

Promoting Family-Centered Care: A Provider Training Effectiveness Study

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Importance: Although family-centered care (FCC) is a best practice in pediatrics, health care providers report challenges in translating FCC from theory to practice.

Objective: To measure the effectiveness of the Better Together (BT) training to enhance providers' changes in FCC practice and self-efficacy.

Design: Pretest–posttest quasi-experimental design.

Setting: Continuing education centers in Israel.

Participants: Eighty-two participants—occupational therapists, speech-language pathologists, physical therapists, and art therapists—working in outpatient or school-based pediatric practices.

Intervention: We developed BT on the basis of adult learning theory to prepare providers to implement best practices in FCC. The training was delivered as six consecutive in-person workshops (30-hr total over 10 wk).

Outcomes and Measures: We used the Measure of Processes of Care (MPOC) Service Provider and Confidence versions to measure providers' perceptions of how they used specific aspects of FCC in their practice and their related self-efficacy.

Results: Observed changes included improved reports of FCC implementation and increased self-efficacy in all MPOC domains, with medium effect sizes. These outcomes were positively interrelated. Before the training, providers in outpatient settings who had more years of experience reported higher FCC use than less experienced participants in other settings; these differences disappeared by the end of the training.

Conclusions and Relevance: BT training can enhance health care providers' perceptions of FCC implementation and self-efficacy and minimize differences in FCC implementation by providers across expertise levels and practice settings. This study can inform the development of future FCC training interventions for providers, managers, educators, and researchers.

What This Article Adds: Intensive training can improve both the way practitioners work with families and their self-efficacy in doing so. This study highlights the importance of self-efficacy in promoting knowledge translation.

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Family-centered care (FCC) is widely recommended as a best practice in pediatric occupational therapy (American Occupational Therapy Association, 2020). The FCC approach is based on establishing successful partnerships between health care providers and families and can lead to better intervention outcomes for children and families, providers, and organizations

(Committee on Hospital Care & Institute for Patient- and Family-Centered Care, 2012; Nickel et al., 2018). However, parents and providers have reported that many services are not sufficiently family centered (Almasri et al., 2018; King & Chiarullo, 2014; King et al., 2017). There is a knowledge translation gap between FCC theory and practice, and one reason is inadequate training of health care

providers (Bamm & Rosenbaum, 2008; King & Chiarello, 2014). To address this gap, we developed the Better Together (BT) training program to promote providers' skills and self-efficacy in delivering FCC.

Studies of FCC training programs have shown that they can enhance FCC-related knowledge and positive attitudes (e.g., Keisling et al., 2017; Whitman et al., 2002) and improve FCC implementation (e.g., Altimier et al., 2015; An et al., 2019; Brown & Woods, 2012; Dunst et al., 2011; King et al., 2011; Toivonen et al., 2019). Although these studies consistently demonstrated the benefits and importance of training, the programs differed in instructional design and research methodology, instructional methods (lecture, workshop, or ongoing mentorship), conceptual models taught, trainees' professions (e.g., nurses, occupational therapists, physical therapists, physicians), expertise (students to experts), and duration (from a few hours to a year). Program outcomes evaluated also differed across studies and included changes in attitudes toward, knowledge about, and implementation of FCC.

Only two studies administered repeated standardized outcome measures (An et al., 2019; King et al., 2011); the others used qualitative or quantitative measures developed specifically for those studies in the form of retrospective or posttest surveys. King et al. (2011) used a pretest–posttest experimental research design to evaluate an 11-mo mentorship program for 25 occupational therapists aimed at enhancing family-centered skills and behaviors. The program included group peer mentoring, consisting of a facilitated discussion of case studies, and individual mentoring for novice practitioners. An et al. (2019) conducted a randomized controlled trial with 16 physical therapists that examined the effects of a 6-wk collaborative intervention model including 6 hr of provider instruction. Consistent with these studies, we used a pretest–posttest design with standardized measures to capture patterns of group- and individual-level change in the novel BT training.

