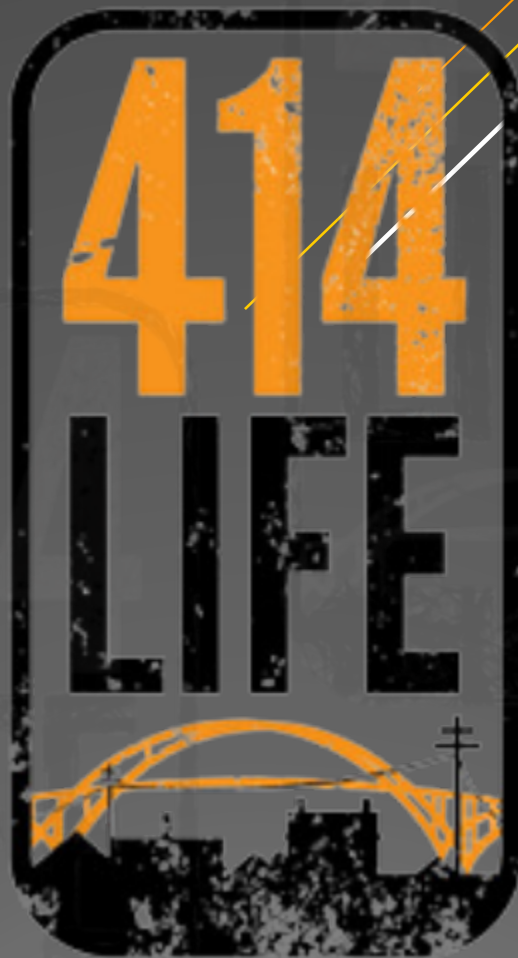


PHASE 1 EVALUATION REPORT FOR 414LIFE



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

PHASE 1 EVALUATION REPORT FOR 414LIFE:

***A Community- and Hospital-Based Violence Intervention Program to
Address Gun Violence in Milwaukee***

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EXECUTIVE SUMMARY

This brief summary provides a high-level overview of the 414LIFE Phase 1 Evaluation Report. Links throughout will redirect to the specific location in the evaluation where greater detail can be found. The structure of this executive summary mirrors that of the full report, although this summary integrates the results and discussion sections. This is followed by evidence-derived recommendations to strengthen the program and description of future evaluations.

INTRODUCTION

The problem. Firearm homicide was identified as the second leading cause of death in Milwaukee from 2000-2017, with an average age of 28 years at time of death for firearm homicide victims.¹ The national Violence Policy Center ranked Wisconsin as second in the nation for Black homicide victimization in 2020.² After a 70% increase in homicides in 2015, the City of Milwaukee expanded its Office of Violence Prevention (OVP) and engaged thousands of residents to develop its first comprehensive violence prevention plan known as the [*Blueprint for Peace*](#).³ The *Blueprint* contains 6 goals and 30 strategies for addressing violence as a public health issue. 414LIFE was one of the programs developed as part of the response to firearm violence in Milwaukee. Despite a steady 4-year decline in homicides and nonfatal shootings from 2016-2019, Milwaukee experienced record-breaking levels of gun violence in 2020 and 2021, continuing into 2022.⁴

The strategy. 414LIFE is a community- and hospital-based violence intervention program. The program has two components developed on [existing evidence-based models](#) – the community component as an adaptation of the Cure Violence (CV) model selected to address community-based violence, and the hospital component as an adaptation of a Hospital-based Violence Intervention Program (HVIP) chosen to prevent re-injury after a gunshot wound requiring hospital attention. 414LIFE team members are hired as “credible messengers” who have relevant life experiences, rapport, and/or knowledge to identify and work with individuals or groups who are at high risk for gun violence victimization or perpetuation. This work centered on individuals and pre-identified priority neighborhoods with the highest rates of gun violence.

EVALUATION PURPOSE

This Phase I report summarizes findings from the evaluation of the initial implementation of 414LIFE. This work was conducted by the evaluation team of the Division of Data Surveillance

& Informatics (DDSI) for the Comprehensive Injury Center (CIC) of the Medical College of Wisconsin (MCW). The evaluation was supported through philanthropic and federal funds.

Assessed are the first few years of the program (October 2018 – December 2022). This notably includes 2020, thus the influence of the COVID-19 pandemic and other key local events are incorporated throughout the report. Program inputs, outputs, and initial outcomes of both the hospital and community components are presented. The included analyses focus on how the program was implemented, its geographic and target population reach, and initial outcomes. All questions addressed by this evaluation are summarized in Appendices B and C.

METHODS

Data Sources. Data sources included program records, internal and external stakeholder interviews and focus groups, community component case management databases, pre- and post-surveys from the school Restoration of Consciousness (ROC) workshops, a data repository containing criminal justice interactions, the hospital component referral database, electronic medical records, hospital Trauma Registry, and the hospital case management database. Each data source has its strengths and limitations. An overall limitation of the data used in this evaluation is inconsistent data availability and documentation due to database changes, contracting challenges, creation of new data points to be collected, and timeliness of database access.

Data Analyses. Descriptive analyses were conducted for the inputs, outputs, and outcomes of both components, and the school workshops. Geospatial density maps were created to describe the density of locations of program activities. An Intent-To-Treat analytic approach was utilized to assess hospital program re-injury rates. This means that all referred individuals are analyzed regardless of their actual engagement with the program. Hospital re-injury was assessed with a historic comparison group, meaning, 414LIFE referred patients were compared with similar patients who could have been referred to the program, had the program existed at the time of their injury. Lastly, interviews and focus groups were coded to support formulation of program recommendations and identification of representative quotes and stories to complement quantitative analyses of program activities.

RESULTS & DISCUSSION – Answers to Key Evaluation Questions

COMMUNITY COMPONENT

How was the 414LIFE community-based component implemented in Milwaukee?

Overall, the community-based component of the program was intended to be an [evidence-based approach](#) to violence prevention from a public health perspective as an adaptation of the CV model. The [overall program reputation](#) was viewed favorably by internal and external stakeholders as reported through interviews and focus groups. Team members described being driven by a desire to give back to their community and the work being a matter of a higher calling. External partners also echoed a sentiment of the higher purpose of 414LIFE's work in saving lives from gun violence. Both types of stakeholders indicated hope and continuing to support having the right people aligned to work together in this space.

Challenges to program implementation included limited resource and infrastructure support, in terms of funding and [size of the team](#). At its largest, the program was comprised of 13 team members, including administrative roles, during the initial implementation phase. Independent of this, there were challenges because of significant turnover in team members and leadership both internally and externally resulting in differential access to tangible and intangible resources (e.g., knowledge from experienced/senior personnel, mental health support for 414LIFE team members, database and training access, and streamlined communication between partners). In addition, the COVID-19 pandemic and other [key local events](#) interrupted aspects of the program implementation and processes while also causing a temporary shift in some of the focus in 2020 toward COVID-19 community response, local activities related to the national protest movement, and support for safe voting during the 2020 Presidential Election.

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

[The program has largely reached the priority individuals and neighborhoods](#). Referrals for mediations and participants for case management are being received from community partners for individuals at high risk of firearm violence. Violence Interrupters conducted 257 conflict mediations of which 71% were reported as resolved or conditionally resolved. Outreach Workers and outreach and community coordinators conducted 110 community events to build

relationships with community partners, bring awareness to community violence, and provide resources to community members. The 133 participants recorded as being involved in case management reflected those known to be at high risk for gun violence (i.e., young, Black men). Most participants were 15-35 years old (80%), Black or African American (87%), and male (95%). For those with completed risk assessments, 90% were considered high or medium risk for involvement in violence. The largest deviation from the CV model was the actualized spread of program activities citywide. The geographic focus was not as concentrated as often found in other CV implementations. For example, although there was some concentration of activities within the priority neighborhoods, [community activities](#) and [mediations](#) occurred citywide.

Did participants avoid situations involving violence after program participation?

Participant [success stories](#) highlight the direct impact of the community-based program on some participants refocusing on self-actualization rather than violence, as reported from the perspective of team members. Examples include participants focusing on returning to school, starting a new business, or being a role model for their children. In addition, [outcomes from the school programming](#) post-survey indicated that 93.5% of students felt a little bit, somewhat or much better prepared to avoid involvement in violence after participation in the program.

HOSPITAL COMPONENT

How was the 414LIFE hospital-based program implemented in Milwaukee?

Results of the evaluation suggest the 414LIFE program was implemented with fidelity as an HVIP model. The four components of an HVIP include: 1) intervention, 2) care, 3) follow-up services, and 4) addressing social determinants of health.⁵ All four are achieved by the 414LIFE [hospital component](#) and the program has accelerated innovation for similar programs nationally through the novel incorporation of 414LIFE hospital responders into outpatient care (i.e., the outpatient Trauma Quality of Life Clinic for gunshot wound patients at Froedtert Hospital).

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

There were 1,075 referrals to the hospital component during the evaluation period which included patients from across Milwaukee County. [Participants reflected those most at risk](#) for gun violence – most were young (average age 30.2 years), Black or African American (84%), men (81%). Patients can be referred if they are aged 15 – 35 years, were injured by a gunshot

wound, and were injured in or are a resident of Milwaukee. However, exceptions are made when risk of retaliation is high. The majority (97%) of referred patients experienced a gunshot wound, while the remaining 3% experienced another assaultive mechanism of injury (e.g., stab wound, blunt assault). A portion of the referrals were injured in priority neighborhoods for 414LIFE and/or those defined as priority by the *Blueprint for Peace*. Ability to reach patients was limited due to the program's ability to only support one hospital responder from May 2019 – July 2022. Another reach limitation was that in the acute period of the COVID-19 pandemic, the hospital responder could only connect with patients remotely.

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

The program reached high-risk individuals, as defined by the program, as 62% met all eligibility criteria, and 99% met at least one eligibility criteria. Program participants indicated a [significant number of needs](#) across a range of areas, of which the most frequently reported were mental health, financial, retaliation, and safe housing concerns. The cases for hospital responders are complex, with patients often requiring extensive follow-up care, which highlights the need to streamline discharge criteria and continue in transitioning participants from the hospital to the community component of the program when longer-term follow up is needed. It similarly indicates the significant pre-injury levels of unmet needs for individuals at high risk for gun violence, which the program aims to serve.

Did program participants demonstrate significantly lower levels of reinjury and involvement in violence after program participation?

Compared to a historic match comparison group of patients with gunshot wounds sustained prior to program implementation, those referred to 414LIFE did not experience a statistically significant difference in re-injury by gunshot wound or by other assaultive injuries. The overall [re-injury rate](#) for both the 414LIFE and the comparison group was relatively low, at 3% or less. It is important to note that program referral does not necessarily indicate contact or level of engagement with the program. Given the [Intent-To-Treat approach](#) of this evaluation analysis, these results suggest that the presence of the 414LIFE program in the hospital is not sufficient to impact re-injury outcomes. [Re-contact with the criminal justice system](#) as measured through new charges was also relatively low for both the 414LIFE and the comparison groups at 4% or less, but a slightly higher percent were involved in additional homicide and nonfatal shooting incidents either due to additional victimization or identified as causing harm.

Comparison to previous violence prevention and intervention programs.

Published evaluations from community-focused violence intervention programs have commonly investigated the fidelity of focused deterrence, HVIPs, and community programming implementations within pre-defined small areas – usually about 2-4 neighborhoods.⁶⁻⁹ Data were typically sourced only from local police department records which were then analyzed to compare rate change of gun violence over time. 414LIFE differs from this past work as demonstrated by its citywide reach during the Phase 1 evaluation period. While the [events of 2020](#) (e.g., COVID-19, national protest movement, Presidential election) influenced this deviation, there is citywide work due to case referrals from HRs (who work with injured persons independent of where they live) and desired engagement in *Blueprint for Peace* and [414LIFE priority neighborhoods](#). 414LIFE is unique in its design which integrates a [CV model with a HVIP model](#).

RECOMMENDATIONS

After reviewing results, two primary recommendations were developed for strengthening the program, along with suggested action items.

#1 – Enhance outward communication

- [1.1](#) Expand breadth of recipients of 414LIFE reports
- [1.2](#) Close the loop on communications and referrals received
- [1.3](#) Update written hospital component materials to be specific to gunshot wound victims
- [1.4](#) Re-orient key stakeholders about purpose and scope of 414LIFE

#2 – Clarify and further document aspects of program implementation

- [2.1](#) Re-evaluate the location of the priority neighborhoods and the level of emphasis within them
- [2.2](#) Clarify expectations around engagement with participants and discharge criteria
- [2.3](#) Re-evaluate scope of team member roles
- [2.4](#) Develop centralized tracking of community component participants
- [2.5](#) Increased positive/strength focused data entry training
- [2.6](#) Provide trauma-informed care for 414LIFE frontline workers

FUTURE EVALUATIONS

[Future program evaluations](#) are intended to be iterative with reports being provided in phases to foster continuous learning and program improvement. As such, they will reflect the changes and expansion of the program beyond the feasibility phase. An updated evaluation plan for Phase 2 is being developed in response to the results of this initial evaluation.

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INTRODUCTION

The problem

Violence-related injury is the third leading cause of death in the United States for those 15- to 34-years-old¹⁰ and the fourth leading cause of death for those 10- to 14-years-old as of 2020.¹¹ For more than 20 years firearm-related injury has been the second leading cause of death for children and young adults ages 1 to 19, but in 2020 firearm injury surpassed motor vehicle crashes to become the most frequent cause of death for this age group. In Wisconsin, homicide is a leading cause of death for Black residents, with firearm-related homicide being the fourth leading cause of death in the state from 2011-2020.¹² Firearm homicide was also identified as the second leading cause of death in Milwaukee from 2000-2017, with an average age of 28 years at time of death for firearm homicide victims in Milwaukee.¹ The national Violence Policy Center ranked Wisconsin as second in the nation for Black homicide victimization in 2020.²

After a 70% increase in homicides in 2015, the City of Milwaukee expanded its Office of Violence Prevention (OVP) and engaged thousands of residents to develop its first comprehensive violence prevention plan known as the *Blueprint for Peace*.³ The *Blueprint* contains 6 goals and 30 strategies for addressing violence as a public health issue. The 414LIFE program was one of the programs developed as part of the response to firearm violence in Milwaukee. As shown in *Figure 1* after a steady four-year decline in homicides and nonfatal shootings from 2016-2019, Milwaukee experienced record-breaking levels of gun violence in 2020 and 2021. The high level of firearm violence continued in 2022.⁴



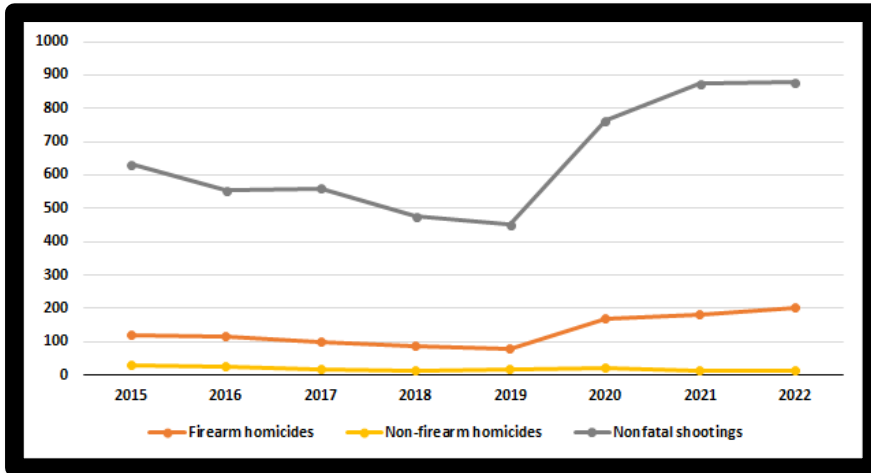


Figure 1. City of Milwaukee, Homicide and Nonfatal Shooting Victims, 2015 – 2022⁴

Unfortunately, Milwaukee has not been alone in this trend. The increased stress from the social, psychological, and economic impact of the COVID-19 pandemic and related community-level challenges have been cited as potential contributing factors to the increase in firearm

violence in areas across the country.¹³ The pandemic and other related factors corresponded to a variety of changes in violence which impacted programmatic activities for many programs, including 414LIFE, as discussed later in this document.

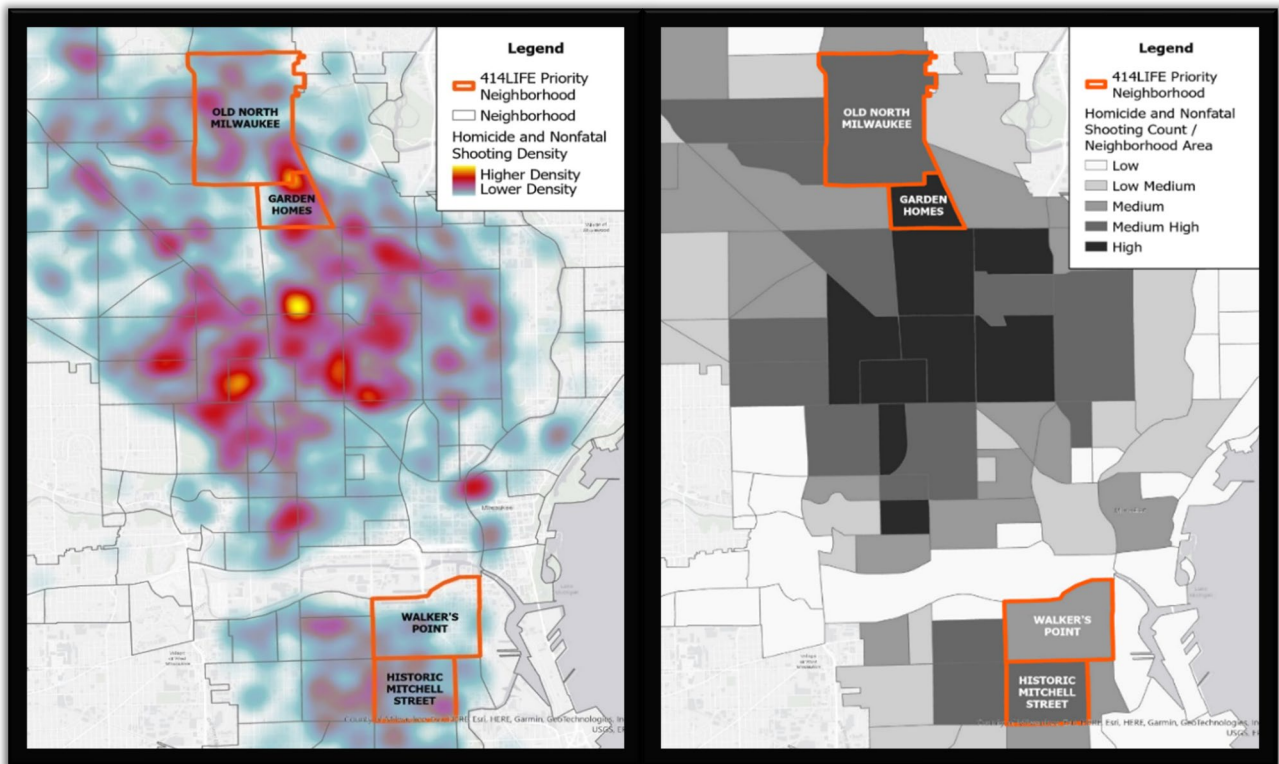


Figure 2. Density Map (Left) and Choropleth Map (Right) of Homicide and Nonfatal Shooting Incidents during the Phase 1 Evaluation Timeframe, October 2018 – December 2022⁴

Evidence-based approach

Goal 1 of the *Blueprint for Peace* called for the use of an evidence-based approach to prevent conflict and retaliatory gun violence in Milwaukee neighborhoods. To support this goal, adaptations of two evidence-based models were chosen to be implemented as the two primary components of what would become the 414LIFE program.

First, after researching several local and national models, the OVP chose to utilize the [Cure Violence](#) (CV)¹⁴ model as the basis for its evidence-based approach. Started by Dr. Gary Slutkin, an epidemiologist and disease control specialist from the University of Illinois Chicago, CV is one of the most replicated and evaluated models for violence interruption used across the world.¹⁵ This specific approach understands violence as a public health issue and addresses gun violence as a preventable disease that is transmitted from person to person.¹⁶ Based on this framework, transmission can be prevented through strategies intended to: detect and interrupt potentially violent situations; identify and change the thinking and behavior of the highest risk transmitters; and change group norms that support and perpetuate the use of violence.¹⁷ To support these goals, the CV model has 5 required operational components:¹⁸

1. Detect potentially violent events and interrupt them to prevent violence through trained credible messengers.
2. Provide ongoing behavior change and support to the highest-risk individuals through trained credible messengers.
3. Change community norms that allow, encourage, and exacerbate violence in chronically violent neighborhoods to healthy norms that reject the use of violence.
4. Continually analyze data to ensure proper implementation and identify changes in violence.
5. Provide training and technical assistance to workers, program managers and implementing agency covering the necessary skills to implement the model correctly.

The implementation of a CV program is intended to be adapted to the local context of violence.

The scale of implementation is most often oriented to local micro hotspots of violence.

Operationally, this typically results in the selection of a limited number of neighborhoods (e.g., 2-7 depending on city size) being chosen as priority areas.⁶⁻⁹ From these priority areas, credible messengers are hired to prevent conflict before escalation to violence, interrupt violent conflicts, and engage in community outreach efforts to support norm change.

The second model selected was the Hospital-Based Violence Intervention Programs ([HVIPs](#)).

These are also evidence-based programs whose primary location of operation is within

hospitals rather than directly within the community.¹⁹⁻²¹ HVIPs are designed to engage with violently injured patients while they are in the hospital to reduce the likelihood of retaliation and recidivism upon hospital discharge. This is because research has shown victims of interpersonal violence are at greater risk of re-injury and/or violence perpetration.²²⁻²⁴ The intention of HVIPs is to have dedicated resources to intervene in the “golden hour” after traumatic injury – a time when individuals may be open to a change they would not normally consider due to having just experienced a potential near-death experience.²⁵ The key components of a HVIP include⁵:

1. Acute brief intervention in the emergency department or bedside during inpatient admission.
2. Case management following injury.
3. Provide follow-up services by culturally competent frontline workers who are from the same or similar communities as from where participants live. Follow-up services expansively cover community-based services, crisis intervention, mentoring, home visits, etc.
4. Address social determinants of health to break the cycle of violence.

Target population for both models are those at highest risk for violence. This generally includes Black and Latino male individuals ages 15 to 35.²⁶ At the community-level, programs are intended to be geographically implemented in areas with high incident rates for the specific type of violence of interest for the local community.

Interrupting violence: 414LIFE

Comprised of both a community and hospital-based component, 414LIFE is built on the CV and HVIP evidence-based models, respectively, to address gun violence to serve those at greatest risk for gun violence (young men from communities bearing the greatest local burden of gun



violence, which are also predominantly Black communities). As shown in *Figure 3*, notable differences between 414LIFE program components are indicated. The overall program, however, operates through a three-prong approach generalized from CV: (1) identification and detection (2) targeted intervention and (3) changing community-wide attitudes, behavior, and norms related to gun violence.

