matching was implemented between groups for mechanism of injury (i.e., gunshot

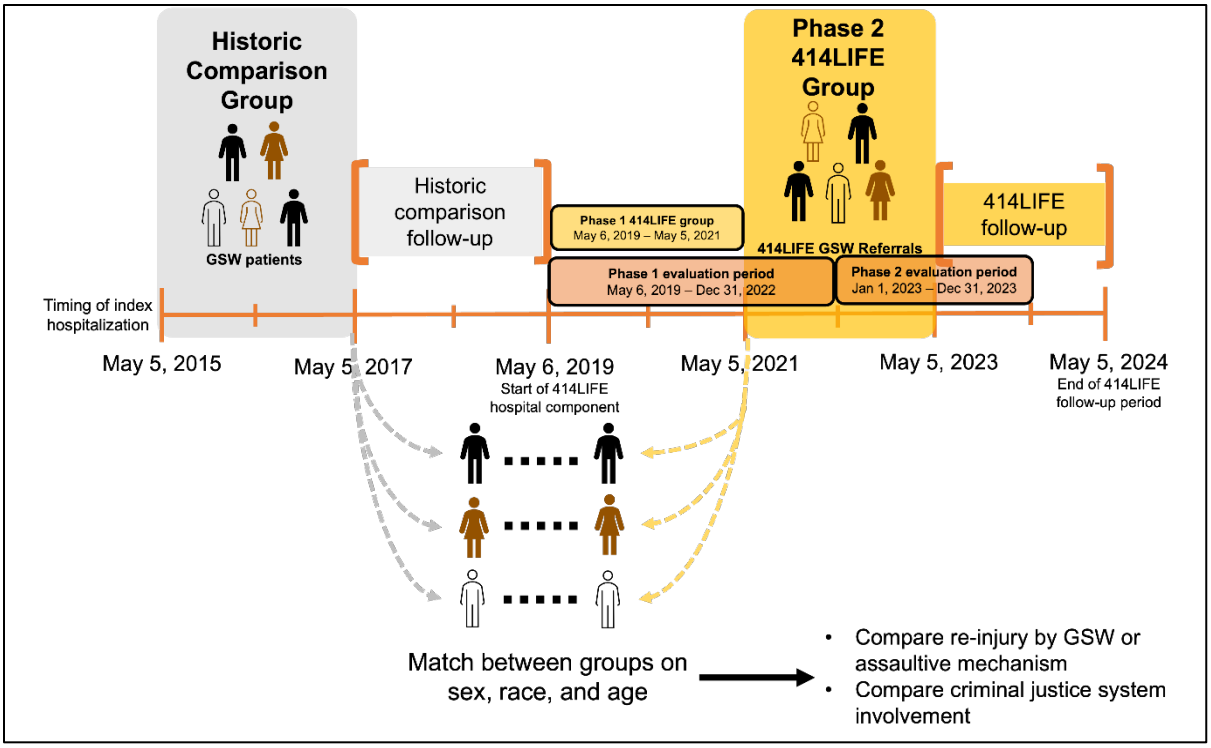

Figure 8. Historic match control analytic match schema for the Phase 2 evaluation

wound), sex, and race, while propensity score matching was used to match age. Propensity scoring is a statistical method used to achieve as balanced of groups as possible where exact matches may not be feasible. For instance, age has more possible values than sex or race, so propensity scoring helps to create as close of a match as possible. Matching is done to examine the effect of the program independent of demographic and injury characteristics. 414LIFE participants and historical match patients

were excluded from the match if missing any of the matching variables or if race was listed as “unknown” or “other.”

Follow-up of key outcomes was evaluated along several timeframes after the “index” gunshot wound: 1-, 3-, 6-months, 1- and 2-years. For each of these groups, participants were followed for consistent time periods to determine whether there was a re-injury during comparable follow-up periods following the index injury that resulted in referral to the program. For instance, re-injury within three-months indicates that the new injury occurred within a period of three months following the date of index injury. Both 414LIFE referred patients and comparison patients had equal amounts of time for follow-up to be evaluated. To allow for adequate time for the historic comparison group and to prohibit follow-up period overlap with the start of the 414LIFE program, the index timeframe for historic comparisons was designated as May 5, 2015 – May 5, 2017 to allow for a two-year follow-up period through May 5, 2019 (Figure 8). The timeframe of interest for 414LIFE referrals for index injuries was designated as May 6, 2021 – May 5, 2023 to allow for a two-year follow-up period for most participants (through May 5, 2024, end of the evaluation period) and to provide comparable timeframe length and seasonality of index gunshot wound injuries with the historic comparison group. A significant difference was indicated at a p-value of ≤ 0.05. These analyses were conducted using R (version 4.3.1 “Beagle Scouts”).

7.11.5.3 Involvement with criminal justice system

Involvement in violence as a victim or individual involved in carrying out a homicide or nonfatal shooting, as well as contacts with the criminal justice system following index injury was assessed. These analyses utilized the same matched pairs as described in the previous section. Both 414LIFE and the comparison patient groups were followed for a two-year period after the date of the index injury based on the date of a new offense being within the follow-up period after index injury (i.e., 1-, 3-, 6-months, 1- and 2-years). Comparison between 414LIFE and comparison matched patients was conducted using Chi-square tests. A significant difference was indicated at a *p*-value of ≤ 0.05. These analyses were conducted using SAS® 9.4 TS1M8 (9.4 M8).

