this case, the complaint does not allege that U-Haul and Budget reached an agreement, despite Mr. Magyar's report to his bosses that he privately encouraged Budget to raise its rates "and they did." *See* Complaint Paragraph 19.

Even if no agreement was reached it does not necessarily mean that no competitive harm was done.[4] An unaccepted invitation to collude may facilitate coordinated interaction by disclosing the solicitor's intentions and preferences. For example, in this case Budget learned from Mr. Magyar that if Budget raised its rates U-Haul would not undercut Budget. Thus, the improper communication from U-Haul could have encouraged Budget to raise rates. Similarly, the public statements made by the CEO of U-Haul could have encouraged competitors to raise rates.

Although this case involves particularly egregious conduct, it is possible that less egregious conduct may result in Section 5 liability. It is not essential that the Commission find repeated misconduct attributable to senior executives, or define a market, or show market power, or establish substantial competitive harm, or even find that the terms of the desired agreement have been communicated with precision.

III. The Proposed Consent Order

U-Haul has signed a consent agreement containing the proposed consent order. The proposed consent order consists of seven sections that work together to enjoin U-Haul from inviting collusion and from entering into or implementing a collusive scheme.

Section II, Paragraph A of the proposed consent order enjoins U-Haul from inviting a competitor to divide markets, to allocate customers, or to fix prices. Section II, Paragraph C prohibits U-Haul from entering into, participating in, maintaining, organizing, implementing, enforcing, inviting, offering or soliciting an agreement with any competitor to divide markets, to allocate customers, or to fix prices. Section II, Paragraph B bars U-Haul from discussing rates with its competitors, with a proviso permitting legitimate market research.

The proviso in Section II, Paragraph D prevents the proposed order from interfering with U-Haul's efforts to negotiate prices with prospective customers, and it would permit U-Haul to provide investors with considerable information about company strategy. This proviso also permits U-Haul to communicate publicly any information required by the federal securities laws.

Sections III, IV, V, and VI of the proposed order include several terms that are common to many Commission orders, facilitating the Commission's efforts to monitor respondents' compliance with the order. Section IV, Paragraph A requires a periodic submission to the Commission of *unredacted* copies of certain internal U-Haul documents. This provision is necessary because U-Haul impeded the Federal Trade Commission's investigation of this matter. Specifically, U-Haul submitted to the Commission, in response to a *subpoena duces tecum*, documents authored by Mr. Shoen, from which were redacted many of the sentences quoted in the complaint. In the Commission's view, there was no justification for the redaction. The proposed order should deter repetition of this conduct.

Finally, Section VII provides that the proposed order will expire in 20 years.

By direction of the Commission.

Donald S. Clark,

Secretary.

Statement of Chairman Leibowitz, Commissioner Kovacic, and Commissioner Rosch

The Commission today has entered into a consent agreement with U-Haul and its parent company, AMERCO, resolving the Commission's allegation that they attempted to collude on truck rental prices. The parties have settled an invitation-to-collude case and not a Sherman Antitrust Act Section 1 conspiracy case. Put differently, the complaint in this case alleges an unfair method of competition in violation of Section 5 of the FTC Act that does not also constitute an antitrust violation.

Invitations to collude are the quintessential example of the kind of conduct that should be – and has been – challenged as a violation of Section 5 of the Federal Trade Commission Act,[5] which may limit follow-on private treble damage litigation from Commission action while still stopping inappropriate conduct. In contrast to conspiracy claims that would violate Section 1, invitations to collude do not require proof of an agreement; nor do they require proof of an anticompetitive effect. The Commission has not alleged that Respondents entered into an agreement with Budget or any other competitors in violation of Section 1. Today's Commission action is instead based on evidence that Respondents unilaterally attempted to enter into such an agreement. The Commission therefore has reason to believe that Respondents engaged in conduct that is within Section 5's reach.

[FR Doc. 2010–14870 Filed 6–18–10: 8:45 am]

BILLING CODE 6750–01–S

[4] The Commission has previously explained that there are several legal and economic reasons to punish firms that invite collusion even when acceptance cannot be proven. First, it may be difficult to determine whether a particular solicitation has or has not been accepted. Second, the conduct may be harmful and serves no legitimate business purpose. Third, even an unaccepted solicitation may facilitate coordinated interaction by disclosing the intentions or preferences of the party issuing the invitation. *In the Matter of Valassis Communications, Inc.*, Analysis of Agreement Containing Consent Order To Aid Public Comment, 71 Fed. Reg. 13976, 13978-79 (Mar. 20, 2006). *See generally* P. Areeda & H. Hovenkamp, VI Antitrust Law ¶1419 (2003).