Figure 4 depicts the logic model for the relationship between the collective activities of both community and hospital components of the program and their intended outcomes and impacts at the individual and community level. The 414LIFE program intends to facilitate safe and healthy neighborhoods in Milwaukee through reduction of homicides and nonfatal shootings and denormalization of violence.ⁱ

The initial structure for the 414LIFE program was launched in two phases starting in October 2018. The first phase focused on hiring and training the initial team members to implement the community intervention component of the program which includes both violence interruption and outreach activities. Initially, the geographic focus was in two neighborhoods within Milwaukee, Old North

Figure 3. The Program Structure of 414LIFE by Service Component

ⁱ This Phase 1 evaluation will primarily focus on the program activities and some of the initial program outputs and outcomes due to its focus on feasibility and implementation.

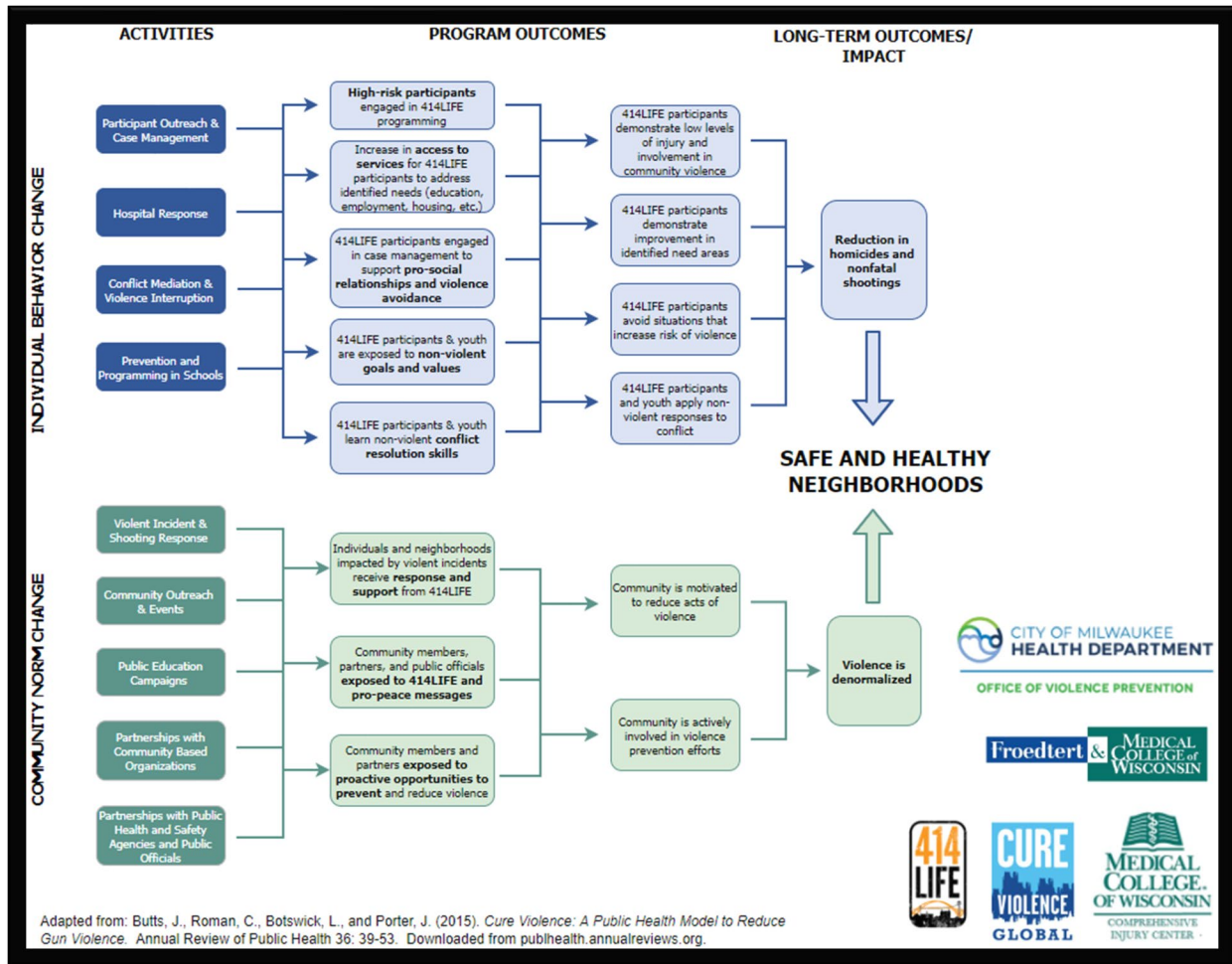


Figure 4. 414LIFE Program Logic Model, adapted from Cure Violence

Milwaukee and Garden Homes, given the high levels of gun violence in those neighborhoods (see [Figure 2](#), [Table 1](#)). Focused programming within these neighborhoods aligns with the overall CV model to have a concentrated geographic focus area for the intervention.²⁷

In alignment with CV, 414LIFE team members are hired as “credible messengers” who have relevant life experiences, rapport, and knowledge to identify and work with the individuals and groups at high risk for gun violence victimization or perpetuation. On the community side, Violence Interrupters (VIs) are trained to identify issues or conflicts that could escalate to gun violence and work with the individuals or groups involved to conduct mediations to establish nonviolent resolutions to conflict using de-escalation techniques. While VIs primarily focus their efforts on monitoring and intervening in conflicts, Outreach Workers (OWs) are intended to proactively engage in direct community outreach, assist with participant recruitment, and provide some direct case management to program participants. OWs establish relationships

with high-risk individuals (i.e., program participants), set specific short-term goals, and facilitate connections to opportunities and resources in the community (e.g., housing, employment, education). They also conduct outreach within the community particularly after a violent incident and they also facilitate community events. OWs help individuals at highest risk of gun violence victimization to think about violence differently and to provide opportunities for positive engagement in the community.



VIs and OWs work together closely to discuss ongoing situations and monitor or facilitate resource connections for participants. Referrals for program participation or for violence interruption or mediations may come from OVP (which regularly receives referrals from other agencies), community members, other partner agencies directly, or from the hospital responders (HRs) from 414LIFE's hospital component. The VI and OW teams, along with a Community Engagement Coordinator, work to advance the broader goal of changing social norms about violence in the community. This is addressed through hosting community events such as pop-ups with food and games for youth, handing out gun locks, or targeted outreach in response to a shooting incident. This also entails specific violence prevention youth-focused programming known as the Restoration of Consciousness (ROC) workshop series within select Milwaukee area high schools with greater volumes of youth impacted by violent incidents across the city.

The second phase of implementation focused on the launch of the hospital response component of the program in May 2019. This phase launched in partnership with Froedtert Hospital (FH), the Medical College of Wisconsin's (MCW's) level 1 trauma center. FH was chosen since it is the only adult Level 1 Trauma Center in the city (and in Southeastern Wisconsin) with approximately 80% of adult gun violence survivors seen at FH through direct transport or outside hospital transfer. While the hospital portion of the program intended to accept referrals from all neighborhoods in Milwaukee, it also accepts referrals (where there is risk for recidivism) from across Southeastern Wisconsin due to the trauma center's catchment area. Gunshot wound (GSW) survivors arriving at FH are referred to a HR through the hospital paging system, which provides a notification to the HR about a referral for a new GSW patient. After receiving a referral, a HR meets with the patient, and often their loved ones (family or friends), while they were still in the hospital. The HR then employs similar mediation techniques as VIs to reduce the risk of retaliation, revictimization, or further violence. The HR also facilitates



connection to resources for any immediate needs of the patient or their loved ones (e.g., crime victim compensation application, emergency housing, mental health concerns). If additional mediation for the violent situation preceding the injury is needed, then the HR provides a warm handoff to the community component of the program for follow-up as needed. Only one Hospital Responder was employed during the initial feasibility phase of the hospital response component.

Key implementation events

There have been several critical events and milestones that are necessary to contextualize the implementation and subsequent evaluation presented of the 414LIFE program ([Figure 5](#)). There have been changes to the overall structure, funding, and location of components of the program since the initial launch in October 2018. The initial structure of the program was modeled after [Safe Streets](#) in Baltimore (a CV adaptation) where the program was funded by the Health Department and implemented through a sub-contract with a partner agency. In Milwaukee, initial contracting was carried out through a competitive Request for Proposals (RFP) and associated selection process convened by OVP. The initial implementation contract for the community component of the program was awarded to [Uniting Garden Homes](#), Inc. (UGHI), a community-based organization in Milwaukee. The community component of the program was launched through UGHI starting in October 2018 where it remained for the first few years of the program. A second competitive RFP process was then carried out by OVP in 2021 in which MCW was selected and awarded the contract. The program transitioned to MCW in July 2021. Currently, the program remains managed and implemented by MCW as the contracted agency, through its Comprehensive Injury Center's (CIC) Division of Community Safety.

In addition to the transition to MCW, there were also leadership changes during the initial years of the program including, but not limited to, changes in the: director of OVP, health commissioner as the head of the Health Department, 414LIFE program director, and executive director of UGHI. All these positions played important roles in setting the direction and providing various levels of support for the program. At multiple points there was also turnover in the team members that corresponded with some of these leadership or organizational changes (see [Figure 5](#)), which as discussed further on in the results, can impact program implementation. Funding was in place by December 2022 to support filling positions in addition to an expansion of the community component team. This will be reported in the next evaluation phase.

The priority neighborhoods also shifted at various points in the program implementation on the community side of the program ([Table 1](#)). Initially, Garden Homes and Old North Milwaukee were the priority neighborhoods at the onset of the program in October 2018. These two remained the primary priority neighborhoods until Historic Mitchell Street was also added as a southside neighborhood in July 2021, in part due to requests to specifically address some of the challenges on the southside of the city. In January 2022, the focus on Garden Homes was reduced, and Walker's Point was added as an additional neighborhood on the southside of the city and then in March 2022 the focus on Historic Mitchell Street was also reduced. After March

2022, the primary priority neighborhoods were Old North Milwaukee and Walker’s Point, which continued to be the focus through the end of this initial evaluation period (December 2022). It should also be noted that the neighborhood focus was not adhered to as directly during the COVID-19 pandemic.

| Table 1. 414LIFE Priority Neighborhoods and Dates of Operation | |
|---|-----------------------------|
| Neighborhood | Dates of Operation |
| Garden Homes | October 2018 – January 2022 |
| Old North Milwaukee | October 2018 – Present |
| Historic Mitchell Street | July 2021 – March 2022 |
| Walker’s Point | January 2022 – Present |

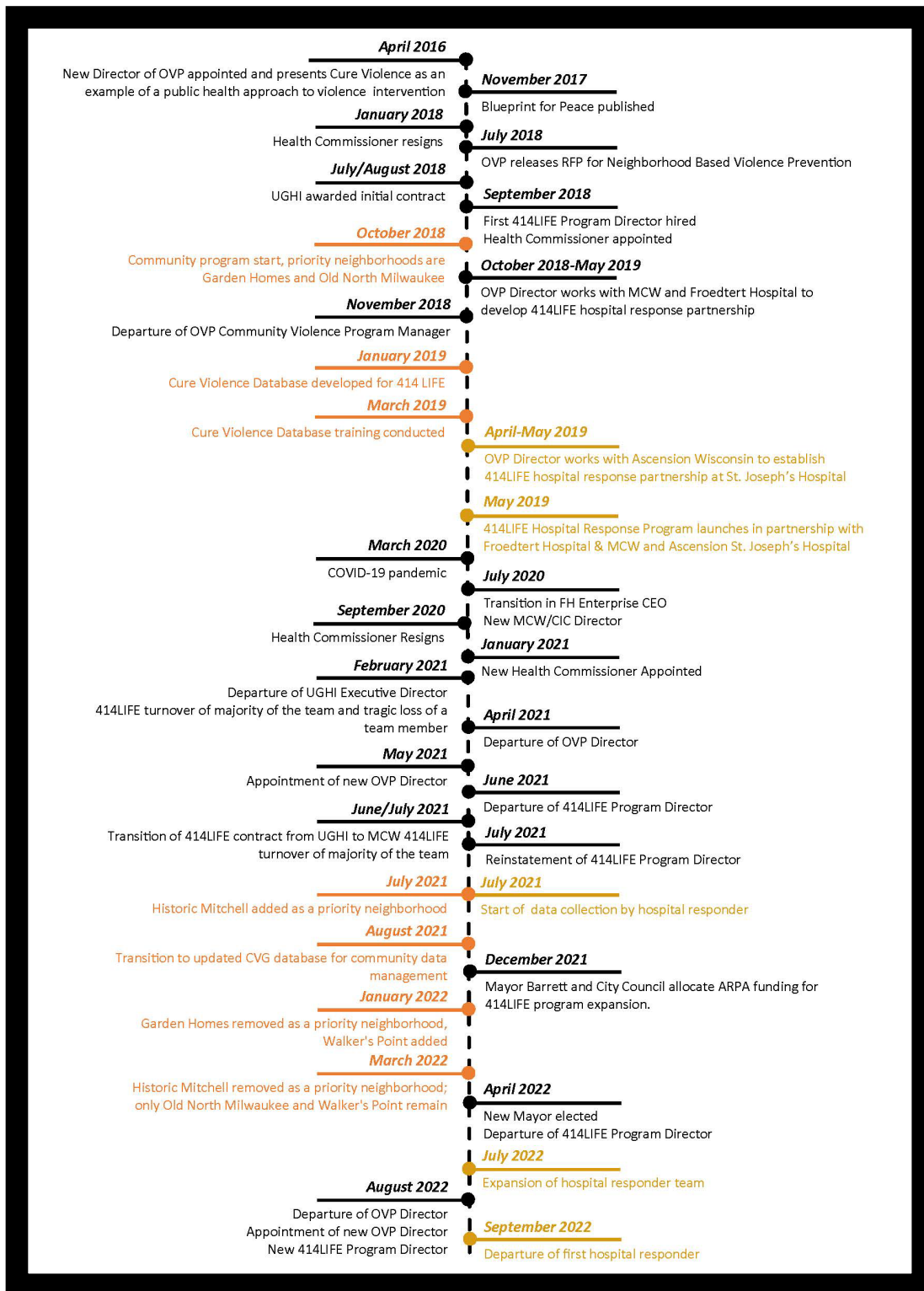


Figure 5. Timeline of Key Events Relevant to the Implementation of 414LIFE

PURPOSE

Aims & objectives of 414LIFE evaluation

The design of the aims and objectives of this evaluation are in line with the more robust reports available in non-peer reviewed, public publications of [CV](#) and [HVIP](#) programs. The aims and objectives of this evaluation are divided by program components – community and hospital – and then by inputs, outputs, and outcomes ([Appendices B & C](#)). To recognize the unique purpose and work of the two components, the measures of interest differ by component, though, are principally focused on program implementation, as well as violence and recidivism risk reduction.

The primary questions addressed in this evaluation phase include:

- *How was the 414LIFE community-based component implemented in Milwaukee?*
- *What was the reach of the community-based component, including by geographic area and target population?*
- *Did program participants avoid situations involving violence after program participation?*
- *How was the 414LIFE hospital-based violence intervention component implemented in Milwaukee?*
- *What was the reach of the hospital-based component, including by geographic area and target population?*
- *Did the hospital-based component reach high-risk individuals as intended and assist in addressing their goals and needs?*
- *Did hospital-based component participants demonstrate significantly lower levels of reinjury and involvement in violence after program participation?*

The current evaluation focuses on the initial implementation of the program model, from October 2018 – December 2022. It is contextualized based on participant demographics and related characteristics of the program participants to assess whether the program is reaching the target population, as well as where the program activities took place across Milwaukee to address the reach of the program both within and outside of the priority areas.

This is the first in a series of evaluation reports that will be produced by the evaluation team on an annual basis through at least 2025. The intent is for these reports to be iterative and provide the opportunity for the implementation of recommendations for program changes or

enhancements. It also allows for additional follow-up on the program over time and assessment of longer-term outcomes ([Figure 4](#)). As such, the evaluation reports will also evolve over time and will reflect the changes and expansion of the program implementation beyond the feasibility phase.

Evaluation team

This evaluation was carried out by the Division of Data Surveillance and Informatics (DDSI) at MCW. Although part of the CIC, this division was responsible for the evaluation as a neutral entity that did not have a direct tie to the implementation, management, oversight, or funding for the program. This positioning of the evaluation team with respect to 414LIFE enabled the evaluation team to have direct access to work with the 414LIFE team members and leadership to establish on-going



communication about program operations and program implementation. It also facilitated access to data and information to understand the limitations of the various data sources utilized in this evaluation. Multiple positions were added to the DDSI to develop a data management and evaluation team, including a program evaluator positioned under the Division's Director and Deputy Director, the latter also occupying a position as the CIC's data science faculty member.

METHODS

Design

This evaluation leverages data triangulation and mixed methods to yield a comprehensive examination of the initial implementation of the 414LIFE program. Numerous databases and datasets were used across multiple agencies and institutions to support this evaluation. In addition, primary data were collected through interviews and focus groups with various external stakeholder groups, 414LIFE team members, and program leadership to provide more context for the implementation and operation of the program, as well as suggestions for program improvement. The timespan of interest for this Phase 1 evaluation covers multiple years – October 2018 through December 2022.ⁱⁱ Complimentary data sources were thus required in some instances to obtain information across this entire timeframe. As the evaluation is intended to be an iterative process that builds on the prior phases, an update will be made to the plans for later phases of the evaluation based on the results of this Phase 1 evaluation.

Program participant inclusion

Program participants from both the community and hospital components were included in this Phase 1 analysis if the date of referral and/or program participation was between program start and December 31, 2022. Longer-term evaluation of specific outcomes for community component participants was not possible in this initial phase due to participants being deidentified in early program years (see [Data limitations](#)). For hospital component participants, indirect follow-up (e.g., re-injury as recorded through hospital records) was able to be conducted as patients had to be identified through hospital records for program referral. Though this evaluation period limits how many participants may have follow-up information available for this initial evaluation, additional follow-up will be reported in the Phase 2 evaluation.



ⁱⁱ The initial evaluation plan was intended to only include data through mid-2021. However, given the change in the timing of the release of the initial report, data are now included through December 2022.

Data sources

Community Component

Inputs. Program design, implementation, engagement, management, barriers, and facilitators were learned in part through focus groups and interviews conducted between March 2023 and July 2023 with internal and external key stakeholders. The focus groups were divided by program role: team members (i.e., VIs, OWs), supervisors, leadership, and external partners. When situations arose that prevented attendance at a focus group, individual interviews with the evaluation team were conducted. Interview guides are provided in [Appendix D](#). Records related to the program implementation were also reviewed as background, particularly on the program resources and inputs.

Outputs. Violence interruption, outreach work, and case management information was extracted from archived records from the program's original data system (CiviCore), which was used from program inception until July 2021. Then, data from the current Cure Violence Global (CVG) database (implemented in August 2021) was used.ⁱⁱⁱ All community component team members were expected to maintain daily data entry in CVG database, where



there are forms to report daily activities, community activities, ongoing or completed mediations, participant case management, and other areas of program operations. The number of community activities and mediations completed in the evaluation period were recorded with an indication if the activity occurred within the priority neighborhoods. Participant risk assessment and demographics (e.g., age, gender, and race) were entered into CVG. No other identifying information was recorded in the database. Team members were also able to enter free responses for success stories for their participants as they arise, and this information provided another source of data for the community portion of the evaluation.

ⁱⁱⁱ Please see the [Data limitations](#) section for a discussion of some data limitations with both data collection systems during early program implementation.

Characteristics of program participants were also taken from data recorded in the two data systems. Participants are considered eligible for participation if they meet 4 of the following 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

School Programming

Inputs. Though the evaluation of school programming was intended to be completed in the Phase 2 evaluation, the team was able to collect data from the end of the 2021-2022 school year and the start and end of the 2022-2023 school year. The early Restoration of Consciousness (ROC) workshop series was conducted in two schools but became an official part of the program's community component after the transition of 414LIFE's contract from UGHI to MCW in 2021. After the transition, the workshops were held in a few high schools in the Milwaukee area with greater volumes of high-risk youth. Students were identified by school administration. For the last 2 school years, referral criteria mirrored that of the community component, with the addition of utilizing high suspension & referral^{iv} rates due to violent



incidents or significant behavior challenges.

Workshops were held once a week during the school year and were led by a VI, OW, or other 414LIFE team member. Curriculum included general check-ins with participants (i.e., asking how they are doing), conversations about life known as Circle Time, didactics on violence as a disease, and gang violence and popular culture, viewing and

^{iv} Referral here refers to forms used by schools due to challenging behavior and may not always lead to a suspension.

discussing *The Interrupters* documentary, and Dead Prez’s *HIP HOP* music video. Records on the school programming were reviewed and some information was also obtained from the focus groups. The coordinator was the same position that also organized the curriculum and managed the ROC workshops.

Outputs. The school evaluation included the administration of a pre- and post-survey to participating students. In the 2021 – 2022 academic year, there was only a post-survey administered as it was the first time the workshop survey was utilized. In the following 2022 – 2023 academic year, a pre- and post-survey was administered. Additionally, no personally identifiable information was collected with the surveys due to privacy, so it was not possible to link pre- and post-surveys. Survey administrators included a team of VIs, OWs, and the community outreach coordinator that were part of leading the ROC sessions. Survey responses were recorded on paper and then entered in a REDCap database hosted by MCW.

The survey included basic demographic characteristics such as school name, age, and grade level. This was followed by 8 questions pertaining to pre-post knowledge of violence and responses to violence. This matrix of 8 questions allowed participants to answer on a 5-point Likert scale to indicate level of agreement (*Strongly Disagree, Disagree, Not Sure, Agree, and Strongly Agree*). A question regarding preparedness and likelihood to be involved in violence followed the matrix of questions.

Refer to [Appendix D](#) for a copy of the pre-survey and post-survey.

Outcomes. Outcomes were sourced from the school ROC workshop post-surveys. Participant likelihood to engage in violence and workshop satisfaction were scored on a Likert scale. Likelihood to engage in violence was asked as whether students 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 satisfaction scale (*Very Satisfied, Satisfied, Neither Satisfied nor Dissatisfied, Dissatisfied, and Very Dissatisfied*). Free response questions focused on what aspect(s) of the workshop had the greatest impact, anything students may do different because of the workshop, and any suggestions for improvements to the workshop.

Hospital Component

Inputs. Program design, implementation, engagement, management, barriers, and facilitators were learned through focus groups and individual interviews with key program stakeholders conducted between March 2023 and July 2023. These focus groups were divided by program role – HRs, leadership, and external partners. A HR supervisor was not interviewed due to the role’s vacancy at the time of interviewing. When situations arose that prevented attendance at a focus group, individual interviews were conducted. Interview guides are provided in [Appendix D](#).