Accumulating evidence indicates that the key training ingredients to foster the application of FCC knowledge in practice are the content taught (what) and the instruction methods used (how). *What* should be taught includes knowledge and skills in core FCC elements; translation of knowledge and skills into methods for collaboration between family members and health care providers; consideration of family contexts; FCC-related policies and procedures; and education interventions for clients, families, and health care professionals (Kokorelias et al., 2019). *How* it should be taught is to use a learner-centered approach based on adult learning theory (Knowles et al., 2012). The principles of adult learning theory include encouraging learner involvement in learning and evaluation processes, highlighting practical learning through experiencing and problem solving, drawing from

learners' past knowledge, and presenting topics with immediate relevance (Knowles et al., 2012).

King (2009) offered a model, subsequently tested in an FCC training program (King et al., 2011), for the ongoing process of clinical expertise development. This process has two requirements: (1) Individual learners draw on their capacities, motivation, and particular experiences and (2) the environmental context provides support, resources, and opportunities for optimal experiences and processing. King also described strategies to foster expertise by combining multiple learning methods, including experiential, instructional, and observational learning. Research on professional development in FCC has shown that learners perceive experiential learning, feedback, mentoring, and reflection to be the most valuable elements (Dunst & Trivette, 2009; Dunst et al., 2011; King et al., 2011; Vilaseca et al., 2019). We integrated all these elements into the BT content and instructional design (Gafni-Lachter, 2015).

Self-efficacy is an important provider characteristic, and few FCC studies have addressed it. Bandura (1997, 2006) defined *self-efficacy* as task-specific confidence in or self-judgment of how well one can perform a specific action in a specific situation. Self-efficacy is a core belief that is the foundation of human motivation, performance, accomplishments, and emotional well-being. Health care providers' self-efficacy beliefs about their clinical capabilities influence their clinical behavior. When providers lack clinical self-efficacy, their implementation of clinical knowledge is limited (Godin et al., 2008; Greenhalgh et al., 2004). Evidence shows that providers' low self-efficacy in FCC practices can be a barrier to FCC implementation (Bamm & Rosenbaum, 2008), whereas high self-efficacy facilitates implementation (Tang et al., 2012). Hence, in this study we evaluated self-efficacy as an essential component in moving practitioners from knowing to implementing FCC.

The purpose of this study therefore was to answer three questions: (1) Can the BT training improve providers' perceptions of the extent to which they implement specific aspects of FCC? (2) Can the BT training enhance providers' perceptions of their FCC-related self-efficacy? and (3) What are the associations between providers' perceptions of their FCC implementation and their related self-efficacy?

Method

Participants

Participation in the BT training was offered as an elective continuing education program advertised by Israeli professional associations. Recruitment to participate in the study was voluntary. All BT enrollees who were actively practicing at the time of the training received an email describing the study. Of 105 enrolled trainees, 82 (78.1%) consented to participate.

Measures

Measure of Processes of Care–Service Provider

The Measure of Processes of Care–Service Provider (MPOC–SP; Woodside et al., 1998) is a 27-item self-report questionnaire assessing health care providers' perceptions of the extent to which they implement specific aspects of FCC. The MPOC–SP has four domains: Showing Interpersonal Sensitivity (SIS), Communicating Specific Information About the Child (CSI), Treating People Respectfully (TPR), and Providing General Information (PGI). Respondents rate each item on a 7-point scale from 1 (*not at all*) to 7 (*to a very great extent*). The Hebrew MPOC–SP was validated in Israel with good internal consistency across domains, both in the current study ($\alpha = .70-.85$) and in a previous study ($\alpha = .65-.89$; Schenker et al., 2016).

Measure of Processes of Care–Confidence

The Measure of Processes of Care–Confidence (MPOC–Con; Gafni-Lachter et al., 2019) is a 27-item self-report questionnaire developed for this study as a sequel to the MPOC–SP to measure health care providers' perceptions of their self-efficacy (confidence) in implementing specific FCC behaviors. Consistent with Bandura's (2006) guidelines for measuring self-efficacy, respondents rate their confidence in their ability to perform each MPOC–SP item successfully on a scale from 0 (*complete lack of confidence*) to 10 (*complete confidence*). Scores are computed for the same domains as the MPOC–SP (i.e., SIS, CSI, TPR, and PGI). In the current study, internal consistency across the domains was good ($\alpha = .76-.91$). Significant positive Pearson correlations between the MPOC–SP domains and the corresponding MPOC–Con domains indicate good construct validity for the MPOC–Con.

