A B S T R A C T

The inspection certificate program consists of food establishments voluntarily posting a certificate to inform patrons that inspection reports can be accessed from operators or the public health department. A three-month pilot program was evaluated for program improvement purposes. Only 65% of the selected operators were willing to participate, which suggests a challenge to fully implementing the program. Thirty-nine randomly selected restaurant operators participated. Most operators posted the certificate at the front entrance, and patrons indicated that reports were clear. Operators were supportive of the program. Some operators reported that the program was good for business and offered suggestions to improve it. A total of 583 requests for reports were made which suggests that the program empowered patrons to request reports, mostly from operators. Most patron evaluation forms came from a few operators that had no deficiencies, which limits generalizability.

A B R É G É

Le programme des certificats d'inspection est un programme selon lequel les établissements de restauration acceptent volontairement d'afficher un certificat informant leurs clients que les rapports d'inspection sont disponibles auprès du restaurateur ou du service de santé publique. Un programme pilote de trois mois a été évalué en vue de voir comment améliorer le programme en question. Seuls 65 % des établissements sélectionnés étaient prêts à participer, ce qui laisse penser que la pleine mise en oeuvre du programme ne se fera pas sans difficulté. Trente-neuf restaurateurs sélectionnés au hasard ont participé. La plupart ont affiché le certificat à la porte d'entrée de leur établissement et les clients ont dit l'avoir clairement vu. Les restaurateurs étaient en faveur du programme. Certains d'entre eux ont dit que cela aidait leur commerce et ont offert des suggestions pour l'améliorer. Cinq cent quatre-vingt trois (583) demandes de consultation du rapport d'inspection, essentiellement auprès du restaurateur, ont été faites au total, ce qui suggère que le programme a habilité les clients à en faire la demande. La plupart des formulaires d'évaluation par les clients sont venus de quelques restaurateurs qui n'avaient rien à se reprocher, ce qui limite la généralisation.

Formative Evaluation of an Inspection Certificate Program (ICP) Pilot in Toronto

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The Environmental Health Division in the NYPHD developed the Inspection Certificate Program (ICP), a strategy of proactive disclosure of public health violations in North York restaurants. Consumers currently can access inspection results of food establishments within 30 days under the Municipal Freedom of Information Act. The ICP allows for more timely access to inspection results. The ICP empowers consumers to make informed decisions about whether or not to frequent an establishment which, in turn, provides an incentive for operators to maintain high food safety and sanitation standards.¹

The ICP consists of food establishments voluntarily posting a certificate that informs patrons that the establishment is routinely inspected by a public health inspector (PHI) and that inspection reports can be accessed either from the owner or operator of the establishment or the NYPHD. Upon receiving a request, the NYPHD discloses inspection results in writing within 24 hours.

Several disclosure programs²⁻⁵ were reviewed, and the ICP was designed to be similar to the Ottawa-Carleton Health Department's disclosure strategy, which consists of food services establishments voluntarily posting an information plaque. Ninety percent of the establishments posted plaques in 1993.² There is little docu-

mentation on the evaluation of Ottawa's program.

Disclosing public health inspection reports has not been adequately evaluated. The ICP was in an early stage of development, therefore, a formative evaluation, which focuses on program improvement, was more appropriate than an evaluation of the program's merit. A program needs to be well conceptualized and of good quality before its effectiveness can be properly assessed. Accordingly, a formative evaluation of a pilot was done as an initial step to possible full implementation in 1998. This article reports on (a) the feasibility of implementing the ICP, (b) the acceptability of the program among operators and consumers, and (c) the ability of the program to empower consumers.

METHOD

Participants and sampling

The primary target group was operators of high-risk restaurants in North York. High-risk restaurants prepare hazardous foods, and serve a high-risk population and/or use processes that include many preparation steps and foods often associated with food-borne illness.⁶

The sample was randomly selected from the list of 369 high-risk restaurants in the North York Environmental Health Information System (EHIS)(see Figure 1). Initially, 118 restaurants were asked to participate in the pilot. Of these, 77 operators were willing to participate. They were randomly assigned to either ICP (39) or comparison (38) restaurants.†

To examine whether there was selection bias, the 39 ICP restaurants and 41 restaurants not willing to participate in the pilot were compared on their average total num-

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* Effective January 1, 1998, the City of North York Public Health Department (NYPHD) was amalgamated into the new City of Toronto Public Health Department.

ber of different EHIS deficiencies most recently observed before the pilot. The average total score could range from 0 to 11. A two-tailed t-test indicated that ICP restaurants had significantly fewer EHIS deficiencies ($M = 0.4$; $SD = 0.6$) than did restaurants not willing to participate in the pilot ($M = 0.8$; $SD = 0.9$) ($t = -1.99$, $df = 78$, $p \leq 0.05$).

