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RESEARCH METHODS

Outreach to California Medicaid Smokers for Asian Language Quitline Services

Anne Saw, PhD,[1] Susan L. Stewart, PhD,[2] Sharon E. Cummins, PhD,[3] Neal D. Kohatsu, MD, MPH,[4] Elisa K. Tong, MD, MA[5]

Introduction: Asian male immigrants have high smoking rates. This article describes outreach approaches in the Medi-Cal Incentives to Quit Smoking project to incentivize California Medicaid (Medi-Cal) calls to the California Smokers' Helpline (Helpline) Asian-language lines.

Methods: Outreach efforts adapted Medi-Cal Incentives to Quit Smoking materials for the Asian-language lines. Community-based efforts included outreach at ethnic supermarkets and distribution through community networks. Leveraging the Helpline's Asian print media campaign, three press releases promoted Medi-Cal Incentives to Quit Smoking with Lunar New Year or community physician messaging. Medi-Cal all-household mailings with tracking codes also included the Asian-language lines. Helpline caller characteristics and trends were examined for project period 2012−2015. Analyses were conducted in 2018.

Results: Among 4,306 Asian American Pacific Islander Medi-Cal callers, there were 37% Asian-speaking Asian Americans (9.5% Chinese, 17.2% Vietnamese, and 10.5% Korean); 44% English-speaking Asian Americans; 9% Pacific Islanders; and 10% Asian American Pacific Islander not otherwise specified. Almost 10% of Asian-speaking Asian Americans were activated by the financial incentive and this was similar for all-household mailings, although this was lower than the other groups. Medi-Cal calls to the Asian-language lines increased, from an average of 18 calls/month to 47 calls/month (162% increase) in the first and last 12 project months respectively. Community outreach was limited by timing and sustainability. The 3-month call totals before and after the Asian-language press releases were significantly greater for Asian-speaking calls than for English-speaking calls (Cochran−Mantel−Haenszel $p < 0.001$, OR=1.70, 95% CI=1.45, 1.99).

Conclusions: Whereas community outreach is challenging, promising population-based methods for in-language, culturally tailored outreach can include press releases with ethnic media and direct-to-member mailings.

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INTRODUCTION

California has the largest number and concentration of Asian Americans (AAs).[1] AAs represented approximately 17% of those covered by Medicaid in California (i.e., Medi-Cal) in 2012−2015.[2] Promoting culturally appropriate and linguistically accessible smoking-cessation resources for AA Medi-Cal members is important because nearly two thirds are immigrants and originate from countries where up to 50% of men smoke.[3−5] Yet, reaching AAs is challenging

From the [1]Department of Psychology, DePaul University, Chicago, Illinois; [2]Department of Public Health Sciences, University of California, Davis, Sacramento, California; [3]Department of Family Medicine and Public Health, University of California San Diego, San Diego, California; [4]Kohatsu Consulting, Carmichael, California; and [5]Department of Internal Medicine, University of California, Davis, Sacramento, California

At the time of study, Dr. Kohatsu was with the Department of Health Care Services, Sacramento, California.

Address correspondence to: Anne Saw, PhD, DePaul University, 2219 N. Kenmore Ave., Chicago IL 60614. E-mail: asaw@depaul.edu.

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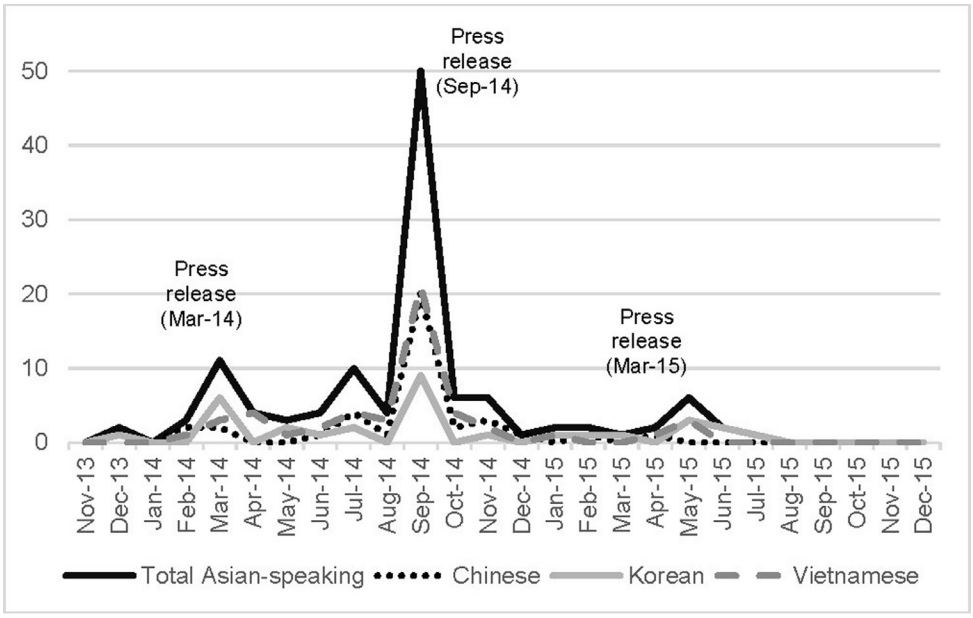

