Do-Eat
Performance-Based
Assessment Tool
for Children

The Do-Eat Assessment is a reliable and valid assessment that was developed to evaluate the areas of strength and difficulty in activities of daily living and instrumental activities of daily living among children with a variety of disorders, such as developmental coordination disorder, attention deficit hyperactivity disorder, non-verbal learning disabilities and learning disabilities. The Do-Eat is suitable for children with either a chronological or behavioral age of five to eight years.

The Do-Eat is composed of three related activities, performed one after the other, similar to sequences required in daily life. Each activity is designed according to a sequence of tasks required to perform the overall activity. The observation and the scoring are performed on two dimensions: observation and analysis of the tasks required for each activity, and a parallel observation and analysis of the performance skills (sensory-motor, executive functions and behavioral and emotional measures). The information gathered can be used to define therapeutic goals, for meaningful intervention that takes the child’s level of functioning in his or her natural environment into account.

The Do-Eat is an ecologically valid assessment as it is based on both top-down and bottom-up approaches. It is unique as it examines sensory-motor performance skills, executive functions, behavioral and emotional measures and their impact on global performance of daily activities. In addition, The Do-Eat Assessment includes dynamic assessment principles with the aim of evaluating the type of conditions, assistance and mediation the child needs to perform the activity successfully. Mediation is given through a standard, structured, pre-determined system of cues.

Advantages of the Do-Eat include:
• The assessment can be performed in just about any environment
• The assessment provides a wealth of information about how the child functions in his or her natural environment, in just half an hour
• Children enjoy the assessment and are cooperative
• The assessment can also be used to foster a relationship between the tester and the child
• The parents are partners in the process; they contribute knowledge about the child’s functioning from their perspective

Developed by Sara Rosenblum PhD., Naomi Josman PhD. and Ayelet Goffer M.Sc.

Catalog Number: 71829-0000
DLOTCA™ and DLOTCA-G™ (geriatric version) are a series of cognitive tests that enable a therapist to evaluate clients with neurological deficits in order to obtain a detailed cognitive profile, enabling intervention planning for management and maintenance.

Both DLOTCA™ and DLOTCA-G™ build off the research used to develop the original LOTCA series; however, the previous versions of LOTCA™ and LOTCA-G™ were static in nature measuring only the “here and now”. The DLOTCA™ and DLOTCA-G™ incorporate a dynamic learning component that provides the examiner with the ability to measure learning potential and recognize thinking strategies through the use of mediation.

Primary goals of each assessment are:

- To identify the abilities and disabilities of the individual subjects in the different cognitive areas
- To measure learning potentials and recognize thinking strategies through the use of dynamic assessment
- To identify the level of awareness of the subject to his or her condition and cognitive disability

5 levels of mediation:

- General intervention
- General feedback
- Specific feedback
- Partial intervention
- Copying or subtracting amount (simplifying task)

For each sub-test, except Orientation, Awareness and Memory, there is a structured 4-5 step mediation option. An individual’s initial incorrect response is not taken as the final product of the evaluation task. Instead, the examiner utilizes a systematic approach to modify the task through prompts or mediation. This enables the examiner to begin to understand the type of information that is necessary for the individual to complete certain tasks. This understanding is helpful in developing effective remediation strategies and can be used as a baseline for choosing and designing an intervention program.

Each version was designed to provide standardized testing procedures and establish norms for systematic data collection in cognitive assessment. Published studies are available upon request.
DLOTCA™ – Intended for the evaluation of people aged 18-69. Consists of 28 subtests in 7 cognitive areas:
• Orientation
• Awareness
• Visual Perception
• Spatial Perception
• Praxis
• Visuomotor Construction
• Thinking Operations
• Memory

DLOTCA-G™ – Intended for evaluation of clients aged 70 and over, the geriatric version was developed to address certain difficulties people may experience during the normal aging process such as difficulty being able to see or manipulate small objects. The differences between DLOTCA and DLOTCA-G are:
• Shorter administration time
• Enlarged items
• Reduced pictorial detail
• Addition of a short memory screening

DLOTCA-G™ consists of 24 subtests in 8 cognitive areas:
• Orientation
• Awareness
• Visual Perception
• Spatial Perception
• Praxis
• Visuomotor Construction
• Thinking Operations
• Memory

Catalog Number: 71826-2000

Catalog Number: 71826-2050
The DOTCA-Ch™ Battery – Dynamic Occupational Therapy Category Assessment for Children

The DOTCA-Ch™ was designed to provide a baseline measurement of cognitive interventions for children who are referred for treatment as a result of possible developmental, cognitive, or academic and learning difficulties. It can also be used for children with brain injuries, as well as mild intellectually impaired children. The DOTCA-Ch™ serves as a foundation for the cognitive evaluation of children in an efficient and friendly format while providing pediatric practitioners with the tools they need to plan intervention strategies tailor-made for the individual child.

