Exhibit 6

CDC Briefing Transcript

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Centers for Disease Control and Prevention

CDC Newsroom

Transcript for the CDC Telebriefing Update on COVID-19

Press Briefing Transcript

Wednesday, February 26, 2020

- Audio recording [MP3 – 6 MB]

Please Note: This transcript is not edited and may contain errors.

Welcome and thank you for standing by. At this time, all participants are on listen-only mode until our question and answer session. At that time, if you would like to ask a question, please press star then one. Please be advised today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I would like to turn the meeting over to Mr. Benjamin Haynes. Thank you. You may begin.

Thank you. And thank you all for joining us for today's update on CDC's COVID-19 response. We are joined by the director of CDC's national center for immunization and respiratory diseases who will give opening remarks. I will now turn the call over.

Thank you for joining us. The global novel coronavirus situation is rapidly evolving and expanding. There are still a lot of news coverage about community spread in a few countries since the last time we talked. This means that cases of COVID-19 are appearing without a known source of exposure. Communities include Hong Kong, Italy, Iran, Singapore, South Korea, Taiwan, and Thailand. Community spread is often a trigger to begin implementing new strategies tailored to local circumstances that blunt the impact of disease and can slow the spread of virus. The fact this virus has caused illness – including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of the pandemic. The world moves closer towards meeting the third criteria. Worldwide spread of the new virus. The U.S. has been implementing an aggressive containment strategy that requires detecting, tracking, and isolating all cases. As much as possible and preventing more introduction of disease notably at points of entry. We've restricted travel into the United States while also issuing extensive travel advisories for countries currently experiencing community spread. Our travel notices are changing almost daily. We've also enacted the first quarantine of this scale in the U.S. And are supporting the state department and HHS in repatriating citizens from high-risk areas. We are doing this with the goal of slowing the introduction of this new virus into the U.S. And buying us more time to prepare. To date, our containment strategies have been largely successful. As a result, we have very few cases in the United States and no spread in the community. But as more and more countries experience community spread, successful containment at our borders becomes harder and harder. Ultimately, we expect we will see community spread in this country. It's not so much a question of if this will happen anymore but rather more a question of exactly when this will happen and how many people in this country will have severe illness. We will maintain for as long as practical a dual approach where we continue measures to contain this disease but also employ strategies to minimize the impact on our communities. At this time, there's no vaccine to protect against this new virus and no medications approved to treat it. Non-pharmaceutical interventions or NPIs will be the most important tools in our response to this virus. What these interventions look like at the community level will vary depending on local conditions. What is appropriate for one community seeing local transmission won't necessarily be appropriate for a community where no local transmission has occurred. This parallel, proactive approach of containment and mitigation will delay the emergence of community spread in the United States while simultaneously reducing its ultimate impact. To illustrate how this works, I'd like to share with you some of the specific recommendations made in the document I mentioned last Friday including some of the steps we would take here if needed. This document is called Community Mitigation Guidelines to Prevent Pandemic Influenza United States 2017. It draws from the findings of nearly 200 journal

