Issue 03

MAY 18, 2020

RETURN TO
WORK TOOLKIT:

A GUIDE TO IAQ + HVAC CONSIDERATIONS

The Boston Real Estate

COVID CONSORTIUM

A knowledge share of current industry best practices and due diligence around workplace design and construction requirements adapting to changes in code and regulatory amendments in the post COVID-19 world.

OUR MISSION

Boston's Real Estate COVID Consortium's mission is to conduct a knowledge share of current industry best practices and due diligence around workplace design and construction requirements adapting to changes in codes and regulatory amendments in the post-COVID-19 world. Its members include professional multiple disciplines of real estate industry, including architecture and interior design, audio visual integrator, code consultants, commercial real estate brokerage, commissioning agents, environmental engineers, general contractors, furniture dealers, MEP/FP engineers and owner's project managers.

WE ARE HERE FOR YOU

Since March 10th, when Governor Charlie Baker made the difficult decision to shut down large portions of Massachusetts, we have all been bombarded with a steady stream of COVID-19 impacts to the real estate industry, best practice guidelines and prognostications. Our mission is to curate this information and distill it down to the best of the best to help simplify & streamline your return to work planning process.

WE WANT TO HEAR FROM YOU

We aim to be a trusted resource for our valued Boston real estate community. If you have any questions or ideas for content, please don't hesitate to reach out to Denise Pied (denise.pied@stvinc.com).

Please note, that although our current focus is limited to standard office space, we plan to cover special considerations for Life Science/Pharma, Healthcare & Academic markets in future publications.

ISSUE 03 RETURN TO WORK TOOLKIT:
A Guide to IAQ + HVAC Considerations

Indoor Air Quality (IAQ) has been a hot topic for the last three months. As we navigate the COVID-19 pandemic, it is essential that we understand the basics of IAQ - safety over energy savings, the more outside air the better, improved filtration is critical, and evaluation of active mitigation is highly recommended.

There is no single solution and building operators/occupants may not be certain what steps to take. The good news is that we can take action to improve IAQ, which we've described how to do in this week's issue. The even better news is that these actions to improve IAQ will make this a better, safer and more productive world.

Future issues will take a deeper dive to spotlight relevant and timely topics including:

- Enhanced Cleaning Protocols
- Technology - Things to Consiter
- Change Management & Communication Plans
- Coronavirus Legal Advisory Topics
- Workplace Standards + Furniture
- Long Term Real Estate Strategies

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Cover Artwork courtesy of SGA and Anthony Delanoix

TENANT RETURN TO WORK CHECKLIST

Have you reviewed your lease to understand the IAQ language?

Most leases do not address IAQ (indoor air quality). We recommend that all new or renegotiated leases include a provision for the building to provide 30% more outside air than the minimum required by code. Landlords should also provide a minimum filter rating of MERV 13 on all recirculation air handling equipment.

Better decision-making and a decrease in absenteeism has been proven to be directly related to increased outside air and lower CO2 levels in indoor environments. A Harvard study showed that spending 40 dollars per person in annual energy cost to condition a higher percentage of outdoor air can result in achieving $6,500 per person in increased productivity. *(Allen, Joseph G. (2017) Research: Stale Office Air Is Making You Less Productive. Harvard Business Review. 17 March 2017.)*

In addition, companies pursuing LEED and WELL Building certification, can earn points for increased outdoor air and improved filtration.

Thank You to this week's lead contributer,

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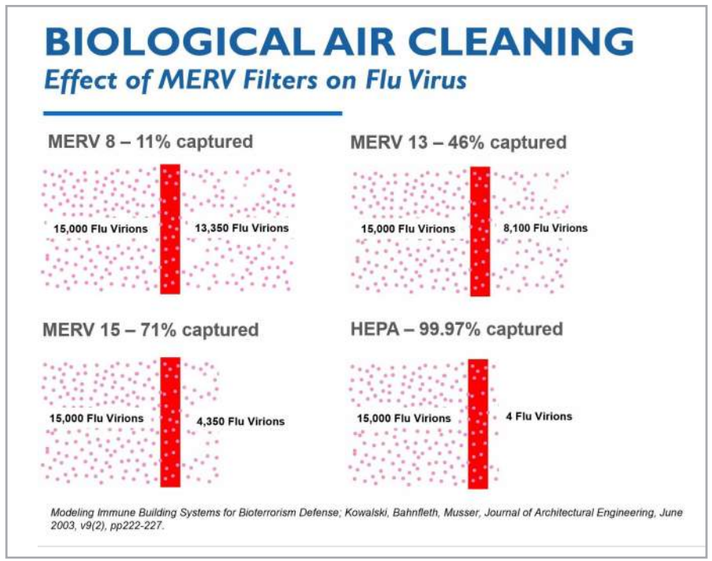
What is the basis for the industry standard for IAQ?

The standard for IAQ is based on the minimum code requirement defined by the governing International Mechanical Code at the time a building or tenant space is built. Most buildings subscribe to the prescriptive model code to minimize the OA (Outside Air) in order to reduce operating expenses.

While many standards help define IAQ, the filtration standards are regulated by most building permit office reviewers. Therefore, it is more than likely to have a MERV 6 or 8 filter in the unit that supplies air to an office space. LEED, WELL, and some city Green Building codes have increased the minimum rating above MERV 8.

It is important to note that a MERV 13 filter will be 40% more effective than a MERV 8 at filtering out recirculated flu particles that are airborne.



Effect of MERV filters

Bag Filters

BUILDING OWNER RETURN TO WORK CHECKLIST

Have you confirmed you are maximizing the OA (Outside Air)?

Is your system capable of operating at 100% outside air (airside economizer)? If it is, then you should run a dilution ventilation mode of operating the unit as much as possible while the building is fully/partially vacant (conditions permitting). Operating in dilution ventilation mode should be standard when the space is not occupied (after hours) as a method of flushing the building.

Other things to think about include how much outside air the system(s) are designed for. Can it accommodate an increase in outside air during normal operation? Does it have the heating/cooling coil capacity to achieve this? If the amount of outside air delivered to the system is increased, there will be an impact to energy used by the heating/cooling system for the additional loads. Are there opportunities to recover energy to offset the increased load of greater outside air? A professional engineer can assess the impact of increasing outside air.

Have you completed all the Monthly, Quarterly, Semi-Annual, and Annual PM (Preventive Maintenance) activities?

The idea that this issue is not directly related to COVID-19 is correct, however, maintaining a high state of reliability will maximize the building HVAC system, thus providing a higher comfort factor for your returning tenants.

In the event your building has the resources and can get ahead of some of your semi-annual or annual PMs that require the HVAC system shutdowns, buildings will have more uptime and constant ventilation when back online. It will also free up a building's management team and building engineer to address returning tenant concerns.

Have you considered increasing the MERV (Minimum Efficiency Rating Value) filters from the current value to the maximum that your fan system can support?

Typical ratings for filters in air distribution systems designed in the last 10-15 years are MERV 6-8. We recommend replacing existing MERV 6-8 with a higher MERV rated filter, such as MERV 13-15. MERV 13 filters will capture approximately four times the amount of virus particles than a MERV 8 filter will. The capability of your fans and air distribution systems to accommodate the increase in pressure drop along with impacts to running costs and energy usage should be assessed by a professional engineer.

Have you considered UVGI, PCO, and Ionization to improve IAQ?

UVGI (Ultraviolet Germicidal Irradiation)

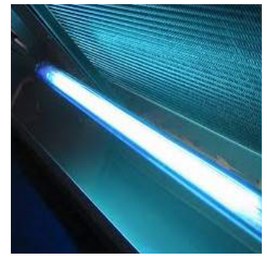
While UV A and B wavelengths will give you a tan or sunburn, for this solution, it is important to understand the ozone layer filters of the UVC wavelengths in the upper atmosphere. ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) and others have studied the effectiveness of UVC radiation, and its ability to irradiate viruses. UVC lamps that create the correct band of wavelengths can be used in different strategies to kill molds, bacteria, and viruses.

Exposure or residence time is the variable that is the most critical. If the particles are not moving, then they are easier to kill.

Using UVC light in an occupied space is not recommended as it will cause skin cancer and long-term eye damage and it is not practical for a few reasons. Using UVC where a space is not occupied makes sense for rooms with clean surfaces, few or no windows, and very tight procedural controls – for example, in surgical suites.

Even if an office space is unoccupied, there are a number of concerns with using UVC and it is just not a recommended solution. UVC light will not bend around corners or help on hidden surfaces and it could be a hazard to the people outside of the interior or external glass.

That said, UVC could be utilized in a duct to kill airborne virus in the event that the duct is long enough with the correct velocity, and the UVC lamp output could be configured. We have found that the length of duct run and number of lamps made this strategy impractical in most applications.



UVC Lamp at cooling coil

Applying UVC at the cooling coil to kill all mold, bacteria, and viruses that are on the coil is the most cost-effective and, in most applications, a reasonable return on investment. Improved IAQ due to a cleaner coil is the top benefit. One consideration is that it is not an effective COVID mitigation method in the winter months because the coil's dry air particles pass through the coil.

PCO (Protocathotic Oxidation)

Many of the older generations of PCO systems on the market created ozone so it essential to confirm the system ozone output is below the EPA maximum values.

The modern PCO systems work similar to the catalytic converter in your car. In your car, the precious metals are activated by the engine heat to create hydroxyls (OH- & OH+) to break down the partially burned fossil fuels in the exhaust to create CO2 and H2O which reduce pollution and smog.

In an AHU (Air Handling Unit) system, the PCO system consists of two pleated layers of material with a titanium wire mesh interwoven with a ceramic coating material. The two layers have a cavity with a UVC lamp located in the middle. The UVC lamp charges the titanium wire mesh to create hydroxyls. Typically, a unit is about 18" deep and requires a pre-filter.

The hydroxyls have a half-life less than ½ second. The unstable hydroxyls break down all the bacteria, pollen, mold, VOC (Volatile Organic Compounds), and virus.

When applied in an AHU at an air velocity of 500 feet per minute, it can be 70-90% percent effective. Third-party testing by manufacture should be reviewed to confirm effectiveness against a specific contaminant. These systems have been proven against SARS virus.

ASHRAE does not currently endorse PCO technology but it does have an active study projects in progress. The organization does agree that independent third-party testing could be a valid source for verification of PCO system performance.

PCO Filters

PCO Panel

Ionization

Ionizers create negative oxygen ions and positive hydrogen ions to bind with and tear apart the viruses, bacteria, molds, and VOC at a molecular level. Ionizers also clump suspended duct particles to allow the HVAC filter to be more productive.

All ionizer products are not equal, and if considering the application of a system, it is important to confirm that the system does not produce ozone above the EPA maximum limits.

The systems flood the occupied zones with ions to attach the harmful carbon molecule in the air and on surfaces such as COVID-19. The effectiveness of systems in the market varies for each carbon contaminant and if it is airborne or on a surface.

Most ionizers create breathing zone ions with a half-life of 300 seconds. The concern is that ions break down both carbon molecules and human molecules. Until more long-term studies have been performed to confirm the impact to humans (ionizers are under review but have not been endorsed by ASHARE), we are not recommending ionizer systems to be operated in occupied mode.

After hours or midday unoccupied mode ion flush operation may be an option to utilize this type of strategy.

NEW QUESTIONS ON IAQ + COVID-19

Is COVID-19 transmitted via airborne particles?

The short answer is yes, COVID-19 is transmitted via airborne particles. ASHRAE's position paper in the Appendix references several medical studies on infectious viruses and defines the airborne transmission based on particle size and travel distance. Larger particles greater than 10 microns will drop to rest between 3-7 ft. The particles of concern are less than 10 microns, which will spread as airborne particles for hours, and perhaps days. Effective ways to control these airborne particles' changes to building operations, including the operation of heating, ventilating, and air-conditioning systems, can reduce airborne exposures.

How does the CDC statement "50 ACH (air changes) over an 8-minute period will remove 99.9% of the existing indoor air" (assumes perfect mixing, with perfectly clean air) impact my office building?

General scientific and medical industries agree that a virus particle can remain airborne and viral for 2–4 hours. Typical office buildings provide 3-6 air changes per hour recirculating through air handling systems. Therefore, the virus particles, with consideration for filter efficiency, could be returned to an area between 6 and 24 times an hour. The higher the percentage of ventilation (outside air) that is introduced to the building and then exhausted from the building, the lower the percentage of potentially viral virus particles.

While the CDC Guidelines makes a good point, most office buildings are not clean rooms and cannot provide 50 ACH of 100% outside air or 7.5 CFM/sf in office space with an 9-foot ceiling height.

This means that we need to provide multi-faceted solutions that include higher filtration, and more active mitigation such as UVGI, PCOs, and Ionization.

Does humidification impact the transition of airborne viruses?

Medical studies have proven that 40-60% RH (Relative Humidity) provides the most effective reduction in the transmission of airborne viruses. In the 40-60% RH range, the reduction in airborne transmission of viruses can be as high as 40%.

RH below 40% has an exponential decrease in effectiveness to reduce airborne viruses. Above 60% RH, the effectiveness varies based on the virus type. At best, the results show no improvement, and at worst, the airborne transmission increases.

Summer months in the northeast typically require that HVAC systems be set to air conditioning mode and therefore are providing passive dehumidification. In this mode, more HVAC systems will be in the range of 40-60% RH.

In winter months and most spring and fall months in the northeast, HVAC systems provide stable control of indoor temperature but very few office buildings have humidification control. Many will average 20% in the winter months and on the coldest days will see humidity levels as low as 10%.

There are several concerns to keep in mind at 40% RH in an existing building. The main concern is condensation at the window and other thermal breaks that will create housekeeping and maintenance issues. The second, and maybe more troubling in some ways, is controlling moisture migration. When the air is moist inside the building and is dry outside the building, the moisture will push through the walls, and when it reaches the dew point, it will condense inside the wall and grow mold. Mold in the wall or inside the space will lead to other IAQ problems that can be very costly.

Applying a year-round 40-60% RH strategy is a realistic goal in new construction when thermal breaks, insulation values, and vapors barriers can be designed into the building exterior.

Construction materials are not adversely affected by RH in the 40-60% range.

Humidification
(Steam entering the air stream)

View Here:

Q&A Effects of Humidity in the Indoor Environment

Presented By:

Stephanie Taylor,

MD, M Arch, Harvard Medical School, ASHRAE Distinguished Lectruer, Taylor Healthcare Consulting, CEO

If I do all of the above mitigation, do I still have to ask the occupants to wear masks and maintain social distancing rules?

The short answer is yes. Even though the above mitigation strategies will help reduce the potential viral load via airborne particles and reduce the time people are exposed to those, wearing masks and washing hands are still the most effective in preventing spread. Masks are the first line of defense in limiting virus shedding by cough or sneezing or exhaled breath. Washing hands frequently, or using hand sanitizer, limits fomite transmission.

Until there is real herd immunity from this virus, or a vaccine, the CDC guidance for masks and handwashing should be followed.

Can thermal imaging help screen people entering the building and help reduce exposure?

There is not enough data to show that taking a person's temperature is a reliable way to screen everyone for COVID-19. There are many instances where spread was documented by asymptomatic (or pre-symptomatic) carriers. These carriers will not be found by temperature screening.

CDC Presymptomatic Transmission Article >>

Conclusion

Generally, the goal of all the engineering solutions noted here is to create a healthy environment. Many are costly and require a greater emphasis on maintenance. Every situation is unique, some or all of the above may make sense for your facility. Commitment to spending resources on these mitigation strategies can only be evaluated on a case-by-case basis. They all show a good faith effort to make the work environment as healthy and safe as it can be. However, communicating with, and understanding, the occupants wants and needs will be every bit as important as showing a willingness to do everything possible to keep them safe.

MEET THE TEAM

HEAR FROM THE INDUSTRY EXPERTS

STV|DPM has brought together a multidiscipline industry team (Project Management, Construction, Commercial Real Estate Brokerage, Commissioning, Code Review, Design, Environmental Engineering, Technology & Furniture) to conduct a knowledge share of current industry best practices and due diligence around workplace design and construction requirements adapting to changes in codes and regulatory amendments in the post-COVID-19 world. We strongly believe innovative project strategies & checklists around these disciplines could assist our active clients and other Real Estate leaders in assessing new in office & remote work requirements as they bring their employees back to work and going forward. The ultimate goal is to develop a "Toolkit" of best practices resources that could be rolled out as part of ongoing & new project work.

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WE WANT TO HEAR FROM YOU

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Michael has 18+ years of experience in the industry, leading projects and people. His natural talent for being able to motivate a team to do great work and address complex scenarios is why he is leading WB's COVID-19 remobilization efforts.

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APPENDIX

1. ASHRAE Position Document on Infectious Aerosols.pdf
2. Infectious Droplets and RH Levels.pdf

ASHRAE Position Document on Infectious Aerosols

Approved by ASHRAE Board of Directors
April 14, 2020

Expires
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COMMITTEE ROSTERS

The ASHRAE Position Document on Infectious Aerosols was developed by the Society's Environmental Health Position Document Committee formed on April 24, 2017, with Erica Stewart as its chair.

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HISTORY OF REVISION/REAFFIRMATION/WITHDRAWAL DATES

The following summarizes this document's revision, reaffirmation, and withdrawal dates:

6/24/2009—BOD approves Position Document titled *Airborne Infectious Diseases*

1/25/2012—Technology Council approves reaffirmation of Position Document titled *Airborne Infectious Diseases*

1/19/2014—BOD approves revised Position Document titled *Airborne Infectious Diseases*

1/31/2017—Technology Council approves reaffirmation of Position Document titled *Airborne Infectious Diseases*

2/5/2020—Technology Council approves reaffirmation of Position Document titled *Airborne Infectious Diseases*

4/14/2020—BOD approves revised Position Document titled *Infectious Aerosols*

Note: ASHRAE's Technology Council and the cognizant committee recommend revision, reaffirmation, or withdrawal every 30 months.

Note: ASHRAE position documents are approved by the Board of Directors and express the views of the Society on a specific issue. The purpose of these documents is to provide objective, authoritative background information to persons interested in issues within ASHRAE's expertise, particularly in areas where such information will be helpful in drafting sound public policy. A related purpose is also to serve as an educational tool clarifying ASHRAE's position for its members and professionals, in general, advancing the arts and sciences of HVAC&R.

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ASHRAE Position Document on Infectious Aerosols

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ABSTRACT

The pathogens that cause infectious diseases are spread from a primary host to secondary hosts via several different routes. Some diseases are known to spread by infectious aerosols; for other diseases, the route of transmission is uncertain. The risk of pathogen spread, and therefore the number of people exposed, can be affected both positively and negatively by the airflow patterns in a space and by heating, ventilating, and air-conditioning (HVAC) and local exhaust ventilation (LEV) systems. ASHRAE is the global leader and foremost source of technical and educational information on the design, installation, operation, and maintenance of these systems. Although the principles discussed in this position document apply primarily to buildings, they may also be applicable to other occupancies, such as planes, trains, and automobiles.

ASHRAE will continue to support research that advances the knowledge base of indoor air-management strategies aimed to reduce occupant exposure to infectious aerosols. Chief among these ventilation-related strategies are dilution, airflow patterns, pressurization, temperature and humidity distribution and control, filtration, and other strategies such as ultraviolet germicidal irradiation (UVGI). While the exact level of ventilation effectiveness varies with local conditions and the pathogens involved, ASHRAE believes that these techniques, when properly applied, can reduce the risk of transmission of infectious diseases through aerosols.

To better specify the levels of certainty behind ASHRAE's policy positions stated herein, we have chosen to adopt the Agency for Healthcare Research and Quality (AHRQ) rubric for expressing the scientific certainty behind our recommendations (Burns et al. 2011). These levels of certainty, as adapted for this position document, are as follows:

Evidence Level	Description
A	Strongly recommend; good evidence
B	Recommend; at least fair evidence
C	No recommendation for or against; balance of benefits and harms too close to justify a recommendation
D	Recommend against; fair evidence is ineffective or the harm outweighs the benefit
E	Evidence is insufficient to recommend for or against routinely; evidence is lacking or of poor quality; benefits and harms cannot be determined

ASHRAE's position is that facilities of all types should follow, as a minimum, the latest published standards and guidelines and good engineering practice. ANSI/ASHRAE Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b) include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a) covers both outdoor and total air ventilation in healthcare facilities. Based on risk assessments or owner project requirements, designers of new and existing facilities could go beyond the minimum requirements of these standards, using techniques covered in various ASHRAE publications, including the ASHRAE Handbook volumes, Research Project final reports, papers and articles, and design guides, to be even better prepared to control the dissemination of infectious aerosols.

EXECUTIVE SUMMARY

With infectious diseases transmitted through aerosols, HVAC systems can have a major effect on the transmission from the primary host to secondary hosts. Decreasing exposure of secondary hosts is an important step in curtailing the spread of infectious diseases.

Designers of mechanical systems should be aware that ventilation is not capable of addressing all aspects of infection control. HVAC systems,[1] however, do impact the distribution and bio-burden of infectious aerosols. Small aerosols may persist in the breathing zone, available for inhalation directly into the upper and lower respiratory tracts or for settling onto surfaces, where they can be indirectly transmitted by resuspension or fomite[2] contact.

Infectious aerosols can pose an exposure risk, regardless of whether a disease is classically defined as an "airborne infectious disease." This position document covers strategies through which HVAC systems modulate aerosol[3] distribution and can therefore increase or decrease exposure to infectious droplets,[4] droplet nuclei,[5] surfaces, and intermediary fomites[6] in a variety of environments.

This position document provides recommendations on the following:

- The design, installation, and operation of heating, ventilating, and air-conditioning (HVAC) systems, including air-cleaning, and local exhaust ventilation (LEV) systems, to decrease the risk of infection transmission.
- Non-HVAC control strategies to decrease disease risk.
- Strategies to support facilities management for both everyday operation and emergencies.

Infectious diseases can be controlled by interrupting the transmission routes used by a pathogen. HVAC professionals play an important role in protecting building occupants by interrupting the indoor dissemination of infectious aerosols with HVAC and LEV systems.

COVID-19 Statements

Separate from the approval of this position document, ASHRAE's Executive Committee and Epidemic Task Force approved the following statements specific to the ongoing response to the COVID-19 pandemic. The two statements are appended here due to the unique relationship between the statements and the protective design strategies discussed in this position document:

Statement on airborne transmission of SARS-CoV-2: Transmission of SARS-CoV-2 through the air is sufficiently likely that airborne exposure to the virus should be controlled. Changes to building operations, including the operation of heating, ventilating, and air-conditioning systems, can reduce airborne exposures.

Statement on operation of heating, ventilating, and air-conditioning systems to reduce SARS-CoV-2 transmission: Ventilation and filtration provided by heating, ventilating, and air-conditioning systems can reduce the airborne concentration of SARS-CoV-2 and thus

[1] Different HVAC systems are described in *ASHRAE Handbook—HVAC Systems and Equipment* (ASHRAE 2020).
[2] An object (such as a dish or a doorknob) that may be contaminated with infectious organisms and serve in their transmission.
[3] An aerosol is a system of liquid or solid particles uniformly distributed in a finely divided state through a gas, usually air. They are small and buoyant enough to behave much like a gas.
[4] In this document, *droplets* are understood to be large enough to fall to a surface in 3–7 ft (1–2 m) and thus not become aerosols.
[5] Droplet nuclei are formed from droplets that become less massive by evaporation and thus may become aerosols.
[6] Fomite transmission is a form of indirect contact that occurs through touching a contaminated inanimate object such as a doorknob, bed rail, television remote, or bathroom surface.

the risk of transmission through the air. Unconditioned spaces can cause thermal stress to people that may be directly life threatening and that may also lower resistance to infection. In general, disabling of heating, ventilating, and air-conditioning systems is not a recommended measure to reduce the transmission of the virus.

1. THE ISSUE

The potential for airborne dissemination of infectious pathogens is widely recognized, although there remains uncertainty about the relative importance of the various disease transmission routes, such as airborne, droplet, direct or indirect contact, and multimodal (a combination of mechanisms). Transmission of disease varies by pathogen infectivity, reservoirs, routes, and secondary host susceptibility (Roy and Milton 2004; Shaman and Kohn 2009; Li 2011). The variable most relevant for HVAC design and control is disrupting the transmission pathways of infectious aerosols.

Infection control professionals describe the chain of infection as a process in which a pathogen (a microbe that causes disease) is carried in an initial host or reservoir, gains access to a route of ongoing transmission, and with sufficient virulence finds a secondary susceptible host. Ventilation, filtration, and air distribution systems and disinfection technologies have the potential to limit airborne pathogen transmission through the air and thus break the chain of infection.

Building science professionals must recognize the importance of facility operations and ventilation systems in interrupting disease transmission. Non-HVAC measures for breaking the chain of infection, such as effective surface cleaning, contact and isolation precautions mandated by employee and student policies, and vaccination regimens, are effective strategies that are beyond the scope of this document. Dilution and extraction ventilation, pressurization, airflow distribution and optimization, mechanical filtration, ultraviolet germicidal irradiation (UVGI), and humidity control are effective strategies for reducing the risk of dissemination of infectious aerosols in buildings and transportation environments.

Although this position document is primarily applicable to viral and bacterial diseases that can use the airborne route for transmission from person to person, the principles of containment may also apply to infection from building reservoirs such as water systems with *Legionella spp.* and organic matter containing spores from mold (to the extent that the microorganisms are spread by the air). The first step in control of such diseases is to eliminate the source before it becomes airborne.

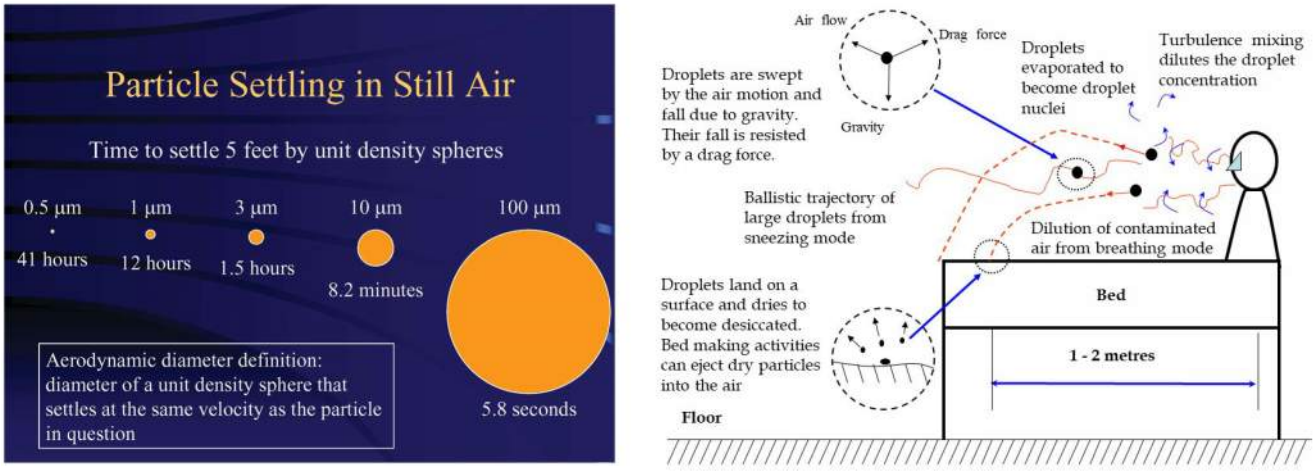
2. BACKGROUND

ASHRAE provides guidance and develop standards intended to mitigate the risk of infectious disease transmission in the built environment. Such documents provide engineering strategies for reducing the risk of disease transmission and therefore could be employed in a variety of other spaces, such as planes, trains, and automobiles.

This position document covers the dissemination of infectious aerosols and indirect transmission by resuspension but not direct-contact routes of transmission. *Direct contact* generally refers to bodily contact such as touching, kissing, sexual contact, contact with oral secretions or skin lesions and routes such as blood transfusions or intravenous injections.

2.1 Airborne Dissemination

Pathogen dissemination through the air occurs through droplets and aerosols typically generated by coughing, sneezing, shouting, breathing, toilet flushing, some medical procedures, singing, and talking (Bischoff et al. 2013; Yan et al. 2018). The majority of larger emitted droplets are drawn by gravity to land on surfaces within about 3–7 ft (1–2 m) from the source (see Figure 1). General dilution ventilation and pressure differentials do not significantly influ-



(a) (b)

Figure 1 (a) Comparative settling times by particle diameter for particles settling in still air (Baron n.d.) and (b) theoretical aerobiology of transmission of droplets and small airborne particles produced by an infected patient with an acute infection (courtesy Yuguo Li).

ence short-range transmission. Conversely, dissemination of smaller infectious aerosols, including droplet nuclei resulting from desiccation, can be affected by airflow patterns in a space in general and airflow patterns surrounding the source in particular. Of special interest are small aerosols (<10 µm), which can stay airborne and infectious for extended periods (several minutes, hours, or days) and thus can travel longer distances and infect secondary hosts who had no contact with the primary host.

Many diseases are known to have high transmission rates via larger droplets when susceptible individuals are within close proximity, about 3–7 ft (1–2 m) (Nicas 2009; Li 2011). Depending on environmental factors, these large (100 µm diameter) droplets may shrink by evaporation before they settle, thus becoming an aerosol (approximately <10 µm). The term *droplet nuclei* has been used to describe such desiccation of droplets into aerosols (Siegel et al. 2007). While ventilation systems cannot interrupt the rapid settling of large droplets, they can influence the transmission of droplet nuclei infectious aerosols. Directional airflow can create clean-to-dirty flow patterns and move infectious aerosols to be captured or exhausted.

3. PRACTICAL IMPLICATIONS FOR BUILDING OWNERS, OPERATORS, AND ENGINEERS

Even the most robust HVAC system cannot control all airflows and completely prevent dissemination of an infectious aerosol or disease transmission by droplets or aerosols. An HVAC system's impact will depend on source location, strength of the source, distribution of the released aerosol, droplet size, air distribution, temperature, relative humidity, and filtration. Furthermore, there are multiple modes and circumstances under which disease transmission occurs. Thus, strategies for prevention and risk mitigation require collaboration among designers, owners, operators, industrial hygienists, and infection prevention specialists.

3.1 Varying Approaches for Facility Type

Healthcare facilities have criteria for ventilation design to mitigate airborne transmission of infectious diseases (ASHRAE 2013, 2017a, 2019a; FGI 2010); however, infections are also transmitted in ordinary occupancies in the community and not only in industrial or healthcare occupancies. ASHRAE provides general ventilation and air quality requirements in Standards 62.1, 62.2, and 170 (ASHRAE 2019a, 2019b, 2017a); ASHRAE does not provide specific requirements for infectious disease control in homes, schools, prisons, shelters, transportation, or other public facilities.

In healthcare facilities, most infection control interventions are geared at reducing direct or indirect contact transmission of pathogens. These interventions for limiting airborne transmission (Aliabadi et al. 2011) emphasize personnel education and surveillance of behaviors such as hand hygiene and compliance with checklist protocols and have largely been restricted to a relatively small list of diseases from pathogens that spread only through the air. Now that microbiologists understand that many pathogens can travel through both contact and airborne routes, the role of indoor air management has become critical to successful prevention efforts. In view of the broader understanding of flexible pathogen transmission modes, healthcare facilities now use multiple modalities simultaneously (measures that are referred to as *infection control bundles*) (Apisarnthanarak et al. 2009, 2010a, 2010b; Cheng et al. 2010). For example, in the cases of two diseases that clearly utilize airborne transmission, tuberculosis and measles, bundling includes administrative regulations, environmental controls, and personal protective equipment protocols in healthcare settings. This more comprehensive approach is needed to control pathogens, which can use both contact and airborne transmission pathways. Similar strategies may be appropriate for non-healthcare spaces, such as public transit and airplanes, schools, shelters, and prisons, that may also be subject to close contact of occupants.

Many buildings are fully or partially naturally ventilated. They may use operable windows and rely on intentional and unintentional openings in the building envelope. These strategies create different risks and benefits. Obviously, the airflow in these buildings is variable and unpredictable, as are the resulting air distribution patterns, so the ability to actively manage risk in such buildings is much reduced. However, naturally ventilated buildings can go beyond random opening of windows and be engineered intentionally to achieve ventilation strategies and thereby reduce risk from infectious aerosols. Generally speaking, designs that achieve higher ventilation rates will reduce risk. However, such buildings will be more affected by local outdoor air quality, including the level of allergens and pollutants within the outdoor air, varying temperature and humidity conditions, and flying insects. The World Health Organization has published guidelines for naturally ventilated buildings that should be consulted in such projects (Atkinson et al. 2009).

3.2 Ventilation and Air-Cleaning Strategies

The design and operation of HVAC systems can affect infectious aerosol transport, but they are only one part of an infection control bundle. The following HVAC strategies have the potential to reduce the risks of infectious aerosol dissemination: air distribution patterns, differential room pressurization, personalized ventilation, source capture ventilation, filtration (central or local), and controlling temperature and relative humidity. While UVGI is well researched and validated, many new technologies are not (ASHRAE 2018). (Evidence Level B)

Ventilation with effective airflow patterns (Pantelic and Tham 2013) is a primary infectious disease control strategy through dilution of room air around a source and removal of infectious

agents (CDC 2005). However, it remains unclear by how much infectious particle loads must be reduced to achieve a measurable reduction in disease transmissions (infectious doses vary widely among different pathogens) and whether these reductions warrant the associated costs (Pantelic and Tham 2011; Pantelic and Tham 2012). (Evidence Level B)

Room pressure differentials and directional airflow are important for controlling airflow between zones in a building (CDC 2005; Siegel et al. 2007) (Evidence Level B). Some designs for airborne infection isolation rooms (AIIRs) incorporate supplemental dilution or exhaust/capture ventilation (CDC 2005). Interestingly, criteria for AIIRs differ substantially between regions and countries in several ways, including air supply into anterooms, exhaust from space, and required amounts of ventilation air (Fusco et al. 2012; Subhash et al. 2013). A recent ASHRAE Research Project found convincing evidence that a properly configured and operated anteroom is an effective means to maintain pressure differentials and create containment in hospital rooms (Siegel et al. 2007; Mousavi et al. 2019). Where a significant risk of transmission of aerosols has been identified by infection control risk assessments, design of AIIRs should include anterooms. (Evidence Level A)

The use of highly efficient particle filtration in centralized HVAC systems reduces the airborne load of infectious particles (Azimi and Stephens 2013). This strategy reduces the transport of infectious agents from one area to another when these areas share the same central HVAC system through supply of recirculated air. When appropriately selected and deployed, single-space high-efficiency filtration units (either ceiling mounted or portable) can be highly effective in reducing/lowering concentrations of infectious aerosols in a single space. They also achieve directional airflow source control that provides exposure protection at the patient bedside (Miller-Leiden et al. 1996; Mead and Johnson 2004; Kujundzic et al. 2006; Mead et al. 2012; Dungi et al. 2015). Filtration will not eliminate all risk of transmission of airborne particulates because many other factors besides infectious aerosol concentration contribute to disease transmission. (Evidence Level A)

The entire ultraviolet (UV) spectrum can kill or inactivate microorganisms, but UV-C energy (in the wavelengths from 200 to 280 nm) provides the most germicidal effect, with 265 nm being the optimum wavelength. The majority of modern UVGI lamps create UV-C energy at a near-optimum 254 nm wavelength. UVGI inactivates microorganisms by damaging the structure of nucleic acids and proteins with the effectiveness dependent upon the UV dose and the susceptibility of the microorganism. The safety of UV-C is well known. It does not penetrate deeply into human tissue, but it can penetrate the very outer surfaces of the eyes and skin, with the eyes being most susceptible to damage. Therefore, shielding is needed to prevent direct exposure to the eyes. While *ASHRAE Position Document on Filtration and Air Cleaning* (2018) does not make a recommendation for or against the use of UV energy in air systems for minimizing the risks from infectious aerosols, Centers for Disease Control and Prevention (CDC) has approved UVGI as an adjunct to filtration for reduction of tuberculosis risk and has published a guideline on its application (CDC 2005, 2009).[7] (Evidence Level A)

Personalized ventilation systems that provide local exhaust source control and/or supply 100% outdoor, highly filtered, or UV-disinfected air directly to the occupant's breathing zone (Cermak et al. 2006; Bolashikov et al., 2009; Pantelic et al. 2009, 2015; Licina et al. 2015a, 2015b) may offer protection against exposure to contaminated air. Personalized ventilation may be effective against aerosols that travel both long distances as well as short ranges (Li 2011).

[7] In addition to UVGI, optical radiation in longer wavelengths as high as 405 nm is an emerging disinfection technology that may also have useful germicidal effectiveness.

Personalized ventilation systems, when coupled with localized or personalized exhaust devices, further enhance the overall ability to mitigate exposure in breathing zones, as seen from both experimental and computational fluid dynamics (CFD) studies in healthcare settings (Yang et al. 2013, 2014, 2015a, 2015b; Bolashikov et al. 2015; Bivolarova et al. 2016). However, there are no known epidemiological studies that demonstrate a reduction in infectious disease transmission. (Evidence Level B)

Advanced techniques such as computational fluid dynamics (CFD) analysis, if performed properly with adequate expertise, can predict airflow patterns and probable flow paths of airborne contaminants in a space. Such analyses can be employed as a guiding tool during the early stages of a design cycle (Khankari 2016, 2018a, 2018b, 2018c).

3.3 Temperature and Humidity

HVAC systems are typically designed to control temperature and humidity, which can in turn influence transmissibility of infectious agents. Although HVAC systems can be designed to control relative humidity (RH), there are practical challenges and potential negative effects of maintaining certain RH set points in all climate zones. However, while the weight of evidence at this time (Derby et al. 2016), including recent evidence using metagenomic analysis (Taylor and Tasi 2018), suggests that controlling RH reduces transmission of certain airborne infectious organisms, including some strains of influenza, this position document encourages designers to give careful consideration to temperature and RH.