7.11.5.4 Geospatial distribution

To assess the geographic reach of the program, geospatial analyses were completed using ESRI's ArcGIS Pro version 3.0.3. The analysis included publicly available base map layers and a shapefile of the city of Milwaukee's neighborhood boundaries from the City's public geographic information system (GIS) portal website.[24] For the community component of the program, the closest street intersection for mediations and community events as recorded in the program databases (i.e., CiviCore and CVG database) were extracted. For the hospital component of the program, the location where the injury occurred was extracted from the electronic medical record. All locations were geocoded and joined to the city neighborhood shapefile.

Density maps were created to understand the distribution of community component mediations and activities, and the number of hospital component referrals, across the city

and by neighborhood. To demonstrate the density of events, referrals, and related point data, a kernel density calculation was utilized with a search radius of 0.25 miles between points for all maps. This radius was chosen as the average city block is approximately 330 feet by 660 feet. Due to the size of the city, the search radius was increased incrementally, and 0.25 miles (approximately four city blocks) is the radius that most accurately displayed the density of the data points for the area being mapped.

7.11.6 Qualitative analyses

7.11.6.1 Focus group & interviews

Semi-structured interview guides from Phase 1 were reviewed and updated for this evaluation phase to ensure alignment with priority content areas of the program evaluation matrices (Appendices A & B). Interview guides were refined based on interviewees' roles in relationship to 414LIFE, resulting in separate interview guides for 414LIFE frontline team members (i.e., HRs, VIs, OWs), supervisors, and leadership. Separate interview guides by role allowed questions to be worded based on their position to comment on different aspects of program operations (Appendices E, F, G). When there were scheduling conflicts, one-on-one interviews were offered and conducted for a minority of participating team members.

Focus groups were conducted virtually to allow for real-time audio recording and transcription using an institutional license of Microsoft Teams (version 24243.1309.3132.617). The transcriptions were reviewed following the completion of the focus group for accuracy against the audio recording. Audio recordings were deleted once

the accuracy of the transcript was ascertained. Transcripts were de-identified and securely stored by the evaluation team.

MaxQDA 2022 (Release 22.8.0) was utilized for the storage, coding, and thematic content analysis of the transcripts. The result of the thematic content analysis is a set of recommendations for strengthening the program, contextualizing quantitative answers, and for answering standalone evaluation questions, such as, what training entailed for team members and what were perceived barriers and facilitators to program implementation.

Two members of the evaluation team generated an initial codebook for internal stakeholders from two of the internal focus group transcripts. The same process was executed for external stakeholder interviews to yield a codebook for that analysis. All codes were generated from the objectives of the evaluation (Appendices A & B) to ensure that only information relevant to these questions was captured. Both evaluators met to refine the codebook through discussion on discrepancies in application of codes and the addition of new codes. The evaluators agreed on the codes utilized. One evaluator then coded all transcribed interviews, while the second reviewed how the codes were utilized. Upon review, there were no disagreements in how the transcripts were coded.

The codes were then used in a thematic content analysis.[25] A thematic content analysis was the chosen qualitative analytic approach because the purpose of the focus groups and interviews with 414LIFE was to be able to characterize program operations, any programmatic quality improvement efforts in response to the Phase 1 evaluation, and answer questions from the evaluation question set (Appendices A & B) that were not

addressable through quantitative data alone. Theme(s) were identified for each evaluation question. Themes were also used as answers or additional context to support quantitative responses presented in the Results section. Emblematic quotes were selected and are highlighted throughout this report. Recommendations and themes were discussed first internally with the Evaluation Team, and then with internal 414LIFE leadership to address any questions or issues with clarity.

7.11.6.2 Surveys

School ROC participation surveys and Participant Outcome Surveys both had free response questions. The free response question for the school ROC post-participation survey was reported in the first 414LIFE program evaluation. This evaluation reports the pre-participation survey free response question results. That question asked students, "What do you hope to learn in these workshops?" These responses were aggregated and inductively coded. Overall themes of what students hoped to learn were reported. Of note, average response length was one sentence.

In the Participant Outcome Survey, there were two free response questions and six free response follow-up questions for three of the four closed ended questions. The purpose of the free response follow-up questions was to obtain an example strategy when respondents answered that they agreed or strongly agreed with a statement of non-violence. Conversely, when respondents answered that they were unsure, disagreed or strongly disagreed with a statement of non-violence, there was a follow-up question to inquire why they felt that way. For example, one closed ended question was, "Since working with 414LIFE, I can use options and methods to resolve a conflict other than

violence." If respondents (strongly) agreed with this, then the next question asked was, "What options or methods have you been able to use to resolve conflict other than violence?" For respondents who answered the leading question with "*Not Sure*", "*Disagree*", or "*Strongly disagree*", then their next question was, "Why is it challenging to use non-violent methods to resolve conflicts?" Responses were aggregated by whether they were in response to a positive or negative follow-up question and then inductively coded. Overall themes of positive example behaviors and strategies in response to violence are reported, as well as reasons for why a non-violent response may be challenging. Of note, average response length ranged from a few words to full sentences.

7.11.6.3 Media

Traditional media headlines and social media post content were also thematically analyzed using inductive coding (ref. *2.3.1 Data sources, Program-wide*). The types of headlines and content were thus identified from this coding and reported with emblematic headlines. The purpose of this analysis was to identify the types of stories and content either about 414LIFE or in which 414LIFE is mentioned. These results thus indicated how and in what context the program is being discussed, as well as its relationship to other violence prevention efforts in Milwaukee, WI.

7.12 Appendix L – Timeline of Key Programmatic Events, 2022-2023