U.S. Department of Labor

Office of Workers' Compensation Programs
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Dr. Steven Markowitz
Chair
Advisory Board on Toxic Substances &
Worker Health
Queens College, Remsen Hall
65-30 Kissena Boulevard
Flushing, NY 11367

Dear Dr. Markowitz:

I am pleased to send you the Department of Labor's response to the recommendations made by the Advisory Board on Toxic Substances and Worker Health, at the Board's April 2017 public meeting. The Department appreciates the dedication and expertise that the Advisory Board provides to the Energy Employees Occupational Illness Compensation Program and its stakeholders. Your important work is making a difference.

On behalf of the Department, the Office of Workers' Compensation Programs, the Energy program, and the communities we serve, I look forward to the continued efforts of the Advisory Board.

Sincerely,

Julia K. Hearthway
Director
Office of Workers' Compensation Programs

Enclosure

Department of Labor Responses to Recommendations from the April 2017 Public Meeting of the Advisory Board on Toxic Substances and Worker Health

Recommendation #1

Presumptions for Asbestos-related Diseases

1. All DOE [Department of Energy] workers who worked as a maintenance or construction worker at a DOE site for 250 days or more prior to January 1, 2005 and who are diagnosed 15 years or more after the initiation of such work with 1 of 5 asbestos-associated conditions will be presumed to have had sufficient asbestos exposure that it was at least as likely as not that asbestos exposure was a significant factor in aggravating, contributing to, or causing such asbestos-associated conditions. The five asbestos-associated conditions are asbestosis, asbestos-related pleural disease, lung cancer, and cancer of ovary and larynx.

2. All DOE workers who worked as a maintenance or construction worker at a DOE site for 30 days or more and who are diagnosed 15 years or more after the onset of such work with malignant mesothelioma of any bodily site will be presumed to have had sufficient asbestos exposure that it was at least as likely as not that asbestos exposure was a significant factor in aggravating, contributing to or causing the malignant mesothelioma.

3. All claims for one of the six asbestos-associated conditions named above that do not meet the exposure criteria described in items #1 and #2 above will be referred to an industrial hygienist for exposure assessment and to a CMC [contract medical consultant] for evaluation of medical documentation and causation. These six conditions are asbestosis, asbestos-related pleural disease, malignant mesothelioma, lung cancer, and cancer of ovary and larynx.

4. Chronic obstructive pulmonary disease may have a contribution from asbestos exposure. However, claims for this disease should be evaluated as part of a broader set of presumptions for chronic obstructive pulmonary disease.

Exposure criteria	Asbestos-specific Diseases Mesothelioma	Asbestos-specific diseases Asbestosis, Asbestos-related pleural disease	Other Asbestos-related Cancers Lung cancer, Cancer of ovary and larynx
Duration	≥ 30 days	≥ 250 days	≥ 250 days
Job titles	Maintenance Construction	Maintenance Construction	Maintenance Construction
Calendar years	Pre-2005	Pre-2005	Pre-2005
Latency (minimum)	15 years	15 years	15 years

Response:

With regard to Recommendation #1-1, OWCP agrees that the 250-day aggregate duration of exposure is a reasonable standard to apply when assessing presumptive standards for asbestos related health effects pertaining to the following five asbestos-associated conditions: asbestosis, asbestos-related pleural disease, lung cancer, and cancer of ovary and larynx.

OWCP currently makes a distinction between *exposure* presumptions and *causation* presumptions. The Division of Energy Employees Occupational Illness Compensation (DEEOIC or the program) has determined that certain presumptions may be made as to the nature, frequency, and duration of a specific *exposure*. Presumptions are based on knowledge and evidence OWCP has obtained through industrial hygiene, knowledge of labor categories and work processes, and environmental health and safety practices in existence. Therefore, OWCP's exposure presumptions are specific to certain labor categories, work processes, and/or timeframes. If an exposure presumption exists, the claims examiner will apply the criteria to the specified toxic substance. As long as all criteria have been met, the case does not need to be reviewed by an industrial hygienist. With regard to exposure to asbestos specifically, the program recognizes that asbestos is a toxic material that was present in all DOE facility locations; however, OWCP assumes different levels of exposure depending on the employee's labor categories and years of employment. The program has developed a list of labor categories considered to have had significant exposure to asbestos at high or low levels (referred to by the Board as "Attachment 1.") If an employee worked in one of these labor categories before December 31, 1986, the program considers that he or she had significant exposure at high levels. If the employee worked in one of the labor categories between 1987 and 1995, in one of these labor categories, the employee is presumed to have significant exposure to asbestos at low levels. While employees in all other labor categories or during other years of employment are assumed to have had some level of exposure to asbestos, the level of exposure is determined by guidance from an industrial hygienist on a case-by-case basis. OWCP applies these exposure presumptions before applying any causation presumptions.