Satisfaction Report

We developed the Satisfaction Report for this study to measure participants' satisfaction with course content, content novelty, and instruction quality and their desire to learn more. Participants rated 21 survey items on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). They also rated the contribution of different learning activities (e.g., class discussion, experiential learning and reflection activities, peer mentoring tasks, and lectures) to their learning experience using a 5-point scale from 1 (*no contribution*) to 5 (*major contribution*).

Intervention

The BT training curriculum and instructional design (Gafni-Lachter, 2015) are based on adult learning theory (Knowles et al., 2012), King's (2009) model of the development of professional expertise, and evidence on factors that promote FCC. We selected the BT content to address key factors that enhance or impede the implementation of FCC at the workplace, provider,

and family levels. Workplace factors include policies, processes, and services to support families (King et al., 2017). Provider factors include attitudes, knowledge, and confidence related to FCC (Bamm & Rosenbaum, 2008; King & Chiarello, 2014). Family factors include culture, values, knowledge, and priorities regarding the care received (Almasri et al., 2018). The initial BT curriculum was reviewed by parents, parent advocacy professionals, educators, and health care providers, and we integrated their feedback into later versions.

The final curriculum includes six content modules based on core knowledge and skills in FCC: (1) principles and evidence, (2) learning from families and development of cultural competence, (3) strategies for effective communication with families: listening and sharing information, (4) collaborative goal setting, (5) FCC processes and measures, and (6) promotion of FCC in the workplace. Consistent with King's (2009) model, each BT training module is taught through interactive lectures with group discussion, experiential (workplace) learning tasks, reflective assignments with instructor feedback, and peer mentoring tasks. In accordance with adult learning theory, learners' involvement in the learning process is encouraged through individualized action plans to address problems and concerns in their practice, advance their preferred skills and knowledge, and guide their application of FCC in the workplace.

Procedure

The University of Haifa institutional review board approved this study (No. 263/16). Liat Gafni-Lachter delivered this biweekly training in Hebrew in six 5-hr consecutive in-person workshops over 10 wk (30 hr total).

Between 2017 and 2019, Gafni-Lachter delivered four iterations of the training to groups of 20 to 29 participants. The training sessions were offered in continuing education centered in northern Israel and affiliated with the university. Study participants completed the MPOC–SP and MPOC–Con before and after the training, a short background questionnaire before the training, and the Satisfaction Report after the training.

Data Analysis

We determined the sample size according to G*Power calculations for repeated-measures multivariate analysis of variance (MANOVA), including within- and between-group comparisons, and set a medium effect size (f) of .80 and a significance level of $p < .05$. The calculation yielded a minimum sample of 60 participants. Data were analyzed using IBM SPSS Statistics, Version 25. Tests of normality indicated that parametric tests could be used. MPOC–SP and MPOC–Con pretest–posttest score changes were analyzed using repeated-measures MANOVA with statistical significance set at the .05 two-tailed error rate appropriate to

the hypothesis (Newcomer & Conger, 2010). Pearson correlations were conducted to examine relationships between MPOC-SP and MPOC-Con score changes and participants' background information. No significant differences in MPOC-SP or MPOC-Con scores were found between any of the four training cohorts, so we aggregated the analysis of data.

Results

The sample consisted of 82 practicing health care providers, including 68 (82.9%) occupational therapists, 9 (11.0%) speech-language pathologists, 2 physical therapists (2.4%), and 3 (3.7%) art therapists. Forty-six participants (56.1%) worked primarily in school-based settings and 36 (43.9%) in outpatient or clinic settings. Sixty (73.2%) identified their primary language spoken at work as Hebrew and 22 (26.8%) as Arabic, but all were proficient in Hebrew. Forty-five participants (55.0%) held a bachelor's degree, 34 (41.5%) a master's degree, and 3 (3.7%) a doctoral degree. Participants' mean age was 37.3 yr ($SD = 8.5$, range = 24–55), and they had a mean of 10.5 yr of pediatric experience ($SD = 7.6$, range = 1–33). Providers working in outpatient or clinic settings had marginally significantly fewer years of experience ($M = 8.6$ yr, $SD = 7.0$) than providers in school-based practice ($M = 12.0$ yr, $SD = 7.8$), $t(81) = 1.963$, $p = .05$.

