EXHIBIT 1-H

Declaration of Dr. Jessica McCannon

I, Dr. Jessica McCannon, do declare:

1) I am a double board-certified physician in pulmonary disease and critical care at Massachusetts General Hospital ("MGH"), where I also serve as Vice Chair for Faculty Development for the Division of Pulmonary and Critical Care Medicine. I completed a clinical / research fellowship in pulmonary and critical care medicine with MGH, Brigham and Women's Hospital, and Beth Israel Deaconess Medical Center. I completed my residency and internship in internal medicine at MGH. I received my Doctor of Medicine from the Weill Medical College of Cornell University.

2) Currently, seventy percent of my time is spent in ambulatory and inpatient medical care of patients with pulmonary disorders and critical illness. I care for patients with all pulmonary disorders, including asthma, and I have evaluated, managed, and followed hundreds of patients with asthma across my practice of over a decade.

3) Prior to my current role treating patients with asthma and other pulmonary illnesses, I served as director of Critical Care Services at Mount Auburn Hospital (2016-2021), in addition to other major administrative leadership positions. I also have been appointed as an instructor in medicine at Harvard Medical School (2008-2009; 2013-2021), teaching courses and teaching / supervising rotations and lectures involving pulmonary and critical care medicine.

4) This declaration is based on my expertise and experience as a practicing, Board Certified pulmonologist for 14 years, my review of Ms. Öztürk's available medical records regarding her asthma diagnosis and treatment from Turkey and Tufts University, and my remote oral conversations with Ms. Öztürk to elicit her clinical history. Because Ms. Öztürk is still detained in Louisiana, I was unable to personally conduct a physical examination, personally perform objective measurements in lung function or peak expiratory flow, or otherwise meet with her in person.

5) Asthma is a lung disease characterized by chronic inflammation of the airways, and associated with variable and recurrent symptoms, as well as variable expiratory airflow limitation or bronchial hyperresponsiveness. Symptoms include shortness of breath, chest tightness, wheeze, and cough. These symptoms vary in frequency and intensity over time depending on a myriad of triggers, and their outcome can be severe or even fatal if they are not addressed properly.

6) In my practice, I frequently hear patients describe the experience of an asthma attack as feeling like they are suffocating. They often express that it can be very scary to feel like they can't breathe.

7) Common triggers for asthma symptoms include but are not limited to exercise, exposure to inhaled allergens such as cats, dogs, pollen, or irritant exposures such as cleaning supplies, detergents, perfumes and other strong smells; changes in weather/seasons; stress; and upper respiratory infections.

8) Goals of asthma management are to control symptoms, to reduce risk of exacerbations, to preserve lung function and to minimize side effects of medications. There are a range of pharmacologic regimens used including inhaled steroids and inhaled bronchodilators. Typically, this can include what is colloquially referred to as a "maintenance inhaler," which is used daily to help decrease inflammation, reduce symptoms and risk of asthma exacerbations. Regimens also typically include what is colloquially referred to as a "rescue inhaler," which is intended to be used intermittently for quick emergency relief to reduce symptoms caused by airway inflammation or hyperresponsiveness occurring because of exposure to a trigger.

9) A rescue inhaler is a temporizing measure which is meant to help alleviate worsening symptoms after exposure to a trigger. If the exacerbation was caused by an environmental factor, a rescue inhaler will have only limited efficacy if the person is not able to remove themselves from the trigger itself. It is somewhat akin to throwing a flotation device to someone in the ocean: it can help them stay afloat, but on its own it does not solve the dangerous situation.

10) If a person is exposed to an environmental or allergic trigger for their asthma and is both unable to avoid the trigger and only has access to their typical maintenance and rescue inhalers, their asthma control may worsen to the point that they require nebulized bronchodilators, systemic oral treatment with steroids such as prednisone and/or evaluation and care in an emergency room, hospital or intensive care unit setting.

11) The field of pulmonology has learned over the course of the last decade that even patients who have well-controlled asthma or infrequent symptoms still have an increased risk of asthma exacerbations, asthma exacerbation requiring hospitalization, and asthma exacerbation leading to death if their asthma symptoms are not properly addressed.

12) Because asthma is a chronic condition, the goal in treating patients with asthma is not to cure the condition—which is not possible—but to do everything possible to make sure their asthma is well-controlled. Control of asthma is assessed by understanding weekly burden of

symptoms, frequency of nighttime awakening, frequency of use of quick relief inhaler, and ability to participate in routine activities. There are tools designed to help medical providers and patients understand asthma control over a 4-week period, but it is also important to assess general trends in symptoms and frequency of rescue inhaler use and activity limitations over longer periods of time. Assessing for presence of risk factors for exacerbations is also an important part of assessing control.

13) The ACT is a validated 5-question tool designed to help patients and health care teams understand asthma control. Scores range from 5 to 25. Scores > 19 indicate well-controlled asthma. Scores of 16-19 indicate not well-controlled asthma. Scores 5-15 indicate very poorly controlled asthma. (Schatz M et al. J Allergy Clin Immunol. 2009;124(4):719–723).