In addition, immunobiologists have correlated mid-range humidity levels with improved mammalian immunity against respiratory infections (Taylor and Tasi 2018). Mousavi et al. (2019) report that the scientific literature generally reflects the most unfavorable survival for microorganisms when the RH is between 40% and 60% (Evidence Level B). Introduction of water vapor to the indoor environment to achieve the mid-range humidity levels associated with decreased infections requires proper selection, operation, and maintenance of humidification equipment. Cold winter climates require proper building insulation to prevent thermal bridges that can lead to condensation and mold growth (ASHRAE 2009). Other recent studies (Taylor and Tasi 2018) identified RH as a significant driver of patient infections. These studies showed that RH below 40% is associated with three factors that increase infections. First, as discussed previously, infectious aerosols emitted from a primary host shrink rapidly to become droplet nuclei, and these dormant yet infectious pathogens remain suspended in the air and are capable of traveling great distances. When they encounter a hydrated secondary host, they rehydrate and are able to propagate the infection. Second, many viruses and bacteria are anhydrous resistant (Goffau et al. 2009; Stone et al. 2016) and actually have increased viability in low-RH conditions. And finally, immunobiologists have now clarified the mechanisms through which ambient RH below 40% impairs mucus membrane barriers and other steps in immune system protection (Kudo et al. 2019). (Evidence Level B)

This position document does not make a definitive recommendation on indoor temperature and humidity set points for the purpose of controlling infectious aerosol transmission. Practitioners may use the information herein to make building design and operation decisions on a case-by-case basis.

3.4 Emerging Pathogens and Emergency Preparedness

Disease outbreaks (i.e., epidemics and pandemics) are increasing in frequency and reach. Pandemics of the past have had devastating effects on affected populations. Novel microor-

ganisms that can be disseminated by infectious aerosols necessitate good design, construction, commissioning, maintenance, advanced planning, and emergency drills to facilitate fast action to mitigate exposure. In many countries, common strategies include naturally ventilated buildings and isolation. Control banding is a risk management strategy that should be considered for applying the hierarchy of controls to emerging pathogens, based on the likelihood and duration of exposure and the infectivity and virulence of the pathogen (Sietsema 2019) (Evidence Level B). Biological agents that may be used in terrorist attacks are addressed elsewhere (USDHHS 2002, 2003).

4. CONCLUSIONS AND RECOMMENDATIONS

Infectious aerosols can be disseminated through buildings by pathways that include air distribution systems and interzone airflows. Various strategies have been found to be effective at controlling transmission, including optimized airflow patterns, directional airflow, zone pressurization, dilution ventilation, in-room air-cleaning systems, general exhaust ventilation, personalized ventilation, local exhaust ventilation at the source, central system filtration, UVGI, and controlling indoor temperature and relative humidity. Design engineers can make an essential contribution to reducing infectious aerosol transmission through the application of these strategies. Research on the role of airborne dissemination and resuspension from surfaces in pathogen transmission is rapidly evolving. Managing indoor air to control distribution of infectious aerosols is an effective intervention which adds another strategy to medical treatments and behavioral interventions in disease prevention.

4.1 ASHRAE's Positions

- HVAC design teams for facilities of all types should follow, as a minimum, the latest published standards and guidelines and good engineering practice. Based on risk assessments or owner project requirements, designers of new and existing facilities could go beyond the minimum requirements of these standards, using techniques covered in various ASHRAE publications, including the ASHRAE Handbook volumes, Research Project final reports, papers and articles, and design guides, to be even better prepared to control the dissemination of infectious aerosols.
- Mitigation of infectious aerosol dissemination should be a consideration in the design of all facilities, and in those identified as high-risk facilities the appropriate mitigation design should be incorporated.
- The design and construction team, including HVAC designers, should engage in an integrated design process in order to incorporate the appropriate infection control bundle in the early stages of design.
- Based on risk assessments, buildings and transportation vehicles should consider designs that promote cleaner airflow patterns for providing effective flow paths for airborne particulates to exit spaces to less clean zones and use appropriate air-cleaning systems. (Evidence Level A)
- Where a significant risk of transmission of aerosols has been identified by infection control risk assessments, design of AIIRs should include anterooms. (Evidence Level A)

- Based on risk assessments, the use of specific HVAC strategies supported by the evidence-based literature should be considered, including the following:
  - Enhanced filtration (higher minimum efficiency reporting value [MERV] filters over code minimums in occupant-dense and/or higher-risk spaces) (Evidence Level A)
  - Upper-room UVGI (with possible in-room fans) as a supplement to supply airflow (Evidence Level A)
  - Local exhaust ventilation for source control (Evidence Level A)
  - Personalized ventilation systems for certain high-risk tasks (Evidence Level B)
  - Portable, free-standing high-efficiency particulate air (HEPA) filters (Evidence Level B)
  - Temperature and humidity control (Evidence Level B)
- Healthcare buildings[8] should consider design and operation to do the following:
  - Capture expiratory aerosols with headwall exhaust, tent or snorkel with exhaust, floor-to-ceiling partitions with door supply and patient exhaust, local air HEPA-grade filtration.
  - Exhaust toilets and bed pans (a must).
  - Maintain temperature and humidity as applicable to the infectious aerosol of concern.
  - Deliver clean air to caregivers.
  - Maintain negatively pressurized intensive care units (ICUs) where infectious aerosols may be present.
  - Maintain rooms with infectious aerosol concerns at negative pressure.
  - Provide 100% exhaust of patient rooms.
  - Use UVGI.
  - Increase the outdoor air change rate (e.g., increase patient rooms from 2 to 6 ach).
  - Establish HVAC contributions to a patient room turnover plan before reoccupancy.
- Non-healthcare buildings should have a plan for an emergency response. The following modifications to building HVAC system operation should be considered:
  - Increase outdoor air ventilation (disable demand-controlled ventilation and open outdoor air dampers to 100% as indoor and outdoor conditions permit).
  - Improve central air and other HVAC filtration to MERV-13 (ASHRAE 2017b) or the highest level achievable.
  - Keep systems running longer hours (24/7 if possible).
  - Add portable room air cleaners with HEPA or high-MERV filters with due consideration to the clean air delivery rate (AHAM 2015).
  - Add duct- or air-handling-unit-mounted, upper room, and/or portable UVGI devices in connection to in-room fans in high-density spaces such as waiting rooms, prisons, and shelters.
  - Maintain temperature and humidity as applicable to the infectious aerosol of concern.
  - Bypass energy recovery ventilation systems that leak potentially contaminated exhaust air back into the outdoor air supply.
- Design and build inherent capabilities to respond to emerging threats and plan and practice for them. (Evidence Level B)

[8] It is assumed that healthcare facilities already have emergency response plans.