Outputs. Patient referral information was obtained from the page sent by hospital providers to the 414LIFE HR. Patients are eligible for program referral if they meet the following criteria:

- 1) Gunshot wound injury
- 2) Age 15-35 years
- 3) Injured in or resident of the City of Milwaukee

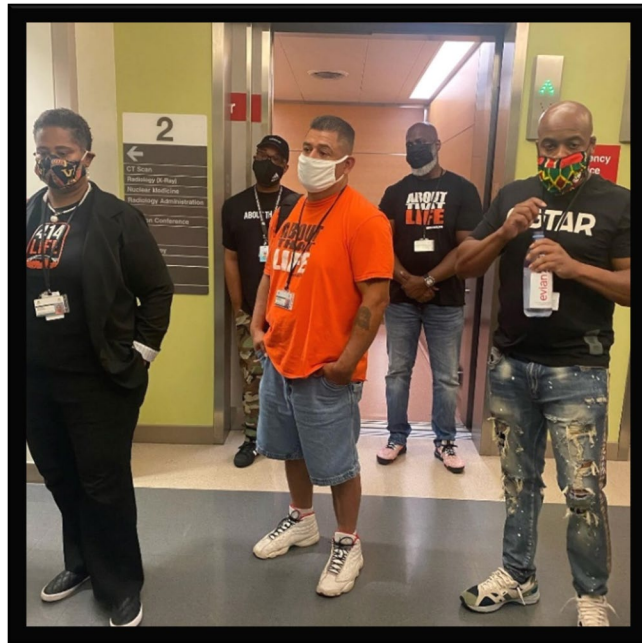
On occasion, exceptions to the criteria were made due to risk of violent retaliation. Referral pages included referring provider name, identification of the patient, and any other pertinent information needed to assess the level of retaliation risk of the patient and/or circumstances of the patient’s injury. This information was abstracted and then stored in an institutionally secured database managed by the evaluation team. Detailed collection of specific patient needs and resource provision began in July 2021 in a REDCap data collection system managed by the evaluation team, but fuller implementation of this data collection system did not begin until the hospital component expansion in July 2022. Therefore, limited data was available on the specifics of the interactions with patients (see [Data limitations](#) below). More detail on the specifics of the hospital intervention and associated dosage are planned for Phase 2 of this evaluation.

Hospitalization and medical care information was extracted from the electronic medical record pertaining to the hospital admission and related follow-up care for the injury that connected the individual to the hospital component (i.e., “index” hospital admission). This information was supplemented with data requested from the level 1 Trauma Center’s Trauma Registry. A Trauma Registry is a database of trauma patient demographics, injuries, medical care, and outcomes intended to improve care for trauma patients and prevention of injury. 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.²⁸

The HR role was also incorporated into the clinical treating team in the Trauma Quality of Life (TQoL) Clinic. This clinic was formally established in November 2020 to provide comprehensive (i.e., medical and psychosocial) follow-up care for gunshot wound survivors following inpatient treatment by the Trauma Surgery Service at FH.²⁹ Gunshot wound patients are referred to TQoL Clinic approximately one week after hospital discharge even if they were already engaged with a HR. This was a standard of care appointment to ensure adequate healing and recovery after discharge. During their visit at the TQoL Clinic, a patient would see a trauma medical provider, psychologist, physical therapist, social worker, and the 414LIFE HR.

Due to this design, the clinic also provided a second opportunity for patients to be referred to 414LIFE. In some cases, a patient may not have connected with the HR while in the hospital due to short length of stay, intensive medical care, or other extenuating circumstances. The TQoL Clinic did not replace the violence interruption focus of the HR role. Rather, the clinic provided the opportunity for the HR role to be embedded within the outpatient care team, not only the inpatient care team during hospitalization. It was important to include reference to the TQoL Clinic in this evaluation as patients may have had exposure to both programs.



Outcomes. Clinical data for both groups were extracted using the electronic medical record, the Trauma Registry, and a clinical data repository known locally as the [Clinical Research Data Warehouse](#). The latter data source aggregates clinical encounters from across the entire enterprise of Froedtert Health. Historic match comparison injury patients were statistically compared to 414LIFE participants to investigate re-injury by gunshot wound and/or re-injury by other violent mechanisms (i.e., stab, blunt assault) and initial measures of criminal justice

system involvement following program participation. 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) 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.^v The datapoints were accessible through a data repository known as DataShare, which is hosted and managed by MCW, with permission from the contributing agencies,^{vi} as well as through the WCCA.^{vii} It is important to note that the outcomes could only be reported for those where a record could be identified and matched to the various criminal justice data sources.

Data limitations

There are several limitations to be noted pertaining to the data sources utilized for this evaluation. As already described, there were differences in the database systems used for community component-related data collection and management. The CiviCore and CVG 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). Within the results section below, it will be noted where data points were available in both systems, and when data points were only collected and reported from one system. In addition, for the community reporting 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 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 program period included in this evaluation. The evaluation relied on the information entered in the database and is therefore

^v Additional data sources and contact points are being explored for inclusion in future evaluation phases related to criminal justice outcomes.

^{vi} The data were obtained from DataShare, 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. DataShare was established as a collaboration across multiple partner agencies to enhance the use of data to inform decisions to improve the health and safety of individuals and the community. The findings represent the views of the author/s and may not necessarily represent the views of DataShare and its members.

^{vii} The Wisconsin Circuit Court Access (WCCA) data can be publicly accessed at <https://wcca.wicourts.gov/>

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.

An additional limitation on the community component data was for the school ROC workshops. Surveys to assess pre- and post- program impact were only available for the 2022 – 2023 school year. Only post-intervention surveys were administered and collected for ROC workshops in the 2021 – 2022 school year. Therefore, while the 2022 – 2023 school year permits a pre- and post-comparison to be described, surveys were anonymized and thus exclude the opportunity for individual-level change to be identified. Also, the pre-survey was excluded given that the sample size was too small to meaningfully represent a pre-workshop baseline.

Also, initial data collected for the community-based component has not been collected in a way to support follow-up with participants to determine longer term impact of program participation, including belief and behavior change. The data collection was de-identified for reasons related to confidentiality and privacy protection for both participants and team members. This is 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.

On the hospital side of the program, as mentioned above, the REDCap database created in July 2021 intended for the entry and management of hospital case data 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. The database was intended to capture issues and needs identified by the HR in working with their referred patients. It also contained space to document what the HRs did in response to the identified needs and what resources were provided, as well as additional information such as the amount of time spent with and level of engagement from participants and their families. Again, due to limited use for the full evaluation period of this report, what is included in this report reflects only what was documented through December 2022 and does not reflect all hospital patients referred to or engaged with 414LIFE. This is an on-going area of emphasis in the recommendations for program tracking and additional documentation to enhance data collection for future evaluation phases.

Analytic approach

This evaluation utilized an analytic approach commonly conducted for randomized controlled trials (RCTs) of interventions that can also be utilized in non-randomized comparison group

comparison studies. Known as the intent-to-treat (ITT) analysis³⁰, the underlying assumption is that all participants are treated according to their original group assignment - individuals in the treatment group would have received the intervention and individuals in a control group did not receive the intervention. This would mean that whichever condition a participant was offered, either intervention or no intervention, that they would be analyzed as such. This group assignment holds even in cases where an intervention participant did not actually receive the intervention. Conversely, if a participant did not receive the full intervention, such as in situations where they started but did not complete the program, they would still be analyzed as receiving the intervention.

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 as would be the case in an experimental study design, such as an RCT (often considered a “gold standard” for research). This was an ethical decision, as it was determined that the intent was to provide this resource whenever possible to all potentially eligible participants (e.g., all GSW patients coming into FH) rather than withholding the intervention from half of potential participants to develop a control group when no active control intervention existed to support survivors. This aligned with prior publications of evaluations of gun violence prevention and intervention programming.^{20,31-33}

Although 414LIFE was not implemented as an RCT, ITT for the current evaluation was chosen due to this approach’s underlying assumption of participation. This was vital because it offers a conservative approach that underestimates program effect so that the effects that are observed were unbiased.^{34,35} 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.

All individuals referred to 414LIFE, regardless of actual participation, were thus treated as if they received the full intervention of the program. For example, if an individual is referred to 414LIFE and for any reason does not get connected with services or they drop out of participation, they would still be considered as if they received the program engagement.

An example of participant drop-out is best highlighted from the program’s hospital component. 414LIFE’s hospital component was hospital-wide and intended for GSW 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 to the program, regardless of the actual level of engagement with the program. Future evaluation phases will 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. This was not possible in the first phase of the evaluation due in part to data limitations in the early phases of the program (see [Data limitations](#)).

Analytic plan

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, focus on group comparison, and evaluate all participants within the first few years of the program. The historic comparison sample was limited to the number of participants from the first few years of the program due to 1:1 matching, which thus determined the number of matched patients required.

Descriptive analyses of hospital and community components

Descriptive analyses included a review of all data sources for both the community and hospital components to quantify frequencies and averages of characteristics of interest for program activities and participants and to address program reach.

School ROC workshop data

Basic descriptive characteristics of program participants were summarized in counts, percentages, and means. This was tabulated from all survey respondents (pre- and post-surveys). Only post-surveys from each school year were aggregated together to comment on responses to questions pertaining to understanding violence as a disease and ability to choose non-violent options to conflict. These responses were similarly analyzed descriptively.

Clinical data

Descriptive characteristics. Clinical characteristics among hospital component participants (Trauma Quality of Life Clinic attendance, location of injury) were descriptively analyzed alongside program screening, participation rates (in comparison to annual gunshot wound rates), and participant demographic and injury characteristics such as gender, age,

race/ethnicity, city of residency, and 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.

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 6). This meant that the efficacy of the HR “treatment” 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.

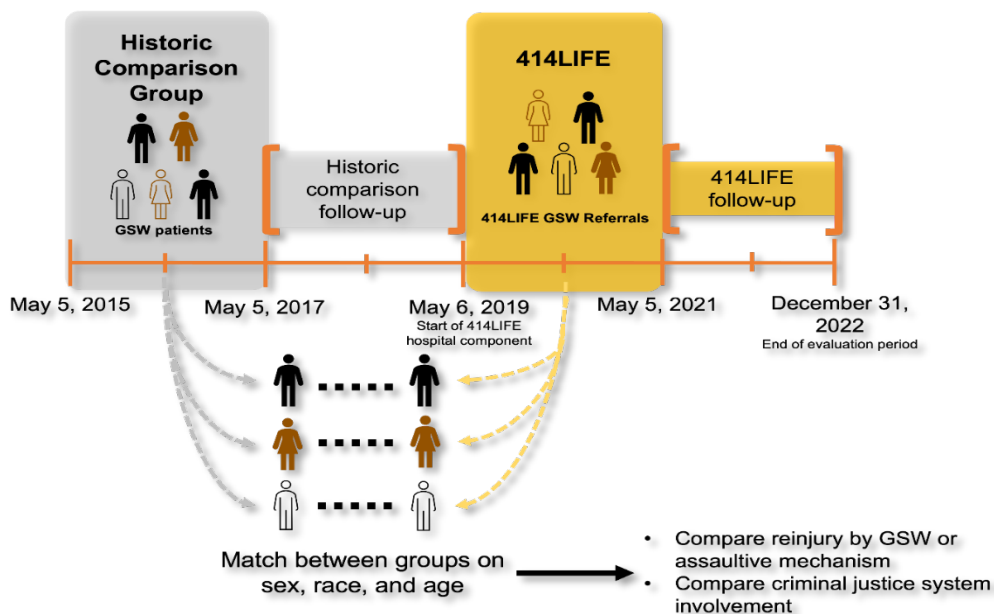


Figure 6. Historic control match design between 414LIFE referred patients and their matched comparison from before 414LIFE started.

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 wound), sex, and race, while propensity score matching^{viii} was used to match age. 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.^{ix} 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 6). The timeframe of interest for 414LIFE referrals for index offenses was designated as May 6, 2019 – May 5, 2021 to allow for a two-year follow-up period for most participants (through December 31, 2022, end of the evaluation period) and to provide comparable timeframe length and seasonality of index gunshot wound injuries with the historic comparison group (Figure 6).

Reinvolvement in violence data

Re-involvement in violent behavior following participation in the hospital component of 414LIFE was similarly described with frequencies of re-involvement from multiple sources. Criminal justice and hospital database sources were leveraged to provide an assessment of violent re-injury, involvement in violence as a victim or individual involved in carrying out a homicide or nonfatal shooting, as well as new contacts with the criminal justice system following their index injury. These analyses utilized the same matched pairs as described in the previous section. Both groups were followed for a two-year period after the date of the index injury based on the date of a new offense being at least a day after the recorded date of injury. Historic match comparison injury patients were statistically compared to 414LIFE participants through Chi-square tests.

^{viii} Propensity scoring is a statistical method used to achieve as balanced of groups as possible where exact matches may not be feasible. For example, since age is more variable than sex or race it may not be possible to match patients exactly on age between groups, so propensity scoring achieves as close of a match as possible.

^{ix} For each of these groups, participants were followed for consistent time periods to determine whether or not there was a re-injury during the follow-up period following the event that resulted in referral to the program (the index event). For example, the three-month group only included those that had three full months after the index event and the re-injury was only counted if it occurred during that 3-month follow-up period.

Geospatial

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

Once geocoded, 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.

Qualitative

Focus Groups & Interviews. Semi-structured guides ([Appendix D](#)) were developed to enhance consistency between the focus groups and individual interviews in questions asked and order of question presentation. Questions were generated from priority areas in the evaluation matrices ([Appendices B & C](#)) where quantitative data was insufficient. Interview guides were created based on interviewees' roles in relationship to 414LIFE, yielding separate interview guides for 414LIFE HRs, VIs, OWs, supervisors, leadership, and external partners. Separate interview guides allowed questions to be targeted based on one's exposure to 414LIFE's work and thus ability to comment on different aspects of the program's functioning.

Focus groups were audio-recorded and transcribed in real-time using an institutional license of Microsoft Teams (version 1.6.00.4472, 64-bit). The transcription was reviewed following the completion of the focus group for accuracy against the audio recording. MaxQDA 2022 (Release 22.7.0) was utilized for coding and thematic analysis of the focus group transcripts. A separate codebook and thematic analysis were conducted for internal stakeholders (414LIFE team members, supervisors, and leadership) and external stakeholders (community organizations, elected officials, police department, etc.). The decision for two analyses was

driven by the differential exposure internal versus external stakeholders would have to the program. The result of each thematic analysis is a set of recommendations for strengthening the program, contextualizing quantitative answers, and for answering standalone items, 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 B & C](#)) 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 the how the transcripts were coded.

The codes were then used in a loose thematic content analysis.³⁶ Rather than extracting themes, recommendations were the main outcome. The themes were operationally a foundational source of the [Recommendations](#) proposed at the end of this report. Themes were also used as answers or additional context to support quantitative responses presented in the *Results* section. Recommendations and use of codes paired quantitative answers were revised based on internal feedback prior to finalization. Finally, emblematic quotes were selected and are highlighted throughout.

Not all stakeholders were able to be interviewed. Interview requests of external stakeholders and responses to those requests are outlined in [Appendix F](#).

Success Stories. Free response entries in the CVG database of participant success stories were reported as anonymized direct quotes. To complement these brief stories, additional longer length stories provided by 414LIFE team members were captured through the same recording process used for the focus groups and interviews as described above. After recording, stories were automatically transcribed by Teams and then reviewed by an evaluation team member for accuracy against the recorded audio.

RESULTS

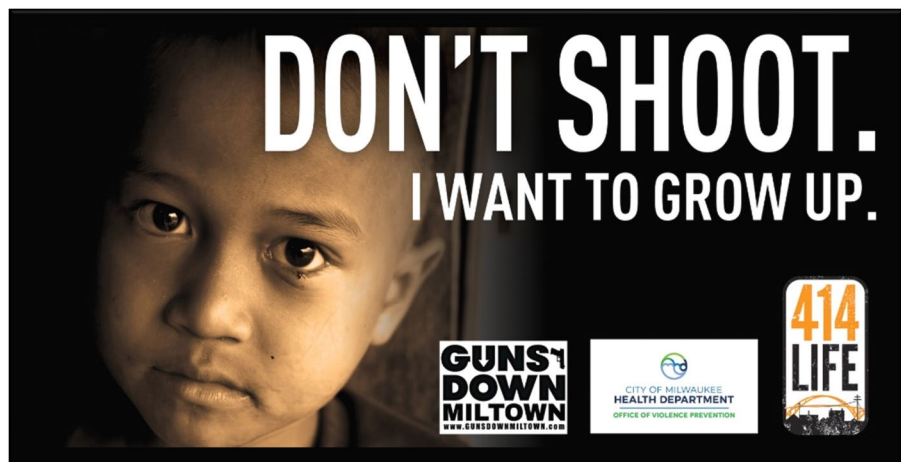
Program-wide Inputs

Funding

The program was funded from multiple sources during the initial implementation period for both the community and hospital-based programs. The funding was primarily utilized to support the staffing for the program, as well as related costs for training, travel, equipment, etc. The primary funding sources included, in alphabetical order: Advancing a Healthier Wisconsin Endowment, Annie E. Casey Foundation through the Greater Milwaukee Foundation, Everytown for Gun Safety, Froedtert Hospital, Kellner Family Fund, Office of Violence Prevention within the City of Milwaukee's Health Department including American Rescue Plan Act funding, Milwaukee Bucks Foundation, Milwaukee County Department of Health and Human Services - Milwaukee County Credible Messengers, Milwaukee Healthcare Partnership through the United Way of Greater Milwaukee, and Uniting Garden Homes, Inc. Given that complete program budget information was not made available for the entire evaluation period, specifics on the program funding levels are not presented in this report. The funding levels from 2022 forward should be available for inclusion in future evaluation reports.

Marketing

A significant component of the program implementation was the development of various marketing tools to spread the word about the program and resources across Milwaukee. This included the development of a logo, printed and electronic materials, as well as billboards placed across the city. The image here is an example of one of the billboard formats. The billboards were placed in multiple locations near the start of the program (2018-2019) with a particular emphasis on areas with higher levels of violence and were managed through Clear Channel (billboard



company) and Schober Outdoor Advertising. Specific records from the program’s marketing campaign were not available to report the details of the cost, locations, or projected viewership for the billboards or other marketing materials.

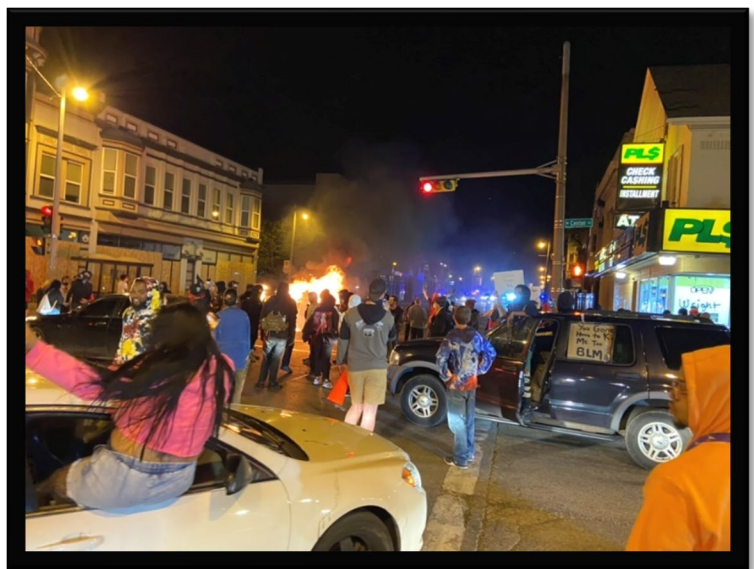
Structure

Administrative program personnel included a program director, a program coordinator, and an outreach coordinator at UGH, and then a program director, a program operations manager (initially a communications coordinator), and a program administrator under the overall leadership of the Division of Community Safety within MCW’s CIC. These positions oversaw the day-to-day operations of 414LIFE and all its components and services, including providing leadership to supervisors and team members for both the hospital and community components.

Key Events in 2020

In response to the onset of the COVID-19 pandemic in Wisconsin, 414LIFE was directed to adhere to the statewide “Safer at Home” order starting in March 2020. For their health and safety, 414LIFE team members were restricted from engaging in any outdoor activities including outreach, conflict mediations, community events, or shooting responses. The 414LIFE HR was also restricted from responding in-person to gunshot wound patients at Froedtert Hospital, thus requiring creative work to connect remotely. The team was encouraged to continue to maintain contact with their participants via phone, focus on data entry, and address any concerns regarding ongoing conflicts or mediations through remote options.

Unfortunately, like other cities across the country, Milwaukee did not see a decline in the pace of gun violence in the months following stay at home orders. On April 27, 2020, the team was requested to respond to a mass shooting on the corner of 10th St and Locust St. Five victims of the same family were shot and killed by an adult family member suffering from severe mental health challenges. Given the volume of family members, neighbors,



and other concerned residents, the OVP requested an all-hands-on-deck response from 414LIFE, the Salvation Army Chaplaincy Program, and the Milwaukee County Trauma Response Team. This was the first major shooting incident that the team responded to in-person to provide emotional support and distribute personal protective equipment (PPE), including masks and gloves. It was still unclear the method and scale of COVID-19 transmission, but PPE and social distancing were strongly encouraged for gatherings of people.

Further, when the City of Milwaukee proceeded with the Spring 2020 Presidential Primary Election, 414LIFE aided the City of Milwaukee's Health Department to ensure that the Election could be carried out safely. The team partnered with Mask Up MKE and the Kern Institute at MCW to distribute thousands of masks to residents throughout the community. These masks were distributed during and after the elections upon request from individuals, families, or community agencies. The team also participated in the creation of a PSA encouraging the use of masks.

Subsequently, the summer of 2020 saw the launch of the national protest movement. 414LIFE was engaged in crowd control and distributing PPE to protestors throughout the rest of the year. During this time, 414LIFE team members saved several buildings from damage and fires along Martin Luther King Drive, including that of the Milwaukee Health Services, Inc. These activities were being conducted as the team also continued to respond to a record-breaking number of shootings and homicides in 2020 and to provide virtual support to shooting victims at the nearby



regional Level 1 Trauma Center.

Data entry during this time was not consistent both due to these aforementioned shifts in work, as well as the transition of Cure Violence Global to a new database system.

Perceived barriers and facilitators

Program implementation barriers and facilitators were discussed during internal and

external stakeholder interviews. One internal factor was reported as unclear internal communications between leadership and frontline workers, as well as a reported lack of communication. This factor was reported as being present before and after the contract transition from UGHI to MCW. At times, this was experienced as contradictory information being received after work was already planned or accomplished, and other times as a perceived lack of follow-through on receiving requested job trainings.

Another often cited barrier to implementation from external stakeholders was the lack of return communications on referrals received by 414LIFE. External stakeholders felt beholden to follow through with individuals even after referral to 414LIFE due to concerns that the referral was possibly not received, or that extenuating circumstances prevented connection with 414LIFE. Related to this barrier were parallel concerns about transparency of program metrics. Several stakeholders from various agencies reported not having access to or receiving copies of 414LIFE routine reports. There was a desire to regularly know more about the program to support knowledgeable collaboration between organizations.

Related to this goal, internal interviews with team members revealed a strong desire for a centralized storage place of community resources that could then be provided to participants. While it was acknowledged that there is desire for 414LIFE team members to come into the program with their own local networks and knowledge of community resources, a competing desire for more equitable and time-sensitive access to resources was reported by team members. With regards to equity, it was described that some team members may not have as many resources in their networks at time of hire as other team members. This results in more resource-rich team members working to provide resources and referrals for other team members' participants. With regards to the time-sensitivity, team members proposed the solution of creating a more accessible centralized storage place of resources, if not actual person-time help, to quickly identify resources when time sensitive situations occur. The current Microsoft Teams file was reported as not readily accessible in the field.

There were also many facilitators to implementation reported. Some 414LIFE team members report coming into this work as a matter of a calling of higher purpose. This was reported as being driven by a desire to give back to a community within which they recognize they once may have led a life similar to their participants. Team members regularly mentioned in their interviews that "...we care about saving the lives, so let's get out there and do it. And everybody have the same mission." External partners also echo a strong support for the higher purpose of

414LIFE, and the absolute necessity for the continued support and protection of team members with lived experience. One external partner captured this sentiment when they described hiring team members with lived experience in the community as “That’s a big deal. That’s lightning in a bottle. Don’t screw that up. Bureaucracy in any institution needs to understand the value of that.”