The DOTCA-Ch™ was designed based on the research used to develop the original LOTCA™ series. However, unlike LOTCA™, which is static in nature and only measures the “here and now”, DOTCA-Ch™ is a dynamic assessment providing professionals with the opportunity to estimate the individual’s potential for learning or receptiveness to instruction.

The DOTCA-Ch™ consists of 22 subtests in five cognitive areas:

1. Orientation
2. Spatial Perception
3. Praxis
4. Visuomotor Construction
5. Thinking Operations

Standardization, reliability and validity properties were established and collected for typical children ages 6-12 and groups of children with learning disabilities and brain injury.

The DOTCA-Ch™ was designed to be administered in three test phases:

1. Static phase: The child undergoes testing of his/her cognitive status to establish a baseline
2. Dynamic phase: The examiner provides, as required, the child with structured hierarchical cues to elicit his/her maximum learning potential
3. Learning potential and receptiveness to instruction: The examiner re-administers the test items and determines if the child’s performance has improved

When the purpose of the test administration is to establish a baseline measurement of a child’s cognitive performance, the static testing phase can be administered alone. When the test is being administered to determine a child’s ability to benefit from mediation or to plan intervention all 3 test phases should be utilized.

The DOTCA-Ch™ consists of 22 subtests in five cognitive areas:

1. Orientation
2. Spatial Perception
3. Praxis
4. Visuomotor Construction
5. Thinking Operations


Catalog Number: 71823-0000

The Cognitive Performance Test (CPT) is a standardized occupational therapy assessment initially developed as a research instrument to assess cognition in daily task performance and change over time in individuals with Alzheimer’s disease (AD). Currently, the test is used with a variety of diagnostic groups in hospital settings, outpatient and community clinics, in sub-acute and long-term care facilities and in the home. The CPT is used to explain and predict the client’s capacity to function in various contexts and guide intervention plans, as well as to measure and track the severity of a cognitive-functional disability such as with AD. It examines cognitive integration with functioning in an environmental context; by incorporating cognitive challenges within the complexity of an IADL context in order to evaluate higher levels of cognition in function and in particular rate executive control function, the group of cognitive processes that mediate goal-directed activity.

CPT is comprised of 7 subtasks for which the task cues and working memory requirements can be systematically varied to assess the severity of disability. Four of the subtasks (Medbox, Shop, Phone, and Travel) scale to level 6, and three subtasks (Wash, Toast, and Dress) scale to level 5, as these involve less complex processing requirements. CPT performance levels range from intact performance (Level 6 or 5) to profound disability (Level 2). At each higher CPT level, the task cues used in performance are more complex resulting in working memory behavior that is more organized and complex. Each CPT subtask performance is rated with a gross level score (e.g., 6.0; 5.0; 4.5; 4.0; 3.5; 3.0; 2). Subtask scores are then averaged (added and divided by the number of subtasks given) for a total score. The ceiling is 5.6 and generally reflects intact cognitive-functional abilities. Interpretations of CPT scores (e.g., CPT total scores) are made within the context of the demands of the client’s own activities and environments and within the context of their individual mediating factors. General profiles for interpretation are supported by empirical evidence at CPT half-level correlates.

<table>
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<tr>
<th>CPT Level</th>
<th>Characteristics of Functional Cognition</th>
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<tbody>
<tr>
<td>5.6</td>
<td>Intact functioning. Relevant information from all memory stores can be activated and used purposefully to carry out complex activity with accuracy.</td>
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<tr>
<td>5.0</td>
<td>Mild functional decline due to deficits in executive control functions. Check-in support and assistance with IADLs may be needed. ADLs typically show no change.</td>
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<tr>
<td>4.5</td>
<td>Mild to moderate functional decline due to significant deficit in executive control functions; difficulty with divided attention and solving problems. Complex tasks are performed with inconsistency or error. With IADL, the person struggles to manage the details. Independent living and driving poses significant risk. IADL assistance and/or in-home assistance are needed. Assisted living environments may provide a good fit.</td>
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<tr>
<td>4.0</td>
<td>Moderate functional decline; from abstract to concrete thought processes. The person relies on familiar routines and environments and uses what they see for cues as to what to do. IADLs need to be done by or with others. ADLs are remembered but typically the quality shows decline. The person is not safe to live alone.</td>
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<tr>
<td>3.5</td>
<td>Moderate functional decline; concrete thought processes. ADLs require set-up and often direction during performance. Needs 24-hour care; may benefit from supportive residential placement.</td>
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<tr>
<td>3.0</td>
<td>Moderate to severe functional decline; from concrete to object-centered thought processes. Increased cues needed during tasks. One-to-one assistance for all ADLs.</td>
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<tr>
<td>2.0</td>
<td>Severe functional decline; from object-centered to movement/sensory processes. Poor use of familiar objects. Total assist with ADL. May be resistant with cares. Little speech.</td>
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CPT empirical evidence from NIA longitudinal studies, VA GRECC, and UMN references are included in the manual.