Measures

Various measures were developed to track where inspection certificates were posted, distribution of ICP information materials, promotion of the ICP, and number of requests for reports. Patron comment cards, which were put on tables in ICP restaurants for seven consecutive days in September, and an interview guide for ICP restaurant operators were developed.

Evaluation design

A post-test-only design, which consisted of implementing and monitoring the three-month pilot and assessing outcomes during and after the program, was used.

Procedure

A workgroup developed a program logic model to conceptualize the program and make it ready for an evaluation. It described the goals, target groups, outcome objectives and corresponding indicators, and process objectives and corresponding indicators.

† The authors discussed the idea of examining whether the pilot improves ICP restaurants' "state of health", as measured by EHIS deficiency indicators before and after the pilot. They did not expect any change because inspection results may not be stable over the short time period of the pilot and the pilot is too short to observe such an improvement. Nonetheless, initially, 77 restaurants that were willing to participate in the pilot were randomly assigned to either ICP (39) or comparison (38) restaurants to examine the impact of the pilot on inspection results for exploratory purposes only. Thus, the response rate was 65% (i.e., 77 restaurants willing to post a certificate ÷ (77 restaurants willing to post a certificate + 41 restaurants not willing to post a certificate)). However, the topic was not subsequently examined because considerable resources were needed to retrieve the EHIS data simply to do exploratory data analyses, and the required resources were no longer available due to circumstances unrelated to this project. It would be worthwhile to examine this topic in the future when the ICP has been implemented for a sufficient length of time.

Instruments for each of the indicators were developed. Restaurants were randomly selected. An in-service was given to environmental health management and staff. Background information on the ICP was provided and administration of the instruments in a standardized manner was discussed.

The pilot was implemented and monitored from July 1 to September 30, 1997. PHIs interviewed 37 of the 39 ICP restaurant operators in October to obtain their feedback on the pilot. Two new operators were not interviewed because they were not very familiar with the pilot.

Data analyses

SPSS for Windows was used to do descriptive statistics. There were some incomplete measures and hence, the analysis of data for some measures was sometimes based on a different number of respondents. Responses to open-ended questions were examined to identify typical and insightful comments. Quotations indicate verbatim comments and the symbols < > indicate non-verbatim comments.

RESULTS AND DISCUSSION

Feasibility of implementing ICP

Promotion of ICP Information Materials

Flyers, newsletters, and other materials were distributed at various sites to promote the program. Thirty-eight people phoned the NYPHD to obtain the list of restaurants participating in the ICP, based on reading promotional materials and newspaper articles about the program. PHIs provided information about the program during various presentations to students, the public, and environmental health staff.

Where Certificates were Posted

PHIs recorded where certificates were posted. Thirty-three restaurants had a certificate clearly visible when entering the premises. These certificates were posted at the front entrance (24) and in the cash register area (6) and dining room (3). The remaining restaurants had a certificate not clearly visible when entering the premises. (A PHI did not record where the certificate was posted in a restaurant that recently had a change of ownership as the new owner was not familiar with the pilot.) However, a certificate posted behind the bar also prompts patrons to request the report. One restaurant that posted the certificate in the bar area received 87 requests.

Timeliness of Reports

Four patrons requested a total of 8 reports from the NYPHD. On average (median), reports were made available within 24 hours. This finding should be interpreted cautiously because it was based on only a small number of requests.

Clarity of Reports

PHIs prepared reports that clearly communicated the health status of restaurants

to patrons. Patrons who read the report at ICP restaurants were asked to complete a form to comment on the clarity of the report. A total of 575 forms were completed. All patrons, exception one, indicated that the report was clear and easy to understand.

Acceptability of ICP among operators

Operators' Willingness to Participate in ICP

Seventy-seven operators were willing to participate in the pilot. Operators were not willing to participate for the following reasons: not interested (12); did not reply to PHIs' request (16); did not want reports made available to the public (5); too much paper work (7); and participate after the pilot "ironed out the bugs" (1).