14) GINA (Global Initiative for Asthma) is a collaborative led by leading asthma experts from around the world that shapes asthma care, providing recommendations and strategies based on scientific evidence to care teams and patients worldwide. GINA control assessment includes four questions about asthma control over the preceding 4 weeks with yes/no answers, specifically does the patient have and/or use: 1) Daytime asthma symptoms more than twice a week, 2) Any nighttime awakening due to asthma, 3) Short acting quick relief medication for symptoms more than twice weekly, 4) Any activity limitation due to asthma. If a patient answers no to all questions, their asthma is well-controlled. If a patient answer yes to 1 or 2 of these questions, their asthma is partly-controlled, and if a patient answers yes to 3 or 4 of these questions, they have uncontrolled asthma. (Global Initiative for Asthma. (2024). Global Strategy for Asthma Management and Prevention. Updated May 2024. Available from: https://ginasthma.org/)

15) One side effect of an increased use of a rescue inhaler can be a fast heart rate and a feeling of tremulousness and uneasiness.

16) Based on the clinical history that Ms. Öztürk shared with me, she has a childhood history of seasonal/environmental allergies, allergic rhinitis and eczema—which are common among patients with asthma—and she recounted an episode of urticaria (hives), all of which speak to her predisposition to allergic disease. She also has a family history of asthma. Additional risk factors for worsening of asthma control include acid reflux which she has been treated for in the past, as well.

17) Ms. Öztürk described her triggers to include pollen, dust, cats, upper respiratory infections and stress. Strong odors from cleaning supplies, detergents, smoke, perfumes also cause acute symptoms. When she is exposed to these triggers, she reports experiencing increased frequency and intensity of paroxysms of cough, as well as chest tightness.

18) Ms. Öztürk reports, and the records I reviewed reflect, that she was diagnosed with asthma in June of 2023, when she presented with several weeks of persistent dry cough, predominantly at night, with a history of allergic rhinitis. In office spirometry demonstrated that three of the four measurements were normal, but one (the FEF-25-75%) was low, which can indicate an impairment in the function of small airways, suggestive of asthma. At that time she was started on a once daily maintenance inhaler and she was provided with a rescue inhaler, as well.

19) Based on our conversations and the medical records that I reviewed, it my opinion that Ms. Öztürk has asthma, most likely cough-variant asthma, with an element of allergic asthma, as well.

20) Ms. Öztürk shared, and her records reflect, that she experienced an acute exacerbation of her asthma in the context of a COVID infection in July of 2023. She described that for several days she was experiencing unstoppable coughing, she felt chest tightness, and she was scared. It is not unusual for patients with asthma to have significant exacerbations of their symptoms if they contract upper respiratory infections. During this exacerbation, Ms. Öztürk was evaluated and followed closely by student health services and reassessed frequently over many days.

21) Based on my conversations with Ms. Öztürk and what I understand from her medical records from Tufts, in the year and half between that July 2023 exacerbation and Ms. Öztürk's arrest on March 25, 2025, her asthma was well-controlled. During that time, she would often use her maintenance inhaler once a day at night. There were periods during the winter months when her asthma was so well-controlled that she did not need to use it regularly, but she would restart using it on a daily basis once the seasons changed or if she had an upper respiratory infection, was exposed to strong scents or chemicals, or as on one occasion, a cat. Ms. Öztürk shared that she had approximately 8 additional asthma attacks (after July 2023), meaning a period of increased frequency and intensity of cough and shortness of breath, during which period she would use her rescue inhaler slightly more frequently. She would otherwise typically use her rescue inhaler an average of between 1-2 times a week, depending on the season and her exposures.

22) Ms. Öztürk took steps to mitigate her exposure to her triggers to help with her disease control. For example, she would open windows when she cleaned and she would occasionally wear a mask, and she used cleaning supplies and detergent without fragrance. Ms. Öztürk entered the library early in the morning to avoid foot traffic and exposure to perfumes and other scents. In addition, her friends who know about her condition were cautious about her triggers, including perfume, pets and dust. Ms. Öztürk had variation in her

symptoms, which is typical of asthma, but she was able to manage them effectively with the use of her medications and her avoidance of triggers.

23) Avoidance and mitigation of environmental triggers is a key part of any treatment plan that I create with patients whose asthma is exacerbated by inhaled allergens and irritants.

24) Since Ms. Öztürk has been detained in a crowded congregate setting in Louisiana, she has experienced a steady pattern of worse asthma symptoms, including increased frequency, intensity, and duration of her paroxysms of cough, associated with chest tightness, all of which has required her to use her rescue inhaler far more than her baseline, despite using a daily maintenance inhaler.