Relatedly, there is hope that an organization like MCW taking the contract for 414LIFE will add further credibility to violence prevention work as a career, help people to see it as a serious issue, and assist in developing respect for the professionalism of the work. Although there had been past violence prevention programming supported by MCW that did not persist, there is renewed hope that this work will continue due to the current movement and leadership’s support of 414LIFE. Internal and external stakeholders alike report the almost serendipitous nature of support aligning to make 414LIFE’s implementation possible not only in the community but also at FH. It was described as the right people coming together at the right time with the right support. The individual-level and organizational-level collaborations that have been created and enhanced due to 414LIFE appear to be the “secret sauce” of 414LIFE’s implementation.

“...what do you think the secret sauce is? ... it's the people. Which it shouldn't depend on people, but I think certain people are really, really gravitate to this kind of work and we have been able to capture those people.”

- *Anonymous External Partner*

Hiring team members with lived experience in the community is “a big deal. That’s lightning in a bottle. Don’t screw that up.”

- *Anonymous External Partner*

Community Component

Inputs

Structure. Overall, the 414LIFE team was relatively small during this Phase 1 initial evaluation (Table 2). The community component initially included 11 total positions including five full-time and one part-time OWs and VIs, as well as a community response and engagement worker, along with two supervisors, an outreach coordinator, and a program director. When the program transitioned to MCW in July 2021, this increased by two positions to 13 total, all of which were full-time. At the end of the Phase 1 Evaluation period, the number of positions was the same, but the structure of the positions had changed slightly with one position becoming the program operations manager (see [Program-wide inputs, Structure](#)). The team was anticipated to grow to approximately 25 positions in a planned program expansion, however this expansion was not in place by the end of this evaluation period (December 2022). The expansion was made possible with the procurement of additional funding sources, including but not limited to, the American Rescue Plan Act (ARPA) funding through OVP. However, because there existed open positions

Table 2. 414LIFE Community Component Positions at Program Start, Transition to MCW, and End of Phase 1 Evaluation

| Position Title | Program Start (October 2018) | UGH to MCW (July 2021) | End of Phase 1 Evaluation (December 2022) |
|---|---------------------------------|---------------------------|--|
| OW (FT) | 2 | 4 | 4 |
| OW (PT) | 1 | 0 | 0 |
| VI (FT) | 3 | 3 | 3 |
| Outreach coordinator | 1 | 1 | 0 |
| OW/VI supervisors | 2 | 2 | 2 |
| Community program coordinator | 0 | 1 | 1 |
| Community response and engagement worker (PT) | 1 | 0 | 0 |
| Program Administrator | 0 | 1 | 1 |
| Program Operations Manager | 0 | 0 | 1 |
| Program Director | 1 | 1 | 1 |
| Total Positions | 11 | 13 | 13 |
| <i>Note.</i> OW = Outreach Worker, VI = Violence Interrupter, PT = Part Time, FT = Full Time. | | | |

that were not currently filled in 2022, this expansion is anticipated to occur next evaluation period (i.e., Phase 2). Even when this expansion occurs, the community-based team would still be relatively small given the breadth of responsibilities, geographic placement of activities, and priority areas, as discussed further in later sections below.

Training. Training for VIs and OWs was multifaceted. There was CV management training for supervisors and standard onboarding modules about the CV model for all team members. The CV training focused on how to interrupt violence. This was broken down into didactics on how to identify a potential conflict, information gathering, strategies to employ during the interruption and follow-up, leveraging social media, inroad, and mediation mapping, and discussing case studies. Team members and supervisors also completed 40 hours of Violent Incident Response Training, which emphasized violence interruption and mediation strategies.

Other training programming included the Academy for Transformation Change and Professional Community Intervention Training Institute. The former focused on working with community and addressing change through social capital and building community connections. The latter focused on community violence interruption for frontline workers, in which they learned how to move, assess, and engage in a group incident, such as a mediation or interruption.

Training on data entry varied and was more difficult to assess when the program was first initiated. When the transition to MCW occurred in July 2021, training for some team members involved an overview of the database and data entry expectations for the new CVG database launched in August 2021.

However, due to contractual delays between CVG and the City of Milwaukee, there was not always access for team members to enter data directly, and in some cases, accounts could not be created for new team member hires. This resulted in some team members being trained to enter data in Microsoft Word documents designed to mimic the CVG daily log as a temporary fix. This challenge persisted until mid-2023 and



impacted training and utilization of the CVG database for data entry and tracking as discussed further in the [Strengths and limitations](#) section.

The frequency of trainings also varied. This was due to several factors, such as timing of hires, timing of the active contract with CVG, and funding. This led to differential exposure to the various trainings outlined above. The proposed metric for the onboarding of new team members was to complete training within 2 months of hire. Unfortunately, documentation was not available with which to report how soon team members completed training during the initial program implementation, thus there was limited information to report in this phase of the evaluation. An onboarding checklist was created in October 2022 that included the documentation of dates related to completion of training, which led the evaluation team to anticipate this information's availability for future evaluation phases. Team members' perceptions of the trainings were sourced from the focus groups.

When team members were asked if new hires received the same extent of training as detailed above, an emblematic quote of the received training was:

"Because the new people don't even really get the training off the top like that. They have to wait some months before they get the training -- so they just -- when they just brought this new group in they brought [omitted name] and [omitted name] in. They only did one day of the two-three-day training and then I think [omitted name] had an emergency and no, [omitted name] had an emergency and they both couldn't make it, so they never came back to finish that initial training. But they did bring them in right after they were hired to get that training."

In parallel, on-the-job training and shadowing was occurring. For example, in one team member's "first week in, there was a big shooting that happened. I mean, just walked on the block, just parked the cars, jumped out. It was maybe 50 feet away from the cars. I don't think the job can really prepare you."

A common highlight of the trainings were the tactical strategies taught to the team:

"...videos, some trainings that the, the newer members haven't had it yet, but we've [more senior members] had it. I think the, that was very helpful because they told us where we had to go. Yes, where we had to go. The placement, the placement that we had to be in, in case it was a shootout because there was stuff that I didn't even know. You think, well, you hide behind a car. What part of the car you can hide behind? I always said the back of the car. It's not the back of the car - it's the front of the car."

Overall, there were trainings outlined for the community component team members which aligned with the [CVG's 5 main components](#), but opportunities were identified for improvement in the implementation and tracking of the training.

Outputs

The overall activities and outputs for the community component were drawn primarily from the two database systems utilized by the team. Due to the substantial change in data tracking from the CiviCore to CVG in August 2021, outputs are presented in aggregate and according to the data system used for tracking ([Table 3](#)). In total, the team recorded engaging in 257 conflict mediations between program inception (October 2018) and December 31, 2022. Of these, 213 (82%) had documented locations and were able to be mapped; 26 (25%) were conducted within the 414LIFE priority neighborhoods and 95 (44%) were held in Blueprint for Peace priority neighborhoods. Mediations were counted as conducted in priority neighborhoods according to the four 414LIFE priority neighborhoods (dates of operation in [Table 1](#)). Locations of mediations occurred primarily in the Old North Milwaukee (7%), Franklin Heights (7%), Garden Homes (6%), Historic Mitchell (6%), and Harambee (3%) neighborhoods ([Figure 7](#)).

Community events were categorized in different ways across data systems. Counts of events by event type are included in [Table 3](#). In total, there were 110 community events recorded from program start through December 31, 2022. Of these, 101 (91%) had documented locations and were able to be mapped; 26 (25%) were held within the 414LIFE priority neighborhoods and 47 (46%) were held in Blueprint for

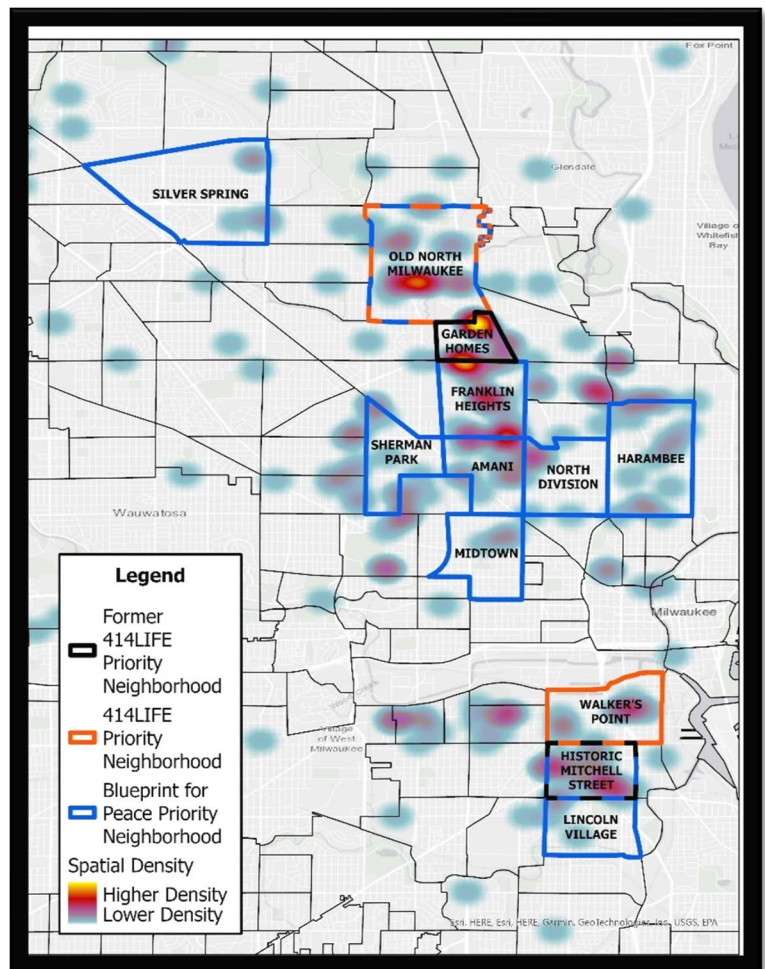


Figure 7. Spatial Density of 414LIFE Community Mediations, October 2018 – December 2022

Peace priority neighborhoods. Community activities were counted as held in 414LIFE priority neighborhoods according to the dates of emphasis on these areas (see [Table 1](#)). Locations of community events occurred primarily in the Garden Homes (15%), Old North Milwaukee (8%), Harambee (7%), and Sherman Park (7%) neighborhoods (*Figure 8*).

Over the course of the initial period of the community component of the program through December 2022, records were entered on 133 individuals who were indicated to have met 4 out of 6 program eligibility criteria including:

- 1) being age 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^x

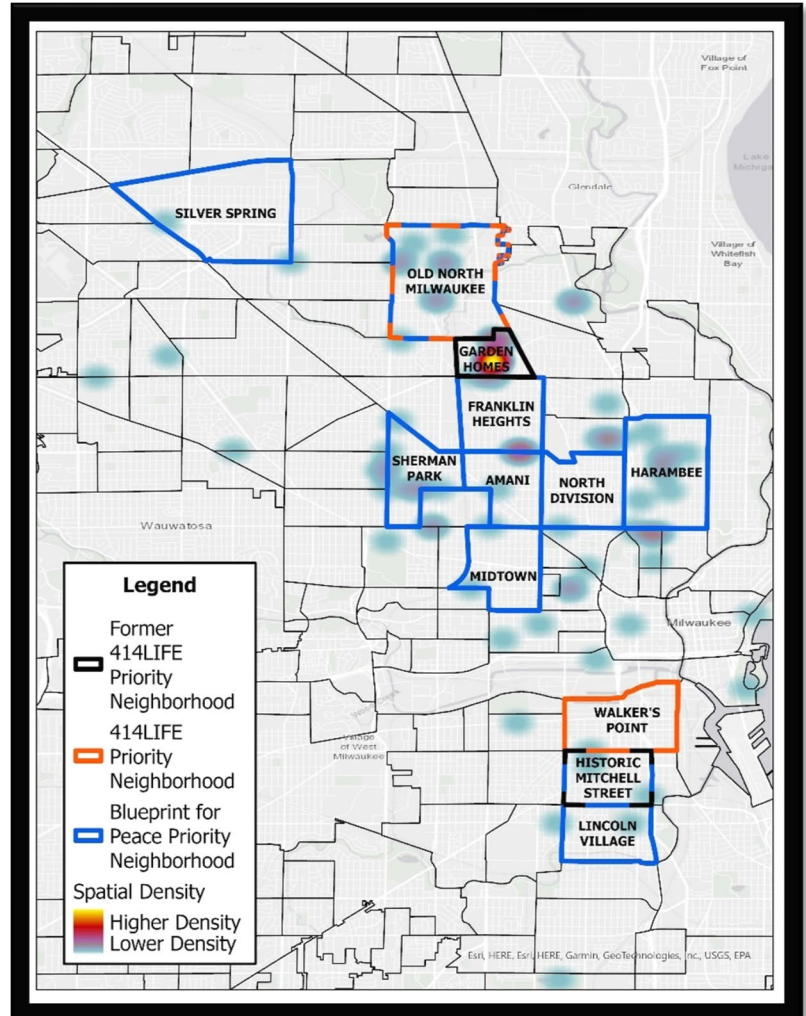


Figure 8. Spatial Density of 414LIFE Community Activities, October 2018 – December 2022

There were 5 potential participants deemed ineligible after screening.

The 133 individuals were tracked as participants in the case management system ([Table 3](#)). Participants were predominantly young adults (average age = 26.3), Black or African American (87%), and male (95%). The majority (80%) of participants fell within the target age range of 15-35. Risk assessments for participants were recorded only in the CVG database. Risk level from

^xDetermination of whether a participant meets the eligibility criteria is determined by team members and is intended to be verified by a supervisor as part of the intake process. The specifics of the criteria have evolved during this implementation phase of the program.

the CiviCore database was not well documented or reported and therefore not included in this evaluation. Risk level was entered for 57 of the 88 CVG participants (64.7%). Of these 58 participants, 34 were considered high risk (59.6%) and 18 medium risk (31.6%).

Risk in the CVG database was determined by evaluating the likelihood (1- very unlikely to 5- very likely) in the last 30 days of the following 9 circumstances:

- 1) being assaulted or injured by violence
- 2) lacking positive relationships in life
- 3) having someone close as a recent victim of violence
- 4) involvement in group or gang activity
- 5) being at risk for a substance use disorder
- 6) financial crisis or period of financial instability
- 7) having a low access to educational opportunities
- 8) involvement with both parents throughout their life
- 9) experiencing legal challenges

Table 3. 414LIFE Community Component Outputs

| Output | Type | Characteristic | CiviCore Database | Cure Violence Global Database | Total |
|-------------------------|----------------|--|-------------------|-------------------------------|---------------|
| Mediations | Total | # Mediations | 119 | 138 | 257 |
| | | # Mediations in 414LIFE Priority Area | 21 (21%) | 26 (22%) | 47 (20%) |
| | | # Mediations in Blueprint Priority Area | 40 (41%) | 55 (47%) | 95 (44%) |
| | | # Resolved | 71 (60%) | 62 (45%) | 133 (52%) |
| | Outcome | # Conditional | 28 (24%) | 20 (14%) | 48 (19%) |
| | | # Unresolved | 9 (8%) | 49 (36%) | 58 (23%) |
| | | # Unknown | 11 (9%) | 7 (5%) | 18 (7%) |
| | | # Events | 52 | 58 | 110 |
| Community Events | Total | # Events in 414LIFE Priority Area | 15 (32%) | 11 (20%) | 26 (25%) |
| | | # Events in Blueprint Priority Area | 18 (39%) | 29 (52%) | 47 (46%) |
| | | Building relationships with community partners | 24 | -- | 24 |
| | Event type (#) | Community violence awareness | 12 | -- | 12 |
| | | Norm change | 2 | -- | 2 |
| | | Providing resources | 4 | -- | 4 |
| | | Raise awareness of Cure Violence Program | 6 | -- | 6 |
| | | Community Event | -- | 48 | 48 |
| | | Presentation/Public Education | -- | 5 | 5 |
| | | Other | 4 | 5 | 9 |
| Participants | Total | # of Participants | 45 | 88 | 133 |
| | Age | Average | 29.8 years | 24.5 years | 26.3 years |
| | | Range | 17 – 54 years | 11 – 52 years | 11 – 54 years |
| | | Within target age range | 37 (82.2%) | 70 (79.5%) | 107 (80.4%) |
| | Gender | % Male | 87 | 100 | 95 |
| | Race | % Black or African American | 98 | 82 | 87 |
| | | % Latinx | -- | 11 | 8 |
| | | % Multiracial | <5 | <5 | <5 |
| % Non-Hispanic White | | -- | <5 | <5 | |

Note. The original data system, CiviCore, was used October 2018-July 2021. Cure Violence Global (CVG) database used August 2021-December 2022. Cells with “ -- ” indicate differences between the two databases which did not inherently collect the same information. Of the 257 total mediations, only 213 (82%) were able to be mapped for counting activities in priority areas. Of the 110 total community events, only 101 (91%) were able to be mapped for counting activities in priority areas. Target age range is 15-35 years old. Blueprint priority areas include Silver Spring, Old North Milwaukee, Franklin Heights, Sherman Park, Amani, North Division, Harambee, Midtown, Historic Mitchell Street, and Lincoln Village.

Outcomes

Outcomes for the community-based component of the program focused on a few specific areas due to a variety of factors, including the availability of data and programmatic aspects of the initial program implementation. As discussed further below, additional outcome measures will be included in future evaluation phases.

Participant outcomes. Participants involved in community case management worked with 414LIFE team members to identify needs and set goals. Due to limited data and poor data quality, reported are the needs and goals of only participants captured in the CVG database. Of the 88 participants recorded in the CVG database, 57 had completed needs assessments

Primary participant goals concerned finances, safety from violence, education, and housing.

(64.7%). The primary needs identified by participants were having a regular job, employment, and finances to get by (42%), regular healthy amounts of sleep per day (40%), and access to clean air (e.g., air conditioning, heat, non-smoking environments (22%). Of the 88 CVG participants, 32 had set goals (36.3%). The primary goals reported concerned finances (50%), safety from violence (43%), education (28%), and housing (25%).

Mediation outcomes. The outcomes of mediations can be reported as resolved, unresolved, conditional, or unknown. Conditional outcomes indicate the situation was currently resolved, but that both sides of the conflict have conditions that must be met to prevent continued conflict, which makes the situation potentially volatile. Unresolved mediations indicate that there was either the inability to establish a mutual agreement of ceasefire or work on the mediation was still on-going. Program wide, there were 257 reported mediations of which 52% were resolved, 23% unresolved, 19% conditionally resolved, and 7% were of unknown status ([Table 3](#)).

Given the differences in the community component databases (see the [Data sources](#) section), mediations are also reported per database. Pre-August 2021 (in the CiviCore database), of the 119 mediations reported, 60% were resolved, 8% unresolved, 24% conditional, and 9% unknown. After August 2021 (in the CVG database), of the 138 mediations reported, 45% were resolved, 36% unresolved, 14% conditional, and 5% unknown.

These results indicate that most mediations concluded positively, as in, resolved or conditionally resolved. Unlike the status of unresolved, conditional is a dynamic status – it is intended to be a temporary solution on the path towards resolution. Although unresolved indicated that a resolution was unable to be negotiated at that time, it does not indicate that there was a lack of work toward that end.

A missing piece of context was how many hours were invested to reach a resolved, conditional, or unresolved mediation outcome. What was known was that the team increasingly dealt with higher level, more intense mediations that inherently involved greater effort and hours to reach a satisfactory conclusion. For example, one team member stated “Every mediation ain't the same. Let's just put like this, most of the mediations we're dealing with now, when the people that we're dealing with get arrested, they get arrested by the FBI, not by the Milwaukee police.” Future evaluation phases will work to capture more about the time invested by team members in various aspects of their daily work and how this relates to program outcomes.

Collaborations. The nature of the work of the VIs and OWs inherently involved connection with individuals, stakeholders, and organizations. However, it is interesting to note that one team member reported “think[ing] that was one of the reasons why they hired me too, because they knew I was connected with out of 10 people in most spaces, I know seven.” Focus groups thus revealed that the program presented a bi-directional opportunity for networking, as well as tangible resource and information sharing. This was characterized by one external partner who described that “[414LIFE team members] know they can call on [OVP Partner] for anything suicide or mental health related, I'm there. Or if I know there's a retaliatory situation that's taking place, I can reach out to them.”

Several external partners similarly stated their desire to collaborate and share information. This appeared to stem from a communal acknowledgement that “we're not everywhere, every day, every time. We don't know everything that's going on. But there are organizations in other communities that knows what's going on in that spot. So them having that moment of saying, ‘hey,...I need to connect you to someone.’” A similar communal sentiment was that 414LIFE is a part of the violence prevention and intervention space, and credit to improvements in the space, such as increased collaboration, is shared. One partner explained this best when they said that they “can't say if I necessarily credit [increased organizational relationships] directly to 414, but I would just say it's more of a cultural thing.” Other interviewed stakeholders expressed similar sentiments of 414LIFE as part of this space in Milwaukee and therefore as part of the

movement away from siloed efforts. While 414LIFE did not create cohesion within this space, they did add to it.

Success Stories. An important aspect of the outcomes of the community-based component of the program was understanding the changes in the lives of program participants. The following provides examples of success stories for program participants who avoided involvement in violence after program participation. These were obtained directly from 414LIFE team members.^{xi}

Success stories suggest resources and connections to address goals or needs have been established, as needed, for some participants

Brief CVG stories

“I have gotten him to control his anger with the staff a little better than before I met him.”

“He successfully is maintaining 2 jobs, one is at a meal program, and he owns a automotive business. No current run in with the system, and just completed his federal paper. He is also in stable safe housing.”

“Today [Participant] contacted me to let me know she got a job at [place omitted] and so did her best friend. [Participant] displayed drive and motivation when it came to finding a job but consistently either going to fill out apps or doing follow up calls to set interviews if possible. I did congratulate her on this.”

“This participant was struggling in high school but made a huge shift. made honors at the end of the school year and is now at [university] and is doing well.”

“Participant has removed his self from toxic relationship. He plans to start non profit for athletes.”

^{xi} A goal for future evaluation phases is to have more direct data collection from community component participants to better assess the individual-level outcomes for those engaged in the program. This would be conducted in conjunction with the 414LIFE team members to maintain participant confidentiality and rapport with team members.

Longer, audio recorded stories

“He got off my case because he's doing so well on the ground. He has a job and he is in school doing well. It was a triple homicide last summer they both witnessed and the year before that the best friend was killed in front of them. So they've been doing well these past two years and that was my two most recent. Yeah, recent [success], but also a long time coming.”

“This year there was a fight with two families at [High School]. Mothers n the whole family got involved. We were able to mediate between the mother and another mother to get that family, stop fighting with each other and that brought peace. We brought peace to that situation. The fight happened at the school, but [the mediation] took place, we, we mediated here [at MCW]. We just had them sitting across [from each other] and we listen to both sides of they story, let them talk it out without letting them get disrespectful with each other.”

“I got two women to agree to go to a detox, two heroin addicts, to agree to go to detox. I worked with them. I found a detox that would accept both of them. One of them went to the [a behavioral health detox] in [city], and then I took the other one personally to the detox in [different city]. Most people who are on drugs, they don't wanna be on drugs. I don't think anybody wants to be in that condition. So you just have to appeal to the better side of them, you have to appeal the better side of everybody, everybody got a good side.”