Figure 1. Monthly calls to the helpline by request for $20 gift card incentive: total and by Asian-language line.

given the heterogeneity of the population; particular attention must be paid to culture, ethnicity, and language.

Telephone quitline counseling has been found to be an effective cessation intervention,[6] including for smokers utilizing the Asian Smokers Quitline (ASQ), a free nationwide service operated by the California Smokers' Helpline (Helpline) with dedicated Asian language lines in Chinese (i.e., Mandarin and Cantonese), Vietnamese, and Korean.[7,8] The ASQ is promoted nationwide through advertisements in ethnic media and offers free nicotine patches. Although quitlines are freely available throughout the U.S., they remain relatively underutilized.[9]

Despite the important benefit of strategically targeting outreach in-language and through culturally appropriate communication channels,[10–12] little research has examined outreach strategies to promote quitlines for diverse AA communities. The Medi-Cal Incentives to Quit Smoking (MIQS) project promoted modest financial and medication incentives to encourage Medi-Cal smokers to utilize the Helpline. This article describes outreach approaches to increase Medi-Cal calls to the Helpline's Asian-language lines (Chinese, Korean, Vietnamese), and the impact compared with English-speaking AAs and Pacific Islanders (AAPIs).

METHODS

The MIQS program was funded by the Centers for Medicare and Medicaid Services and provided incentives to eligible Medi-Cal members aged ≥18 years between March 2012 and July 2015. Outreach efforts promoted a $20 gift card incentive, which eligible callers to any of the Helpline's five language lines could ask for and earn by completing a counseling session. After September 2013, the Helpline asked all eligible Medi-Cal callers if they would like a free 1-month supply of nicotine patches, for which callers did not need to complete a counseling session.

Description of Linguistically, Culturally, and Community Appropriate Outreach Efforts

MIQS outreach posters and postcards were developed and disseminated, in conjunction with the California Tobacco Control Program (CTCP), in English and the three Asian languages offered by the Helpline and featuring images of diverse populations. The Helpline staff helped select culturally appropriate images and language for outreach materials (Appendix Figure 1, Chinese postcard example; available online). Dissemination of the outreach materials occurred through (1) general outreach to state and county organizations and providers; (2) mailings sent directly to Medi-Cal members; (3) a pilot in-person outreach in Chinese-speaking neighborhoods; (4) community consultants through AAPI cancer control community networks; and (5) press releases to ethnic print media incorporating Lunar New Year messaging and community physicians as spokespeople.

General outreach. General outreach promoted the MIQS project and availability of in-language materials

to organizations engaged in tobacco control and cessation activities, utilizing the CTCP's existing communication infrastructure. In-person outreach was conducted for eight counties with high smoking prevalence among Medi-Cal members. See Tong et al.,[13] this issue, for more information on general outreach. Between August 2013 and February 2015, a total of 33,267 Chinese, Korean, and Vietnamese posters or postcards were requested by county agencies, CTCP grantees, and providers and clinics serving patients with Medi-Cal.