25) Based on my conversations with Ms. Öztürk, my understanding is that she had one asthma attack in the airport on the way to Louisiana, and has had 7 additional asthma attacks during the 38 days she has been at the detention center. She states that she has had to take between 2-3 doses of her rescue inhaler for each attack. Ms. Öztürk relayed to me that these attacks have been more intense and they have lasted longer than the attacks that she had prior to her detention. She also said that aside from the asthma attacks, she has separately needed to use her rescue inhaler additional times, far more than she has needed to do in the past.

26) I would describe Ms. Öztürk's experience as a significant change in her asthma condition. Her asthma is no longer well-controlled, and based on the validated Asthma Control Test (ACT), as well as the GINA (Global Initiative for Asthma) Assessment of Asthma Control described above, she has poorly controlled asthma. Ms. Öztürk's score on the ACT was 14, and she answered three of the GINA Assessment of Asthma Control questions as yes. Poorly controlled asthma is one of the most important risk factors for exacerbations (Haselkorn T et al. J Allergy Clin Immunol 2009 Nov;124(5):895-902).

27) This is not a surprising result because Ms. Öztürk is currently enclosed in an indoor space for almost all hours of the day where she is regularly being exposed to dust and strong odors from cleaning products and shampoo—which are known triggers for her— as well as insects and rodent droppings, both notable indoor allergens that can lead to worsening asthma symptoms in many patients. Her living environment is also humid, as the showers are in the same room as the living space and not enclosed, which increases the risk of development of mold, another common inhaled allergen that triggers asthma. According to Ms. Öztürk, she has very limited access to fresh air, and her living space has poor ventilation. Unlike when she lived in Somerville, Ms. Öztürk can no longer remove herself from these environmental triggers or mitigate their effects or regularly adjust and manage her treatment program with her medical care team.

28) It is my opinion that the risk of Ms. Öztürk's condition worsening if she is not released from detention is fairly high. The reason for this risk is that she is experiencing ongoing, static exposure to triggers from which there is no respite. Under these circumstances, there is only so much that her maintenance inhaler and rescue inhaler can do. She is currently managing as best as she can, but it is my opinion that Ms. Öztürk has a real risk of having an asthma exacerbation that would necessitate an urgent evaluation, nebulized medications, oral steroids, and even possibly an emergency room visit.

29) My understanding is that at the detention facility she is currently receiving Pulmicort, which is an inhaled steroid alone and different than what she had been using in Somerville, which was a combination inhaler that included an inhaled steroid and a long-acting bronchodilator. While changing her maintenance medication back to the combination inhaler that she had previously been using might help control her symptoms, it is my opinion that even with this change, Ms. Ozturk would still have a real risk of having an asthma exacerbation that would necessitate an urgent evaluation, nebulized medications, oral steroids, and even possibly an emergency room visit.

30) I have two additional professional concerns about Ms. Öztürk's condition. First, she is sleeping and living in a space that according to public signage is designed for seating capacity of 14 people but is currently detaining 24 people for approximately 22 hours a day. This puts her at greater risk for contracting an upper respiratory infection, which could also lead to an asthma exacerbation.

31) Second, Ms. Öztürk shared that during her first two asthma attacks at the facility, her cellmates needed to bang on the door to try to get someone's attention for assistance, and that it took several minutes before anyone paid attention. She further shared that it took between 20 and 60 minutes between the onset of her asthma attack and when she was seen by a member of the nursing staff during these two incidents.

32) Respiratory status can deteriorate very rapidly in someone with asthma, and it can be life threatening if there is not a quick response. Based on what Ms. Öztürk shared with me, I am concerned that she could decompensate and not receive adequate medical attention in time.

33) Ms. Öztürk also shared that during one of her asthma attacks, a member of the nursing staff at the facility told her that it was "all in her mind". It would be dangerous to ignore a possible asthma attack in someone who is diagnosed with asthma; without proper recognition and treatment, the consequences could be progressively worsening respiratory status and the potential need for emergency care.

34) It is my professional opinion that Ms. Öztürk's condition will not improve if she remains in detention. Without release, she is at risk for progressive symptoms, worsening disease control, and adverse outcomes, including asthma exacerbation requiring acute medical attention which is not easily available to her, and even potentially fatal asthma exacerbation.

35) Based on my review of the medical records and my conversations with Ms. Öztürk, I think there is a high likelihood that her condition would improve, and that her asthma would return to being well-controlled, if she was released and able to return to Somerville.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on May 2, 2025

_____

Jessica McCannon MD

The Faculty of Medicine of Harvard University

Curriculum Vitae

Date Prepared: April 26, 2025

Name: Jessica McCannon

Office Address: 55 Fruit Street, Boston, MA 02114

Education:

09/1992 - 06/1996	BA	Romance Language and Literature	Princeton University
08/1999 - 09/2000	Post Baccalaureate Program	Pre-Medicine	Bryn Mawr College
08/2001 - 06/2005	MD	Medicine	Weill Medical College of Cornell University

Postdoctoral Training:

2005 - 2006	Intern	Internal Medicine	Massachusetts General Hospital
2006 - 2008	Resident	Internal Medicine	Massachusetts General Hospital
2009 - 2012	Clinical/ Research Fellow	Pulmonary and Critical Care Medicine	Massachusetts General Hospital, Brigham and Women's Hospital, Beth Israel Deaconess Medical Center

Faculty Academic Appointments:

2008 - 2009	Instructor in Medicine	Medicine	Harvard Medical School
2013 - 2021	Instructor in Medicine	Medicine	Harvard Medical School

Appointments at Hospitals/Affiliated Institutions:

2008 - 2009	Assistant in Medicine	Medicine	Massachusetts General Hospital
2013 - 2016	Assistant in Medicine	Medicine (Pulm/CC)	Massachusetts General Hospital
2017 - 2021	Assistant Physician	Medicine (Pulm/CC)	Mount Auburn Hospital

2021 – 2024	Associate Physician	Medicine (Pulm/CC)	Massachusetts General Hospital
2024 - current	Physician (renamed)	Medicine (Pulm/CC)	Massachusetts General Hospital

Major Administrative Leadership Positions:

Local

2016	Site Director, Combined Harvard Pulmonary and Critical Care Fellowship	Massachusetts General Hospital/Beth Israel Deaconess Medical Center
2017 - 2021	Director, Critical Care Services	Mount Auburn Hospital
2020 - 2021	Assistant Medical Director, MACIPA	Mount Auburn Hospital
2021 - Present	Vice Chair, Faculty Development for the Division of Pulmonary and Critical Care	Massachusetts General Hospital

Committee Service:

Local

2011 - 2016	Optimum Care Committee	Massachusetts General Hospital
2015 - 2016	Partners Health Care Palliative Care Committee	Partners Health Care
2016	MGH DOM Community Council	Massachusetts General Hospital
2017 - 2021	Antimicrobial Stewardship Committee	Mount Auburn Hospital
2017 - 2021	Critical Care Committee	Mount Auburn Hospital Co-Chair
2017 - 2021	Infection Control Committee	Mount Auburn Hospital
2017 - 2021	Pharmacy and Therapeutics	Mount Auburn Hospital
2017 - 2021	Rapid Response/Code Blue Committee	Mount Auburn Hospital Co-Chair
2021 - Present	DOM Community Council	Massachusetts General Hospital
2021 - Present	DOM Faculty Advancement Executive Committee	Massachusetts General Hospital
2024 - Present	MGH Frigoletto Committee	Massachusetts General Hospital

Honors and Prizes:

2005	Sarah O'Laughlin Foley Prize	Weill Cornell Medical College	Academic
2005	Paul Sherlock Prize in Internal Medicine	Weill Cornell Medical College	Academic
2005	Gustave J. Noback for Advanced Study and Teaching in the Field of Anatomy	Weill Cornell Medical College	Academic
2005	Leonard P. Tow Humanism Award	Arnold P. Gold Foundation	Academic
2014	Nominated for McGovern Award in Clinical Excellence	Massachusetts General Hospital	Clinical
2020	Nominated for Inspiring Clinician Award	Mount Auburn Hospital	Clinical
2023	MICU Teaching Award	Massachusetts General Hospital	Clinical
2024	Pillar of Excellence Award in the Category of Fostering Community	Massachusetts General Hospital	Clinical

Report of Funded and Unfunded Projects

Past

2008	Understanding Barriers to Completing Advance Care Directives in Two Culturally Diverse Primary Care Settings at Massachusetts General Hospital The John D. Stoeckle Center for Primary Care Innovation ($10,000) Co-Investigator The study sought to better understand knowledge and attitudes about advance directives, barriers to completion, preferences about approaches to end-of-life discussions, and utility of current educational materials available to patients in MGH Chelsea and MGH Revere, using open-ended focus group interviews and structured one-on-one interviews.
2010	A Temporal Intervention Trial of a CPR Video in the ICU Co-Investigator The study employed a video-decision aid that illustrates and discusses elements of CPR. The study compared knowledge of CPR, comfort with the video, and symptoms of anxiety and depression for 50 surrogate decision makers. Importantly, it compared the CPR preferences between the group that viewed the video decision aid and the group that did not view the video.