articles written between 1990 and 2016. This document looked at what can be done at the individual and community level during a pandemic when we don't have a vaccine or proven medical treatment for the disease. We're looking at data since 2016 and adjusting our recommendations to the specific circumstances of COVID-19. But this posted document provides a frame work for our response strategy. Based on what is known now, we would implement these NPI measures in a very aggressive, proactive way as he have been doing with our containment efforts. There are three categories of NPIs. Personal NPIs which include personal protective measures you can take every day and personal protective measures reserved for pandemics. Community NPIs which include social distancing measures designed to keep people who are sick away from others. And school closures and dismissals. And environmental NPIs which includes surface cleaning measures. NPIs routinely recommended for prevention of respiratory virus transmission include everyday personal protective measures. These are preventive measures we recommend during influenza season. These NPIs are recommended during a pandemic regardless of the severity level of the respiratory illness. Personal protective measures reserved for pandemics include voluntary home quarantine of household members who have been exposed to someone they live with who is sick. Now I'd like to talk through some examples of what community NPIs look like. These are practical measures that can help limit exposure by reducing exposure in community settings. Students in smaller groups or in a severe pandemic, closing schools and using internet-based teleschooling to continue education. For adults, businesses can replace in-person meetings with video or telephone conferences and increase teleworking options. On a larger scale, communities may need to modify, postpone, or cancel mass gatherings. Looking at how to increase telehealth services and delaying elective surgery. The implementation of environmental NPIs would require everyone to consistently clean frequently touched surfaces and objects at home, at school, at work, and at large gatherings. Local communities will need to look at which NPIs to implement and when based on how transmission and disease is and what can be done locally. This will require flexibility and adaptations as disease progresses and new information becomes available. Some of these measures are better than none. But the maximum benefit occurs when the elements are layered upon each other. Some community level interventions that may be most effective in reducing the spread of a new virus like school closures are also the most likely to be associated with unwanted consequences and further disruptions. Secondary consequences of some of these measures might include missed work and loss of income. I understand this whole situation may seem overwhelming and that disruption to everyday life may be severe. But these are things that people need to start thinking about now. I had a conversation with my family over breakfast this morning and I told my children that while I didn't think that they were at risk right now, we as a family need to be preparing for significant disruption of our lives. You should ask your children's school about their plans for school dismissals or school closures. If ask if there are plans for teleschool. I contacted my local school superintendent this morning with exactly those questions. You should think about what you would do for childcare if schools or day cares close. If teleworking is an option for you. All of these questions can help you be better prepared for what might happen. CDC and other federal agencies have been practicing for this since the 2019 influenza pandemic. In the last two years, CDC has engaged in two pandemic influenza exercises that have required us to prepare for a severe pandemic and just this past year we had a whole of government exercise practicing similarly around a pandemic of influenza. Right now CDC is operationalizing all of its pandemic response plans working on multiple fronts including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19. Before I take questions, I want to address the issue of the test kits CDC is developing. I am frustrated like I know many of you are that we have had issues with our test. I want to assure you that we are working to modify the kit and hope to send out a new version to state and local jurisdictions soon. There are currently 12 states or localities around the U.S. That can test samples as well as we are testing at CDC 400 samples were tested overnight. There is no current backlog or delay for testing at CDC. Commercial labs will also be coming online soon with their own tests. This will allow the greatest number of tests to happen closer to where potential cases are. Last, I want to recognize that people are concerned about this situation. I would say rightfully so. I'm concerned about the situation. CDC is concerned about the situation. But we are putting our concerns to work preparing. And now is the time for businesses, hospitals, community schools, and everyday people to begin preparing as well. Over the last few weeks, CDC has been on dozens of calls with different partners in the health, retail, education, and business sectors. In the hopes that employers begin to respond in a flexible way to differing levels of severity, to refine their business response plans as needed. I also want to acknowledge the importance of uncertainty. During an outbreak with a new virus, there is a lot of uncertainty. Our guidance and advice are likely to be fluid subject to change as we learn more. We will continue to keep you updated. I'd be happy to take a few questions now.

Brittany, we're ready to take questions.

Thank you. We'll now begin our question and answer session. If you would like to ask a question over the phone, press star, then one and record your name clearly when prompted. If you need to withdraw your question, press star then two. One moment as we wait for the first question. Our first question comes from Lisa from PBS. Your line

is now open.

Good morning. Thank you for doing this. I have some more questions about the test kits. Thank you for what you gave us the update on, but can you go into more detail about how they work? Can any hospital now just kind of use a swab to get a sample and then send that to the CDC? And then how long do you estimate it will take to have the kits replaced so that more localities can actually do the analysis and do you have enough money for this kind of field work and test analysis right now?

Okay. I'm going to start from maybe the part of a patient perspective which is, you know, right now our focus is still on individuals with a travel history that would put them at risk for COVID-19. Or people who are close contacts of someone who has COVID-19. Those individuals when they are identified by a health care provider, the health care provider calls the health department. The health department helps them triage those patients to make — and then the samples are worked with the health department. Now, as we move forward, though, if we are looking at the trajectory of expecting that there likely will be community spread of this virus in the united states, the case definition may change away from narrowly around people with travel. Again, that's what we would anticipate doing as there is community spread. If that happens, it will be more and more important that the clinicians have a full tool kit. That's why the availability of commercial kits would be so helpful. So in the short-term, it's the clinician calls the health department. And either the health department already has the test kit themselves or if they don't yet have it stood up, they send it to CDC. Our turnaround at CDC is within a day. There is a little bit of shipping time. But that's the process. In terms of timing, I think at this point what I would say is we are working as fast as we can. We understand the frustration of our partners in the health care sector, in health departments. You certainly can imagine we want to resolve this as quickly as possible. But we have to make sure that while resolving it, we keep to the highest level of quality assurance. Because as important as speed is, it is more important that we make sure that our results are correct. In terms of funding, there's already been funds available that are helping us with the activities that we have now that is the diagnostic testing at CDC. And we'll continue to proceed focused on our priorities which as I've said are getting this test kit out to state health departments so they can be doing that themselves as an interim step to getting it commercially available would be a great advancement. Next question.