Direct-to-member mailings. Direct-to-member mailings included a series of all-household benefit update mailings and Medi-Cal managed care plans' general newsletters or targeted mailings to identified smokers (by language). Three benefit update mailings were sent to all Medi-Cal households (first mailing in Fall 2013, second and third mailings in first and second half of 2014, respectively). The all-household mailing was a double-sided 8.5″ × 11″ flyer for English and Spanish with a tracking promotional code (hereafter referred to as "all-household mailing code"), but the phone numbers for the Asian-language lines were included on an updated flyer for the second and third mailing (Appendix Figure 2, available online). Four Medi-Cal managed care plans identified current smokers through diagnostic and billing codes and targeted mailings to those households, and two (Molina and Health Plan San Mateo) further targeted smokers whose primary language was Chinese, Korean, or Vietnamese and sent in-language materials to them. Molina sent mailings to 111 Vietnamese speakers, seven Korean speakers, and two Chinese speakers. Health Plan San Mateo sent mailings to 131 Chinese speakers and two Vietnamese speakers. See Anderson and colleagues[14] and Hood-Medland et al.,[15] this issue, for detailed description of direct-to-member mailings and timing for distribution.

Pilot in-person community outreach. APartnership, a media agency that promoted ASQ ads in ethnic media, was contracted to pilot a "Street Team" of culturally and linguistically matched individuals to disseminate outreach materials in the San Gabriel Valley area of Los Angeles County frequented by Chinese speakers. Ethnic supermarkets were identified in low-income neighborhoods for the Street Team to approach the public. In November 2013, the media agency distributed 27,300 postcards over 2 days. Anecdotal observations were recorded by Street Team members following the outreach activity.

Community consultants. Two National Cancer Institute–funded Community Network Programs for AAPI community-based participatory research were contacted to help disseminate MIQS materials between the last quarter of 2014 and mid-2015. Through these community network channels, Chinese, Korean, and Vietnamese materials were disseminated in Southern California areas. For PIs, the community consultant helped to tailor English-language MIQS materials with a father–daughter

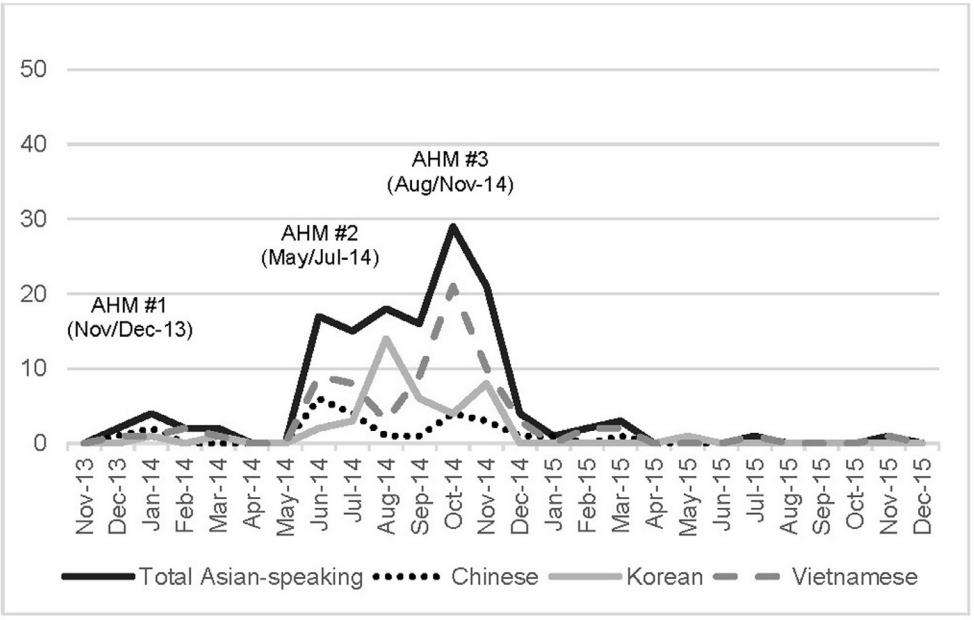

Figure 2. Monthly calls to the helpline by reporting all-household mailing code: total and by Asian-language line.
AHM, all-household mailing.

image from the community. The Asian American Network for Cancer Awareness Research and Training staff assisted with direct outreach into the community by placing materials in local businesses and distributing to health clinics serving the population in Northern California and Los Angeles areas. Pacific Islander Health Partnership, which collaborated with the Weaving an Islander Network for Cancer Awareness Research and Training, assisted in tailoring the MIQS materials and disseminated 5,000 postcards through community channels in Southern California.