2012 - 2015	The Conversation Project, a collaboration with the Institute for Healthcare Improvement (IHI) Advisor, Medical Director The Conversation Project is a grassroots public engagement campaign whose goal is to make it easier for individuals to initiate conversations about end-of-life care such that everyone's wishes will be expressed and respected. I have collaborated with thought leaders and have provided medical perspective to this project, and had a leadership role in creating the "Conversation Starter Kit" – a product of the website launched in August 2012, http://theconversationproject.org which has been downloaded by more than 600,000 individuals and is being used widely across the country and around the world (having been translated into many languages) along with other online tools that I also co-authored, including, How To Talk To Your Doctor.
2013 - 2014	A retrospective study of unexpected readmissions to the RACU Co-Investigator The study explored mortality of a high-risk cohort of chronically critically ill patients who have unexpected readmissions to the RACU.
2013 - 2015	Conversation Ready Learning Community Faculty The Conversation Ready Community was a 9-month learning community, comprised of hospitals, health care systems and community organizations from across the country and internationally. This group was committed to establishing what it means for health care organizations to be "Conversation Ready" by piloting tests of change, with the goal of establishing a change package that could be easily adopted by other health systems to improve end-of-life care.
2014	IHI Open School Course: Skills in End-of-Life Conversations Curriculum Developer The IHI Open School is an international community of health care professionals and health care professions students. This 90-minute interactive course introduces health professions students to skills in conversation, particularly with regard to end-of-life care, and focuses on innovative, experiential ways to help learners become comfortable and more skilled at conversations about death and end-of-life care.
2018	ACTS Trial: Ascorbic Acid, Corticosteroids, and Thiamine in Sepsis Funded by Open Philanthropy Project Site PI, Mount Auburn Hospital (BIDMC, Coordinating Center) The "Ascorbic Acid, Corticosteroids, and Thiamine in Sepsis (ACTS)" trial is a multi-center, double-blind, randomized clinical trial that aimed to determine the impact of Vitamin C, Hydrocortisone, and Vitamin B1 vs. Placebo on organ injury and mortality on participants with sepsis and septic shock.

Report of Local Teaching and Training

Teaching of Students in Courses:

2011	Respiratory Pathophysiology HMS 2nd year medical students	Harvard Medical School Simulation and case facilitator
2018 - 2021	Pulmonary pharmacology lecture, Introduction to the ICU, Reflections on COVID Pandemic, as well as preceptor sessions to review history& physical and case presentations HST Students	Massachusetts Institute of Technology

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs):

2015 - 2016	Ambulatory care rotation morning lecture series on asthma Medical interns and residents, MGH	Monthly
2016	MICU morning lecture series on ventilator acquired PNA Medical interns and residents, MGH	
2017 - Present	MICU morning lecture series (Coordination of monthly curriculum for residents rotating through the ICU and lead sessions) Medical interns and residents, MAH	~8 per month
2022 - Present	Ask the expert session on COPD Primary care junior residents, MGH	1-2 times per year

Clinical Supervisory and Training Responsibilities:

2008 - 2009	Ambulatory Clinic Preceptor Precepted general medicine interns in continuity clinics at MGH Revere
2013 - 2016	Pulmonary Clinic Preceptor Provided didactic sessions about outpatient pulmonary medicine and precepted clinics for 2nd and 3rd year pulmonary fellows
2014 - 2016	Ambulatory Pulmonary Rotation Provided one-on-one experience and didactics to residents who rotated through pulmonary clinic at MGH, as well as community-based pulmonary clinics
2021 - Present	Pulmonary Clinic Preceptor Provided didactic sessions about outpatient pulmonary medicine and precepted clinics for 2nd and 3rd year pulmonary fellows

2021 - Present	Ambulatory Pulmonary Rotation Provide one-on-one experience and didactics to residents who rotated through pulmonary clinic at MGH, as well as community-based pulmonary clinics

Formal Teaching of Peers (e.g., CME and other continuing education courses):

☐ No presentations below were sponsored by 3rd parties/outside entities.

☒ Those presentations below sponsored by outside entities are so noted and the sponsor(s) is (are) identified.

2022	Asthma Diagnosis and Management Division of Pulmonary and Critical Care Pulmonary Course Massachusetts General Hospital
2023 - 2024	Asthma Diagnosis and Management CME Course Internal Medicine: Comprehensive Review and Update Harvard Medical School/Massachusetts General Hospital
2024	Asthma Update: New Guidelines and New Choices Primary Care Internal Medicine CME Course Massachusetts General Hospital
2024	Curbside Consults: Top Questions from PCPs on Asthma: New guidelines and new choices. Sponsored by PriMed

Local Invited Presentations:

☒ *No presentations below were sponsored by 3rd parties/outside entities*

☐ *Those presentations below sponsored by outside entities are so noted and the sponsor(s) is (are) identified.*

2009	Adults with Down Syndrome Update/Grand Rounds Department of Genetics, MGH
2012	The Conversation Project MetroWest Medical Center (Natick), Grand Rounds
2013	The Conversation Project (multiple – see below) Harvard Vanguard Medical Associates, Kenmore, Grand Rounds MetroWest Medical Center (Framingham), Grand Rounds

	BWH Ethics, Grand Rounds MGH Palliative Care, Grand Rounds BMC, Palliative Care, Grand Rounds
2014	Best Practices for the Care of Adults with Down Syndrome Department of Nursing Grand Rounds, MGH
2014 - 2015	Updates in the care of patients with COPD Adult Provider Meeting, MGH Chelsea Adult Provider Meeting, MGH Charlestown Adult Provider Meeting, MGH Revere Adult Provider Meeting, Beacon Hill Practice
2016	Updates in the Care of Patients with Down Syndrome MGH Disability Council
2016	Evaluation and Management of Dyspnea MGH Internal Medicine Residency Noon Conference Series
2017	Updates in COPD Mount Auburn Hospital Medicine Residency Noon Conference Series
2017	Palliative Care Discussion Group, Leader The Dr. Andrew Tager Symposium for Those Living with Idiopathic Pulmonary Fibrosis
2020	A Day in the Life of the ICU Mount Auburn Hospital, COVID19 Grand Rounds
2020	COPD Essentials for Primary Care MGH Chelsea Adult Medicine Conference, in honor of Skip Atkins MD
2024	Asthma-New Guidelines and New Choices Harvard University Health Services Grand Rounds

Report of Regional, National and International Invited Teaching and Presentations

☒ *No presentations below were sponsored by 3rd parties/outside entities*

☐ *Those presentations below sponsored by outside entities are so noted and the sponsor(s) is (are) identified.*

National

2012	The Conversation Project / Session Moderator

	Institute for Healthcare Improvement National Forum, Orlando, FL
2013	The Conversation Project / Featured Speaker Annual Palliative Care Symposium, UPMC, Pittsburgh, PA
2013	The Conversation Project / Session Leader Institute for Healthcare Improvement National Forum, Orlando, FL
2014	Learning lab: Having the conversation, professionally and personally Workshop: Becoming Conversation Ready Institute for Healthcare Improvement Office Practice Summit, Washington, DC
2016	COPD: Pathophysiology and Diagnosis, American Thoracic Society Core Lecture Series ATS Annual Conference, San Francisco, CA
2017	Palliative Care Challenges in Advanced Lung Disease Practical Aspects of Palliative Care Symposium

Report of Clinical Activities and Innovations

Past and Current Licensure and Board Certification:

2005	Massachusetts Limited Medical License
2008	American Board of Internal Medicine
2008	Massachusetts Full Medical License
2011	American Board of Internal Medicine, Pulmonary Disease
2012	American Board of Internal Medicine, Critical Care

Practice Activities:

2008 - 2009	Outpatient clinical practice, with some inpatient (general medicine)	Massachusetts General Hospital	Ninety percent effort devoted to provision of urgent care and primary care services at MGH Revere, as well as rounding on health center inpatients.
2008 - 2016	Outpatient clinical practice, Down syndrome	Massachusetts General Hospital	1-2 sessions/month devoted to consultative care for adults with Down syndrome in the MGH Clinic for Adolescents and Adults with Down Syndrome.
2009 - 2016	Outpatient clinical practice, pulmonary	Massachusetts General Hospital	Fifty to eighty percent effort devoted to provision of care in a variety of outpatient settings, both MGH Pulmonary Associates, MGH Chelsea and

			MGH Charlestown community health centers.
2013 - 2016	Critical Care, Pulmonary Consultation, Pulmonary Transplant	Massachusetts General Hospital	Twenty five percent effort devoted to provision of critical care services in a variety of critical care settings (RACU, MICU, CCU) as well as inpatient pulmonary consult service. Typical RACU census is 8-10 patients with chronically critical illness, tracheostomy and prolonged mechanical ventilatory needs. Supervised fellows and NPs. Typical MICU census 8-10 patients with high complexity.
2017 - 2021	Critical Care, Pulmonary Consults, Outpatient clinic	Mount Auburn Hospital	Ninety percent effort devoted to provision of clinical services; 60% inpatient (MICU, SICU, pulmonary consults), 40% outpatient services. MICU patients with high complexity. Supervision of residents, medical students, with daily didactic sessions and simulations (code, line placement).
2021 - Present	Outpatient clinical practice, pulmonary	Massachusetts General Hospital	Thirty five percent effort devoted to provision of care in a variety of outpatient settings, both MGH Pulmonary Associates and MGH Chelsea community health center.
2021 - Present	Critical Care, Pulmonary Consults	Massachusetts General Hospital	Thirty five percent effort devoted to provision of critical care services in a variety of critical care settings (RACU, MICU, CCU) as well as inpatient pulmonary consult service. Typical RACU census is 8-10 patients with chronically critical illness, tracheostomy and prolonged mechanical ventilatory needs. Supervised fellows and NPs. Typical MICU census 8-10 patients with high complexity.