“I got [Participant]’s family out of the house. He was a target of violence, because he had a camera in upstairs. There was a homicide that happened between two people that lived upstairs to them. And it happened in front of the house. It was a boyfriend and girlfriend that lived in the house. The girlfriend killed the boyfriend. He had the camera footage so he didn't want to give the footage away because the footage would be like, ‘oh, you took a side’, and then it'll cause a retaliation either way it goes so he didn't want to give the footage up. But then because he didn't want to give it up, that put him in a situation to where they thought he took the suspect’s side. And so I got him out of there

because he became a target of violence because of that. They got okayed for a house so I have been in contact making sure he got into a house, so he is getting into a house.”

“Yes, I, I had a a inroad to the daughter of the man who was killed on [street intersection]. Her father was killed and I was able to connect her with [414LIFE VI]. I found the [414LIFE VI] was able to pay for her [to leave city]. And we got her a plane ticket [back] out here so she can go to her father's funeral.”

“I helped [Participant] and his family move, move out of war. I'm helping them move out of the neighborhood where they have been a target of violence. [Participant] has been shot twice due to, um, uh due to them knowing where the people who want to kill him, they know the area that he stays in. So he's been shot on two separate occasions, so I connected him to crisis housing. ‘N I'm working on connecting him to like some type of job and things like that, that's not easy. It's a lot. That's a lot easier said than done, but I'm working on it, but I did connect them to crisis housing.”

“After leaving [High School], me and this brother right here, uh, we notice a youth that looked like he was suspicious. He could have been like trying to steal a car or whatever, and me and him... we approached the brother, you know, just to tell him, like, you know, encourage them to do the right thing. You know, we're not policing nothing. We just come to, you know, just talk to you in the middle of - in between. [414LIFE VI] was talking to him. Uh, we, we didn't know that there was a family driving around the area looking for him. Apparently they thought that he played a part in jumping the niece in the school. He was skipping school and because we were standing right there stopping the jump cause he's about to get jump but would mean me and [414LIFE VI] were standing right there and so he didn't get jumped. So that was an interruption. [Found out about it] because when he walked [away], their family walked up.

These were two grown men. This dude is like 14, but like there's two grown men walked up aggressively, talkin' about 'you trying to jump my niece?'. So we knew they, if we wouldn't, standing right there, he's about to get beat up alright, but we were standing right there. We'd let we let the brothers know like, look, we, we got this taken care of them.”

Fidelity to Cure Violence Model. The following provides an initial assessment of the program's fidelity to the CV model for its initial implementation.

1. *Detect potentially violent events and interrupt them to prevent violence through trained credible messengers.*
 - a. VIs & OWs are credible messengers who have received referrals, identified potentially volatile situations, conducted mediations, and hosted community events citywide and in priority neighborhoods affected by gun violence. The team would meet daily to discuss ongoing or potential rising conflict and how to distribute their mediation resources accordingly. Participants in the community-based component of the program reflect the priority population of interest who were at risk for involvement with violence based on program eligibility criteria.

2. *Provide ongoing behavior change and support to the highest-risk individuals through trained credible messengers.*
 - a. The priority population of individuals at risk of gun violence victimization had been approached by team members and some with the high-risk assessments had been brought into the program as participants and supported through ongoing participation in case management with the team. Participant success stories as reported by VIs & OWs suggest resources and relevant connections for participant goals or needs had been established as needed. However, due to limitations of data collection during this evaluation period, this Phase 1 evaluation was not able to fully describe the frequency with which contact was made for program participants, the risk level of participants, which services participants were connected with, and whether these interactions yielded behavior or belief changes. Success stories provided some evidence of a degree of behavior change related to positive community engagement and avoiding potential violent conflicts. Contacting high risk individuals, establishing a caseload of high-risk individuals, developing risk reduction plans, meeting several times a week with participants, using social services to address education, employment, criminal justice, mental health, reentry, and life skills were part of the intent of the program approach.

3. *Change community norms that allow, encourage and exacerbate violence in chronically violent neighborhoods to healthy norms that reject the use of violence.*

- a. Given the current evaluation focuses on the feasibility of the program's implementation in the first few years, community norms around violence have not yet been assessed. The school-based Restoration of Consciousness (ROC) workshops offer a first look at current norms of violence in youth of various schools in Milwaukee, however these data were preliminary and preclude a pre-/post-intervention assessment. Changing norms, teaching methods of reducing violence, distributing materials to spread the message, hosting events and activities, and responding to shootings were part of the program intent that will receive further attention in future evaluation phases.

4. *Continually analyze data to ensure proper implementation and identify changes in violence.*

- a. The current evaluation team was established in September 2022. Starting in November 2022, this team has provided monthly reports of activities and outputs for both the community and hospital components of the program. Prior to this, there was some periodic reporting of high-level data, but there was not a regular mechanism for sharing this information with team members and stakeholders. This process still has room for improvement as outlined in the recommendations. Given the geographic spread of program activities during this initial implementation period, it was difficult to assess the changes in violence within particular areas. This report includes recommendations related to this aspect of the CV implementation for 414LIFE.

Though there are several limitations to the current evaluation (see [Data limitations](#) section under *Methods*), the current report serves as an assessment of the initial feasibility of the program with recommendations for programmatic changes to improve reach and impact. Future phases of the program evaluation will provide means to continuously improve program processes and evaluate program outcomes as it relates to reducing violence in Milwaukee.

5. *Provide training and technical assistance to workers, program managers and implementing agency covering the necessary skills to implement the model correctly.*

- a. Internal team interviews suggest additional and consistent training and support will be needed overall and particularly around data collection and entry (see [Recommendation #2](#)). Monthly review of data with the evaluation team offers one

avenue for feedback on data entry and management. In addition, recommendations for enhanced program documentation are made due to this evaluation to enable future reports to comment more directly on when and what trainings occur for team members, both in data entry and in CV modules and boosters. The training components of the program drew upon resources from CVG, as well as other training opportunities related to the core functions of the program, but this evaluation also recommends ensuring these are consistently offered and documented as part of the onboarding of new team members as well as sporadic training needs.

Neighborhood-Level Incident Trends. As discussed throughout this document, there was limited geographic concentration in the priority neighborhoods of various activities during the initial period of program implementation. Thus, conducting a detailed analysis of changes in the priority neighborhoods was not the approach taken in this Phase 1 evaluation. However, the intent here was to provide an overall indication of the trends in homicide and nonfatal shooting victims within the priority neighborhoods prior to and since the start of the program implementation. As shown *Figure 9*, each of the priority area neighborhoods demonstrated some level of increase since the start of the program implementation, with most of the increase occurring in 2020 and continuing into 2020. It is also important to note that the overall trend in gun violence was on a steep rise in Milwaukee during much of this initial implementation period

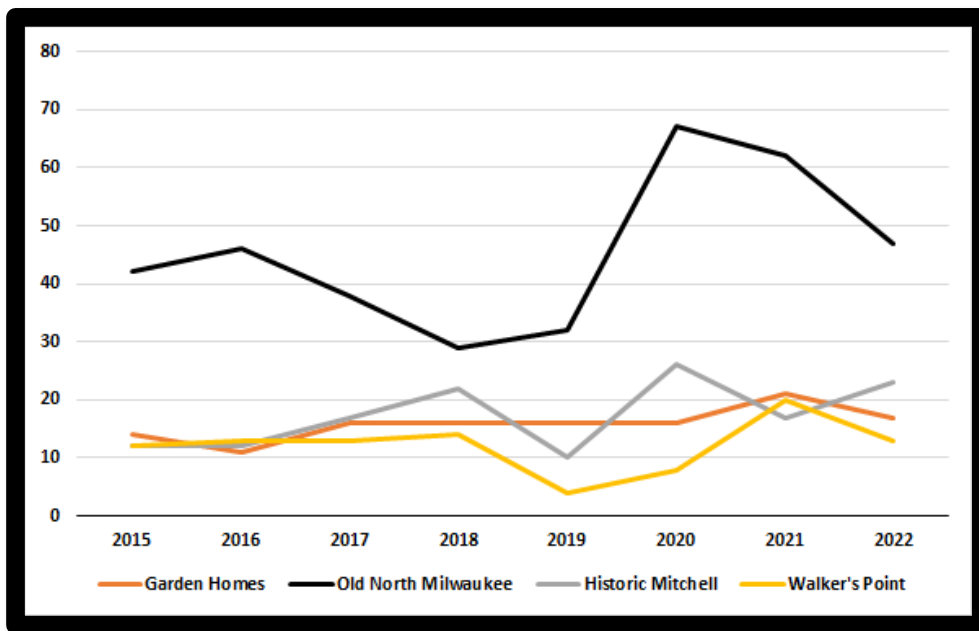


Figure 9. Count of Homicide and Nonfatal Shooting Victims by 414LIFE Priority Neighborhood, 2015 – 2022⁴

starting in 2020, which was mirrored in most of the priority neighborhoods for the program (see *Figure 1* on the historical trend data in Milwaukee).

More recently, three of the neighborhoods, specifically Old North

Milwaukee, Garden Homes, and Walker’s Point, demonstrated decreases in homicides and nonfatal shootings, although not all of them have fully returned to the level prior to the start of the program implementation, using 2019 as the reference point. For this evaluation, more detailed analysis by neighborhood will not be conducted due to the limitations discussed throughout this document, but more analysis is planned for upcoming evaluation phases.

School Component

Inputs

A total of 199 students completed evaluations of the school-based Restoration of Consciousness (ROC) workshops. Most students attended Howard Fuller Collegiate Academy, Marshall High School, and Vincent High School within the Milwaukee area (*Table 4*). The average age of students was 15.2 years (± 1 year; range 14-19 years) and most were in 9th grade (71.2%) at the time of workshop participation though all high school grades were represented.

| School | Count | Age | Grade |
|----------------------------------|-------------------|------------------|-----------------------|
| | <i>Number (%)</i> | <i>(Average)</i> | <i>(Average)</i> |
| Assata High School | 7 (3.5%) | 16.4 years | 11 |
| Howard Fuller Collegiate Academy | 41 (20.6%) | 15.5 years | 10 |
| Marshall High School | 34 (17.1%) | 14.9 years | 9 |
| Mesmer High School | 7 (3.5%) | 15.4 years | 9 |
| North Division High School | 18 (9.1%) | 14.9 years | 9 |
| Nova High School | 23 (11.6%) | 16.2 years | 10 |
| Obama High School | 12 (6.0%) | 14.8 years | 9 |
| Vincent High School | 57 (28.6%) | 14.8 years | 9 |
| Total/Overall | 199 (100.0%) | 15.2 years | 9 th grade |

Outputs

Prior to participation in the ROC workshops, based on the survey at the start of the school year, nearly half of students self-reported that they were a little likely to be involved in violent arguments or physical fights (36, 48.7%). Prior likelihood for violence was not significantly different by age ($\chi^2 = 7.36$, $p = 0.83$), or by grade ($\chi^2 = 4.48$, $p = 0.88$). Nearly a third of students agreed (in general or strongly) that violence can solve problems (28, 37.3%) while

another third were not sure (25, 33.3%). To a lesser extent, 21 students thought that people need to be involved in street activity if they want to survive in their neighborhood (28.0%). The majority disagreed with this though (41, 54.7%).

Outcomes

After the workshop, most students reported being very satisfied (41.5%) or satisfied (40.7%) with the workshops. Students indicated they felt more prepared, to different extents, to avoid or prevent violence after participating in the workshops. For instance, 32.5% felt a little better prepared, 35.8% felt somewhat better prepared, and 25.2% felt much better prepared to avoid or prevent violence now that they have attended the workshop. Similarly, students also reported feeling less likely (26.8%) or maybe a little less likely (55.3%) to be involved in violence because of participating in the workshops.

Students were also asked for their level of agreement with various statements related to their perception of the effect of their involvement in the ROC workshop sessions. As shown in *Table 5*, there was variation across the specific areas. In one area, most students agreed (45.9%) or strongly agreed (23.8%) with feeling able to use options and methods to resolve a conflict other than violence. The majority of students also agreed (33.3%) or strongly agreed (49.6%) that they could be a peaceful person. Although a high percent of students still indicated agreement that (30.1%) they felt they could make a non-violent choice even if they felt disrespected, a higher percent indicated they were not sure (36.6%) and only 18.7% strongly agreed with this statement. The percent showing agreement for this question was lower than for all the other questions, pointing to a difference in responses in relation to their perception of being disrespected. At the same time, most students indicated that they believe they could avoid getting into fights or violent confrontations (23.6% strongly agree and 35.0% agree).

93.5% of students that participated in the ROC workshops felt a little better, somewhat better or much better prepared to *avoid or prevent* violence.

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

| <i>As a result of being part of these sessions...</i> | 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 |

Of particular interest, however, were the responses to the question asking which part of the workshop sessions made the biggest impact on the student. Most responses indicated that the opportunity to come together with the VIs to have real talks made the greatest impact. One such student wrote “I feel when we talk and have deep convos about stuff because I learn and see and hear stuff from other people's point of view.” It was not just the conversations, but also that they presented an opportunity to be asked how they were doing and the opportunity to be heard. This part was referred to as the “check-in” and its impact was that “now I feel like there are people that actually care about how I'm feeling.” Also present were responses that suggested recidivism reduction. These included expressing “I don't want to kill my ex anymore,” “The talking part of the sessions made me a better person somewhat because I haven't had that many fights since I've started,” and “The workshop help me a lot I use to be violence and robbery people but now I stop because workshop.” Thus, the preliminary ROC results provided some positive indications for students participating in the program.

“I don't want to kill my ex anymore”

– Anonymous Student, in response the impact of ROC workshops

Hospital Component

Inputs

Structure. The hospital component of 414LIFE initially included one HR from the start of the program in May 2019 until 2022 when the team expanded with the addition of two HRs in July and one HR in December of that year. The first HR was promoted to HR supervisor in July 2022; however they departed the program by September 2022 for another opportunity. The recruitment to fill the supervisor position was on-going through the end of this evaluation period and was filled just prior to the publication of this report. There were 3 non-supervisor HRs at the end of 2022.

1,075 hospital program referrals
(May 6, 2019 – December 31, 2022)

Since the hospital component of the 414LIFE program had only one HR position through most of the evaluation period, a referral to the program did not necessarily lead to program engagement. This was due to limited person power to contact and engage with every referral. The volume of gunshot wound patients at FH averaged 250 patients a year prior to 2020. However, since then, the average patient volume increased to 455 patients a year. Therefore, while there were 242 gunshot wound patients in 2019 when the hospital component started, the average volume grew substantially shortly thereafter.

Training. Training for the initial HR included an orientation to the Level 1 Trauma Center inclusive of introductions to hospital staff, trainings in hospital protocols, and awareness of clinical standards of care (*Figure 10*). As the first HR, this team member was responsible for working with program leadership to create and implement workflows related to referrals, caseload, and scope of work.

Similar to the first HR, the HRs hired in July 2022 received a half-day hospital orientation in which the team members met with clinicians and administrators from Trauma Surgery and Emergency Medicine. The goal of the orientation was to educate the HRs about the clinical flow that gunshot wound patients experience from the start through the end of their hospitalization. Subsequent hires had the added benefit of shadowing the first HR and role-playing patient encounters. One deviation from this training pattern was with the last HR hire in December 2022 in which the half-day orientation was not repeated. Also different was that the newer HRs were

given some training through CV. Leadership stated that the half day orientation at the trauma center:

“is really meant to be more like program wide and [we] don't know if we have it delineated like, at what point do we have mass capacity of new staff that we need to do this again. But ...they also had the hospital responders Cure Violence training with [Independent Trainer], right? Yeah, so. Which is really new. No, this was recent. Since being at MCW, Cure Violence didn't always have the hospital kind of training component, and so that is more recent.”

The database in REDCap for case management was developed by MCW when the program was transferred in July 2021. Initial utilization of REDCap was limited, but more robust utilization of this system started in July 2022 with the hospital component expansion (i.e., hiring more than 1 HR). Specifically related to data entry training, all HR received training in the data collection for REDCap based on the elements identified for data collection. Training was led by this evaluation team and supplemented with refreshers and quality checks from the program operations manager. The initial training included a review of all data fields, what should be entered in each field, how and when to create records, and procedures related to maintaining records for on-going cases.

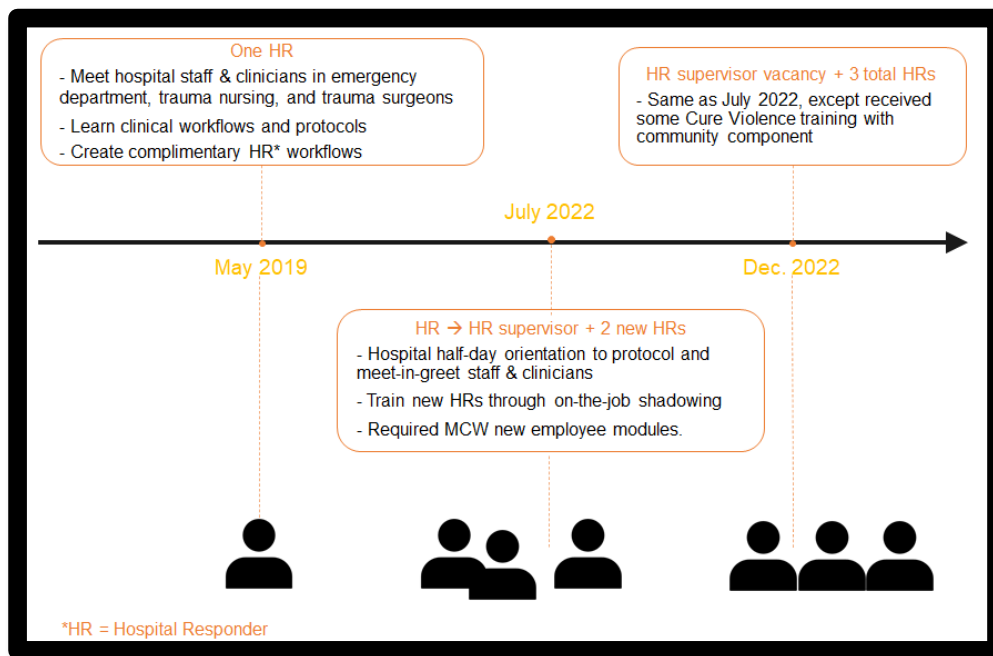


Figure 10. Training input and team structure for the hospital component during implementation

Outputs

Although all gunshot wound (GSW) patients coming into Froedtert had the potential to be referred to the program if they met the eligibility criteria, not all GSW patients were referred. Again, this was a function of limited personnel (i.e., 1 HR for most of the evaluative period). For example, in Program Year (PY) 4, 44% of all GSW patients, and 46% of GSW patients aged 15 to 35 were referred to the program. This occurred for a variety of reasons, including the patient coming in through the Emergency Department (ED) but being discharged prior to a referral being made. Also, not all providers were equally likely to refer to the program.

During evaluation period, May 6, 2019, through December 31, 2022, there was a total of 1,075 program referrals. PY 1 had 241 referrals, PY 2 had 339, PY 3 had 274, and PY4 (through December 31, 2022) had 221 (*Figure 11*). Since the start of more detailed referral data collection in July 2021 in REDCap, out of 223 patients entered, only 4 patients were documented as having rejected 414LIFE services (<2%). Also in July 2021 was the start of a formal hospital to community component referral process for participants. Given the reduced

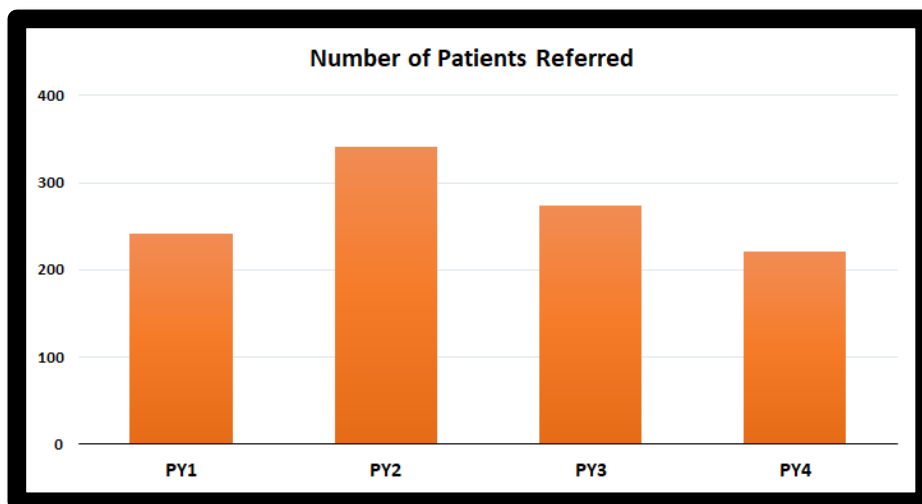


Figure 11. Number of patient referrals by program year (PY)

Note. PY4 only represents 8 months due to the evaluation timeframe cut-off of December 2022.

timeframe, only 28 hospital-based program participants were recorded as referred to the 414LIFE community component VI team after initial contact with a HR. The age range of participants was 15 - 88 years, with the average age of the program cohort being 30.2 years (+/- 10.5 years). Most (74.8%) participants met the priority age criteria (aged 15-35 years). Nearly all referrals were for individuals who lived in or were injured in Milwaukee (98.4%). Most referrals were Black or African American (912, 84.8%) and not Hispanic or Latino (973, 90.8%). Most referrals were male (872, 81.1%).

Referrals placed for deceased patients occurred 42 times (3.9%) for services to be provided to the family and/or loved ones.

Review of geocoded referral addresses based on the location of injury (*Figure 12*) suggested that referrals were clustered in the neighborhoods most affected by firearm violence in Milwaukee: Franklin Heights (6%), Old North Milwaukee (4.7%), Amani (4.7%), Sherman Park (4.6%), and North Division (4.1%) (see *Figure 9*).

There was a statistically significant increase in age between PY 1 and PY 3, and between PY 1 and PY 4 with an increase in the average age of participants since program inception. The average age in PY1 was 28.6 years, in PY2 it was 29.7 years, in PY3 it was 31.1 years, and in PY4 it was 31.9 years. There were no differences by PY in sex or race.