Ethnic media press releases. Two Helpline press releases (March 2014, March 2015) were timed to coincide with the Lunar New Year and distributed in Chinese, Korean, and Vietnamese languages. Press releases promoted "Health and Wealth" messaging about the $20 gift card incentive and the free nicotine patches. A press release in September 2014 additionally used respected physician leaders in Chinese, Korean, and Vietnamese ethnic communities as spokespeople. The Helpline's Asian media agency assisted in disseminating the press release to ethnic radio and print news outlets where ASQ advertisements were concurrently running.

Data Sources and Measures

Helpline call data were analyzed for demographics, referral source, health conditions, and incentives or services for callers who self-identified their primary race/ethnicity as AAPI, alone or in combination, and self-reported having Medi-Cal. Demographic information included age, gender, self-reported ethnicity, education, and whether they were living with a child aged ≤ 5 years. Referral source included friend/family, provider, insurance plan, media, nonprofit/school, or other/don't know. Health conditions included current pregnancy status, current diagnosis of high blood pressure, diabetes, anxiety disorder, depressive disorder, bipolar disorder, schizophrenia and alcohol or drug abuse, and history of heart attack or stroke. For incentives or services, data were collected on whether they requested the $20 gift card incentive, received nicotine patches, reported an all-household mailing code, or completed counseling. Self-reported ethnic data was recategorized by language: Asian-speaking AAs (i.e., callers to Cantonese Chinese, Mandarin Chinese, Korean, or Vietnamese language lines); English-speaking AAs; English-speaking PIs; and English-speaking AAPIs not otherwise specified. See footnote for Table 1 for ethnicities represented in each of the above groups. Besides Helpline caller data, numbers of outreach materials requested by collaborating agencies, clinics, and other organizations were collected. Instances of unpaid media coverage on the project were also collected.

Statistical Analysis

Monthly calls to the Helpline were summarized for the project period. Demographics, health conditions, referral sources, and incentives or services were characterized for each AAPI subgroup. The effect of ethnic media press releases was examined on total calls for the 3 months before and after each press release (1 month during and 2 months after), comparing Asian-speaking and English-speaking AAPI Medi-Cal callers over the three press releases using the Cochran–Mantel–Haenszel test. All analyses were conducted in 2018 using SAS statistical software package, version 9.4.

RESULTS

Table 1 shows characteristics of AAPI Medi-Cal callers to the English- and Asian-language lines. Among 4,306 AAPI Medi-Cal callers in the project period, there were 37% Asian-speaking AAs (9.5% Chinese, 17.2% Vietnamese, and 10.5% Korean); 44% English-speaking AAs; 9% PIs; and 10% AAPI not otherwise specified. Almost 10% of Asian-speaking AAs were activated by the financial incentive and this was similar for all-household mailings, although this was lower than the other groups; however, Asian-speaking AAs were more likely to receive nicotine patches. They were also more likely to complete one counseling session, but still had lower proportions of asking for the $20 gift card incentive or reporting the all-household mailing code. There were no statistically significant differences between Asian-speaking subgroups in terms of those activated by the financial incentive. Among those who asked for the financial incentive, Asian-speaking callers were more likely to report being referred by media compared with English-speaking AAPIs (not shown). Medi-Cal calls to the Asian-language lines increased from an average of 18 calls/month to 47 calls/month (162% increase) in the first and last 12 project months respectively (not shown).

Direct-to-Member Mailings

Figure 2 shows the Medi-Cal monthly call trends from November 2013 to December 2015 for all Asian-speaking AAs who reported the all-household mailing code and by language. There were 146 Asian-speaking AAs that reported the all-household mailing code; of those callers, 140 completed at least one counseling session. From the California Health Interview Survey data, an estimated 329,000 individuals who self-reported Chinese, Korean, or Vietnamese ethnicity and non-English language use at home, were covered by Medi-Cal in 2014 (when the second and third all-household mailings were sent)[2]; reach was conservatively calculated as 0.0003%. As Table 1 shows, Asian-speaking AAs were less likely to report the all-household mailing code

Table 1. Characteristics of Asian American Pacific Islander Medi-Cal Helpline Callers, March 2012 to July 2015 (N=4,306)