Clinical Innovations:

COPD Community Health Center Outreach (2014 - 2016)	Initiated a multidisciplinary community-based pulmonary clinic first at MGH Chelsea, then MGH Charlestown, as well as a system to identify high-risk COPD patients with prior hospitalizations.
COPD Quality Metrics (2016)	Subspecialist subject matter expert for the early development of Partners-wide quality metrics for COPD.
MGPO Pulmonary - Primary Care Collaborative Pilot (2016)	Identified a cohort of high-risk patients with COPD who did not have established contact with pulmonary subspecialist and piloted a virtual/electronic consultation to increase adherence to guideline-based therapies, appropriate screening.
ICU Huddle (2017)	Piloted a multidisciplinary daily huddle in the ICU to create situational awareness, improve adherence to SAT/SBT protocols, prepare for patient/family needs, and to build community. This huddle has endured and is the cornerstone of the day in the ICU.
MAH Phenobarbital Guideline (2019)	Developed and implemented phenobarbital guideline for alcohol withdrawal in the ICU, in collaboration with critical care pharmacist, and ICU RN leadership. Educated medical staff and housestaff. Ultimately, extended use to SDU to improve ICU capacity.
Watch List (2020)	Established a system for hospital-wide awareness of patients admitted to the medical service with COVID19. This facilitated proactive palliative care consultations when needed, early (and safer) ICU transfers, prevented intubations on the medical floor, and enhanced understanding of critical care capacity needs.
COVID Huddle (2020 – 2021)	Re-purposed our ICU huddle during the pandemic, to include 6 “Ps” – PUI status, PEEP, Proning, Paralysis, Palliative care needs, Plan (procedures, disposition).
Hyperglycemic Emergencies Guideline (2021)	Developed clinical guideline to improve care delivery for patients with hyperglycemic emergencies, in collaboration with critical care pharmacist, ICU RN leadership and medical resident, sharing work with ED and internal medicine residency, to improve initiation of therapy and ongoing management.

Report of Teaching and Education Innovations

Vice Chair for Faculty Development (10/2021 – Present)	As Vice Chair for Faculty Development in the pulmonary and critical care division, developed a many-pronged approach to faculty development, including clinical mentorship, communities of practice, promotions, awards. In this role, piloted variety of approaches to sharing clinical expertise across different division conferences, developed a team approach to promotions, with monthly meetings to review progress of each and every faculty member, identifying faculty at earliest moments of readiness for both clinical/hospital promotions and HMS promotions. Developed an onboarding program for new faculty in the division

and introduced similar programming to the Department of Medicine at MGH. Serve as ombudsman between faculty and leadership.

Report of Education of Patients and Service to the Community

☒No presentations below were sponsored by 3rd parties/outside entities.

☐Those presentations below sponsored by outside entities are so noted and the sponsor(s) is (are) identified.

Educational Material for Patients and the Lay Community:

Books, articles, and presentations in other media

2009	YAI Network (serving people with disabilities and their families)	Gave a presentation in Spanish to families, care providers and other medical professionals about medical issues particular to adults with Down syndrome.
2009	Massachusetts Down Syndrome Congress	Gave a presentation to parents of young children with Down syndrome entitled Health of Individuals with Down Syndrome Across the Lifespan
2012	Care New England	Facilitated a workshop for Care New England's Community Wellness Committee, as part of Advisory role for The Conversation Project, testing out new content and as part of goal to transform work environment into being "Conversation Ready" as part of IHI Conversation Ready Campaign.
2013	Senior Coalition Agenda of Rhode Island	Facilitated a workshop for seniors called Talking to Your Doctor About End of Life Care.

Report of Scholarship

* denotes equal authorship contribution

** denotes mentored trainee.

Peer-Reviewed Scholarship in print or other media:

Research Investigations

1. Temel JS, McCannon J, Greer JA, Jackson VA, Ostler P, Pirl WF, Lynch TJ, Billings JA. Aggressiveness of care in a prospective cohort of patients with advanced NSCLC. Cancer 2008 Aug 15; 113(4): 826-33.
2. Cohen MJ, McCannon JB, MD, Edgman-Levitan S, Kormos WA. Exploring Attitudes Towards Advance Care Directives in Two Diverse Settings. J Palliat Med 2010; 13(12): 1427-32.
3. McCannon J, O'Donnell WJ, Thompson BT, El-Jawahri A, Chang Y, Ananian L, Bajwa EK, Currier PF, Parikh M, Temel JS, Cooper Z, Soylemez Wiener R, Volandes A. Augmenting Communication and Decision Making in the ICU with a CPR Video Support Tool: A Temporal Intervention Study." J Palliat Med. 2012 Dec;15(12):1382-7
4. Lavigne J, Sharr C, Ozonoff A, Prock LA, Baumer N, Brasington C, Cannon S, Crissman B, Davidson E, Florez JC, Kishnani P, Lombardo A, Lyerly J, McCannon JB, McDonough ME, Schwartz A, Berrier KL, Sparks S, Stock-Guild K, Toler TL, Vellody K, Voelz L, Skotko BG. National down syndrome patient database: Insights from the development of a multi-center registry study. Am J Med Genet A. 2015 Nov;167A(11):2520-6.
5. Michaud GC, Channick CL, Law AC, McCannon JB, Antikowiak M, Garrison G, Savah D, Huynh RH, Brady AK, Adamson R, DuBrock H, Akuthota P, Marion C, Dela Cruz C, Town JA, Coruh B, Thomson CC. ATS Core Curriculum 2016, Part IV. Adult Pulmonary Medicine Core Curriculum. Ann Am Thorac Soc 2016 Jul; 13(7):1160-9.
6. Courtwright AM, Robinson EM, Feins K, Carr-Loveland J, Donahue V, Roy N, McCannon J. Ethics Committee Consultation and Extracorporeal Membrane Oxygenation. Ann Am Thorac Soc 2016 Sep;13(9):1553-8.
7. Fan E, Zakhary B, Amaral A, McCannon J, Girard TD, Morris PE, Truwit JD, Wilson KC, Thomson CC. Liberation from Mechanical Ventilation in Critically Ill Adults. An Official ATS/ACCP Clinical Practice Guideline. Ann Am Thorac Soc 2017 Mar; 14(3):441-443.
8. Mehter HM, McCannon JB, Clark JA, Wiener RS. Physician Approaches to Conflict with Families Surrounding End-of-Life Decision-making in the Intensive Care Unit. A Qualitative Study. Ann Am Thorac Soc 2018 Feb;15(2):241-249.
9. Crowley CP, Logiudice RE, Salciccioli JD, McCannon JB, Clardy PF. Initiation and Assessment of Timekeeping Roles During In-Hospital Cardiac Arrests to Track Rhythm Checks and Epinephrine Dosing. Critical Care Explor 2020 Jan 29; 2(1): e0069.
10. Moskowitz A, Huang DT, Hou PC, Gong J, Doshi PB, Grossestreuer AV, Andersen LW, Ngo L, Sherwin RL, Berg KM, Chase M, Cocchi MN, McCannon JB, Hershey M, Hilewitz A, Korotun M, Becker LB, Otero RM, Uduman J, Sen A, Donnino MW; ACTS Clinical Trial Investigators. Effect of Ascorbic Acid, Corticosteroids, and Thiamine on Organ Injury in Septic Shock: The ACTS Randomized Clinical Trial. JAMA. 2020 Aug 18;324(7):642-650.