Overall, referrals were primarily made by social workers (64.9%) and the advanced practice nurse prescriber (23.8%) from the ED (59.8%), TQoL Clinic (14.4%) and the intensive care units (18.7%). Changes in referring provider and location were impacted by the introduction of the TQoL Clinic for gun violence survivors mid-PY2 (November 11, 2020). TQoL Clinic referrals were tied to the role of the clinic director, who is an advanced practice nurse prescriber. This clinic did not exist in PY 1, therefore there was a notable increase from zero to 92 referrals in PY 3 and 45 in PY 4. This is similarly represented in the increase of the advanced practice nurse prescribers' referrals from 4 in PY 1, to 126 in PY 3 and 86 in PY 4. Advanced practice nurse prescribers

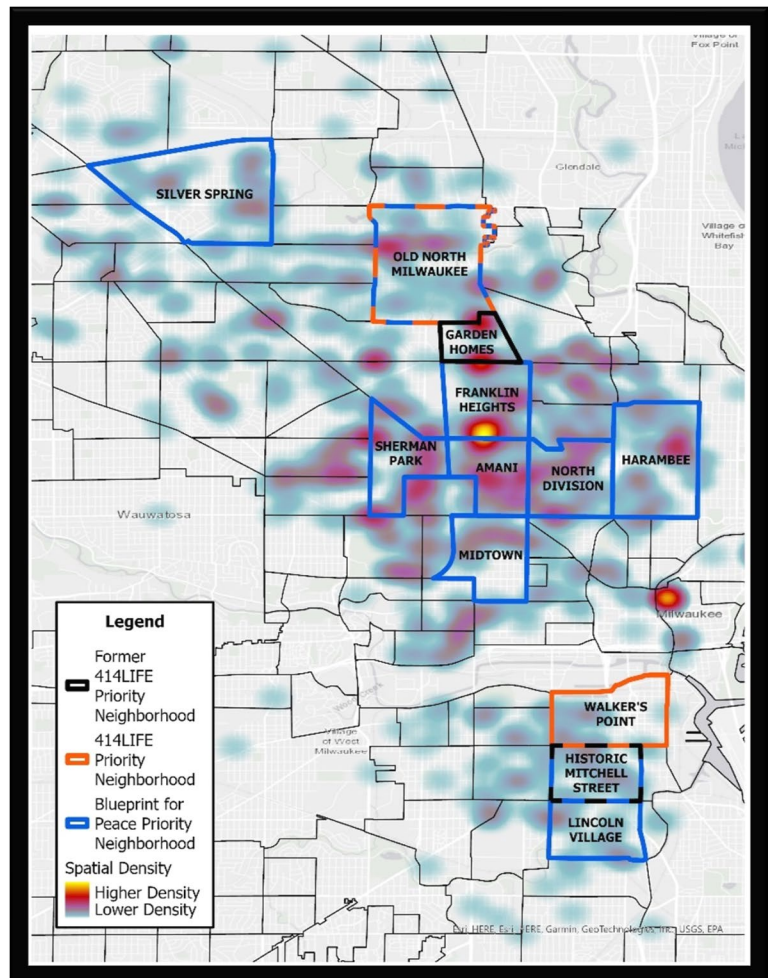


Figure 12. Spatial Density of Injury Locations for Referred Hospital Patients, May 2019 – December 2022

outside of TQoL Clinic could place referrals, though was infrequent and typically occurred on a regular floor unit or intensive care unit.

There was a parallel downward trend in referrals placed by social workers in the emergency department (ED). In PY 1, there were 223 referrals placed by social work, but by PY 4, there were 87 referrals placed. Most social work referrals are placed in the ED (98%). In the ED, referrals decreased from 207 in PY 1 to 80 in PY 4.

By clinical protocol, all GSW patients are referred to TQoL Clinic at the time of discharge. In terms of participation in TQoL Clinic, since the start of the Clinic through the end of the evaluation period (11/11/2020 – 12/31/2022), 301 (27.9%) 414LIFE hospital referred patients attended at least one TQoL Clinic appointment. Also, 156 (14.4%) GSW patients were referred to the 414LIFE HRs *from* TQoL Clinic when they were not connected with the HRs when they first came to FH.

Outcomes

Identified needs. Case management related-data was housed in REDCap at MCW. The use of the database was initiated in July 2021, but more full utilization did not start until the expansion in July 2022. Of the 223 referrals with detailed data in the database (*Table 6*), the primary needs of participants were primarily mental health (52%), financial (51%), followed by retaliation concerns (27%).^{xii}

^{xii} The database also supports collection of information on the resources provided, number of needs resolved, and the number of patients referred to the VIs and OWs in the program's community component.

| Table 6. 414LIFE Hospital Participant Reported Needs by Type | |
|---|----------------------------|
| Need | # of times need identified |
| | <i>n</i> |
| Mental health (e.g., therapeutic services, grief counseling, trauma psychology) | 116 |
| Financial (e.g., employment, government assistance, victim's compensation) | 113 |
| Retaliation (i.e., patient or loved ones will retaliate or be retaliated against) | 60 |
| Safe housing (i.e., concern of return to a safe home) | 52 |
| Support for family or loved ones | 49 |
| Safe discharge (i.e., concern of safe return to community) | 42 |
| Mobility (i.e., patient limited due to physical functioning) | 39 |
| Support for dependents | 33 |
| Transportation (e.g., to and from medical appointments) | 31 |
| Basic needs (e.g., food, water, heat, toiletries, clothing) | 24 |
| Substance abuse | 9 |
| Firearm safety | 8 |
| Spinal Cord Injury (e.g., concern for injury specific programming) | 6 |
| Total | 582 |

Note. *n* = number. Patients may report multiple needs and thus counts do not represent unique individuals. Needs reported by 223 referrals with detailed data in the REDCap database.

Collaborations. By the nature of the HRs' work, collaborations with other stakeholders in the violence intervention and prevention space were formed. Collaborations were principally formed with respect to resources necessary for patients on caseload. Resources were not only tangible, but there were also connections with various clinical providers and services, as well as with organizations. More profoundly, HRs reported learning more about themselves and about their own communities through their collaborations.

Within the greater context of the violence prevention in the local medical space, 414LIFE HRs have been change leaders. One hospital partner captured the overall sentiment when they said:

“I think before 414LIFE, it felt like we were sort of just stuck in the silo of ‘we took care of the patients once they were brought here and then sent them back to the same environment.’ I feel like, maybe we’re fixing the injury but not fixing the bigger problem. And I feel like this is enabled, especially in emergency medicine in trauma surgery, like us to feel like there is more than just like ‘I fixed your injury. Good luck.’ and really connected people with ongoing care and [we] felt like there was a program that they were gonna be able to be part of that was gonna continue to support them.

I think that certainly being able to connect with our social work staff, being able to connect with interdepartmental, like disciplinary, between trauma surgery and emergency medicine has been awesome. But then beyond that, too, the Comprehensive Injury Center. So like all of those groups kind of coming together. The other interesting thing is I think we've made some really good moves from an institution standpoint and advocated for our patients, our patient population too at Froedtert and MCW leadership standpoint too for some policies and et cetera, et cetera, that needed to be updated and changed. And I think we've also advocated a little bit with Milwaukee police. And so I think, I certainly never like had that voice before and not that I necessarily do now, but as a group, I think we're stronger than we are as individuals. So being able to sort of participate in that way has been really amazing and beneficial to me as well.”

Whereas collaboration for the community component was characterized by partnership and embeddedness within local violence prevention and intervention space and efforts, the hospital component was reported to have inspired novel approaches for more comprehensive care for gun violence survivors. Engagement with the first HR led to the organic development of the TQoL Clinic. The clinic model was originally geared for patients injured by any mechanism of injury, but 414LIFE’s collaboration with the Level 1 Trauma Center inspired the reorientation of TQoL Clinic to specifically serve gun violence survivors.

Another novel consequence of 414LIFE’s hospital-based collaboration was the augmented educational opportunities for medical trainees – medical students, residents, fellows, and even faculty. One hospital partner engaged with advising trainees described their experience with one student as follows:

“I was her advisor when she was a student at MCW and she was involved, and I got her involved [in gun violence / violence intervention research] as a resident. And just being at least- she like is so passionate about it that she wants to continue this work and I think that speaks volumes, right, that you're influencing the career- professional career trajectory of our trainees and stuff. And then I think in general too we've had [educational] conferences when some of our patients that come back to talk about their [hospital] experience and how powerful those conferences have been where the patients sharing their story with the residents. And we [surgeons] don't often get to see afterwards what happens. And I think that that perspective and different way of learning about our patient care was really valued by our, by our residents.”

Lastly, 414LIFE also facilitated traditional collaboration with obvious partners, for example, connections between the hospital, OVP, and 414LIFE. These collaborations were not only made but strengthened.

Re-Injury. For the follow-up periods of interest there were 638 eligible historic comparison gunshot wound patients (5/5/2015-5/5/2017), and 517 eligible 414LIFE referrals (5/6/2019-5/5/2021). Again, these are 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 517 414LIFE referrals, 479 (92.6%) were successfully matched to a historic match comparison patient. The 26 unmatched 414LIFE referrals consisted of 20 females of varying races, though majority were Black or African American. This result is unsurprising as most gunshot wound injuries treated at FH are sustained by Black or African American male patients. Thus, due to this unsurprising smaller sample size of female gunshot wound patients, matching female patients was not possible.

3% of 414LIFE hospital referrals returned to Froedtert Hospital for another firearm injury in the two years following their initial referral to the program.

Given the last date of inclusion for the 414LIFE group was 5/5/2021, 399 of the 517 referrals had follow-up available through 2 years as the current evaluation only considered data through 12/31/2022. Of the 517 referrals, 37 were also referred to TQoL and 36 attended the Clinic appointment (only 3 who attended TQoL Clinic had a full 2-year follow-up period). By the 2-year

follow-up, there were 9 historic control patients and 12 referrals from the 414LIFE cohort (1 of which also attended TQoL) who experienced re-injury by GSW based on returning to FH due to a new injury; however, this difference is not statistically significant ($\chi^2 = .37, p = .98$; Table 7). There was also no significant difference in re-injury by other assaultive mechanisms; both groups had 2 re-injuries by other mechanisms (non-GSW) by the end of the 2-year follow-up period. Overall, the number of patients re-injured in both groups was 3% or less by the end of the 2-year follow-up period.

Table 7. Re-injury Before and After Hospital Component Referral at Various Timepoints Post-Index GSW

| | 1-Month | 3-Month | 6-Month | 1-Year | 2-Year |
|---|---------|---------|---------|--------|--------|
| Re-injury via GSW | | | | | |
| Historic Comparison | 1 | 2 | 3 | 4 | 9 |
| 414LIFE | 2 | 3 | 4 | 8 | 12* |
| Re-injury via assaultive mechanism (non-GSW) | | | | | |
| Historic Comparison | 0 | 0 | 0 | 0 | 2 |
| 414LIFE | 0 | 0 | 1 | 2 | 2* |

Note. GSW = gunshot wound. Assaultive mechanisms of injury include non-GSWs, for example, stab wounds and blunt assaults. Timeframe for historic comparison group patient inclusion 5/5/2015-5/5/2017. Timeframe for 414LIFE referral inclusion 5/6/2019-5/5/2021. 37 414LIFE referrals also were referred to TQoL Clinic, though 1 did not attend clinic. Of these 37 TQoL Clinic patients, only 1 was re-injured; though, of note, only 3 TQoL Clinic patients had the full 2-year follow-up period available. *Total sample through follow-up at each time point was $n = 479$, except for the 414LIFE group at the 2-year follow-up where only 399 participants were eligible for follow-up.

Re-Referrals. In addition to tracking the number of patients re-injured during the follow-up period, the number of patients re-referred to the program was also followed. By the end of December 2022, a total of 19 patients referred to 414LIFE had been re-referred to the program, regardless of re-injury type, which represents 1.76% of program referrals. It is important to note this re-referral rate represents a snapshot of the program at the end of December 2022 and not all participants have had the same amount of follow-up time for capturing re-referral.

Re-Contact with the criminal justice system. The initial analysis of specific contact points with the criminal justice system indicated that of patients referred to 414LIFE, a total of 16 of the 399

eligible patients (4.0%) were linked to new criminal charges in Milwaukee County within two years following the index injury. The matched comparison group had 10 of its 479 patients (2.0%) linked to new criminal charges within the two-year follow-up period. Similar to the re-injury results, this difference between the two groups was not statistically significant. For the 414LIFE patients that were charged with a new offense(s), the most frequent charges included disorderly conduct, homicide, and reckless injury.

Those involved in homicide or nonfatal shooting incidents in Milwaukee within two years of initial injury included a total of 33 patients referred to 414LIFE (8.3%) and 22 in the comparison group (4.6%). These included being involved in the incident as a victim or individual suspected of carrying out the incident. It was more common that individuals were listed as victims in both groups, with 24 of the 33 414LIFE patients (72.7%) and 15 of the 22 comparison patients (68.2%) being listed as having been a victim of another nonfatal shooting or homicide after the original injury. A total of six 414LIFE patients (1.5%) were victims of homicide within two years of the index injury that brought them into the program.

Success Stories. As with the community component of the program, an important aspect of the outcomes of the hospital-based component was understanding what impact the program may have had in the lives of program participants. The following provides examples of success stories for program participants who avoided involvement violence after program participation:

“[Participant] was like our first official participant. We ended up getting her placement for housing, in a shelter. And I went to see her. And baby, she was shocked. Yes, I didn't even know who she was. [inaudible] like she was so together, and it made me feel so good that she had did that and not gone back to where we she initially came from.”

“I think for me, my most memorable patient would be -- It's gonna be this, I just got this guy on my caseload. He's a [age omitted] young man and he is trying to do the right thing in his life. You know, he has three kids by three different women. Kind of goes back and forth with the baby mamas and whatnot and whatever. Unfortunately, he was at the wrong place, wrong time, got shot. One of his children he don't get to see at all and kind of feel like the grandmother set him up to take custody of the little girl. And you know this experience that he just had by being shot kind of like made him want to try to fight, at least to start, with visitation for his daughter. And you know he battles and struggles with trying to be a good person, you know, trying to grow up and be that father figure for his

kids. Uh, so he's my most memorable because he knows what he wants and what he has to do. He just needs a support system along the way and so, you know, he's very intelligent and it's like he just wants somebody to tell him 'Go do it, you know, go do it' so that it. That's why he's my most memorable one."

"[Participant] who is still a work in progress, but he actually came into the hospital. He got shot [omitted date]...He was a single father of [number omitted]. He came in, uh, during his stay his kids were taken from him. On the first day of school, I had to meet his [age omitted] son and his mother to let him know that after that day he would not be able to go back to this home that he's lived in for five years with his dad. Because his mother had went and got custody of him. So that was very, um, traumatic for me. It brought so many tears, he shed so many tears...But we were able to -- Like his birthday came. We took him a -- we all pitched in and got him a hover board so I was able to take that do the Webex so that Dad could see him. Since then, though, there's a lot of situations going on. So, a lot of things going on with the mother. So he has -- he's able to still communicate with the kids via phone, but there's no- I can't go up there with the camera anymore. Or with the laptop for them to do, like, FaceTime business because of some legal stuff they have going on anyhow.

He's still in the hospital, still battling and he has been an ongoing work in progress, but I can't wait, I tell him all the time. I can't wait, wait to hear his testimony and that he has to continue to keep moving forward and things will fall in place for him. He's in [Hospital] right now, so he was discharged from Froedtert and got some additional wounds and went to [Hospital]. Since then, he's been there, so he's been there for almost 3 months.

And working with outside Community support, it's been a battle because he had a reputation as far as refusing care in the hospitals. But the reality is, is you, you get that from individuals who are [condition omitted], and a lot of the staff are not trained on diversity, they're not trained on the culture. So, dealing with, and also, he was shot by a woman. So having women staff in his, you know, behind him, are triggers for him and a lot of times.

You know he can be an [expletive], right? But they need to look at what it looks like for him, right, and meet him where he is. And I'm not just advocating saying, 'OK, he

shouldn't do this, and he should be refusing care' because I tried to encourage him to get that care because it's not hurting anyone but you. So now he has three additional wounds. And now we can't get – well I can't say we -- but his insurance company can't get a provider to pick him up then supportive care at home. So now I'm looking for more private, uh, nursing that will work with him. It's a lot, but he is my most memorable.

We have become very, very tight knit due to the fact that he has no support but me. Umm. And even with those situations you still have to streamline, it's a thin line because he's in survival mode too. So sometimes he tries, he plays the fence. And when he does, we call that out to him. And so, we get on the same page real quick, but I can't wait to hear his testimony and he's, you know, he gets to those points where he wants to just give up and I'm saying 'you can't give you can't give up for you first if you can't be what you need to be for you, you can't go and fight for the kids. So, you have to heal.'

And a lot of times because they are in those moments of survival. So, like he discharged. He AMA'd [left Against Medical Advice] initially cause guess what he was trying to get out his kids. He needed his kids.

Umm, they're with someone who they haven't been with for five years based on you know bunch of different things. And his first priority was 'I have to get my kids.' And I said 'well, you don't have anywhere to take your kids, so if you try to get your kids and CPS come out, guess what? You're not keeping your kids, but you have to really focus on you. You have to go and heal.' And he was doing whatever he could do at that moment to just get released, to get home to try and get his kids. And people on the outside looking in, they couldn't get that -- they didn't understand that he's [condition omitted]. And 'why won't he just go here?' Single parent.

Naturally, our kids come first, we do whatever we have to and, in his situation, you know, as you went home, you had open wounds, now you're back in the hospital.

So, we get that 'I know I should have listened, I'm listening now,' but you need that expect all that. You know you're dealing with people that's trying to figure it out and don't have support. That was his thing."

DISCUSSION

Interpretation of results

The following discussion provides some overall interpretation of the evaluation findings. This section is formatted to align with key questions from the Evaluation Matrices ([Appendices B & C](#)). It is then followed by a series of recommendations focused on areas for program improvement.

Community Component

How was the 414LIFE community-based component implemented in Milwaukee?

Overall, the community-based component of the program was intended to be an evidence-based approach to violence prevention from a public health perspective. Implementation was to follow the [design of the CV model](#). Aspects of the core components of this model were represented in the initial implementation of the community-based program activities through a focus on the five CV operational components focused on disrupting conflicts prior to escalation to violence and altering norms through credible messengers. However, the results of the current evaluation suggest that there were deviations from the CV model, discussed in the next section.

Challenges to program implementation included limited resource and infrastructure support. Independent of this, there were challenges due to significant turnovers in members and leadership with internal and external stakeholders. This resulted in differential access to tangible and intangible resources, such as knowledge from experienced/senior personnel, mental health support for 414LIFE team members, CVG database and training access, and streamlined communication between partners). Last, but not least, the COVID-19 pandemic interrupted aspects of the program implementation and processes while also causing a temporary shift of some of the focus in 2020 toward COVID-19 community response, crowd control related to the national protest movement, and support for safe voting during the 2020 Presidential Election.

Despite these challenges, the overall program reputation is viewed favorably by internal and external as reported through this evaluation's interview. Team members described being driven by a desire to give back to their community and the work being a matter of a higher calling. External partners also echoed a sentiment of the higher purpose of 414LIFE's work in saving

lives from gun violence. Both types of stakeholders indicated hope and continuing to support having the right people aligned to work together in this space.

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

The program has largely reached its priority individuals and neighborhoods. Those at high risk for gun violence are being referred, approached, and processed from intake to active case management by the program. Violence Interrupters conducted 257 conflict mediations of which 71% were reported as resolved or conditionally resolved. The 133 participants recorded as being involved in case management reflected those known to be at highest risk for gun violence (i.e., young, Black men). Most participants were 15-35 years old (80%), Black or African American (87%), and male (95%). For those with completed risk assessments, 90% were considered high or medium risk for involvement in violence.

In terms of geospatial reach, the program had a widespread presence that was visualized in terms of [mediations](#) and [community events](#). The reach of these activities revealed a concentration in priority neighborhoods for either 414LIFE (former or present), *Blueprint for Peace*, or both. 414LIFE served at least 133 participants at risk of involvement in gun violence, hosted 110 community activities, and helped to mediate at least 257 conflicts with the majority of those being listed as resolved or conditionally resolved.

However, this indicates the most significant deviation from the CV model was the limited focus of program activities within the designated priority area neighborhoods. There was not as much



of a concentrated geographic focus, both in terms of the size of the areas as well with where activities were clustered, as is often found in other CV implementations. Although there was some concentration of activities within the 414LIFE priority neighborhoods, community activities and mediations for example, occurred over much of Milwaukee. This lack of fidelity to this aspect of the CV model during

the early implementation of the program, and particularly during the COVID-19 pandemic, limits the evaluation of the program's outcomes and impact within 414LIFE priority neighborhoods or in comparison with non-priority neighborhoods. For instance, this phase of the evaluation did not include a specific analysis of homicides and nonfatal shootings before and after program implementation, or in relation to comparison neighborhoods to identify whether there was a measurable change in incidents.

The citywide geographic spread of program activities also poses challenges given the limited size of the community component. This is discussed as part of the [recommendations](#) to determine whether this level of geographic focus is intended for the program moving forward. This will help to inform future evaluation phases and manage external expectations of the program's work and scope in partnership with other local agencies and organizations in the violence reduction space.

Did participants avoid situations involving violence after program participation?

Participant success stories highlight the direct impact of the community-based program on some of the individuals refocusing on self-actualization rather than violence, as reported from the perspective of the team members. For example, focusing on returning to school, starting a new business, being a role model for their children. Similarly, outcomes from the school programming post-survey indicated that 93.5% of students felt a little bit, somewhat or much better prepared to avoid involvement in violence after participation in the program. While challenges remain when youth feel disrespected, most agreed with non-violent alternatives for conflict resolution after workshop participation.

Hospital Component

How was the 414LIFE hospital-based program implemented in Milwaukee?

Results of the evaluation suggest the 414LIFE program was implemented with fidelity as a HVIP. The four components of an HVIP include: 1) intervention, 2) care, 3) follow-up services, and 4) addressing social determinants of health.⁵ All four are achieved by the 414LIFE hospital component and has accelerated innovation for similar programs nationally through the novel incorporation of 414LIFE hospital responders into outpatient care (i.e., the outpatient Trauma Quality of Life Clinic for gunshot wound patients at Froedtert Hospital). However, it must be noted that funding only permitted the support of one HR for the first several years of program implementation. Program reach was therefore limited due the inherently limited capacity of one

HR working to support the high volume of patient referrals. Also, the time period included for the hospital portion of the program for assessing aspects such as re-injury also occurred during the time period where there was only one HR position. Froedtert Hospital's continued support of the program and funding (from various sources) for additional HRs in 2021 will significantly impact the capacity to engage with the volume of program referrals which is expected to be more readily apparent in the Phase 2 evaluation.

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

The hospital referral program reached patients from all over the City of Milwaukee. A substantial portion of the referrals were from priority neighborhoods for 414LIFE and/or those defined as priority by the *Blueprint for Peace*. There were 1,075 referrals to the program recorded during the evaluation period. Participants reflected those most at risk for gun violence – most were young (average age 30.2 years), Black or African American (84%), men (81%). Patients can be referred if they are aged 15 – 35 years, were injured by a gunshot wound, and were injured in or are a resident of Milwaukee.

However, exceptions are made when risk of retaliation is high. Therefore, 97% of referred patients experienced a gunshot wound, while the remaining 3% experienced another assaultive mechanism of injury (e.g., stab wound, blunt assault). A portion of the referrals were injured in priority neighborhoods for 414LIFE and/or those defined as priority by the *Blueprint for Peace*. Ability to reach patients was limited due to the program's ability to only support one hospital responder from May 2019 – July 2021. Another reach limitation was that in the acute period of the COVID-19 pandemic, the hospital responder could only connect with patients remotely.

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

The program reached high-risk individuals, as defined by the program, as 62% met all eligibility criteria, and 99% met at least one eligibility criteria.