Variable	Asian-speaking Asian American,[a] *n* (%) (*n*=1,605)	English-speaking Asian American,[a] *n* (%) (*n*=1,897)	English-speaking Pacific Islander,[a] *n* (%) (*n*=382)	English-speaking Asian American Pacific Islander NOS,[a] *n* (%) (*n*=422)
Age, years				
< 25	15 (0.9)	117 (6.2)	36 (7.3)	31 (7.3)
25–44	240 (14.9)	925 (48.8)	177 (46.3)	227 (53.8)
45–64	788 (49.1)	705 (37.2)	157 (41.1)	139 (32.9)
≥ 65	562 (35.0)	150 (7.9)	12 (3.1)	25 (5.9)
Male	1,423 (89.2)	1,016 (53.8)	143 (37.5)	216 (51.2)
Education				
Less than high school/don't know	494 (31.5)	312 (16.6)	72 (18.9)	46 (16.3)
High school diploma/GED	428 (27.3)	499 (26.6)	142 (37.4)	85 (30.1)
Some college or trade school	293 (18.7)	744 (39.7)	142 (37.4)	98 (34.7)
College degree or higher	355 (22.6)	320 (17.1)	24 (6.3)	53 (18.8)
Pregnant	1 (0.06)	29 (1.5)	12 (3.1)	13 (3.1)
Lives with child aged ≤ 5 years	184 (11.5)	369 (19.4)	102 (26.7)	76 (18.0)
Chronic disease				
Diabetes	324 (20.7)	333 (17.7)	65 (17.1)	47 (16.7)
High blood pressure	684 (43.0)	729 (38.9)	163 (43.1)	87 (20.8)
Prior heart attack	68 (4.3)	70 (3.7)	22 (5.8)	15 (3.6)
Prior stroke	72 (4.5)	83 (4.4)	31 (8.3)	12 (2.9)
Behavioral health				
Anxiety	191 (12.8)	565 (32.7)	117 (33.5)	90 (33.7)
Bipolar	107 (7.2)	315 (18.4)	61 (17.6)	53 (20.0)
Depression	211 (14.3)	624 (35.9)	128 (36.7)	101 (37.7)
Schizophrenia	49 (3.3)	259 (14.9)	35 (9.9)	31 (11.6)
Have abused drugs/alcohol	21 (1.4)	182 (10.4)	36 (10.2)	42 (15.5)
Referral source				
Friend or family	196 (12.6)	214 (11.6)	44 (11.9)	27 (6.5)
Insurance	203 (13.0)	444 (24.0)	84 (22.6)	63 (15.3)
Provider	243 (15.6)	615 (33.2)	120 (32.3)	104 (25.2)
Media	769 (49.4)	319 (17.2)	75 (20.2)	46 (11.2)
Non-profit organization or school	34 (2.2)	71 (3.8)	16 (4.3)	8 (1.9)
Other/don't know	112 (7.2)	187 (10.1)	32 (8.6)	164 (39.8)
Requested $20 incentive	133 (8.3)	249 (13.1)	45 (11.8)	47 (11.1)
Used all-household mailing code	146 (9.1)	391 (20.6)	72 (18.8)	59 (14.0)
Received nicotine patch	1,114 (92.3)	1,010 (72.8)	185 (67.8)	196 (58.9)
Completed counseling session	1,233 (76.8)	1,263 (66.6)	235 (61.5)	210 (49.8)
Requested $20 incentive	133 (8.3)	249 (13.1)	45 (11.8)	47 (11.1)
Used all-household mailing code	140 (8.7)	359 (18.9)	67 (17.5)	53 (12.6)
Other Medi-Cal callers	1,332 (83.0)	1,289 (68.0)	270 (70.7)	322 (76.3)

[a]Asian-speaking Asians (*n*): Cantonese Chinese (166), Mandarin Chinese (245), Korean (452), Vietnamese (742). English-speaking Asians: 68 Asian Indian (151), Cambodian (68), Chinese (172), Filipino (797), Hmong (58), Japanese (248), Korean (179), Laotian (40), Pakistani (28), Thai (34), Vietnamese (122). Pacific Islander: Fijian (41), Guamanian (72), Hawaiian (153), Maori (4), Samoan (97), Tahitian (1), Tongan (14). Asian American Pacific Islander NOS (422).
GED, general education development test; NOS, not otherwise specified.

compared with other groups (9.1% vs 14%–20.6%). There were no statistically significant differences between Asian-speaking subgroups in reporting the mailing code (not shown). No statistically significant changes were observed in Asian-speaking calls from the counties reached by Health Plan San Mateo and Molina in the 3 months before and after targeted mailings (not shown).