[5] *In re Valassis Commc'ns, Inc.*, F.T.C. File No. 051-008, 2006 FTC LEXIS 25 (April 19, 2006) (Complaint); *In re MacDermid, Inc.*, F.T.C. File No. 991-0167, 1999 FTC LEXIS 191 (Feb. 4, 2000) (Complaint, Decision and Order); *In re Stone Container Corp.*, 125 F.T.C. 853 (1998) (June 3, 1998) (Complaint, Decision and Order); *In re Precision Moulding Co.*, 122 F.T.C. 104 (Sept. 3, 1996) (Complaint, Decision and Order); *In re YKK (USA) Inc.*, 116 F.T.C. 628 (July 1, 1993) (Complaint); *In re A.E. Clevite, Inc.*, 116 F.T.C. 389 (June 8, 1993) (Complaint); *In re Quality Trailer Products Corp.*, 115 F.T.C. 944 (Nov. 5, 1992) (Complaint).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary for Preparedness and Response; Statement of Organization, Functions, and Delegations of Authority

Part A, Office of the Secretary, Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS) is being amended at Chapter AN, Office of Public Health Emergency Preparedness (OPHEP), as last amended at 71 FR 38403–05 dated July 6, 2006. This organizational change is to retitle the OPHEP as the Office of the Assistant Secretary for Preparedness and Response (ASPR), and to realign the functions of ASPR to reflect the changes mandated by the Pandemic and All-Hazards Preparedness Act (Pub. L. 109–417) (PAHPA). The changes are as follows.

I. Under Part A, Chapter AN, "Office of Public Health Emergency Preparedness (AN)," delete in its entirety and replace with the following:

CHAPTER AN: Office of the Assistant Secretary for Preparedness and Response

AN.00 Mission
AN.10 Organization
AN.20 Functions

Section AN.00 Mission

On behalf of the Secretary of HHS, the Assistant Secretary for Preparedness and Response (ASPR) serves as the principal advisor on all matters related to Federal public health and medical preparedness and response for public health emergencies. The ASPR serves as the primary advisor to the Secretary of HHS for national public health and medical preparedness, including Emergency Support Function 8 (ESF 8). Furthermore, the ASPR exercises the responsibilities of the Secretary with respect to direction of ESF 8 activities, and coordination of HHS assets in accord with the PAHPA, including the Strategic National Stockpile (SNS) and the Cities Readiness Initiative (CRI).

ASPR leads the Federal public health and medical response to acts of terrorism, nature, and other public health and medical emergencies; coordinates the development and implementation of national policies and plans related to public health and medical preparedness and response; oversees the advanced research, development, and procurement of qualified countermeasures and qualified pandemic or epidemic products; coordinates services for at-risk individuals, preparedness planning, and response efforts; and provides guidance in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response. ASPR is responsible for ensuring a consolidated approach to developing public health and medical preparedness and response capabilities and leading and coordinating the relevant activities of the HHS Operating Divisions (OPDIVs) and Staff Divisions (STAFFDIVs).

The Office of the ASPR is charged with strategic and operational responsibilities for medical and public health preparedness and response. The Immediate Office of the ASPR provides staff guidance to maximize operational effectiveness and is responsible for reviewing staff recommendations of policies developed to further the ASPR and HHS mission.

Strategic responsibilities include policy development and implementation, oversight of the National Health Security Strategy, and coordination across HHS, with other Federal agencies, and state, local and private sector entities. The ASPR is the primary HHS liaison to and leads coordination of Homeland and National Security Councils' policy initiatives and is responsible for the integration of national public health and medical preparedness and response efforts into the Federal interagency planning and policy processes.