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Updated Manual

Catalog Number: 71837-0000
BaFPE™ was developed as a reliable and valid method to assess general components of function that a person needs in order to be able to perform everyday activities of daily living. The test targets the ability for adults and adolescents to perform goal-directed and task-oriented activities as well as the ability to maintain appropriate social relations.

BaFPE™ is consistent with the acquisitional and occupational behavior frames of reference in that it focuses on present functioning, evaluates acquired skills and assumes that successful interaction with the environment includes the productive and active use of these skills. BaFPE™ is appropriate to be used with psychiatric, brain-injured, and developmentally disabled adolescents and adults, as well as with the geriatric population.

The main goal of BaFPE™ is to be used as an indicator to determine the level of overall functional performance. Functional performance requires the ability to relate to both objects and people in the environment. BaFPE™ utilizes two separate evaluations to measure each component of functional performance:

- **Task Oriented Assessment (TOA):** Provides information about cognitive, performance and affective components of functioning. It yields information about a client’s functioning in a task oriented one to one setting.

- **Social Interaction Scale (SIS):** Behavioral scale that assesses behaviors of an individual that are considered important to overall functioning.

The TOA consists of 5 tasks:

- Sorting Shells
- Money & Marketing
- Home Drawing
- Block Design
- Kinetic Person Drawing

Each task is scored according to 12 functional parameters:

- **Cognitive Parameters**
  - Memory for written and verbal instructions
  - Organization of time and materials
  - Attention span
  - Evidence of thought disorder
  - Ability to abstract

- **Performance Parameters**
  - Task completion
  - Errors
  - Efficiency

- **Affective Parameters**
  - Motivation and compliance
  - Frustration or tolerance
  - Self-confidence
  - General affective and behavioral impression
The TOA and SIS may be used separately or together. If used separately information taken from the evaluation cannot be used as an indicator of overall functional performance as that requires the ability to relate to both objects and people.

The BaFPE™ manual includes reliability and validity studies as well as a bibliography of over 30 publications or research studies, addressing the continued validation of the BaFPE™ with various populations. The kit includes a loose leaf binder containing a manual of background information, directions for administering the TOA and the SIS, administration forms, rating guides and worksheets. It also includes a set of sea shells, a set of design blocks and associated items.

A replacement kit which includes 25 copies each of the 11 printed materials (forms, worksheets, rating guides and practice checks) supplied with the full kit is available (71827-0001).

Developed by Judith S. Bloomer Ph.D., OTR and Susan Lang MBA, OTR

**Catalog Number: 71827-0000**
The TCA was designed to examine the ability of adults with brain injury or psychiatric illness to establish categories and switch conceptual sets. The organization of stimuli into categories or groups represents a basic method of coping with environment demands. Sorting tasks are often used to assess categorization skills. The TCA emphasizes qualitative aspects of performance and utilizes dynamic assessment principles that seek to estimate the degree to which the individual’s performance can be modified or changed.

The TCA uses plastic utensils that can be sorted by size, color and type. While administering the TCA the examiner can provide cues or alter test administration procedures if the patient has difficulty.

**Depending on the patient’s performance several different levels of cueing can be used:**

- **General cues** – Involves general comments that are designed to help the patient check his or her work. This is a basic “look again” type of cue.

- **General feedback** – Vaguely provides the patient with information that the groups are not correct but it does not provide information on why they are not correct.

- **Specific feedback** – Provides specific information as to why the groups are not correct.

- **Structured categories** – Enables the examiner to establish one category of size, type or color.

- **Reduced amount** – Enables the examiner to remove one of the categorization sets in order to make the sorting process less complex.

Understanding the reason a patient has difficulty switching conceptual sets as well as the cues that can be used to facilitate performance are essential for choosing intervention strategies. The types of cues the individual responds to provide information that can later be used in treatment planning.

Additionally, the TCA examines the level of the patient’s cognitive self-awareness. Decreased awareness of one’s own cognitive deficits is a common manifestation after brain injury. The ability to evaluate the difficulty of a task in relationship to one’s own capacities, anticipate difficulties and recognize errors when they have occurred are recognized as critical components of learning. Awareness of one’s own deficit is a prerequisite to active compensation. The TCA examines awareness through the use of standard questions. The responses to the questions provide descriptive information that can be used when planning treatment. For ages 18 and older; populations include schizophrenia, neurological impairments such as cerebral vascular accident, brain tumor, head injury, cerebral hemorrhage.

Developed by Joan Toglia MA, OTR

Catalog Number: 71825-0000