Program participants indicated a significant number of needs across a range of areas and the charge of the HR has been to work with participants to address those needs. For this phase of the evaluation however, data are not included on how those needs were addressed, given limited data availability from the evaluation period. However, there is evidence that the cases for the HR are complex, and patients are often in need of follow-up care. This subsequently

highlights the need to streamline discharge criteria and continue the direction of transitioning participants from the hospital to the community component of the program when longer-term follow up is needed to maintain manageable caseloads. The consistently high volume of referrals underscores the dire need for hospital responder expansion to grow in parallel to meet the high volume of gunshot wound survivors and their myriad of post-injury needs. Lastly, the quantity and complexity of needs indicate the significant pre-injury levels of unmet needs for individuals at high risk for gun violence (which the program aims to serve). For instance, food insecurity, substance use disorder, unsafe housing, and others, can be exacerbated by an incident of gun violence, but the incident alone does not always initiate the issue/unmet need.

Did program participants demonstrate significantly lower levels of reinjury and involvement in violence after program participation?

When compared to historic match comparison group of patients with gunshot wound injuries sustained prior to 414LIFE’s implementation, those referred to 414LIFE did not experience a significant difference in re-injury by gunshot wound or by other assaultive injuries (e.g., stab wound, blunt assault). The overall re-injury rate for both the 414LIFE and this comparison group was relatively low, at 3% or less. It is important to note that program referral did not necessitate contact or indicate level of engagement with the program. At least 8.3% of the 414LIFE and 4.6% of the comparison group were documented to have experienced additional exposure to gun violence as a victim or because they were suspected of being involved in the incident within two years of the initial injury. Given the overall Intent-To-Treat analytic approach of this evaluation, these results suggest that the mere presence of the 414LIFE program in the hospital is not sufficient to impact re-injury and related outcomes, at least during the initial implementation of the program when there was one HR position. Future evaluation phases will investigate if contact and level of engagement with the program impacts re-injury and other outcomes.

Similar to the re-injury data there was not a statistically significant difference between the 414LIFE participants and comparison group for having been issued new charges in Milwaukee



County during the two-year period after the initial incident. Overall, 4% or less of both groups had new charges referred or issued within two years of the initial injury date and the difference between the groups was not statistically significant.

Program-Wide

Comparison to previous evaluations of similar programs.

Published evaluations from community-focused violence intervention programs have investigated the fidelity of focused deterrence, HVIPs, and community programming implementations within pre-defined small areas – usually about 2-4 neighborhoods.⁶⁻⁹ Data were typically sourced primarily from local police department records which were then analyzed to compare rate change of gun violence over time. 414LIFE differs from this past work as demonstrated by its citywide reach during the Phase 1 evaluation period. While the events of 2020 (e.g., COVID-19, national protest movement, Presidential election) influenced this deviation, there is citywide work due to case referrals from HRs (who work with injured persons independent of where they live) and desired engagement in *Blueprint for Peace* and 414LIFE priority neighborhoods. 414LIFE is unique in its bimodal design which integrates a CV model with a HVIP model.

Strengths and limitations

There are several notable items related to strengths and limitations of the 414LIFE program implementation and results for this first phase of the evaluation. First, 414LIFE was implemented as a public health program and *not* as a research study. It was therefore not implemented with a direct analytic control group as would be the case as in an experimental design such as a randomized control trial (RCT), often considered a “gold standard” for clinical research. RCTs are ethically implemented when there is the opportunity for a placebo intervention or balance exists with pre-existing practice. As no violence intervention program or hospital-based violence intervention program existed in Milwaukee, Wisconsin in 2018, it would have been unethical and harmful to randomly withhold what was anticipated to be a beneficial intervention when no alternative supports existed.

Second, data collection was a common challenge due to system changes and inconsistent levels of completeness. Although the initial feasibility implementation of the community-based program began in October 2018, data tracking was not initiated until January 2019 and was limited in scope and content due to constraints of the original CiviCore data management system. A new data system hosted by CVG was implemented in July 2021 that afforded greater integrity and reliability of data management. In the current program structure, participants in the community-based program are deidentified for rapport building and safety purposes which prohibits direct (e.g., interview) and indirect (e.g., re-injury due to community violence after initial program involvement) follow-up of specific outcomes. The new system provided greater opportunity for data collection and analysis in future evaluation phases, while participant de-identification continues to pose a challenge with conducting longer-term follow up to identify outcomes such as behavior or belief changes.



Third, after the first two years of the initial feasibility implementation of the program, outreach and mediation activities of the community-component were provided across much of the city of Milwaukee. This limited the ability to track outcomes based on comparison neighborhoods and

change over time as the intervention had a wider reach than the initial focus neighborhoods. Thus, the evaluation focused on effectiveness of 414LIFE in a “real world” scenario and direct neighborhood comparisons could not be completed in this phase.

Fourth, the initial feasibility phase of the hospital response part of the program (May 2019-December 2022) represented the work of one HR position. Though feasibility can be established with one position, programmatic impact is likely limited due to lack of additional HRs to saturate treatment at the hospital level. In addition, given the scope of the work of the team on the community side of the program, the size of the team to date has likely been a limiting factor in terms of the reach and outcomes of the program. There has been a delay due to contracting issues in the scheduled expansion of the program but will be important to revisit the impact of team growth on activities as additional team members are hired in future evaluation phases.

Fifth, as discussed throughout this report, limitations and changes in data collection have impacted the scope of the ability to further assess feasibility or initial implementation 414LIFE. Additional input, output, and outcome measures, data collection enhancements, and related changes are planned for future evaluation phases, but this will also require modifications in current practices program wide. This will include an enhanced focus on participant outcomes, as well as increasing attention on the specific activities of the team members in both the hospital and community components of the program to better understand how they are working with participants, what comprises a standard caseload, how often participant needs are being met and how they are being met, as well as how participants are meeting criteria for program completion. It will be important to also further document external service capacity limitations that impact the ability of program team members to address needs of participants above and beyond merely referring to services (e.g., housing, treatment needs, employment, etc.).

Finally, the rise in violence, and particularly gun violence, across Milwaukee and in many U.S. cities during and following the initial onset of the COVID-19 pandemic (since March 2020) must also be taken into consideration. For instance, Stay-at-Home orders in Wisconsin directly impacted the activities of the community-based team as no community activities or participant case management were reported from approximately March 2020 through April 27, 2020. However, of note, this does not explain the absence of mediation and community activity data entry which was sustained from the start of COVID-19 through August 2021. Similarly, the ability of HR to contact hospital referrals during the COVID-19 pandemic was reduced due to the

amount of work needed to initiate contact safely. Contact during this time was often made remotely via phone calls, video calls, text messages, or communication through providers.

Despite these limitations, this evaluation provides evidence that the initial feasibility implementation of the 414LIFE program is preventing and interrupting the transmission of violence through its three-prong approach: (1) identification and detection (2) targeted intervention and (3) changing community-wide attitudes, behavior, and norms related to gun violence. Both program components were implemented with fidelity, although deviations do exist and are noted. Evidence-derived recommendations have been made to support the further growth and strengthening of the program. 414LIFE continues to evolve in its efforts to play a significant role in the landscape of efforts to reduce gun violence in Milwaukee.

Future evaluation phases

The evaluation process for this program is intended to be iterative with reports being provided in annual phases starting in 2023 through at least the end of current program funding (estimated through 2025). This approach is intended to focus on continuous learning and program improvement. Thus, evaluation reports will also evolve over time, particularly for the community-based portion of the program and will reflect the changes and expansion of the program beyond the feasibility phase. It is important to note that the specific indicators, measures, and program targets included in this report and planned for future phases are subject to change with the completion of each phase of the evaluation. This is due to anticipated program changes as more is learned about the program, as data collection is enhanced and expanded, and as the program expands and program activities develop over time. Future evaluations will also seek to examine capacity issues within the community with regards to meeting participant needs. While referrals may be placed, there may be external barriers to receiving the referred services. For the immediate next phase of evaluation, the Phase 2 evaluation plan is being updated in response to the findings from this initial evaluation.

RECOMMENDATIONS

The following provides a more detailed description of some of the programmatic recommendations that are included in the overall evaluation report. These are intended to be utilized by 414LIFE leadership to make operational decisions as it relates to the recommendations. Recommendations are followed by potential strategies based on the findings of key stakeholder interviews and referral to other information contained in the evaluation.

RECOMMENDATION 1: Enhance outward communication

1) Expand breadth of recipients of 414LIFE reports

Expand upon the current audience targeted for receiving monthly and annual program reports to reinforce collaboration with partnering organizations and agencies and expand knowledge of 414LIFE activities. For example, the Violence Response – Public Health and Safety Team (VR-PHAST) involved agencies/organizations, the Level 1 Trauma Center program, and others would be potential areas for routine dissemination. This can also inform the dissemination of the evaluation results.

2) Close the loop on communications and referrals received

Close the loop on communications and referrals received from partnering organizations and agencies. MPD and ED SW receive infrequent feedback on the outcome of their referrals. The result is uncertainty of whether the individual(s) got connected with 414LIFE or if the responsibility is still on them to connect the individual(s) with alternative services. Recognizing there are confidentiality concerns, consider ways to develop a process to share at least some of the high-level information back to referring agencies (e.g., contact was made, follow-up is being conducted). Although MPD makes their referral through OVP, this high-level information should still be relayed back through the approved line of communication.

3) Update written hospital component materials to be specific to gunshot wound victims

Current 414LIFE materials provided to hospital social workers and clinicians to disseminate to gunshot wound patients and their loved ones are illegible due to font size and may be at too high of a reading level compared to the baseline reading level for the general trauma patient population. They also appear too focused on advertising the Blueprint for Peace, thus reading

more as community outreach material rather than focusing on the resources through the 414LIFE program.

- i) *Refer to scanned materials (in the Phase 1 Evaluation Appendix E) that SW has for distribution to patients.* The material with local resources is helpful, however, copying the same paper copy over time has led to it being illegible. Consider contacting SW to give them the electronic version so when printed the material is legible. Alternatively, consider developing an additional delivery mechanism (e.g., create a QR code) that would allow for electronic sharing of 414LIFE materials. Also consider updating hospital-facing materials to explicitly describe to patients what 414LIFE has to offer them. This is because the current materials read like they are for community outreach to educate the public on either non-414LIFE local resources or the Blueprint for Peace. They do not communicate to patients why the patient should reach out to 414LIFE.

4) Re-orient key stakeholders about purpose and scope of 414LIFE

Create and disseminate key stakeholder-facing materials to clarify and advertise the scope of 414LIFE's work and priority neighborhoods. Have these materials provide specificity around the hospital- and community-based portions of the program, the specialized resources provided by 414LIFE, and the reach of the program. Although there is wide awareness of the program, many key stakeholders could not state what 414LIFE's goal or purpose was when asked. Most reported that the overall goal is to reduce violence but were unable to report anything more specific as to how the team sought to reduce violence, what kind of violence, or which areas of violence. There are also multiple indicators that stakeholders do not have a reasonable expectation about the size or reach of the program. Creating and regularly disseminating additional program materials may help to provide more context and understanding of the role and reach of the program. Focus group interviews with stakeholders have emphasized the nature of collaboration in the local violence prevention/intervention space. 414LIFE is a part of this space, though it is emphasized that 414LIFE is part of the movement and compliments ongoing efforts within the space. Additional marketing of 414LIFE may also help stakeholders to understand the specific role of 414LIFE in this space.

RECOMMENDATION 2: Clarify and further document aspects of program implementation**1) Re-evaluate the location of the priority neighborhoods and the level of emphasis within them**

There appears to be a substantial amount of activity in areas outside of 414LIFE priority neighborhoods. While this is an acknowledged part of the program implementation structure, and while recognizing violence interruption needs occur across the city, it does raise questions about the potential impact of the program given the size of the team and how far spread the activities are around the city rather than being geographically concentrated within the identified priority neighborhoods. Further, with activities occurring citywide with a team size of 12 (at end of 2022 and excluding administrative positions), any effects demonstrated quantitatively within this report may have had a larger impact if focused only in the priority neighborhoods. More clarity around the extent to which the activities, and what types of activities, should be focused in the priority neighborhoods may help to clarify the scope of 414LIFE's work for both the team and for external partners and stakeholders. This will also support enhanced geographic analysis for future evaluation phases. Given the distribution of events and recent trends, this may also be an opportunity to re-evaluate the location of the priority neighborhoods and determine whether any changes should be made.

An important aspect of the continued program implementation is documentation of the specific reasons particular neighborhoods are selected, as well as documenting dates when any changes are made to the priority neighborhoods. This will support clarity within the team and with both internal and external stakeholders on the geographic focus areas, will provide more documentation of the evolution of the program, will help to identify overlap between various parts of the ecosystem of violence prevention in Milwaukee, and will assist with future evaluation phases.

- i) *Refer to geospatial result section maps*; community mediations are clustered in Garden Homes neighborhood (which was a priority neighborhood until approximately July 2021), community activities are clustered in Garden Homes, and hospital referral locations of injury are clustered on the border of Franklin Heights and Amani (two *Blueprint for Peace*, but non-414LIFE priority neighborhoods), and Juneau Town (not a *Blueprint* or 414LIFE priority neighborhood).

2) Clarify expectations around engagement with participants and discharge criteria

In both program components there is a need for clarity around the level and length of engagement with participants. Related to this, there is also a need for criteria to establish when there should be a closeout of regular interactions with the participant on the hospital side (either with a transition to the community component or by closing out the expectation for on-going follow-up) and when a participant is ready to be discharged from the program on the community side. Currently it is challenging to establish how long a participant engages with either program component to be able to assess the level of dosage and length of contact. This will help to track outcomes for participants, as well as make it clearer whether regular data updates should be anticipated with participants, which is also currently difficult to determine. One way to address this is to create case discharge criteria for the hospital and community components of the program. This will support collaboration with other organizations and lean on their specializations while making more time available to 414LIFE team members to focus on their current caseload. The discharge criteria should be documented and should be part of initial and on-going team training and should be reinforced by supervisors. This will also be critical for future evaluations of the program.

3) Re-evaluate scope of team member roles

Re-evaluate scope of team member roles. There are hospital-based violence intervention and case management related activities, community-based violence interruption, shooting response, and case management, outreach activities, school programming, and occasionally chaplain services being offered with a team of 12 with many of these activities taking place citywide. The various roles of 414LIFE positions (VIs, OWs, and HRs) often have multiple areas of responsibility and include both short- and longer-term follow-up with participants. For example, the school programming and curriculum writing was carried out by the community engagement coordinator, who had other responsibilities as well such as coordinating pop up events and other outreach activities. As another example, one ED SW reported wishing that the hospital responders would return to their 24/7 availability, referring to the first years of the program when there was one hospital responder who attempted to respond 24/7 to fill in the gaps created by the current schedule of having one SW on per shift on historically busy shifts. With this approach 414LIFE could work in the ED to provide more immediate response when large

families come into the ED for a gunshot wound patient and to provide referrals to social services.

- i) Therefore, one recommendation is to clarify role responsibilities. If VIs, OWs, and HRs intended to operate as longer-term case managers for participants, then establishing a reasonable and expectations around the expected level of engagement with participants and discharge criteria as outlined above, has the potential to help ensure participants receive the full extent of the program services and that referrals do not exceed ability to render services.
- ii) An alternative is to refocus the Vis, OWs, and HRs to shorter-terms interventions and response and to implement a separate case management component of 414LIFE to conduct longer-term follow-up with participants. This could help to clarify roles and responsibilities, as well as provide the opportunity to hire for different skill sets to match the various roles. This may also make it easier to coordinate with collaborating partner agencies to provide specialized, long-term services so 414LIFE can uniquely focus on violence interruption in the community and in the hospital.

4) Develop centralized tracking of community component participants

Create and implement a secure process for centralized tracking of community component participants. One of the challenges identified is not having a way to currently track the contact information on participants. This information needs to be stored securely, outside of the Cure Violence Global database and should only be accessed by a very limited number of the program staff and leadership. It can either be stored hard copy or electronically but is important for the transfer of participants when an employee leaves so that there is a continuation of support and resources. In addition, this will facilitate the opportunity to work with the team members to conduct follow-up with participants as part of the evaluation process to better gauge future outcomes, as well as identify whether there have been changes in behaviors and beliefs.

5) Increased positive/strength focused data entry training

Team members reported a need for additional or enhanced data entry training. Common example cited is that the type of person best suited for a VI role is not someone who has necessarily had educational backgrounds that would have prepared them to work with collecting data. Further, for individuals with lived experience, this may have involved years of incarceration, thus potentially limiting their exposure to technology, impacting their comfort level

or literacy in this area. Desire for creative means of training and data entry are desired, and to be done on a frequent basis as questions come up during entry. One external key stakeholder reported that as of the day of their interview with the evaluation team, they are still getting phone calls and texts from 414LIFE team members about technology and data entry. It should be noted that the challenges with data entry may have been exacerbated by the period of time where there was a lack of access to the CVG database so ensuring consistent availability of this database or an alternate is critical for program data collection. Some of the limitations of this evaluation reflect the challenges with data collection and entry. Given the importance of data collection for the tracking of program activities, outputs, and outcomes, continuing to support team training, as well as exploring alternate training approaches, is critical to support program success.

6) Provide trauma-informed care for 414LIFE frontline workers

While there was briefly mental health support from the City for 414LIFE team members, this is no longer available due to a sudden transition in OVP leadership. Team members report posttraumatic stress disorder or acute stress disorder (PTSD/ASD) symptoms. This is especially salient for new team members, for whom the acute stress of the job hinders their ability to work independently. Supervisors indicated that they are involved in almost all mediations and that it is not an equally distributed effort amongst all team members, which in part reflects the stress and trauma associated with the positions, particularly for new team members hired into these roles. The lack of post-care compromises the psychological safety of less senior, less experienced violence interrupters which has an immediate effect on job performance. Based on the accounting of team members, they need more mental health support for themselves given the nature of the work.

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APPENDICES

A. Acknowledgements

We wish to express our gratitude to the many invaluable stakeholders that made 414LIFE possible. The following provides an overview of some of the primary stakeholders that are connected to this evaluation effort. The list is not intended to be all-inclusive, nor in any particular order, but provides an indication of some of the agencies supporting aspects of the work.

- Office of Violence Prevention, City of Milwaukee Health Department
- Medical College of Wisconsin
- Froedtert Hospital and the Level 1 Trauma Center Program
- Milwaukee Health Care Partnership
- Milwaukee Common Council
- Mayor’s Office, City of Milwaukee
- Governor’s Office, State of Wisconsin
- Milwaukee Police Department
- Milwaukee County Department of Health and Human Services
- Milwaukee area schools partnering with the 414LIFE program
- Comprehensive Injury Center at the Medical College of Wisconsin, including the Division of Community Safety
- Division of Trauma and Acute Care Surgery and Level 1 Trauma Center program
- Department of Emergency Medicine and Emergency Department Staff
- 414LIFE team members (past and present)
- Trauma Quality of Life Clinic
- Medical Students from the Medical College of Wisconsin, Peter Nguyen & Ramneet Mann
- Agencies and community-based organizations partnering to address violence prevention in Milwaukee, including but not limited to:
 - Milwaukee Christian Center (MCC)
 - Running Rebels
 - Salvation Army
 - St. Vincent de Paul
 - Uniting Garden Homes

- Project Ujima
- Multiple funding organizations and donors, in alphabetical order and including, but not limited to:
 - Advancing a Healthier Wisconsin Endowment
 - Annie E. Casey Foundation through the Greater Milwaukee Foundation
 - Everytown for Gun Safety
 - Froedtert Hospital
 - Kellner Family Fund
 - Office of Violence Prevention within the City of Milwaukee's Health Department including funding through the American Rescue Plan Act (ARPA)
 - Milwaukee Bucks Foundation
 - Milwaukee County Department of Health and Human Services - Milwaukee County Credible Messengers
 - Milwaukee Healthcare Partnership (MHCP) through the United Way of Greater Milwaukee Foundation
 - Uniting Garden Homes, Inc.

B. Evaluation Matrix – Community Component

| INPUTS/ OUTPUTS | | |
|---|---|--|
| Indicators | Definition | |
| How was the 414LIFE community-based program implemented in Milwaukee? | | |
| Implementation | Comparison of program implementation to Cure Violence model | Extent to which the program adhered to the 5 required components of Cure Violence model. |
| | Number of team members by type | Number of outreach workers (OW), violence interrupters (VI), case managers (CM), supervisors, other positions during the evaluation period |
| | Percent of team members trained | Percent of staff trained within 2 months of hire |
| | Content and delivery of trainings for new team members | How new and existing team members were trained on the CV model, internal policies/procedures, data collection and entry into CV database |
| | Funding to support direct program services | Direct funding to support program activities during the evaluation period |
| | Perceived barriers and facilitators to implementation | Perceived barriers and facilitators to program implementation among team members and partner orgs |
| What was the reach of the community-based program, including by geographic area and target population? | | |
| Hospital Response | Number of mediations/interruptions | Number of mediations compared to the prior year |
| | Location of mediations | Percent of the mediations for conflicts that occurred in the priority neighborhood(s) |
| Community Outreach and Events | Number of community events | Number of community events the team holds or participates in per year |
| | Location of community events | Percent of community events occurred in the priority neighborhood(s) |
| | Marketing and public-education efforts | Number, type, and target audience for public education efforts |
| Participant Outreach & Case Management | Number of participants entering the program | Number of participants entering the program for case management per year |
| 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 program participants avoid situations involving violence after program participation? | | |
| Program-wide | Success stories of avoiding violence | Success stories for program participants who have avoided involvement in violence after program participation |

C. Evaluation Matrix – Hospital Component

| INPUTS/ OUTPUTS | | |
|---|---|--|
| Indicators | Definition | |
| How was the 414LIFE hospital-based program implemented in Milwaukee? | | |
| Implementation | Implementation of hospital-based model | Review of the components of hospital-based model |
| | Number of team members by type | # hospital responders (HR), supervisors during the evaluation period |
| | Percent of team members trained | Percent of team members trained within 2 months of hire |
| | Content and delivery of trainings for new team members | How new and existing team members were trained on the hospital-based model, internal policies/procedures, data collection and entry into REDCap |
| | Funding to support direct program services | Direct funding to support program activities during the evaluation period |
| | Perceived barriers and facilitators to implementation | Perceived barriers and facilitators to program implementation among team members and partner orgs |
| What was the reach of the hospital-based program, including by geographic area and target population? | | |
| Hospital Response | Number of referrals by referral source | Number of individuals referred by source by year and percent of GSW patients referred to program |
| | Program participants accepting services | Percent of referrals that did not reject program services and reason for rejection (if applicable) |
| | Location of injury for program participants | Participants will be distributed across Milwaukee and will mirror the distribution of reported homicides and nonfatal shootings |
| | Involvement in Trauma Quality of Life Clinic | Participant was referred and attended sessions with TQOL |
| | Engagement with 414LIFE Community-Based Team | Participant was connected to 414LIFE Community-based team |
| Outcomes | | |
| Did the program reach high-risk individuals as intended and assist in addressing their goals and needs? | | |
| Program-wide | Number of participants meeting program criteria | Number of participants meeting program eligibility criteria (e.g., gunshot wound survivor, race, age, etc.) |
| | Number of issues addressed for participants as part of program participation | Number of resources or referrals provided to participants to address identified issues or needs by type (retaliation, mental health, housing, transportation, etc.); Percent of identified needs where resources or referrals were offered to participants |
| | Number of issues resolved for participants as part of program participation | Number of identified issues or needs resolved by type (retaliation, mental health, housing, transportation, etc.); Percent of identified needs indicated as resolved by type |
| Did participants demonstrate significantly lower levels of reinjury and involvement in violence after program participation? | | |
| Program-wide | Reinjury rate for participants due to community violence | Percent of participants recorded as being victims of gun violence after the start of program participation. |
| | Level of involvement for participants with the criminal justice system 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. |

D. Data collection materials

School Restoration of Consciousness (ROC) workshop surveys

Pre-Survey (2022 – 2023 School Year only)

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).