Operational responsibilities include (but are not limited to) the following:

- Serves as the Incident Manager for ESF 8 during activations;
- Directs and coordinates the development of ESF 8 Playbooks, Concepts of Operations (CONOPS), Operating Plans (OPLANS), and other planning or procedural documents that set forth how HHS response assets are to be employed in various emergency contexts;
- Coordinates preparedness and response planning with state, local, and private sector entities in furtherance of the National ESF 8 mission;
- Assures that planning and procedural documents make explicit the respective roles of ASPR Headquarters staff, ASPR Regional Emergency Coordinators, the ASPR field incident management teams, HHS Secretary's Operations Center (SOC), Centers for Disease Control and Prevention (CDC) Headquarters staff, the Director's Emergency Operations Center, Federal Emergency Management Agency (FEMA) Operations Center, Department of Homeland Security (DHS) National SOC, CDC field staff such as SNS consultants, and other HHS division response assets;
- Assures clarity in state ESF 8 planning by convening state ESF 8 planning meetings with the Department of State, ASPR, CDC, and other organizations as necessary to ensure medical, public health, and human service functions are integrated;
- Manages the Hospital Preparedness Program (HPP) Cooperative Agreement, which provides financial and technical support for medical preparedness to health care facilities throughout the country;
- Facilitates HHS participation in development of International Health Regulations (IHR);
- Manages the National Disaster Medical System (NDMS);
- Manages the Biomedical Advanced Research and Development Authority (BARDA); and
- Manages and operates the HHS SOC.

Section AN.10 Organization

The Office of the Assistant Secretary for Preparedness and Response is headed by the Assistant Secretary for Preparedness and Response (ASPR), who reports directly to the Secretary, and includes the following components:

- Immediate Office/Chief Operating Officer (ANA)
- Office of Biomedical Advanced Research and Development Authority (ANB)
- Office of Preparedness and Emergency Operations (ANC)
- Office of Acquisitions Management, Contracts, and Grants (AND)
- Office of Policy and Planning (ANE)
- Office of Financial Planning and Analysis (ANF)

Section AN.20 Functions

A. Immediate Office/Chief Operating Officer (ANA). The Immediate Office (IO) develops and maintains liaison relationships with HHS operating and staff divisions and represents HHS at interagency meetings, as required. The IO provides information to those individuals and organizations that inquire about or express interest in ASPR. The IO establishes and maintains effective communications to advise mid- and long-range plans to emphasize recent or forthcoming changes in plans and regulations, to receive effective feedback; and explore ways to implement suggestions for improved business operations and performance. The IO is responsible for the direction of executive level business management operations and managing division staff coordination. The IO is responsible for the timely and quality execution of all management related matters under the ASPR mission. The IO provides staff guidance to maximize operational effectiveness. The IO is responsible for reviewing staff recommendations of policies developed to further the ASPR and HHS mission. The IO staff considers the potential impact of political, social, economic, technical, and administrative factors on the recommended policies and formally recommends actions on approving/disapproving policies to the ASPR.

The Immediate Office/Chief Operating Officer (ANA) includes the following components:

- Division of Administrative Management (ANA1)
- Division of Communications (ANA2)
- Division of Legislative Coordination (ANA3)
- Division of Workforce Development (ANA4)
- Division of Executive Secretariat (ANA5)

The Immediate Office/Chief Operating Officer provides for the facility, logistics, and infrastructure support services necessary to maintain day-to-day operations of ASPR; the office provides communication and outreach guidance and support for all external communications, including legislative and executive branch questions and

inquiries, and serves as the principal advisor to the ASPR on all legislative strategies to fulfill the Office of the ASPR and the HHS mission under the PAHPA. Furthermore, the Office covers the functions of Human Resources, Organization and Employee Development, Ethics, and United States Public Health Service (USPHS) Liaison, and develops and maintains liaison relationships with HHS OPDIVs and STAFFDIVs. The Chief Operating Officer manages correspondence control for the Assistant Secretary. In addition, the office provides oversight in the development and operation of tracking systems, which are designed to identify and resolve early warnings and bottleneck problems with executive correspondence.

B. Office of Biomedical Advance Research and Development Authority (ANB). The Office of Biomedical Advanced Research and Development Authority (BARDA), established in April 2007 in response to the Pandemic and All-Hazards Preparedness Act of 2006, serves preparedness and response roles to provide medical countermeasures (MCM) in order to mitigate the medical consequences of chemical, biological, radiological, and nuclear (CBRN) threats and agents and emerging infectious diseases, including pandemic influenza. BARDA executes this mission by facilitating research, development, innovation, and acquisition of medical countermeasures and expanding domestic manufacturing infrastructure and surge capacity of these medical countermeasures.