Changes in Perceived Implementation of and Self-Efficacy in FCC

Repeated-measures MANOVA identified significant changes in MPOC-SP scores with a medium to large effect size, $F(4, 79) = 7.67$, $p < .001$, $\eta_p^2 = .30$. As shown in Table 1, univariate tests indicated significant score changes in three MPOC-SP domains (SIS, CSI,

TPR) and marginally significant changes ($p = .056$) in the fourth domain (PGI).

Repeated-measures MANOVA showed significant score changes in all MPOC-Con domains with a medium to large effect size, $F(3, 74) = 12.03$, $p < .001$, $\eta_p^2 = .33$. Univariate tests also indicated significant score changes in all MPOC-Con domains (see Table 1). Pearson's correlations showed significant positive correlations between score changes in each domain of the MPOC-SP and its corresponding MPOC-Con domain (Table 2).

Subsequent exploration of individual learning patterns identified several MPOC-SP and MPOC-Con associations. For example, the SIS domain (which had the highest effect size) showed four change types: (1) MPOC-SP and MPOC-Con scores increased ($n = 41$; 50.0%), (2) MPOC-SP and MPOC-Con scores decreased ($n = 7$; 8.5%), (3) MPOC-SP scores increased and MPOC-Con scores decreased ($n = 11$; 13.4%), and (4) MPOC-Con scores increased and MPOC-SP scores decreased ($n = 23$; 28.0%), suggesting that learners responded differently to the training.

Participant Satisfaction With Training

After the training, we sent all 82 participants the Satisfaction Report electronically, but only 42 (51.2%) completed it. Participants reported high satisfaction overall ($M = 4.55$, $SD = 0.71$) and high satisfaction with course content novelty ($M = 4.17$, $SD = 1.03$) and instruction quality ($M = 4.23$, $SD = 0.84$). Thirty-six (86%) of the participants who completed this measure indicated that they would like to learn more and be included in future advanced workshops. They attributed their learning outcomes to the class discussions ($M = 4.33$, $SD = 1.01$), experiential and reflective activities ($M = 4.26$, $SD = 0.82$), lectures ($M = 4.28$,

Table 1. Pretest-Posttest Changes in MPOC-SP and MPOC-Con Scores, by Domain ($N = 82$)

Domain	$M (SD)$		$F(1, 81)$	p	η^2
	Pretest	Posttest			
MPOC-SP (scale range = 1–7)					
SIS	4.93 (0.88)	5.27 (0.92)	14.36***	<.001	.15
CSI	5.45 (1.09)	5.68 (1.18)	4.86**	.030	.06
TPR	5.60 (0.70)	6.01 (0.59)	31.16***	<.001	.28
PGI	3.52 (1.26)	3.80 (1.33)	3.75	.056	.04
MPOC-Con (scale range = 0–10)					
SIS	6.90 (1.33)	7.82 (1.36)	34.81**	<.001	.31
CSI	7.88 (1.40)	8.61 (1.36)	16.31**	<.001	.17
TPR	7.64 (1.25)	8.46 (1.35)	20.01***	<.001	.21
PGI	5.38 (2.26)	6.37 (1.95)	8.05***	<.001	.15

Note. CSI = Communicating Specific Information About the Child; MPOC-Con = Measure of Processes of Care–Confidence; MPOC-SP = Measure of Processes of Care–Service Provider; PGI = Providing General Information; SIS = Showing Interpersonal Sensitivity; TPR = Treating People Respectfully.

** $p \leq .01$. *** $p \leq .001$.

Table 2. Pearson Correlations Between Score Changes in the MPOC–SP and MPOC–Con Domains

MPOC–SP Domain	MPOC–Con Domain			
	1	2	3	4
1. SIS	.38**	.15	.32*	.28*
2. CSI	.15	.42**	.08	.26*
3. TPR	.22*	.15	.46**	.21
4. PGI	.29*	.29**	.21	.42**

Note. CSI = Communicating Specific Information About the Child; MPOC–Con = Measure of Processes of Care–Confidence; MPOC–SP = Measure of Processes of Care–Service Provider; PGI = Providing General Information; SIS = Showing Interpersonal Sensitivity; TPR = Treating People Respectfully. * $p \leq .05$. ** $p \leq .01$.