OWCP currently applies a *causation* standard to the conditions of asbestosis, laryngeal cancer, ovarian cancer, and mesothelioma, using criteria specific to each of these conditions. For all four conditions, in order to apply a presumption that the condition is related to exposure to asbestos under Part E, there must be a medical diagnosis of the condition, and the employee must have been employed in a job that would have brought him or her into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. The exposure can be determined by existing asbestos exposure presumptions, as outlined above, or through an industrial hygiene assessment. The program also applies varying latency periods to each of these conditions: for asbestosis, latency is 10 years after initial exposure; for laryngeal cancer, it is 15 years; for ovarian cancer, it is 20 years; and for mesothelioma, it is 30 years. The program has not yet created a presumption for lung cancer as it relates to exposure to asbestos; however, OWCP agrees that sufficient literature exists to develop one. OWCP reviewed the Board's recommendation that the latency period for all of the listed conditions be 15 years and agrees to change existing latency standards for all conditions except asbestosis. Since the current latency period of 10 years for asbestosis is more claimant friendly, and OWCP's research confirms this period is scientifically valid, OWCP will retain the existing 10-year latency period.

In developing the labor categories for use in the asbestos exposure presumption, the program primarily relied on the scientific research conducted and compiled by the Agency for Toxic Substances and Disease Registry (ATSDR) within the Department of Health and Human Services (HHS). They published a booklet on January 29, 2014, entitled *Case Studies in Environmental Medicine, Asbestos Toxicity.* Pages 31-32 include a list of occupations they determined to entail significant asbestos exposures. OWCP worked with its contractor, Paragon (who created the SEM) to review the list and tailor it to the labor categories relevant to the DOE complex. The scientists at Paragon are former DOE nuclear workers and very familiar with labor categories at the DOE facilities. OWCP included in its policy more specific definitions where appropriate (like maintenance mechanic instead of maintenance worker), excluded some on the ATSDR list that were clearly not DOE-related (like longshoremen), and further tailored the list to DOE job descriptions.

In determining the causation standards, the program also relied on this publication, along with updated information from the *International Agency for Research on Cancer (IARC)* and articles and publications based on human studies, including the *American Journal of Epidemiology*, the *American Journal of Respiratory and Critical Care Medicine,* the *American Journal of Industrial Medicine*, and the *Journal of Occupational Medicine and Toxicology.*

In reference to the Board's Recommendation #1-2, to apply an asbestos presumption to "all DOE workers who worked as a maintenance or construction worker at a DOE site," OWCP needs additional information and clarification. Included in the Board's reference materials was a listing of 17 construction and trade worker labor categories related to asbestos exposure, 15 of which are already included in DEEOIC's presumptive labor category listing. The two remaining categories include "Teamsters" and "Administrative/scientific/security" jobs. OWCP requests that the Board clarify whether their recommendations are that OWCP should include these remaining two labor categories and whether there are additional specific labor categories that the Board believes should be included in the listing. OWCP also requests that the Board provide the research relied upon that supports the inclusion of the proposed new labor categories.

In reference to the Board's recommendation to apply an exposure presumption prior to January 1, 2005, as indicated above OWCP currently has guidance concerning presumptions to be made regarding the level of exposure to asbestos. Our Procedure Manual states that the claims examiner is to assume high or low levels of significant exposure to asbestos depending on the years of exposure. Anything after 1995 is referred to an industrial hygienist for an individual assessment and then a physician must conduct a medical assessment. Then the program reviews the evidence for causation presumptions, depending on the latency periods. In the Board's presumptions, it is suggesting not only that a presumption be made that the claimant was significantly exposed to asbestos before 2005, but also that the exposure was sufficient to presume that the asbestos exposure was at least as likely as not a significant factor in aggravating, contributing to, or causing the listed asbestos-associated conditions. While OWCP rescinded EEOICPA Circular No. 15-06, that Circular simply stated that claims examiners should presume that any exposure after 1995 was within safety regulatory limits and therefore need not be reviewed by an industrial hygienist. That Circular did not address causation, and the program has continued to refer cases for an exposure and causation assessment for the listed conditions prior to accepting for causation, where the employee was employed after 1995. The Board recommends changing current guidance to allow for acceptance of these medical

conditions under broader circumstances. OWCP agrees to changing current latency periods for all of the conditions as recommended, and to changing the duration of mesothelioma to greater than or equal to 30 days. However, with regard to the 2005 date, OWCP seeks additional clarity as to the underlying research and the rationale supporting the selection of that date as a temporal basis for application in the Board's presumption. While OWCP agrees with the Board that it is difficult to assign a temporal threshold for use in a presumption, more specific documented basis supporting the date of 2005 is necessary to satisfy the legal requirement that all presumptions must have sufficient scientific rationale to withstand judicial scrutiny. Our research indicates that DOE's predecessor, the Atomic Energy Commission, began developing health and safety standards as early as 1973, after the Occupational Safety and Health Act of 1970 was passed. Those standards became longer and more detailed as the dissemination and enforcement of enhanced safety measures progressed over the next two decades. Those safety measures were standardized in 1995 with the issuance by DOE of Order 440.1, and accordingly, we could agree that 1995 creates a clear demarcation date for causation purposes with a solid supporting rationale that would withstand judicial scrutiny. To move that date out to 2005, on the assertion that it likely took another decade for exposure levels to be significantly lower, is much more problematic. The 2005 date, without additional support, places OWCP in a position of being unable to legally defend the presumption, should it be challenged by an employee who only worked *after* 2005. Accordingly, OWCP requests that the Board provide more substantive medical health science justification or specific DOE operational data that supports the scientific basis for its selection of January 1, 2005 as the exposure demarcation date for use in the recommended presumption.

In response to Recommendation #1-3, OWCP agrees that all claims for the six asbestos-associated conditions named above, that do not meet the exposure criteria, should be referred to an industrial hygienist and to a CMC, as appropriate. By way of further answer and clarification, OWCP currently stipulates in program policy that any case assessed for causation under Part E that does not satisfy an established presumptive standard must undergo a case-specific assessment including review by an industrial hygienist and a qualified physician (Reference Guidance in the Procedure Manual, Exhibit 15-4).

The Program addresses Recommendation #1-4 in its answer to the Board's Recommendation #3 regarding chronic obstructive pulmonary disease (COPD) below.

Recommendation #2

Presumptions for Work-Related Asthma

1. DOL should use the generally accepted unifying term, work-related asthma (WRA) for claims evaluation and decision-making. Work-related asthma includes: a) occupational asthma (OA), or new onset asthma that is initiated by an occupational agent, and b) work-exacerbated asthma (WEA), which is established asthma that is worsened by workplace exposures. The recognition of both forms of work-related asthma should be communicated to claimants, their physicians and consulting IH's [industrial hygienists] and CMC's [contract medical consultants].

2. Medical criteria for the diagnosis of asthma: The diagnosis of asthma by a treating or evaluating physician should be sufficient for the recognition that the claimant has asthma. Bronchodilator reversibility of FEV_1 and/or a positive methacholine challenge test may be helpful but should not be required to accept the diagnosis of asthma, which is made by a health care provider.

3. Work-related asthma, whether OA or WEA, is defined as the presence of medically-diagnosed asthma that is associated with worsening of any one or more of the following in relation to work: asthma-related symptoms, asthma medication usage or asthma-related health care utilization temporally related to work, or change in peak expiratory flows associated with work. Such a history should be documented by a treating or evaluating health care provider, or addressed by a CMC if consulted in a claim evaluation.

4. The same criteria for WRA should be used in evaluating asthma claims whether the claim is made contemporaneous with the period of DOE employment or after the end of that period of employment. A specific triggering event causing onset of WRA may occur but is not typical or necessary. Inciting exposures such as dusts, fumes, heat or cold or others should be specifically identified when possible, but should not be required for the diagnosis of WRA.

Response:

OWCP agrees with Recommendation #2-1, and it has already modified the Procedure Manual to incorporate these into the September 2017 revision (Exhibit 15-4).

OWCP also agrees that a diagnosis of asthma by a treating physician should be sufficient, without specific reference to the tests listed in Recommendation #2-2; however, the physician's opinion should include appropriate medical rationale, based on objective findings, to support the diagnosis, as is required for any other diagnoses claimed under the program.

For Recommendations #2-3 & #2-4, in its most recent update to Chapter 15 of the Procedure Manual, OWCP applies a policy regarding the assessment of work-related/occupational asthma that comports in part with these recommendations. OWCP policy requires evidence of a contemporaneous diagnosis of occupational asthma during covered Part E contractor employment or the well-rationalized opinion of a physician after a period of covered employment, as recommended in #2-3. The policy differs slightly from the recommendation in Recommendation #2-4, by requiring a triggering mechanism that occurred to cause, contribute to, or aggravate the condition. Legally, OWCP must require evidence that the toxic substance was the likely trigger for the condition because a condition can only be accepted as a compensable "covered illness" if "it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility." 42 U.S.C. § 7385s-4(c)(1)(B). A mere temporal association, without identification of a toxic substance, would not satisfy the statutory requirement for eligibility. In addition, neither "heat" nor "cold" (as referenced in the Board's recommendation) can be defined as a "toxic substance" under this definition.

Recommendation #3

Presumptions for Chronic Obstructive Pulmonary Disease

The Advisory Board recommends that the Energy Employees Occupational Illness Compensation Program (EEOICP) revise its exposure presumptions that are used to adjudicate claims for chronic obstructive pulmonary disease (COPD). We recommend that EEOICP replace the presumptions it has established in DEEOIC Bulletin 16-02 with the following alternative presumptions:

1. Any claimant with a physician's diagnosis of COPD who worked in any covered facility either:

> **(a) In any of the labor categories in Attachment 1 (which should be expanded to include all construction and maintenance job titles),**
>
> **Or**
>
> **(b) Who reported exposure to vapors, gases, dusts, and fumes (VGDF) with relevant tasks on the Occupational History Questionnaire for a period, which, in aggregate, totals at least five years,**

is presumed to have experienced sufficient exposure to toxic agents to aggravate, contribute to, or cause COPD.

2. In addition, claims examiners should not deny claims for COPD if the worker had fewer than 5 years of exposure; for example, a claimant who has experienced high intensity exposures to VGDFs for a period < 5 years during work in a covered facility would have an equivalent exposure. Claims that do not meet the requirements set forth here but do have reported exposure to VGDF should be sent for industrial hygienist and/or CMC review under the policy established in Bulletin 16-03.

Response:

OWCP will consider modifications of the current COPD presumptive standard; however, we have a number of questions and concerns with this recommendation as stated.

OWCP's current procedures provide that a claims examiner can assume that exposure to asbestos at a DOE facility meets the Part E definition of causation for COPD if the following criteria are met: 1) the diagnosis of COPD has been established by the medical evidence; and 2) the employee must have been employed for an aggregate of 20 years in a position that would have had significant levels of asbestos exposure. In order to meet the criteria for exposure sufficient to make the causation presumption, the claims examiner must determine that either the employee was employed in any of the labor categories discussed above for an aggregate of 20 years prior to 1986, or an IH has provided a well-rationalized discussion of case-specific exposure at high levels during any time period.

The Board has recommended that the duration of exposure should be 5 years, and cites an article from Dr. Dement that is based on a study of former DOE workers who self-reported both labor categories and exposure. This exposure limit conflicts with the results of OWCP's own search of other medical and scientific information, using the literature as described above in response to Recommendation #1. Accordingly, in order for OWCP to consider these two presumptions further, OWCP requests that the Board provide additional medical or scientific studies that specifically reference these issues.

With regard to the Board's discussion of labor categories in Recommendation #3-1a, OWCP requests that the Board provide the information about labor categories as described in response to Recommendation #1.

Concerning the Board's reference to "vapors, gases, dusts, and fumes," the EEOICPA specifically states that a condition can only be accepted as a compensable covered illness if it is at least as likely as not that exposure to a specific toxic substance was related to employment at a Department of Energy facility. 42 U.S.C. § 7385s-4(c)(1)(B). The program has defined a "toxic substance" for purposes of claim administration as, "any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature." 20 C.F.R. § 30.5(ii). "Vapors, gases, dusts, and fumes" is a broad reference that encompasses many different specific toxic substances. Exposures to vapors, gases, dusts, and fumes apply to virtually all circumstances that exist in either occupational or non-occupational settings. OWCP has evaluated the literature submitted by the Board, and while it appears that different groupings of individual toxic substances can be characterized under the lexicon of vapors, gases, dusts, and fumes in scientific studies, there is not one consistent list of toxic substances in the literature that represents this grouping. In addition, the program is legally required to offset awards for any condition, including COPD, to reflect tort recoveries tied to specific toxic substances (42 U.S.C. § 7385). Therefore, OWCP is unable to implement this recommendation. However, if the Board develops a list of toxic substances that represents vapors, gases, dusts, and fumes, we may be in a better position to consider the presumption.

For all of the above reasons, OWCP is not able to accept this recommendation related to COPD as written. OWCP welcomerecommended revisions to these presumptions, after consideration of these concerns.

Recommendation #4

Revisions of Occupational History Questionnaire

A. The Advisory Board recommends expanding the current list of hazards, exposures, and materials on the current Occupational History Questionnaire (OHQ) to include the list of hazards and/or materials used by the Building Trades National Medical Screening Program (BTMed).

1. For each exposure reported, the worker should be asked to describe how he/she was exposed to each material with an emphasis on describing the tasks associated with the exposure; this would be captured using free text. The worker would also be asked to rate the frequency of exposure to each hazard, using the scale from BTMed. In addition, we suggest adding a box next to each exposure on the list, asking if the worker used the material directly or was exposed as a bystander.

The current version of the OHQ asks about specific exposures that could be expanded with the text box and assessment of exposure frequency.

2. The list of hazards should include asbestos; silica; cement dust; engine exhausts; acids and caustics; welding, thermal cutting, soldering, brazing; metal cutting and grinding; machining aerosols; isocyanates, organic solvents, wood dust, molds and spores. Each of these has been shown to cause chronic obstructive pulmonary disease (COPD) and other health conditions.

The Advisory Board also recommends adding to the OHQ the list of tasks that is currently used in the exposure assessment by BTMed.

B. The Advisory Board recommends adding a specific question to the OHQ regarding vapors, gases, dusts and fumes (VGDF). We suggest adding:

1. **The question: "Have you been exposed to vapors, gases, dusts and fumes in your work at DOE?"**
2. **If the answer to (a) is "yes," the worker should be asked about frequency of exposure to VGDF overall using the scale above.**
3. **If the answer to (a) is "yes" the worker is then asked, "Have you already reported all exposures to vapors, gases, dust and fumes in your answers above?" If not, he/she should be asked to describe additional tasks and materials associated with exposure to VGDF, the frequency using the scale above under recommendation (1), the assessment whether the exposure was through direct use or as a bystander, and an assessment of the number of years of exposure.**

C. The Board recommends that the version of the OHQ developed in response to these recommendations be tested multiple times to determine if it is user friendly and has face validity.

Response:

Upon review of the Board's Recommendations in section A, OWCP agrees that claimants who provide detailed accounts of work processes, labor activities, and other operational descriptions of an employee's work activities are the most reliable and substantive mechanism for assessing employee occupational exposure to toxic substances. In fact, OWCP has revised the OHQ, and the Board's recommendation that the worker be asked to describe how he/she was exposed to each material using free text is included. The draft OHQ also provides more room for description of job tasks, and requests that the claimant advise as to whether he/she was in a

particular union or was part of the Former Worker Program. In the draft, OWCPreduces the lists of toxic substances and instead lists broad categories under which the claimant may provide specific toxic substances (e.g. "high explosives," or "metals.) Over the last 10 years of conducting OHQ's, OWCP has found that the ability of a claimant (particularly a survivor) to affirmatively self-select toxic substance exposures from a list oftentimes does not produce reliable or useful information. With regard to the list used by BTMed (Reference https://www.btmed.org/pdf/WorkHistoryQuestionnaire.pdf), this list refers solely to construction and trades positions, and therefore would not be applicable to a general OHQ that applies to employees in all occupations.

With regard to the Board's Recommendation in section B that proposes to add a section on reported exposure to vapors, gases, dusts, and fumes, our concerns are contained in our response to Recommendation #3 regarding the use of this language. If the Board develops a list of toxic substances that represents vapors, gases, dusts, and fumes, OWCP will consider how that list may be addressed in the OHQ.

OWCP agrees with the Board's Recommendation in section C that the new version of the OHQ be tested multiple times prior to becoming final, and will have the resource centers conduct these tests.

Attached is a copy of the draft OHQ. OWCP welcomes specific recommendations concerning modifications to the draft that the Board may have.

Recommendation #5

Science and Technical Capacity in EEOICP

The Board recommends that the DEEOICP enhance its scientific and technical capabilities to support the development of program policies and procedures, to enhance decision-making on individual claims, and to inform its assessment of the merit of the work of its consulting physicians and industrial hygienists. In its rationale section, the Board further references the National Institute of Medicine's recommendation to improve the SEM by, in part, forming an expert advisory panel of scientists. The Board further states that while OWCP has asked them to provide input into numerous possible exposure-disease links, they do not have the resources to address this request fully. Therefore, OWCP interprets this recommendation to be to convene another expert panel consistent with IOM's recommendation.

Response:

OWCP agrees that it would be useful to have additional scientific and technical research capabilities to support program policies and procedures. While the primary responsibility and mandate of the program is to adjudicate individual claims, OWCP recognizes that with the complexity of Part E exposure and causation issues, it is helpful to be able to generalize whenever possible. To that end, the program contracted with a group of scientists (Paragon), mostly former DOE workers, to create and update the SEM on a regular basis. In addition,

OWCP has a medical director for DEEOIC, as well as several nurses to assist with overall concerns or issues. As mentioned above, the medical director conducts quarterly audits of the reports of the contract medical consultants. The program also employs a toxicologist who researches current studies to assist the program with causation presumptions. Beyond that, OWCP contracts out for medical consultants and industrial hygienists to provide opinions on individual claims. OWCP looks forward to any additional assistance the Board is able to provide in this regard.

Recommendation #6

Interpretation of the Beryllium Lymphocyte Proliferation Test (BeLPT)

The Advisory Board recommends that the finding of two borderline BeLPT tests shall be considered the equivalent of one positive BeLPT for the purposes of claims adjudication under subpart B and subpart of EEOICPA.

Response:

OWCP does not support this recommendation. The recommendation is inconsistent with the explicit statutory requirement that beryllium sensitivity is "established by an abnormal [BeLPT] performed on either blood or lung lavage cells" in 42 U.S.C. § 7384l(8)(A). While the Board may be of the opinion that the BeLPT is "not a perfect test" or that "false negative and positive BeLPT results can occur," DEEOIC is bound by the specific, clear, and unambiguous language of the governing statute.

In the program's administration of Part B, OWCP has adopted a limited number of exceptions to the statutory requirement for the submission of an abnormal BeLPT; however, all of those limited exceptions are based on the presumed existence of an abnormal BeLPT that cannot, for a scientifically accepted reason, be obtained. The Board's recommended presumption seeks to equate two borderline BeLPTs with an abnormal BeLPT, which cannot be done under the statute.

Recommendation #7

Quality Assessment of Contract Medical Consultants

We request that the DOL provide the Board with resources to conduct a quality assessment of a sample of 50 contract medical consultant (CMC) evaluations that have been associated with claim denials. The quality review will assess the nature of the medical information reviewed by the CMC, the use of standards of causation, the reasoning of the CMC, the scientific basis for the CMC conclusions, among other items. The assessment will likely require contracted services of worker-centered occupational physicians who are not associated with the current CMC contract. The review may lead to recommendations, including the development of guidance materials.

Response:

OWCP agrees with the Board that quality assessment of CMC evaluations is important. To this end, the program currently conducts quarterly quality control assessments of 50 written Contract Medical Consultant reports submitted for use in the claim adjudication process. The medical director for DEEOIC conducts the audits. The redacted audit findings are available online to the public. *See* https://www.dol.gov/owcp/energy/regs/compliance/cmc_audits_qtr2016.htm. OWCP met with some members of the Board in July 2017 and explained how this assessment is conducted. OWCP believes that as a result of this briefing, the Board had a better understanding of the current audit process, which should satisfy this last recommendation.