BARDA is headed by a Deputy Assistant Secretary, and includes the following components:

- Division of Influenza (ANB1)
- Division of Emerging Infectious Diseases (ANB2)
- Division of Chemical, Biological, Radiological and Nuclear Threats (ANB3)
- Division of Strategic Science and Technology (ANB4)
- Division of Regulatory and Quality Affairs (ANB5)

C. Office of Preparedness and Emergency Operations (ANC). The Office of Preparedness and Emergency Operations (OPEO) is responsible for providing a well-integrated infrastructure that supports the Department's capabilities to prevent, prepare for, respond to and recover from natural public health and medical threats and emergencies. OPEO leads the preparedness and response activities required to coordinate public health and medical response systems and activities with relevant Federal, state, Tribal, Territorial, local, and international communities under ESF 8, ESF 6 and ESF 14 of the NRF. OPEO is also responsible for the HHS Continuity of Operations (COOP) and the development of the ASPR COOP Plan.

The Office of Preparedness and Emergency Operations (OPEO) is headed by a Deputy Assistant Secretary, and includes the following components:

- Division of Mass Care (ANC1)
- Division of Operations (ANC2)
- Division of Planning (ANC3)
- Division of Infrastructure Coordination (ANC4)
- Division of Emergency Care Coordination Center (ECCC) (ANC5)
- Division of National Disaster Medical System (NDMS) (ANC6)

D. Office of Acquisitions Management, Contracts and Grants (AND). The Office of Acquisitions Management, Contracts and Grants (AMCG) provides ASPR with acquisition support to prepare and respond to the adverse health emergencies and disasters and provides contractual support to the Immediate Office of the ASPR, BARDA, Office of Policy and Planning (OPP), and Office of Financial Planning and Analysis (FPA). The office focuses on providing acquisition and contractual support to BARDA in two specific program divisions: Chemical, Biological, Radiological, and Nuclear Threats (CBRNT) and Influenza (Flu). The Division of Acquisition Programs Support (APS) provides a wide range of program management support to the ASPR as well as direct program support to the following BARDA divisions—CBRN, Influenza, Emerging Infectious Diseases, and Strategic Science and Technology. Functional support activities of the Office include requirements analysis for statement of work/statement of operations development, acquisition strategy development and tracking assistance to include contractual milestone development with measurable success criteria. The office also serves as ASPR's focal point for management, leadership and administration of discretionary and mandatory grants and cooperative agreements.

The Office of Acquisitions Management, Contracts and Grants (AMCG) is headed by a Director, and includes the following components:

- Division of ASPR Support (AND1)
- Division of BARDA Support (AND2)
- Division of Acquisition Programs Support (AND3)
- Division of Grants Management (AND4)
- Division of Acquisition Policy (AND5)

E. Office of Policy and Planning (ANE). The Office of Policy and Planning (OPP) is responsible for policy development, analysis and coordination, research and evaluation, and strategic planning. The OPP: (1) Analyzes proposed policies, Presidential Directives, and regulations, and develops short- and long-term policy objectives for ASPR; (2) leads the development and implementation of an integrated ASPR approach to policy; (3) serves as the focal point for the Homeland Security Council (HSC) and the National Security Council (NSC) policy coordination activities on behalf of ASPR and represents the ASPR, as appropriate, in interagency policy coordination meetings and activities; (4) undertakes studies of preparedness and response issues, identifying gaps in policy, and initiating policy planning and formulation to fill these gaps; (5) leads in the implementation of the PAHPA and is responsible for developing the quadrennial National Health Security Strategy and implementation plan for public health emergency preparedness and response; (6) develops strategic partnerships with stakeholders and leads in the development of ASPR strategies for knowledge and information management; (7) manages the development of the ASPR strategic plan, annual plan, and balanced scorecard, and compiles the ASPR Organizational Assessment by tracking Key Performance Indicators as part of the ASPR strategic management system; (8) develops and maintains liaison relationships with strategic planning personnel of HHS and ESF 8 partner organizations; and (9) manages strategic planning program objectives to ensure programs are consistent with ASPR goals and monitors program development to make sure that timelines are met accordingly.

OPP is headed by a Deputy Assistant Secretary and includes the following components:

- Division of Policy and Strategic Planning (ANE1)
- Division of Medical Countermeasures Policy and Planning (ANE2)
- Division of Health Systems Policy (ANE3)
- Division of International Health (ANE4)
- Division of Biosecurity/Biosafety/Countering Biologic Threats (ANE5)

F. Office of Financial Planning and Analysis (ANF). The Office of Financial Planning and Analysis (OFPA) ensures that ASPR's financial resources are aligned to its strategic priorities. OFPA carries out its responsibilities by

formulating, monitoring, and evaluating ASPR budgets and financial plans that support program activities and ensures the effective and efficient execution of ASPR financial resources. OFPA has administrative oversight of the Administration & Finance section of the emergency management group that is activated under ESF 8 of the NRF during a public health emergency. On behalf of the ASPR, OFPA serves as the primary point of contact with the Office of the Assistant Secretary for Financial Resources, the Office of Management and Budget (OMB) and Congressional Appropriation Committees. In compliance with OMB Circular A–123, FPA ensures accountability and effectiveness of ASPR's financial programs and operations by establishing, assessing, correcting, and reporting on internal controls.