Operators' Return of Evaluation Forms

Operators gave a form to patrons who requested reports. Based on completed forms, patrons accessed reports at only 12 restaurants and 63% of completed forms came from 1 restaurant. It appears that reports were not accessed at most restaurants. A more likely explanation is that patrons accessed reports at some restaurants but operators did not record the number of requests. Several operators indicated that they did not want to do paperwork associated with the pilot. Thus, the number of requests for reports may be underestimated. Also, completed patron comment cards from only 11 ICP restaurants were returned. Thirty-five percent of the cards came from one restaurant. In future, the importance of collecting evaluation data should be emphasized to operators, with a request that they collect at least minimal data.

Feedback from ICP Restaurant Operators

Fifteen operators reported that the program improved food safety and sanitation standards in their restaurants. A typical comment was "Reminds employees to wash their hands ..." In contrast, operators who stated that it made no difference (22) explained that they have always had high standards.

Some operators (7) reported that, financially speaking, the program has been good for their business. This is promising considering that the pilot was carried out for

only three months. No operators said that the program was bad for business.

Operators offered suggestions to improve the program. These included <Make the public more aware of this program.>, <... we need a more visible, attractive certificate.>, and <Give more than 1 certificate or a bigger one.>

Empowerment of consumers

The ICP was successful in empowering patrons to request reports. A total of 583 requests were made. Patrons accessed reports mostly at the point of purchase – 575 requests at the ICP restaurants and 8 requests at the NYPHD.

Reports were accessed most frequently at the beginning of the pilot. Over half (55%) of the reports were accessed within the first four weeks of the pilot. During this period, operators may have been quite enthusiastic about the program and proactively promoted their participation in the program. PHIs could continually promote the ICP during inspection visits to maintain operators' enthusiasm in the program.

The certificate notes that reports are left with the operator of the establishment and are available from the NYPHD. The certificate does not specifically indicate that patrons can access reports from the operator and thus, the certificate wording will be revised.

Acceptability of ICP among consumers

A total of 288 comment cards were completed. Most respondents (79%) reported that they read the certificate. This supports PHIs' observation that, in general, the certificates were clearly visible when entering the premises. Most respondents (89%) reported that they learned how to get information about restaurants' sanitation standards and food handling practices because of reading the certificate.

The results suggest there is an economic incentive for operators to participate in the ICP. Most respondents (78%) would choose to go to a restaurant that posts the certificate rather than a restaurant that does not. This finding should be highlighted when marketing the program among operators. Possible explanations for a "does not matter" answer (15%) is that some patrons may feel comfortable relying on

other factors (e.g., perception of how clean the restaurant is) to choose a restaurant. It is not clear why respondents (7%) would choose a restaurant that does not post the certificate. Perhaps some patrons misinterpreted the wording on the certificate, thinking that the restaurant is regularly inspected because it has problems. The wording will be revised to address this.

Also, there is an economic incentive for ICP operators who have positive reports to make them available to patrons. Most respondents (74%) stated that if they read a report that showed good results, they would go there more often.

CONCLUSION

In summary, the results showed support for the full implementation of the ICP but identified some issues to address. There was mixed support for the acceptability of the ICP among operators. The ICP encouraged patrons to take that important step to self empowerment, namely, requesting reports. The findings support the acceptability of the ICP among patrons.

The results should be interpreted cautiously considering some limitations of the evaluation. First, only 65% of operators contacted were willing to participate. There was selection bias in that operators who had fewer deficiencies at their restaurants were more likely to volunteer to par-

ticipate. A challenge will be to get operators of restaurants with poor inspection records to voluntarily participate. There was further selection bias in that a few operators that have no deficiencies generated most of the forms completed after requesting reports or completed comment cards. Therefore, the results address the acceptability of the program among operators and patrons of restaurants that have good inspection records and cannot be generalized to all operators and patrons.

There is the possibility of an interviewer bias. PHIs did face-to-face interviews with operators during inspection visits to yield a higher response rate and quicker results. However, some operators could have given socially desirable responses. In the future, another method such as a self-administered survey could be used.

This study was a utilization-focused evaluation that was developed and implemented to foster its eventual use.⁷ Management and staff participated in the evaluation process such as writing evaluation objectives, developing the evaluation design and measures, and collecting, analyzing, and interpreting data. This provided them with the opportunity to increase their understanding and appreciation of evaluation, to increase their ownership of the evaluation, and to later utilize the results. They have already made changes to the program based on the results.

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