Buildings have been associated with spread of infectious diseases, such as outbreaks of measles, influenza, and Legionella. With SARS-CoV-2, the majority of outbreaks involving 3 or more people have been linked with time spent indoors, and evidence confirms that far-field airborne transmission (defined as within-room but beyond 6 feet) of SARS-CoV-2 is occurring.1

Controlling concentrations of indoor respiratory aerosols to reduce airborne transmission of infectious agents is critical and can be achieved through source control (masking, physical distancing) and engineering controls (ventilation and filtration).2 With respect to engineering controls, an important flaw exists in how most buildings operate in that the current standards for ventilation and filtration for indoor spaces, except for hospitals, are set for bare minimums and not designed for infection control. Several organizations and groups have called for increasing outdoor air ventilation rates, but, to date, there has been limited guidance on specific ventilation and filtration targets. This article describes the rationale for limiting far-field airborne transmission of SARS-CoV-2 through increasing outdoor air ventilation and enhancing filtration, and provides suggested targets.

To reduce far-field airborne transmission of SARS-CoV-2 in small-volume indoor spaces (eg, classrooms, retail shops, homes if guests are visiting), the suggestions include targeting 4 to 6 air changes per hour, through any combination of the following: outdoor air ventilation; recirculated air that passes through a filter with at least a minimum efficiency rating value 13 (MERV 13) rating; or passage of air through portable air cleaners with HEPA (high-efficiency particulate air) filters.

Despite the dose-response for SARS-CoV-2 being unknown, and continued scientific debate about the dominant mode of transmission, evidence support these suggestions. First, SARS-CoV-2 is primarily transmitted from the exhaled respiratory aerosols of infected individuals. Larger droplets (>100 μm) can settle out of the air due to gravitational forces within 6 feet, but people emit 100 times more smaller aerosols (<5 μm) during talking, breathing, and coughing. Smaller aerosols can stay aloft for 30 minutes to hours and travel well beyond 6 feet.1 Second, high-profile and well-described SARS-CoV-2 outbreaks across multiple space types (eg, restaurants, gyms, choir practice, schools, buses) share the common features of time indoors and low levels of ventilation, even when people remained physically distanced.3

Third, these suggestions are grounded in the basics of exposure science and inhalation dose risk reduction. Higher ventilation and filtration rates more rapidly remove particles from indoor air, thereby reducing the intensity of exposure and duration that respiratory aerosols stay aloft inside a room. Fourth, this approach is consistent with what is used in hospitals to minimize risk of transmission (eTable in the Supplement). Fifth, reviews on the relationship between ventilation and infectious diseases found that the weight of evidence indicates ventilation plays a key role in infectious disease transmission, citing observational epidemiological studies showing low ventilation associated with transmission of measles, tuberculosis, rhinovirus, influenza, and SARS-CoV-1.4 6 All 3 reviews note the limited number of research papers on this topic and limitations of observational data. Sixth, more recently, the National Institute of Allergy and Infectious Diseases cited the importance of adequate ventilation in the suite of COVID-19 control measures,7 and the Centers for Disease Control and Prevention and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) support higher ventilation rates and enhanced filtration as components of holistic risk reduction strategies.

Current Indoor Air Ventilation Measures and Standards

Current ventilation standards for most indoor spaces are established by ASHRAE.7 These standards have been designed with the goal of diluting bioeffluents (such as odors from people) and achieving basic levels of acceptable indoor air quality, rather than infection control.8

While multiple conventions exist to describe ventilation rate (eg, total volumetric flow, volumetric flow per person and area, outdoor air ventilation rates), air exchange rate is frequently used in health care settings and commonly expressed in units of air changes per hour (ACH).

The existing minimum standards for ACH vary based on building type (eTable in the Supplement). For example, according to ASHRAE, the predominant standard-setting organization for ventilation rates, the minimum required total ACH that occur in most households is 0.35 ACH of outdoor air, and schools should be designed for approximately 10 times higher rates, although most schools do not meet this in practice.9 The suggestion for increasing the target to 4 to 6 ACH is more consistent with rates set in hospitals, where the higher ACH requirements underscore the potential role of air change rates as an infection control strategy.

Current Air Filtration Measures and Standards

In addition to air ventilation from outdoor air, respiratory aerosols can also be removed through air filtration. Filtered air can therefore be considered in terms of equivalent air changes per hour (ACHe) and added to the ACH from outdoor air.

Clean air delivery rate (CADR) is a term used to describe the amount of clean air delivered to a space as determined by filtration effectiveness and the amount of air moving through that filter. Portable air cleaners commonly use CADR to describe their effectiveness. For example, if a portable air cleaner has a high-efficiency particulate air (HEPA) filter, it will capture 99.97% of aerosols at 0.3 μm. Filter efficacy is commonly reported based on the aerosol size against which the filter performs most poorly (0.3 μm), although a HEPA filter will capture an even greater percentage of aerosols larger (and smaller) than 0.3 μm. The CADR metric is valuable because it can be used to estimate the ACH of virus-free air being delivered to the room. The estimated ACHe is calculated as [CADR in ft3/min × 60 min] divided...
by the room volume in ft³. A device with a CADR of 300 in a 500-square-foot room with 8-foot ceilings will therefore deliver 4.5 ACH.

This same filtration concept can be applied to air that is recirculated through a central mechanical ventilation system or within-room ventilation system. However, most central mechanical systems were not designed for HEPA filters. Instead, these systems use filters on a different rating scale, minimum efficiency reporting value, or MERV, and typically use a low-grade filter (eg, MERV 8) that captures only approximately 15% of 0.3- to 1-µm particles, 50% of 1- to 3-µm particles, and 74% of 3- to 10-µm particles. For infection control, buildings should upgrade to MERV 13 filters when possible, provided consulting regarding COVID-19 risk.

Conclusions

Increasing air changes per hour and air filtration is a simplified but important concept that could be deployed to help reduce risk from within-room, far-field airborne transmission of SARS-CoV-2 and other respiratory infectious diseases. Healthy building controls like higher ventilation and enhanced filtration are a fundamental, but often overlooked, part of risk reduction strategies that could have benefit beyond the current pandemic.

REFERENCE