The Office of Financial Planning and Analysis is headed by a Director and includes the following components:

- Division of Budget Formulation and Execution (ANF1)
- Division of Requisition Services (ANF2)
- Division of Management Assurance (ANF3)
- Division of Administration and Finance (ANF4)

II. Delegations of Authority. All delegations and redelegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegation, provided they are consistent with this reorganization.

Dated: June 14, 2010.

E.J. Holland, Jr.,

Assistant Secretary for Administration.

[FR Doc. 2010–14997 Filed 6–18–10; 8:45 am]

BILLING CODE 4150–37–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities; Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: "Avoiding Readmissions in Hospitals Serving Diverse Patients." In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3520, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by August 20, 2010.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by e-mail at *doris.lefkowitz@AHRQ.hhs.gov.*

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by e-mail at *doris.lefkowitz@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Avoiding Readmissions in Hospitals Serving Diverse Patients

An important part of AHRQ's mission is to disseminate information and tools that can support improvement in quality and safety in the U.S. health care community. The transition process from the hospital to the outpatient setting is nonstandardized and frequently inadequate in quality. One in five hospital discharges is complicated by an adverse event (AE) within 30 days, often leading to an emergency department visit and/or rehospitalization. Many readmissions stem from errors that can be directly attributed to the discontinuity and fragmentation of care at discharge. High rates of low health literacy, lack of coordination in the "hand-off' from the hospital to community care, gaps in social supports, and other limitations also contribute to the risk of rehospitalization.

Boston University Medical Center (BUMC), through a grant from AHRQ, previously defined the discharge process and determined what improvements could be made to improve this care transition for patients. This new process was called the "re-engineered discharge" (RED). The RED consists of 11 elements, including educating the patient throughout the hospital stay, making follow-up appointments, and giving the patient a written discharge plan. The RED was tested in a randomized controlled trial in an academic safety net hospital at BUMC with English speaking, general medical patients being discharged to home or community settings. Results of this trial of 749 patients showed a reduction in rehospitalizations within 30 days and emergency department visits following hospital discharge. Participants also followed up with primary care providers more often and reported higher patient satisfaction with the discharge process. Project RED researchers created several tools to help hospitals replicate RED. After AHRQ and Project RED researchers fielded many inquiries about how to implement Project RED at hospitals nationwide, AHRQ realized that the Project RED Toolkit did not provide sufficient guidance to potential replicators. Various components of the RED were not documented, and issues regarding implementing the RED at hospitals serving linguistically and culturally diverse patient populations had not been addressed. AHRQ has therefore contracted with the RED researchers to create a revised RED Toolkit that will address these issues.

This proposed information collection supports AHRQs mission by improving upon the RED Toolkit. This project has the following 3 goals:

(1) To revise the Project RED Toolkit to comprehensively address all components of the RED, as well as the needs of culturally and linguistically diverse patients;

(2) To pre-test the revised RED Toolkit in ten varied hospital settings, evaluating how the RED Toolkit is implemented in varied hospital settings by: (a) Documenting the implementation process; (b) assessing the fidelity of implementation; and (c) identifying the factors that affect redesign fidelity, including intensity of technical assistance (TA).

(3) To modify the revised RED Toolkit based on pre-testing and to disseminate it.

BUMC will provide TA at two varying levels. Four selected hospitals will receive "train-the-trainer" TA, which includes:

(1) Telephone assistance in conducting a baseline needs assessment;

(2) Master trainer training;

(3) Access to Webinar trainings specifically designed for each user (nurse, IT professional, hospital leadership, and pharmacist);

(4) An electronic template to print an After Hospital Care Plan (AHCP) booklet; and

(5) E-mails regarding updates to the RED Web site and the opportunity to ask questions about the newly revised and enhanced RED tools and implementation via telephone and email.

Six selected hospitals will receive intensive TA, which includes: