ingful statements to form a Q-set. Statements in the Q-set were pilot tested for understanding and redundancy in a small group of asthma patients. Thirty-eight statements were included in the final Q-set. Forty-five study respondents rank ordered the set of statements by a structured command called the condition of instruction. The resultant pattern of distribution of statements formed a Q-sort. After the Q-sorts were formed, by-person factor analysis was conducted to find clusters of Q-sorts with shared similarities or common attitudes. **RESULTS:** Five subjective attitudes were identified that may influence adherence with asthma regimens. 1) respondents did not want to be dependent on their medication and would rather take medication once a day; 2) respondents did not like others knowing they took medication and thought they were taking too much medication; 3) respondents did not feel they were sick and thought they did not need medication if they removed triggers from their home; 4) respondents did not believe their medications worked and had other priorities than to worry about their asthma; and 5) respondents did not want to be dependent on their medication and believed they were taking too much medication. **CONCLUSION:** Interventions to improve adherence can be targeted to the characteristics of patients defined in the factors from the Q-analysis.

PAA16

PREDICTORS OF SELF-REPORTED ADHERENCE IN PATIENTS WITH ASTHMA

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OBJECTIVE: To examine the relationship between patient, disease, and treatment variables and self-reported compliance with asthma controller medications. **METHODS:** This was a secondary analysis from a cross-sectional study of adults with asthma enrolled in a managed-care organization (MCO). Data were obtained from a mailed questionnaire and the MCO's patient/claims databases. Compliance was reported using the 4-item questionnaire developed by Brooks, et al. and scored as a mean of the responses, with 5 meaning highest compliance. Independent variables included age, gender, race, education, number of comorbidities, years with asthma, health-belief questions, social support, income, number of MDI instructors, inhaler technique, perceived physician access, patient-perceived severity, guideline-derived severity, and three health-related quality of life scores, the Asthma Quality of Life Questionnaire (AQLQ) summary and the physical (PCS) and mental (MCS) component summaries of the SF-36. Multivariate regression analysis was used to determine the independent variables with the strongest relationship to self-reported compliance. Stepwise backward-elimination was used, with the final model consisting of variables with a $p < 0.05$. **RESULTS:** The 573 respondents were primarily Caucasian (89.5%) and female (71.0%), with an average age of 40.5 ± 12.4 years (mean ± SD) and average asthma duration of 18.3 ± 14.2 years. The mean compliance scale score was 3.7 ± 1.1, with 84.6% indicating some level of noncompliance (score < 5). The final model had an adjusted R^2 of 0.26 and included 6 independent variables. Better adherence was associated with longer duration of asthma, more MDI instructors, lack of depression, stronger beliefs in the benefits of treatment and trigger avoidance, and greater perceived severity of asthma. **CONCLUSIONS:** A complex set of beliefs, perceptions, and experiences constitute the variables associated with compliant medication-taking behavior. Future longitudinal studies should include these variables to determine the predictive strength of the model.

PAA17

THE ASSOCIATION BETWEEN ADHERENCE, ASTHMA CONTROL, GENERIC AND DISEASE SPECIFIC QUALITY OF LIFE INSTRUMENTS IN ASTHMA

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OBJECTIVE: Prior studies have investigated the association between generic health related quality of life (HRQOL) and adherence. The objective of this study is to assess the association between medication adherence HRQOL using disease specific in addition to generic instruments. **METHODS:** As part of a larger study a convenience sample of adult ambulatory asthma patients were recruited from community pharmacies in GA, USA. Adult asthma patients identified to participate in the study were asked to complete a self-administered HRQOL survey. Patients were asked to complete generic (Short Form—SF-12, Health Utilities Index3—HUI3, EuroQol Index—EQ5D, EuroQoL visual analogue scale—EQVAS) and disease specific (Juniper's mini-Asthma Quality of Life Questionnaire—AQLQ) HRQOL metrics. Adherence was measured using Morisky's instrument. Asthma control was assessed using Juniper's Asthma Control Questionnaire (ACQ, objective measure) in addition to a self assessment (5-point Likert Scale, subjective measure). SF-12 was assessed using mental and physical summary scores (MCS and PCS, respectively). **RESULTS:** Data were available on a convenience sample of 36 patients (25 female: 11 male) with an average age of 44.8 years. Spearman correlation between ACQ and self assessed asthma control was high ($r = -0.825$, $p < 0.001$). Excluding PCS, spearman correlations between asthma control metrics (subjective and objective) and HRQOL measures were moderate to high in the predicted direction ($r = 0.52$ to 0.822). However, correlations between adherence and HRQOL measures were not significant. Quick relief beta-agonist use was also highly correlated with ACQ ($r = 0.67$, $p < 0.01$) and moderately with HRQOL instruments in the predicted direction. **CONCLUSION:** Overall, our study findings show no association between adherence and HRQOL, supporting the results by Cote and colleagues (2003) that factors other than medication compliance are important in explaining HRQOL. Asthma control is a potentially important variable in predicting HRQOL in asthma patients.

PAA18

THE ASSOCIATION BETWEEN MEASURES OF HEALTH STATE UTILITIES, QUALITY OF LIFE AND WILLINGNESS TO PAY IN ASTHMA

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OBJECTIVE: The objective of this study is to assess the association between health state utilities, HRQOL and willingness to pay. **METHODS:** As part of a larger study a convenience sample of adult ambulatory asthma patients were recruited from community pharmacies in the state of Georgia, USA. Adult asthma patients identified to participate in the study were asked to complete a self-administered HRQOL survey. Patients were asked to complete generic (Short Form—SF-12, Health Utilities Index3—HUI3, EuroQol Index—EQ5D, EuroQoL visual analogue scale—EQVAS) and disease specific (Juniper's mini-Asthma Quality of Life Questionnaire—AQLQ) HRQOL instruments. SF-12 was assessed using mental and physical summary scores (MCS and PCS, respectively). Willingness to pay (WTP) was assessed using the payment card approach for two scenarios: a hypothetical asthma cure and a treatment. **RESULTS:** Majority