Pilot In-Person "Street Team" Community Outreach

The media agency who conducted the pilot outreach reported that individuals offered MIQS flyers were

more interested in how to enroll in Medi-Cal than how to participate in the MIQS project and receive incentives for quitting smoking. Nonsmokers were more likely to return the flyers because they assumed they were receiving grocery coupons and did not find them relevant. Some smokers were not happy to receive the flyers given the anti-smoking message. Team members distributing the flyers spent more time than anticipated answering questions, particularly about Medi-Cal enrollment. No statistically significant changes were observed in Chinese-speaking Medi-Cal calls in the 3 months before and after the "Street Team" outreach (not shown).

Ethnic Media Press Releases

Table 2 summarizes total calls for the 3 months before and after each of the three press releases by language line. The 3-month call totals before and after the Asian-language press releases were significantly greater for Asian-speaking calls than for English-speaking calls (Cochran–Mantel–Haenszel $p < 0.001$, OR=1.70, 95% CI=1.45, 1.99). The March 2014 press release was picked up by 23 ethnic print media outlets with Californian circulations of 20,000–70,000. The September 2014 press release was picked up by the same 23 media outlets. That month, the press release was covered by ten TV stations; one Vietnamese TV station covered the project twice a day for 2 weeks. The March 2015 press release was picked up by at least nine print outlets and one radio station. Ethnic media was concentrated in San Francisco Bay Area and Los Angeles markets.

DISCUSSION

The current study demonstrates that whereas community-based outreach is challenging, promising population-based methods for in-language, culturally tailored outreach can include press releases with ethnic media and direct-to-member plan mailings. The MIQS program collaborated with agencies, providers, and health plans serving the target population, respected leaders in the community, and the media agency for ASQ, which had established media contacts. Multiple types of outreach were used, including general and targeted mailings, face-to-face dissemination of materials, press releases, and newspaper, TV, and radio stories. Press releases that were covered by ethnic media and direct-to-member mailings yielded the highest and yet similar rates of response.

Outreach to Asian-speaking smokers in the current study reflected the continua of tailoring described by Hawkins and colleagues[16] and others. Health communication varies in tailoring by audience segmentation and degree of customization; communication may be general/mass audience (reflecting low audience segmentation and customization), group targeted (reflecting moderate segmentation and customization), and individually tailored (reflecting high segmentation and customization). Initial outreach efforts were directed at a general audience of Medi-Cal members, with materials in English except for the numbers for the three Asian-language lines of the quitline. Later outreach efforts were more group targeted, with greater customization or tailoring to Chinese, Korean, and Vietnamese cultures.

In-language press releases resulted in significant increases in call volume for Asian-speaking AAs. These press releases were culturally tailored in terms of timing two press releases to the Lunar New Year, a time for family gatherings and to encourage good fortune, health, and longevity. Although since the 1980s, the holiday has been promoted by tobacco companies in China and elsewhere as a time to gift cigarettes,[17] given the holiday's focus on good health and family, future health behavior change interventions targeting certain Asian cultures

Table 2. Three-Month Call Totals for Asian American Pacific Islander Medi-Cal Helpline Callers Before and After Press Releases by Language Line

	March 2014		September 2014		March 2015	
Language line	Total calls 3 months before press release	Total calls 3 months after press release	Total calls 3 months before press release	Total calls 3 months after press release	Total calls 3 months before press release	Total calls 3 months after press release
Chinese	29	77	52	141	36	59
Korean	25	61	53	70	38	51
Vietnamese	26	60	91	145	54	67
Total Asian-speaking	80	162	196	279	128	177
Total English-speaking[a]	221	209	451	359	229	242

[a]English-speaking include all Asian American, Pacific Islander, and Asian American Pacific Islander—not otherwise specified callers to the English-language California Smokers' Helpline.

may consider promoting behavior change messages during this time and emphasizing how behavior change would positively impact personal and family health and prosperity. One study timed a "Quit and Win" smoking-cessation contest in the Vietnamese community in California during the Lunar New Year.[18]

Press releases were also tailored by having respected physicians within each ethnic community promote the MIQS program through quotes for the ethnic media to use. Use of opinion leaders is a prevalent concept in many health promotion theories, including the diffusion of innovations theory.[19] Within these Asian-language communities, physicians are highly respected role models; therefore, involving them to promote MIQS in press releases likely enhanced media and caller interest.