Other peer-reviewed scholarship

1. Gunther-Murphy C, McCutcheon Adams K, **McCannon J**. Is Your Organization "Conversation Ready"? Healthcare Executive 2013; 28 (4): 62.

2. Reddy KP, **McCannon JB**, Venna N. Diaphragm paralysis in Lyme disease: late occurrence in the course of treatment and long-term recovery. Ann Am Thorac Soc. 2015 Apr;12(4):618-20.

3. Walker A, Rupal A, Jani C, Al Omari O, Singh H, Patel D, Perrino C, **McCannon J**. Longstanding Phenytoin Use as a Cause of Progressive Dyspnea. *Chest*. 2022 Feb;161(2):e91-e96. doi: 10.1016/j.chest.2021.08.079. PMID: 35131079.

4. **McCannon JB**, Shepard JO, Wong AK, Thomas MF, Helland TL. Case 35-2023: A 38-Year-Old Woman with Waxing and Waning Pulmonary Nodules. *N Engl J Med*. 2023 Nov 16;389(20):1902-1911. doi: 10.1056/NEJMcpc2300968. PMID: 37966289.

5. McIntyre AM, Scammell MK, Kinney PL, Khosla K, Benton L, Bongiovanni R, **McCannon J**, Milando CW. Portable Air Cleaner Usage and Particulate Matter Exposure Reduction in an Environmental Justice Community: A Pilot Study. *Environ Health Insights*. 2024 Jun 10;18:11786302241258587. doi: 10.1177/11786302241258587. PMID: 38863688; PMCID: PMC11165963.

Non-peer reviewed scholarship in print or other media:

Reviews, chapters, and editorials

1. McCannon J, Temel J. Comprehensive management of respiratory symptoms in patients with advanced lung cancer. J Support Oncol 2012; 10(1): 1-9.
2. McCannon J, B Kinane. Pulmonary Disorders. The Massachusetts General Hospital Guide to Medical Care of Autism Spectrum Disorder Patients Eds. E. Hazen, C. McDougle. Springer 2018.
3. McCannon J, Zeidman J. Pulmonary Disorders. Pocket Primary Care Notebook Series, second edition. Eds. M. Kiefer, C.Chong, Wolters Kluwer 2018.

Abstracts, Poster Presentations, and Exhibits Presented at Professional Meetings:

1. J. McCannon, E.C. Huang, M. Vivero, A.R. Letourneau, G. McMahon, H.G. Rennke, F. Marty, E. Robinson, M. Barshak, S. Sharma. Thriving on steroids: an unexpected case of disseminated strongyloidiasis. ATS Case Presentations, 2011.
2. J. McCannon, WJ O'Donnell, BT Thompson, A El-Jawahri, et al. Augmenting Communication and Decision Making in the ICU with a CPR Video Support Tool: A Temporal Intervention Study. ATS Poster Session, 2012
3. J. McCannon, P. Currier, R. Berube, L. Tran, H. Lee, W. O'Donnell. Readmissions of the Chronically Critically Ill: A retrospective study of "bounce-backs" and Readmissions to a post-ICU unit. ATS Poster Session, 2013