Thank you. And our next question comes from Craig from KNX 1070 news radio Los Angeles. Your line is now open.

Thank you, doctor. I appreciate your time. Couple of questions. There's been a lot of talk about what's being done to prepare for possible people who would be quarantined. I'd like to know what that is. And also is the Chinese government leveling with you? Are they telling you the truth? Have they given you the straight dope, so to speak, as to what you need to know about the coronavirus?

So in answer to your first question, I would say generally we are working on a daily basis with state and local health departments across the country on exactly those issues. What are the local considerations for quarantine or isolation and how can they be resolved? And in each location in the united states, it may end up being a slightly different answer. Our focus is on the best health of the individual whom we are working with in terms of whether they need quarantine or isolation. In terms of the Chinese government, there has been a WHO team on the ground in China as well in Wuhan. There are data coming out from those efforts. We have a lot of information from china. Frankly, we have a lot of new information from all the other countries around the world now that are reporting community spread and we are as quickly as possible trying to synthesize that information. It is providing us more data in terms of making our own estimations in the U.S. Of what we're going to see. Communities that are having community spread are certainly very informative in terms of what we might expect in the united states. And I think that whole body of evidence is frankly coming really quickly at us. That's why we have a team of people here at CDC synthesizing it all.

Next question, please.

Thank you. And our next question comes from Megan from STAT. Your line is now open.

Hi there. Thank you so much for taking my question. I'm wondering if you could expand a little bit on whether you are reconsidering testing people with travel history to other countries now where they might be infected. And I'm also wondering if you could say whether or not the agency has considered getting tests from another country that's supplying tests to other nations as well.

So the answer to the first question is certainly, we're considering what the spread of illness in other countries looks like and how it impacts the potential risk the Americans traveling abroad in those countries. Those conversations are going on as we speak. We obviously are working closely with the partners on those considerations. And when there is new information in terms of case definitions, we'll definitely publicize that broadly. You know, as I said, we are still at the stage of containment, but we are already starting to plan for mitigation. And part of the mitigation planning is the participation of community spread in the united states. And as that happens, it would certainly dramatically impact how we're considering who is on the case. As you can imagine, the symptoms of novel coronavirus look a lot like other viral respiratory diseases that are circulating this time of year. So it's going to be difficult for clinicians to differentiate fully on the basis of those — solely on the basis of the symptoms. In terms of diagnostic tests, what I would say is we're working closely with FDA on this. And obviously with the state and local health department partners. And I think that we are rapidly moving towards getting those kits more available in the U.S. In the systems that we have. Really I think we're close. I just wouldn't want to give an estimate of when until we're there. But I think we're close. And remember, a dozen states now have the kit and are testing and there's tests available in the U.S. So I think we're making forward progress.

Thank you. And our next question comes from Lena Sun from Washington Post. Your line is now open.

Thank you. I had a couple questions. One is if a dozen states have the kit, then do they still need to send those tests to CDC for confirmation? Which are the states that have the tests? And more broadly, your comments today seem to represent a significant escalation in the sort of severity and urgency of the now. At a briefing this morning for Congress, I believe some members were told that we now face a very strong chance of an extremely serious outbreak. Is that the CDC's feeling right now that we face an extremely strong chance of a serious outbreak?

Okay. So let's see. The first question, it's 12 state or local health departments. And so it's not 12 states total. We are still as a point of part of how we roll out these tests, those tests that are positive still do come to CDC for confirmation. I think that's just part of a normal process to ensure we are keeping to the utmost quality control. I don't have a list of state or local health departments in front of me, but I think we can provide that. In terms of a change in tone, I guess what I would say is as I look back on the scripts of the telebriefings that we've given over the past month, we have for a long time been saying — we have for many weeks been saying that while we hope this is not going to be severe, we are planning as if it is. The data over the last week and the spread in other countries has certainly raised our level of concern and raised our level of expectation that we are going to have community spread here. So I think that that's perhaps the change of tone you've seen. I think what we still don't know is what that will look like as many of you know. We can have community spread in the united states and have it be reasonably mild. We could have community spread in the united states and have it be very severe. And so that is what — that is what we don't completely know yet. And we certainly also don't exactly know when it's going to happen. I think it would be nice for everybody if we could say, you know, on this date is when it's going to start. We don't know that yet. And so that's why we're asking folks in every sector as well as people within their families to start planning for this because as we've seen from the recent countries that have had community spread when it is hit in those countries, it has moved quite rapidly. So we want to make sure that the American public is prepared.

Thank you. And as a reminder, if you would like to ask a question, please press star one. Limit to one question and one follow-up. Our next question comes from Eben from Fox news. Your line is now open.

Thank you very much for doing the call today. There has been some political back and forth now that democrats are accusing the president which essentially means the administration and everything that falls under that as being ill prepared for coronavirus, requesting too little of amount in terms of their request for $2.5 billion. Do you feel that we are ill prepared from a financial standpoint? I know you are a clinician and I don't want you to get too much into politics, but do you have what you need to do your job?

I guess I'll answer that two ways. The first is HHS can provide information or answer questions about the funds that are available. What I can say from my perspective is I've been at CDC for 25 years and that if you asked public health officials over the course of that time what they feared as an expectation, it was something exactly like this. And so the idea that we might have a pandemic of influenza or a pandemic of a respiratory viral infection is something that we've known about and have been planning and preparing for. That's why we at CDC have been exercising with the state and local health departments. That's why the whole of government exercise last year, that's why we've invested so much on the foundation we are now responding. But that being said, we are never going to ever be able to be so completely prepared that we're prepared for any inevitability. We always are going to find that diseases surprise us and that there was some consideration that is slightly different from what we planned for. So have we made a lot of

progress in the 25 years I've been here? Yes. Are we better prepared today than we were 20 years ago? Yes. But are we completely prepared? You know, diseases surprise us and therefore we need to be reacting to the current situation even if it differs from what we planned for. You know, in general we are asking the American public to work with us to prepare in the expectation that this could be bad. I continue to hope that in the end we'll look back and feel like we are over-prepared, but that is a better place to be in than being under-prepared. And just like the preparedness for a pandemic influenza provides such a strong foundation for this response, any preparedness we do as a country, at schools, businesses, within our families will always be helpful for whatever the next event is. And so I don't think in general that preparedness will ever go to waste.

Next question, please.

Thank you. Our next question comes from Mike from A.P. Your line is now open.

Hi. Thank you for taking my call. If I could ask a couple. One is just the latest case count, it's been a little confusing for some of us just to sort out exactly how many U.S. Cases there are and how they're being sorted out. Second, if you could speak to your best and latest understanding of the severity of the disease. Of course there's some news today about the WHO mission coming back and statements about not finding a lot of undetected cases. I was wondering if that's related to CDC gearing up for these NPIs. And lastly, talking about the exercising you've been doing, what was the weakness or weaknesses that kept coming up in the exercises that you're most concerned about and you're really trying to stay on top of now that we have a real time experience happening? Thank you.

Okay. So let me — so let me start by saying that I know the case counts can be confusing. I will try to sort out what the numbers are as of today and try to explain why it perhaps is a little confusing. There remain 14 confirmed U.S. Cases. We are separating out the cases among repatriated individuals. So those are 14 U.S. Cases. 12 of those are travelers who returned from an area where disease is circulating. Two of those are close contacts of another case. That's 14. There are three novel coronavirus patients among people who are repatriated from Hubei that is in the repatriated flights. And our website says 36 because we updated this yesterday, but in fact as of this morning, there are 40 positives among individuals repatriated from the "Diamond Princess." so these are Americans who were on board the "Diamond Princess" repatriated back to the United States. And that's 40. So that means just to go back that there are 14 confirmed cases picked up through the U.S. public health systems. And 40 plus 3 makes 43 among individuals repatriated into the United States. I do hope that helps. In terms of the severity, I think that there are a variety of reports that give information about severity. We've looked at severity among people, among reported people from Hubei. We've looked at reported people from elsewhere in china. And certainly the data coming out from Korea and Iran and Italy suggests also deaths which are concerning. In terms of our messaging today, I really would say that it is more driven by the community spread in other countries than it is specifically from data from china. And so I think it really is the spreading of COVID-19 through other countries that makes all of us feel that the risk of spread in the united states has — is increasing. In terms of exercising, you know, there are always small and big things that we learn from exercising. Maybe two specific things I'll point out is that our exercising did show us that if we had a pandemic, there were going to be supply issues. And I think that we are now across the whole of government thinking through and working on those supply issues. One of them is enough protection for health care workers. This is clearly a priority. The health care workers put themselves on the front line caring for ill patients and has to be a priority to make sure they are protected. Another issue is the NPIs. The non-pharmaceutical interventions. We have worked across governmental sectors to get input into our planning guidance. But it's one thing to plan for those NPIs. It's certainly another thing to be able to implement them at a large scale. And I think one of the reasons that we're talking about this so proactively today is that we recognize that implementing NPIs at this level that we want to prepare the american people that their lives could be interrupted. Next.