4.2 ASHRAE's Commitments

- Address research gaps with future research projects, including those on the following topics:
  - Investigating and developing source generation variables for use in an updated ventilation rate procedure
  - Understanding the impacts of air change rates in operating rooms on patient outcomes
  - Determining the effectiveness of location of supply, return, and exhaust registers in patient rooms
  - Conducting controlled interventional studies to quantify the relative airborne infection control performance and cost-effectiveness of specific engineering strategies, individually and in combination, in field applications of high-risk occupancies
  - Evaluating and comparing options to create surge airborne isolation space and temporary negative pressure isolation space and the impacts on overall building operation
  - Understanding the appropriate application of humidity and temperature control strategies across climate zones on infectious aerosol transmission
  - Investigating how control banding techniques can be applied to manage the risk of infectious aerosol dissemination
- Partner with infection prevention, infectious disease, and occupational health experts and building owners to evaluate emerging control strategies and provide evidence-based recommendations.
- Educate stakeholders and disseminate best practices.
- Create a database to track and share knowledge on effective, protective engineering design strategies.
- Update standards and guidelines to reflect protective evidence-based strategies.

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ASHRAE Arkansas Chapter

Indoor Air Hydration

The game changer to staying healthy during COVID-19 and beyond!

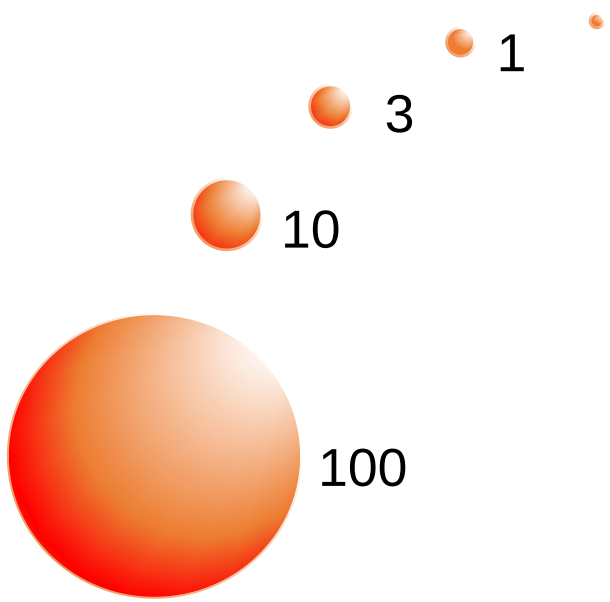
Stephanie Taylor, MD, M Arch
Harvard Medical School
ASHRAE Distinguished Lecturer
Taylor Healthcare Consulting, CEO

HARVARD MEDICAL SCHOOL

Infectious droplets shrink, travel far and evade surface cleaning when the air is dry

Droplet diameter in microns (um)

Float time



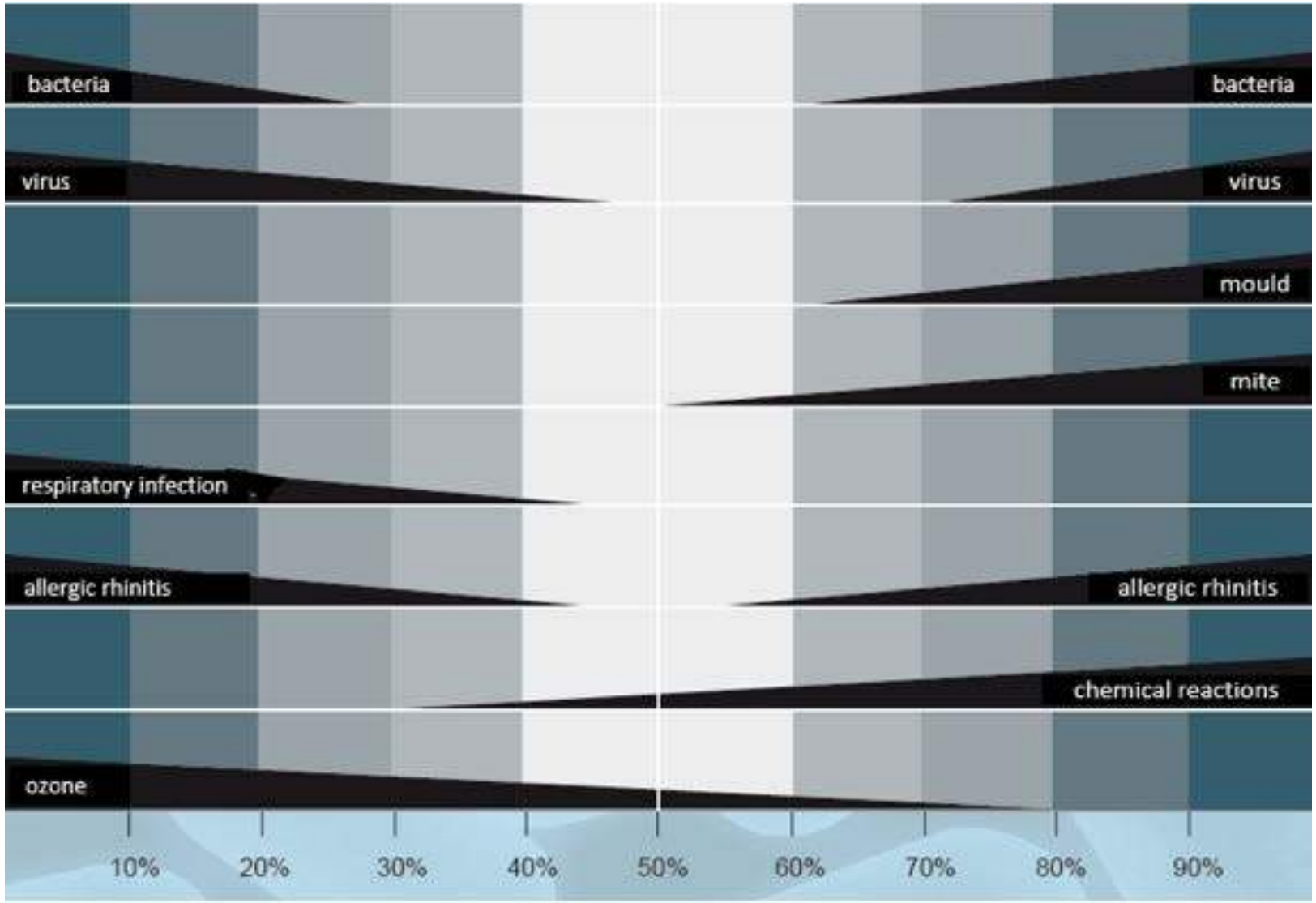
41 hours – 21 days

1.5 hours

6 seconds

Distance travelled: 1m 10m+

ASHRAE 1985:“Optimal RH Level For Health” = 40%–60%



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