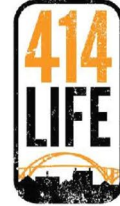
| Very likely | A little likely | Not very likely | Not likely |
|-------------|-----------------|-----------------|------------|
| | | | |

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!--

Post-Survey (2022 – 2023 School Year Version)



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 |
| <input type="checkbox"/> | <input type="checkbox"/> |

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**).

| <i>As a result of being part of these sessions...</i> | 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 |

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 |
|----------------|-----------|------------------------------------|--------------|-------------------|
| | | | | |

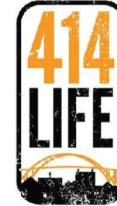
12. What part of the workshop sessions made the biggest impact on you, and why?

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!--*

Post-Survey (2021 – 2022)



414LIFE ROC SESSIONS

RESTORATION OF CONSCIOUSNESS (ROC)

Today's date: _____

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

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. Your responses will not be connected to your name.

| <i>As a result of being part of these sessions...</i> | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|-------------------|----------|----------|-------|----------------|
| 1. I understand violence as a disease. | 1 | 2 | 3 | 4 | 5 |
| 2. I have a better understanding of the conditions that promote violence and gang 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. Feel 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 |

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

| Much better | Somewhat better | A little better | Not much better | Not At All better |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. Do you think you are less likely to be involved in violence or fights, now that you've experienced these workshops?

| 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. How could these workshops be improved?

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

Focus group interview guides

414LIFE Team Member Interview Guide

The four evaluation 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.

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

I. Introduction

Thank you for participating in this interview. My name is <insert name>. I am conducting this interview on behalf of the evaluation team to assess the effect of the 414LIFE program. The purpose of this interview is to help us better understand the effect that the 414LIFE program has had 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 and #2

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. Why do you think participants choose to engage in the program?

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

10. 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?
11. How would you rate the overall success of 414LIFE using a scale from one to ten with one being “not at all successful” and 10 being “very successful?”
Prompt, as necessary:
 - a. Why?
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. Can you think of anything that 414LIFE could do differently to address the challenges or barriers?
15. What does success in your role look like for you?
Prompt, as necessary:
 - a. What do you look for to know your work is effective?
 - b. How do you keep track of the progress you are making with your participants?
16. What do you see as the concerns for this role?
Prompt, as necessary:
 - a. What might contribute to burnout?
17. What support is available to you in this role?
Prompt, as necessary:
 - a. Would support be useful?
18. In your opinion, what are the most important outcomes or benefits that have resulted from 414LIFE for participants in the program?
19. Can you tell me about one of your most memorable participants?
Prompt, as necessary:
 - a. Do you know of any incident where your participant avoided violence after participating in the 414LIFE program?

IV. CONCLUSION

Those are all the questions I have for you today.

20. 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>

414LIFE Supervisor Interview Guide

The four evaluation 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.

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

I. Introduction

Thank you for participating in this interview. My name is <insert name>. I am conducting this interview on behalf of the evaluation team to assess the effect of this program. The purpose of this interview is to help us better understand the effect that the 414LIFE program has had 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 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 and #2

1. 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?
2. What skills, experiences, or characteristics does one need to be an effective supervisor of the 414LIFE program?
3. 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?
4. 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?
5. What skills, experiences, or characteristics does one need to be an effective hospital responder, violence interrupter, and outreach worker for 414LIFE? 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.)
6. How often and in what capacity do you interact with participants in the 414LIFE program?
7. Can you describe your approach to working with participants?
Prompt, as necessary:
 - a. How do you establish trust with participants?
 - b. What interpersonal approach do you take when interacting with participants? (Empathetic, tough love, etc.)

8. Why do you think participants engage in the program?

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

9. 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?
10. How would you rate the overall success of 414LIFE using a scale from one to ten?
Prompt, as necessary:
a. Why?
11. What do you think has contributed to the success of the 414LIFE program?
12. What, if any, challenges or barriers have you experienced that have impacted the implementation of 414LIFE?
13. What could 414LIFE do differently to address the challenges or barriers?
14. What do you see as concerns for the team and leadership of 414LIFE?
15. What support is available to you in this role?
Prompt, as necessary:
a. Would support be useful?
16. In your opinion, what are the most important outcomes or benefits that have resulted from 414LIFE for participants in the program?
17. Are there other factors or circumstances that you think contributed to the success of 414LIFE?
Please explain.

IV. CONCLUSION

Those are all the questions I have for you today.

18. 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>

414LIFE Leadership Interview Guide

The four evaluation 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.

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

I. Introduction

Thank you for participating in this interview. My name is <insert name>. I am conducting this interview on behalf of the evaluation team to assess the effect of this program. The purpose of this interview is to help us better understand the effect that the 414LIFE program has had 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 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 and #2

1. Please describe the main responsibilities of your role as a leader 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?
2. What skills, experiences, or characteristics does one need to be an effective leader of the 414LIFE program?
3. What did training look like for you?
4. 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?
5. 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?
6. What skills, experiences, or characteristics does one need to be an effective hospital responder, violence interrupter, and outreach worker for 414LIFE?
7. Why do you think participants engage in the program?

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

8. Can you describe the design, implementation, and operation of 414LIFE in the early years of the program?
9. Were there any notable transitions that 414LIFE underwent?
Prompt, as necessary:
 - a. Can you describe how that may have impacted the program?
10. What, if anything, is different after moving to MCW and expanding the hospital responder piece of the program?

11. In your role with 414LIFE, what kind of internal partnerships (MCW/FH) have you made? External partners (non-MCW/FH)?
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. How would you rate the overall success of 414LIFE using a scale from one to ten?
Prompt, as necessary:
 - a. Why?
13. What, if any, challenges or barriers have you experienced that have impacted the implementation of 414LIFE?
14. What could 414LIFE do differently to address the challenges or barriers?
15. What do you see as the concerns for the staff and leadership of 414LIFE?
16. 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?
17. In your opinion, what are the most important outcomes or benefits that have resulted from 414LIFE for participants in the program?
18. Are there other factors or circumstances that you think contributed to the success of 414LIFE?
Please explain.

IV. CONCLUSION

Those are all the questions I have for you today.

19. 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>

414LIFE External Partner Interview Guide

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

- What are the perceived barriers and facilitators to program implementation among partner organizations?

I. Introduction

Thank you for participating in this interview. My name is <insert name>. I am conducting this interview on behalf of the evaluation team to assess the implementation and outcomes of the 414LIFE hospital- and community-based violence intervention program. The purpose of this interview is to help us better understand the effect that the 414LIFE program has had on participants, the community, and public health in general in Milwaukee.

It is important that you respond to all the interview questions based on your experience and perspective. 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 the Objective

1. From your perspective, what is the main purpose or goal of the 414LIFE program?
2. What has been your organization's relationship with 414LIFE?
Prompt, as necessary and applicable:
 - a. What did you/the organization hope to achieve by partnering with 414LIFE?
 - b. What is your professional history as a partner of 414LIFE?
3. Prior to your partnership with 414LIFE, what was your knowledge of violence prevention or intervention programs?
Prompt, as necessary:
 - a. Were you aware of the Cure Violence model?
 - b. Were you aware of hospital-based violence intervention programs?
 - c. Have you heard of other programs around the country?
 - d. Have you been aware of other similar efforts in Milwaukee?
4. From your perspective, in what way(s) has the 414LIFE program met the program goals and objectives?
5. From your perspective, in what way(s) has the 414LIFE program not met the program goals and objectives?
6. Has your partnership with the 414LIFE program helped you make connections with other people or organizations?
Prompt, as necessary:
 - a. If so, what types of connections and with whom?
 - b. Can you think of ways in which your organization has benefitted from the new connections made through the 414LIFE program? If so, please explain.
7. In your opinion, what are the most important outcomes or benefits that have resulted from the 414LIFE program?
8. How would you rate the overall success to date of 414LIFE using a scale from one to ten with one being "not at all effective" and 10 being "very effective?"
Prompt, as necessary:
 - a. Why?
9. What, if any, challenges, or barriers do you think have impacted the implementation of 414LIFE?
10. Are there other factors or circumstances that you think have contributed to the success (or challenges) of the 414LIFE program to date? Please explain.

III. CONCLUSION

Those are all the questions I have for you today.

11. 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>

E. 414LIFE Hospital Component distribution materials for Emergency Department Social Workers

Front Side

Back Side



414LIFE RESOURCES

DOMESTIC VIOLENCE, SEXUAL ASSAULT & HUMAN TRAFFICKING PREVENTION

Milwaukee Muslim Women's Coalition: 414-727-4900
 Sojourner Family Peace Center Hot line: 414-933-2722
 Aurora Healing and Advocacy Services: 414-219-5555
 The Asha Project: 414-252-0075
 UMOS Latina Resource Center: 414-389-6500
 The Benedict Center: 414-347-1774
 Human Trafficking Taskforce: 414-323-7273
 Hmong American Women's Association: 414-462-5031
 Inner Beauty Center: 414-416-7303
 Pathfinders: 414-810-1536
 Alma Center: 414-265-0100
 Gerald L. Ignace Health Center: 414-383-9526
 Office of Violence Prevention, Karin Tyler: 414-708-3141

ADDICTION SERVICES

Community Access to Recovery Services: 414-257-8085
 Aurora AODA Treatment: 414-454-6586
 Meta House: 414-962-1200
 Narcotics Anonymous: 1-866-913-3837
 Wisconsin Community Services: 414-343-3569
 M&S Clinical Services, Inc: 414-263-6000

HOUSING/SHELTER

Repairers of the Breach: 414-342-9323
 The Guest House: 414-345-3240
 Milwaukee Rescue Mission Safe Harbor: 414-344-2211
 Casa Maria: 414-344-5745

LEGAL SUPPORT

Legal Aid Society of Milwaukee: 414-727-5300
 Wisconsin State Public Defenders: 414-227-4130
 ACLU: (414) 272-4032
 Legal Action of Wisconsin: (414) 278-7722
 Disability Rights Wisconsin: (414) 773-4646
 Tenant Resource Center: (414) 431-7337
 Fire and Police Commission: (414) 286-5000

SOCIAL SERVICES

Community Advocates: 414-875-2048
 Impact 211: 211
 Social Development Commission: 414-906-2700
 Milwaukee County Crime Victim Services: 414-278-4667

CONFLICT MEDIATION & VIOLENCE PREVENTION

414LIFE: 414-828-2006
 10,000 Fearless Stop the Beef Hotline: 414-369-2790
 Team Havoc: 414-313-8290
 CommForce: 262-289-0412
 Wisconsin God Squad: 414-585-9511
 Safe and Sound: (414) 220-4798

HOME & FAMILY RESOURCES

W2 Agencies

Maximus: 414-203-8500
 UMOS: 414-389-6600
 Milwaukee Fatherhood Initiative: 414-286-5653

Foodshare

Marcia P Coggins Center
 1220 W. Vliet St Milwaukee, WI 53205
 Monday - Friday 8am-5pm

UMOS

2701 S Chase Ave Suite C, Milwaukee, WI 53204
 Monday - Friday 8:30am-5pm

Food Pantries

COA Youth and Family Centers: 414-449-1757
 2320 W. Burleigh st, Milwaukee, WI 53206
 Milwaukee Islamic Dawah Center: 414-462-1998
 5125 N Teutonia Ave, Milwaukee, WI 53209
 St. Bens Meal Program: 414- 271-0135
 1015 N. 9th St, Milwaukee, WI 53233

Lead Testing and Water Filters:

414-286-2165

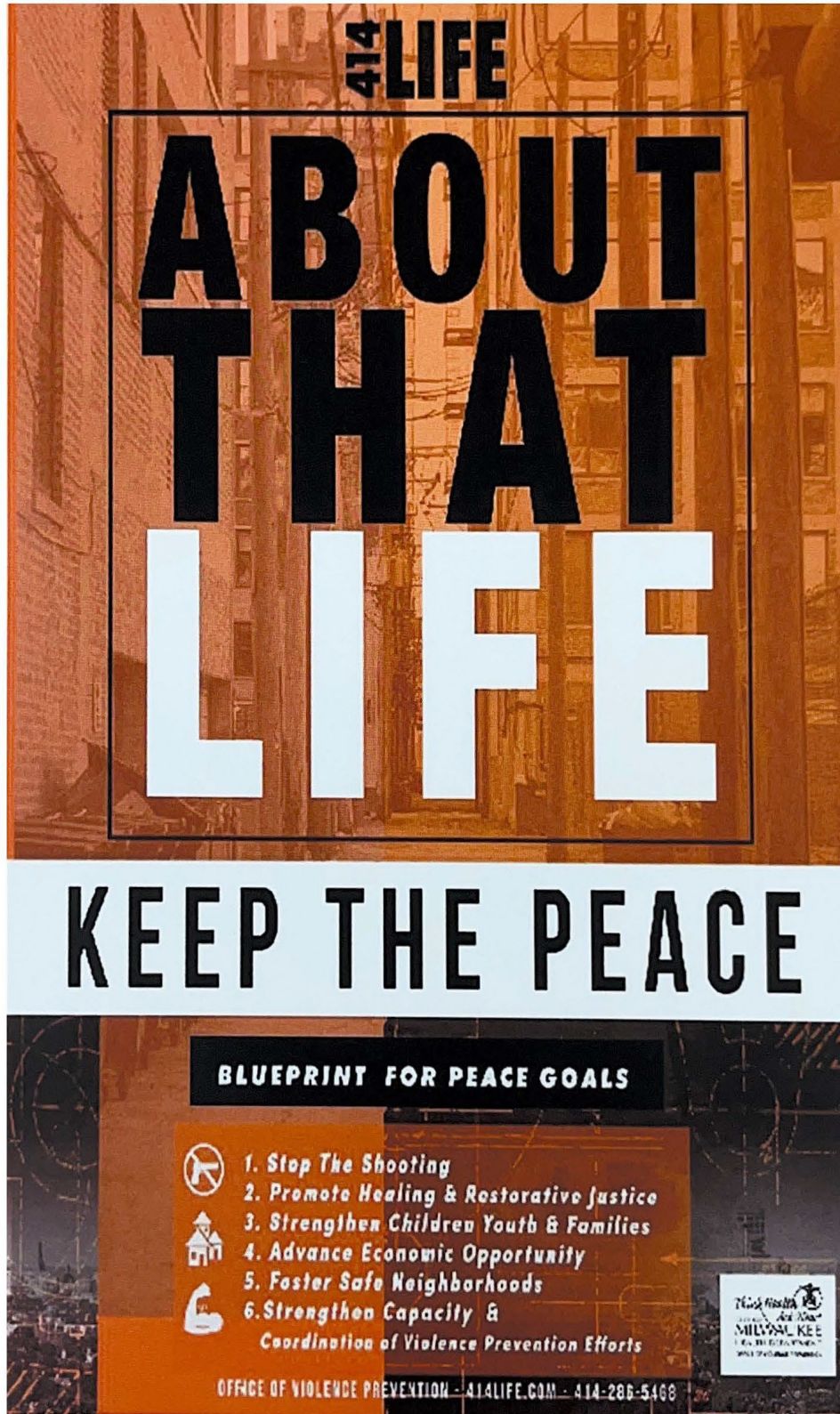
STD TESTING AND TREATMENT

Sixteenth Street Community Health Center:
 414-672-1353
 Keenan Health Center: 414-286-8840
 Northwest Health Center: 414-286-8830
 Southside Health Center: 414- 286-8620






Front Side



414LIFE

ABOUT THAT LIFE

KEEP THE PEACE

BLUEPRINT FOR PEACE GOALS

1. Stop The Shooting
2. Promote Healing & Restorative Justice
3. Strengthen Children Youth & Families
4. Advance Economic Opportunity
5. Foster Safe Neighborhoods
6. Strengthen Capacity & Coordination of Violence Prevention Efforts

OFFICE OF VIOLENCE PREVENTION - 414LIFE.COM - 414-286-5468

Think Health
MILWAUKEE
THE HEALTHY COMMUNITIES FOUNDATION

Back Side

YOUTH SERVICES
 BOYS & GIRLS CLUBS – 414-267-8100
 CHILDREN'S MOBILE CRISIS – 414-267-7621
 COA YOUTH & FAMILY CENTERS – 414-269-8383
 DIVERSE & RESILIENT – 414-380-3444
 PATHFINDERS – 414-964-2886
 RUNNING REBELS – 414-264-8222
 URBAN UNDERGROUND – 414-444-8728
 WALKERS POINT YOUTH & FAMILY CENTER – 414-447-8200
 WESTCARE – 414-233-9359

DOMESTIC VIOLENCE/SEXUAL ASSAULT/HUMAN TRAFFICKING:
 SOJOURNER FAMILY PEACE CENTER – 414-276-1811
 ARROW HEALING AND ADVOCACY SERVICES – 414-219-3999
 PRICELESS INCITE – 414-780-3886
 THE AFNA PROJECT – 414-282-0076
 UMOS LATINA RESOURCE CENTER – 414-381-8500
 THE BENEDICT CENTER – 414-347-1774
 A CRY FOR HELP – 414-334-4081
 FOUNDATIONS FOR FREEDOM – 414-328-7273
 HONOR AMERICA WOMEN'S ASSOCIATION – 414-482-6031

ADDICTION SERVICES:
 12 STEP CLUB INC. – 414-871-0610
 ARROW AODA TREATMENT – 414-454-8588
 META HOUSE – 414-462-1200
 NARCOTICS ANONYMOUS – 1-866-873-3837

HOUSING:
 REPAIRERS OF THE BREACH – 414-342-8323
 THE GUEST HOUSE – 414-345-3240

EMPLOYMENT:
 EMPLOY MILWAUKEE – 414-276-1700
 MILWAUKEE CHRISTIAN CENTER – 414-946-6260
 NORTHCOTT NEIGHBORHOOD HOUSE – 414-972-3770
 UMOS – 414-381-1607
 MISCELLANEOUS COMMUNITY SERVICES – 414-260-0400
 WRTP BIG STEP – 414-347-9787

LEGAL RESOURCES:
 LEGAL AID SOCIETY OF MILWAUKEE – 414-727-5200

SOCIAL SERVICES:
 COMMUNITY ADVOCATES – 414-876-3048
 IMPACT 211 – 414-773-0211 (1-866-211-1288 TOLL FREE)
 SOCIAL DEVELOPMENT COMMISSION – 414-306-2700
 MENTAL HEALTH AMERICA – 414-278-3122 (1-800-273-8266 CRISIS LINE)
 STATE OF WISCONSIN VICTIMS OF CRIME SERVICES – 1-800-448-6584

CONFLICT RESOLUTION/VIOLENCE PREVENTION MEDIATION SERVICES:
 10,000 FEARLESS STOP THE BEEF HOTLINE – 414-399-2790
 TEAM HAVOC – 414-313-8200
 X-MEN UNITED – 414-618-1819
 WISCONSIN BOB SQUAD – 414-585-9511

PARENTING RESOURCES:
 HAVE VISITING PROGRAM – 414-285-8628
 LEAD TESTING – 414-286-3921
 MILWAUKEE FATHERHOOD INITIATIVE – 414-236-3663
 M/F FATHER'S HOUSE – 414-353-9015
 THE PARENTING NETWORK – 414-871-0588

ADDITION SERVICES:
 12 STEP CLUB INC. – 414-871-0610
 ARROW AODA TREATMENT – 414-454-8588
 META HOUSE – 414-462-1200
 NARCOTICS ANONYMOUS – 1-866-873-3837

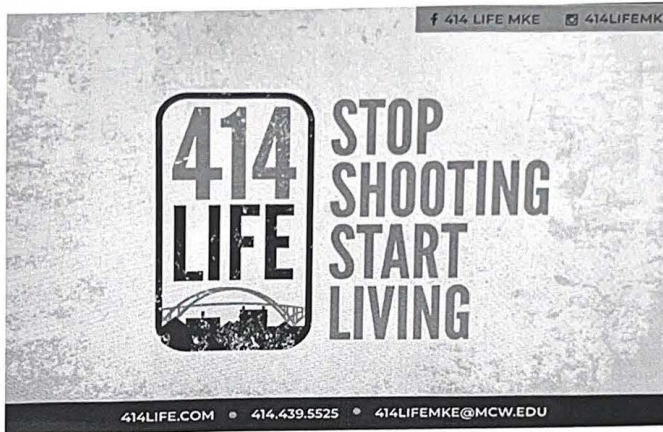
STD TESTING:
 HOLTON STREET CLINIC – 414-264-8800
 KEENAN HEALTH CENTER – 414-896-6926
 SIXTEENTH STREET COMMUNITY HEALTH CENTER – 414-672-1858

FOOD PANTRIES:
 FEEDING AMERICA – 414-931-7400
 MILWAUKEE ISLAMIC DAWAH CENTER – 414-462-1888

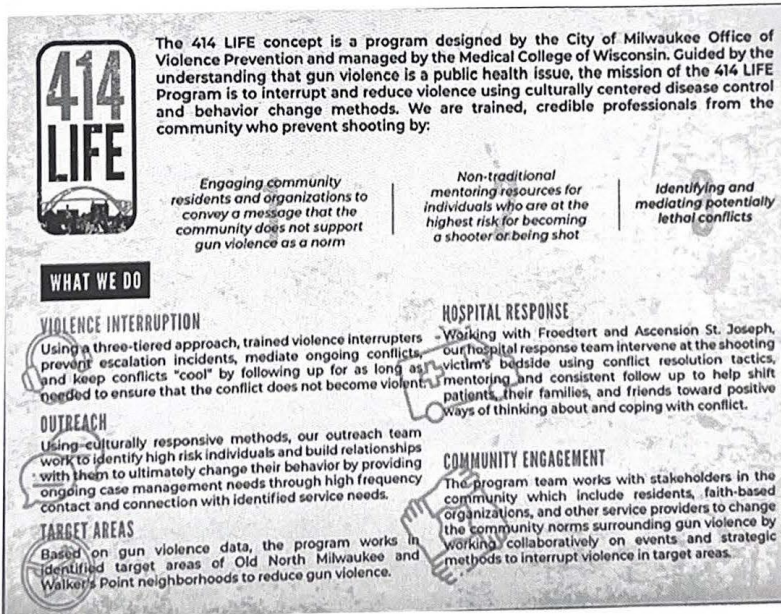
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OFFICE OF VIOLENCE PREVENTION - 414LIFE.COM - 414-286-5468

414LIFE: 414-439-5525 414LIFE.COM



Front Side



Back Side

F. Scheduling efforts with and participation of external stakeholders in evaluation interviews & focus groups

| Appendix F. External Partner Participation in Evaluation Interviews/Focus Groups and Scheduling Efforts | | |
|--|---------------------|--|
| External Partner Organization | Participated | Total Partners Participated (Total Contacted) |
| Milwaukee Office of Violence Prevention (OVP) | ✓ | 2 |
| Milwaukee Police Department (MPD) | ✓ | 5 |
| Milwaukee County Department of Health and Human Services | ✓ | 1 |
| Community-Based Organizations (4) | ✓ | 2 (9) |
| Milwaukee Public Schools (MPS) | X | 0 (3) |
| City of Milwaukee Elected Officials | ✓ | 1 (4) |
| Froedtert Hospital | ✓ | 8 (13+) |