Ethnic media, particularly newspapers and magazines, continue to be important channels to disseminate information. Half of callers to the nationwide ASQ heard about the service through print media.[20] The current study similarly found that half of callers were referred through media. Paid advertising in ethnic media is expensive; however, press releases (including where ASQ already purchased ads) resulted in earned (free) media mentions, articles, and features.

Medi-Cal plans with members whose primary language is not English may be particularly interested in these findings. Federal requirements of language accessibility ensure that all Medicaid plans are aware of members' primary language, and California mandates that Medi-Cal managed care plans provide translated materials for those members whose primary language is considered a threshold language (i.e., primary language of 3,000 beneficiaries or 5% of beneficiaries in a given geographic area, whichever is lower).[21] Of the 13 distinct dialects/languages that qualify as threshold in California, seven are languages spoken by AAs and three are Chinese dialects. Future outreach efforts or interventions may consider working with managed care plan health education teams to utilize available member data for targeted, tailored efforts. When combined with other in-person community or provider outreach, managed care plans may be able to help reinforce messages for health behavior change.

Similar call response rates were observed among those who asked for the $20 gift card incentive (indicating they or their family/friends were responding to press releases or ethnic media stories) and referenced an all-household mailing code (indicating they were responding to a direct-to-member mailing). Weighing the costs and benefits of both approaches, ethnic media provided greater reach to not only the target population but also non–Medi-Cal members who might be thinking about quitting, while being inexpensive because of receiving unpaid coverage of the program. At the same time, direct-to-member mailings can be highly targeted, provided in-language, and relatively inexpensive.[15] Likely, a combination of multiple outreach approaches is needed to encourage widespread behavior change.

Although the in-person community outreach was less impactful, lessons learned may improve future efforts. Although one outreach study suggests that Asian grocery stores are an appropriate venue for outreach about smoking-cessation resources and a Street Team approach is impactful,[12] future outreach for Medi-Cal enrollees might consider more targeted messaging for smokers, or partner with efforts to enroll the public in Medi-Cal. Outreach to PIs, who have smoking prevalence rates higher than the general population,[22] needs to be timed with large community festivals for higher impact, a common outlet for reaching communities for health promotion.[22]

Limitations

Previous research has found a significantly greater proportion of nonsmoking family and friends calling on behalf of smokers (termed *proxy*) on the Asian-language lines compared with the English-language quitline in California,[23] but this study only includes Medi-Cal smokers. Other outreach promoting free nicotine patches for callers to the Asian Smokers' Quitline co-occurred during the MIQS program—a Centers for Disease Control and Prevention–funded nationwide campaign and a countywide campaign funded by Los Angeles County's Community Transformation Grant. Thus, examining Medi-Cal call volume is likely overestimating the impact of MIQS outreach; rather, the Ask for $20 financial incentive and the MIQS all-household code are better measures for MIQS-specific outreach. At the same time, these measures are likely underestimates for MIQS-specific outreach as callers may forget to ask for $20 without prompting.[15] Furthermore, because the authors were not able to track direct-to-member mailings to potential ASQ callers, the reach of these mailings was likely underestimated.

CONCLUSIONS

Given more resources for outreach, further audience segmentation and message customization could have been considered, such as targeting nonsmoking family members of smokers.[24–26] Moreover, given the vast heterogeneity of the AAPI population, tailoring strategies of outreach for different segments of the diverse communities may enhance impact, with ethnic media likely being the most effective for less acculturated AAs with limited English proficiency.

Comprehensive yet culturally, linguistically, and community-tailored outreach can promote quitline utilization in Asian-language populations. The current study suggests that well-timed earned ethnic media featuring community leaders, in addition to mailings and in-person outreach with audience segmentation, are innovative channels to promote incentives for behavior change.

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Authors contributed as follows: (1) conception and design of the study (all authors); (2) data acquisition (SC); (3) data analysis (AS, EKT, SLS); and (4) interpretation (all authors). All authors assisted in writing and revising the article, and read and approved the final version of the submitted manuscript.

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Dr. Kohatsu serves on the editorial board for the *American Journal of Preventive Medicine*. He had no involvement in the peer review and decision-making processes for this paper.

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SUPPLEMENTAL MATERIAL

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