Thank you. Our next question comes from Eric of ABC news. Your line is open.

Thanks, Benjamin. Thanks, Nancy for taking our questions. I'm wondering like the chicken and the egg with the case definition and the testing. If you're telling us today it's not a question of if but when there'll be community spread and it's very difficult to — for clinicians to know the difference between flu and COVID-19, how come you're not widening the case definition to test more people?

So let me answer that two ways. One is that we have more than one layer of surveillance. I think I talked about this in a previous call, but maybe just to talk about it a little more. There is a specific patient-under-investigation case definition that really does focus on travel because that is where the cases that are picked up through our public health systems are. But we are also aware and concerned about the possibility for broader spread in the U.S. That's

why the Secretary and we announced last week that we were going to be doing more community-based surveillance relying on the infrastructure of our influenza. So we have already started that surveillance system. We're rapidly working within the next couple weeks to expand that more broadly. As well, we have a variety of other more community-oriented surveillance systems that we're working to stand up to be able to look for those cases in the community. So this is proceeding in stages with the one surveillance but community surveillance also rapidly starting.

Brittany, we have time for two more questions, please.

Thank you. And our next question comes from Lauren from San Antonio Express News. Your line is now open.

Thank you for taking my call. I wanted to ask about the 14-day incubation period that has been reiterated by many public health officials including the quarantine of the evacuees. We've seen some isolated reports coming from other countries suggesting that it is possible that the incubation period has been longer in some individuals in other countries who have been quarantined for more than 14 days. And I was wondering if you guys have any reason to suspect whether the incubation period may be longer than 14 days for those of Wuhan that have been released from their quarantine.

Thank you. That's actually a really important question. And something we're looking at closely. Some of the reports that you've seen are reports in the media, not reports in peer reviewed literature. And it impacts our ability to fully scientifically evaluate them. As I've said in previous meetings, there are a team of — there are more than 50 modeling mathematical modeling groups in the United States all working with us to look at a variety of issues around this response to novel coronavirus. One of the things they're certainly analyzing is all of the available data on the incubation period. And the data so far still supports using 14 days as the top window. In terms of isolated reports elsewhere, there are a variety of possibilities. One possibility is — there's a variety of possibilities – what we'll do is continue to synthesize and evaluate the available data trying to make a data-driven decision. And if more data becomes available that suggests a longer incubation period, we will certainly be visible and public about that. I think at this point, we're still comfortable that 14 days is the appropriate top line for that.

Last question, please.

Thank you. And our final question comes from Ben from CNN. Your line is now open.

Hi, thanks so much for taking my question. This morning while he was traveling in India, President Trump said that he thinks that the coronavirus is a problem that is going to go away. He seems very optimistic about this and we're trying to figure out exactly why he believes so strongly that to be the case. And so my question for you is what information is your agency specifically giving the president and the White House about the current state of the coronavirus outbreak?

As you imagine, we brief the Secretary daily and the Secretary is the lead of the White House task force. And Ddr. Redfield the CDC director is briefing them daily. In terms of the course of this illness, we have a — again, a team of mathematical modelers working with us to try to predict the trajectory. One hypothesis is that we could be hopeful that this could potentially be seasonal. Other viral respiratory diseases are seasonal including influenza and therefore in many viral respiratory diseases, we do see a decrease in disease in spring and summer. And so we could certainly be optimistic that this disease will follow suit. But we're not going to know that until time keeps ticking forward. We're going to be, again, preparing as if this is going to continue, preparing as if we're going to see community spread in the near term. But I'm always going to be hopeful that that disease will decline either for the summer or that, you know, we'll be over-prepared and we won't see the high levels of transmission here in the U.S.

Thank you, doctor. And thank you, all, for joining us for today's briefing. Please visit CDC's 2019 novel coronavirus website for continued updates. And if you have further questions, please call the main media line at 404-639-3286 or email media@CDC.gov. Thank you.

Thank you for your participation in today's conference. All participants may disconnect at this time.

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