$SD = 0.81$), and peer mentoring ($M = 4.05$, $SD = 1.0$).

Background Variables Associated With Scores on Outcome Measures

We conducted exploratory analyses to identify the contribution of years of experience, practice setting, and academic education to the pre- and posttraining scores on the MPOC–SP and MPOC–Con. Years of clinical experience was positively correlated with pretraining scores in all domains ($r_s = .23-.32$, $p < .05$) except MPOC–SP CSI. No significant correlations were found for years of experience and posttraining scores. Providers in outpatient or clinic settings had marginally higher pretraining MPOC–SP scores than school-based providers, $F(3, 76) = 0.88$, $p = .047$, $\eta_p^2 = .12$; however, these differences faded by posttraining. No significant differences between practice settings in MPOC–Con scores were found at pre- or posttraining. Finally, no significant differences in pre- or posttraining scores were found by level of academic education. We did not test for differences between professions because few participants were not occupational therapists.

Discussion

In this study, we evaluated BT, a novel 10-wk FCC care training for health care providers. Participants reported significant increases in their implementation of specific aspects of FCC in practice and in their FCC-related self-efficacy after the training. This study is one of few FCC training studies to incorporate standardized measures in a pretest–posttest design. Regarding the study’s first and second research questions, the BT training enhanced providers’ self-reported implementation of and self-efficacy in FCC, which involves showing interpersonal sensitivity, fostering respectful relationships, and communicating information with families. These changes were independent of differences in participants’ years of

experience and practice settings. Regarding the third research question, changes in participants’ FCC implementation were positively associated changes in their FCC-related self-efficacy.

Changes in Participants’ Use of Specific Aspects of FCC Implementation

Although participants as a group reported fairly high estimates of their use of specific FCC aspects before the training, we were still able to see significant increases in all domains posttraining. MPOC–SP scores demonstrated that behaviors reflecting partnership competency, considered a core FCC capacity (Kokorelias et al., 2019), increased the most. Other increases occurred in participants’ perceptions of the extent to which they treated parents as experts regarding their children, intentionally made parents feel like partners and effective guardians, provided positive feedback, were nonjudgmental, offered opportunities for parents to explain their needs and goals, maintained consistent parent–provider relationships, and adapted interventions to family needs and lifestyles.

Changes in providing general information were marginally significant ($p = .056$). In a review of 20 yr of MPOC research, Cunningham and Rosenbaum (2014) found that PGI scores were consistently the lowest of all domains. This domain encompasses sharing information on community resources; providing information on topics such as financial costs or assistance, genetic counseling, and respite care; and connecting families. Many practitioners perceive this domain as beyond their scope of practice (Cunningham & Rosenbaum, 2014), and parents have reported it as the area of practice requiring most improvement (Almasri et al., 2018; Molinaro et al., 2017). King et al. (2011) suggested that occupational therapy practitioners’ provision of general information was influenced primarily by organizational characteristics and their own familiarity with community resources and was not a part of their formal professional knowledge. Thus, PGI remains an area for further exploration and enhancement in future training.

Changes in Participants’ FCC-Related Self-Efficacy

This study was the first to measure changes in FCC-specific self-efficacy after provider training. The MPOC–Con developed for this study holds promise (Gafni-Lachter et al., 2019). It showed adequate internal consistency and correlation with MPOC–SP scores, indicating preliminary construct validity. Even though participants reported high self-efficacy in FCC at pretest, the training significantly enhanced it across all measured domains. The significant correlations between MPOC–SP and MPOC–Con domain scores demonstrate a two-way association between participants’ perceived use of specific aspects of FCC and their self-efficacy. This suggests that enhanced

understanding of implementation can increase self-efficacy and self-efficacy can increase the use of FCC in practice. This finding aligns with the premise that self-efficacy beliefs are essential in translating adult learning into action (Hammond & Feinstein, 2005; Locke & Latham, 2002), particularly in clinical practice (Godin et al., 2008; Greenhalgh et al., 2004; Tang et al., 2012).

Although MANOVA and effect size calculations demonstrated positive score increases and associations between MPOC-SP and MPOC-Con domains in the sample as a whole, not all participants had increased MPOC-Con scores or showed positive associations between their implementation of FCC practices and self-efficacy. Some participants suggested an anecdotal explanation for decreased or stable self-efficacy. They explained that as they learned more about FCC during the training, they became aware of how much they did not know or apply; thus, their lower perceived use of FCC skills or confidence may have reflected their belief in how much further they could advance. Learners' increased awareness of a need to improve their FCC-related practices and resulting decreases in self-efficacy may be either a motivating force or a barrier to continued learning, individually or within a learning program. Further research is warranted to identify how decreases in self-efficacy influence the learning experience and whether they motivate or hinder providers' continued development of expertise. In addition, some participants may not have benefited from the training because they required different learning and development approaches—for example, more observations of FCC practice, more structured progress goals, and more feedback. Training programs must assess each learner's progress and adapt the learning plan accordingly.

Posttraining Feedback

Findings from the Satisfaction Report indicate that participants attributed their improvements in perceived FCC implementation and self-efficacy to the diverse learning activities in the BT training. These activities include lectures, experiential and reflective learning activities (e.g., interactions with families), group discussions, and peer mentoring. This finding is consistent with Bandura's (1997) social learning and self-efficacy theory, which hypothesizes that people learn from others through direct and vicarious experience and social persuasion. Although King (2009) did not specify self-efficacy in her framework, the current findings nevertheless reinforce that framework, which highlights the importance of engaging in deliberate practice, obtaining feedback, and processing it via reflection to enhance expertise in FCC.

Background Variables and Training Effectiveness

Our pretraining test results were similar to those of previous studies, which showed that experienced

providers reported implementing more FCC in care (King et al., 2011) and greater FCC self-efficacy (Tang et al., 2012). In addition, similar to Fingerhut et al.'s (2013) findings, providers in outpatient settings were more family centered than those in school-based settings.

In contrast, in our posttesting, we found that neither differences between experienced and novice practitioners nor differences by practice setting persisted after the BT training. This finding suggests that training can promote change regardless of initial practice experience level or work setting. We attribute this finding to the effectiveness of the learner-centered professional training implemented in this study. In the BT training, each provider develops a personal goal for FCC improvement based on their own strengths and challenges. The personalized goal fosters motivation, commitment, and an individualized learning process. We recommend that program instructors encourage learners to create personalized learning goals and experiences based on their individual needs and motivations.

Limitations and Future Research

This study's main limitation was the lack of an objective measure of aspects of FCC implementation in practice besides participants' self-reports. We recommend also obtaining reports from parents, supervisors, or colleagues in future studies. In addition, we did not measure participants' knowledge acquisition or aspects of their actual FCC practice. Moreover, participation in the training was voluntary; hence, participants may have held more positive attitudes and stronger motivation to learn about FCC than enrollees who did not participate, limiting the generalizability of their achievements.

We recommend two lines of inquiry for future studies. First, use of a qualitative design could illuminate and help characterize the different individual learning patterns for improving FCC implementation and self-efficacy and the best strategies to support each learner's pattern. Second, testing the BT program with other professionals and in other countries and practice settings can enhance knowledge regarding the program's generalizability for interprofessional teams.

Implications for Occupational Therapy Practice

The findings of this study have the following implications for occupational therapy practice:

- The BT training program can enhance providers' FCC practices, including interpersonal sensitivity, respect, and communication of information with families.
- The BT training can overcome participants' initial differences in experience and practice settings.

- Experiential and reflective learning techniques are essential to foster learners' self-efficacy in implementing FCC practices.
- Training program developers should consider ways to accommodate learners' individual needs.
- Using standardized tools to measure outcomes enables trainers to quantify the magnitude of changes in learners.
- Measuring outcomes can help trainers improve their program and communicate the value of the training to stakeholders, including managers, colleagues, and families.

Conclusion

Our study shows that an intensive training program, BT, can improve the extent to which health care providers implement aspects of FCC and experience self-efficacy in doing so, as reflected in their scores on standardized outcome measures. The learning participants acquired minimized the effects of differences in clinical experience and practice settings. To bring about meaningful change in providers' FCC-related behaviors, training programs should incorporate a variety of techniques, especially experiential and reflective learning activities, to promote translation from knowledge to application. We encourage health care providers, educators, managers, and researchers to consider the value of enhancing practitioners' self-efficacy in implementing FCC skills and behaviors. 📌

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