ORAL HISTORY INTERVIEW WITH JOYCE JIGGETTS
Duke University Libraries and Archives
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Researcher: Danielle Okotcha

COLLECTION SUMMARY

This collection features an oral history I conducted with Joyce Jiggetts on 02-23, 2024 for the Bass Connections Agents of Change oral history project. The 65-minute interview was conducted at Duke Medical Center Library. Our conversation explored the CMHRP program, her experiences as a LPN, and racial relations in healthcare. The themes of these interviews include community and women's health, racial discrimination, and healthcare.

This document contains the following:

The materials we are submitting also include the following separate files:

- Audio files of the interview*
  - Stereo .WAV file of the original interview audio
  - Mono .MP3 mixdown of the original interview audio for access purposes
- Photograph of the interviewee (credit:)
- Scan of a signed consent form

*At the end of the interview recording, we recorded a self-introduction and room tone for use in a production edit of the interview.

BIOGRAPHY

Joyce N. Jiggetts, RN, BSN, CMHRP, was born on June 6, 1964, in South Hill, Virginia. Her journey into healthcare began with a deep childhood love for science and caring for others. After gaining a Bachelor of Science in Nursing from Hampton University in 1987, Joyce embarked on a career dedicated to nursing, specifically in the reproductive care sector. In 1995, Joyce joined the Durham County Health Department, where she became a vocal advocate for maternal health. Her tenure at Durham County Health Department marked the beginning of her relentless pursuit of equitable healthcare for underserved populations. Later around 2017, she officially joined the Duke Health system as part of what would later become the Baby-Love/CMHRP (Care Management for High-Risk Pregnancies) program.

Joyce has made significant contributions to maternal health. An integral part of the CMHRP, Jiggetts actively contributes to a groundbreaking initiative that pairs high-risk pregnant women covered under Medicaid with pregnancy care managers. In this multifaceted role, she serves as a coach, counselor, and nurse, leveraging her skills to contribute to healthier outcomes for both mothers and babies. Through CMHRP, she provides holistic care that addresses the unique challenges faced by each patient. Her work with CMHRP goes beyond conventional medical care and provides patients with resources including diapers, strollers, clothes, and food for mother and baby, often through collaboration with community organizations. As Joyce says herself “Whatever they need, if we can't do it, we find somebody who does.”

Outside of the CMHRP program, she continues to be actively involved in reproductive health equity. Joyce serves as a founding member of the Black Maternal Health Equity Initiative, a program that pairs pregnant mothers with high-risk pregnancies with medical students, who can provide support and help explain complex medical conditions.

Overall, Jiggetts distinguishes herself through a commitment to patient-centered care. She prioritizes connecting patients to resources, advocating for their needs, and encouraging self-advocacy. Her comprehensive healthcare approach and active participation in various programs underscore a commitment to prioritize the overall well-being of patients, aiming to achieve optimal health outcomes.

INTERVIEW TOPIC LOG (Joyce_Jiggetts_finaledited.wav)

00:00 Introduction to career and background
1:33 Professional journey and background (briefly)
4:08 Brief story about
5:27 Details of her entry into her career and decision to become an registered nurse.
6:43 Discussion of challenges faced by mothers with low socioeconomic status
8:48 Details of Joyce Jiggetts experience as a Black woman and as a Black nurse.
11:52 Her journey into Duke Health
14:46 How and why she became part of the CMHRP/Baby-Love program. How the program works.
18:57 Details of how the program had aided families and/or mothers of low SES (including at the community level).
20:37 Joyce Jiggetts provides further details about aspects of the program.
23:39 Details of Joyce Jiggetts' average day working as a high-risk pregnancy manager.
26:24 A memorable story of significance in her career
28:20 Her process of interacting with patients
31:56 Her time working in a prison and a story of great signifance while working there.
39:21 Involvemenet in the Black Maternal Health Equity Initiative.
42:02 The positive impact of the program.
43:10 Briefly describing her time on a podcast.
44:39 Discussion around Black mental health and her own history with this.
49:14 Ms. Jiggetts tells a story and details her time at Lincoln Health Center.
53:33 How the CMHRP program has changed over time.
55:58 What makes the Duke CMHRP program unique.
57:25 Her personal experience with Black maternity and the healthcare system.
1:00:16 Suggestions she has to help alleviate some of the disparities seen in Black maternal health.
1:03:36 Brief discussion on if Joyce Jiggetts sees herself as an activist or agent of change.

TRANSCRIPTION (Joyce_Jiggetts_finaledited.wav)

JJ 0:00

My name is Joyce Jiggetts, I am a registered nurse. Been with Durham County Health Department for... Ooh 29 years. I've been in maternal health the whole time. Right now my present position is case management of high-risk pregnancies. Even though I work for the health department, I'm stationed, I'm embedded in the Duke high-risk OB clinic and I think I've been embedded there for maybe six or seven years.

Back in the day, when I first started, because I started with the health department in '95, the program was called Baby Love, which, I absolutely love that name, Baby Love. And then we had to change our names because the state took over. So now we're case management of high-pregnancies CMHRP.

DO 0:52

Hello, I'm so glad to be here. My name is Danielle Okotcha. Thank you, again for being here for the interview. Your insights are invaluable. And we're very excited to capture this oral history with you. Overall, the project, we're trying to identify agents of change in the history of Duke Health, and you've been identified as one of those. So yeah, let's get started. Today's date is February 24 2024. We're currently in the Trent Seman building for health education, to recall this oral history. So for the first question, could you tell me a bit about yourself, or provide a brief overview of your background, your professional journey and experiences that have brought you to your current point?

JJ 1:33

Okay. I started out, I graduated college '87 and like most of the people tell us, when you get out of nursing school you do med surg [medical-surgical nursing], so I did med-surg two years, and that helped me figure out what I didn't want to do. So I worked there, then I went to home health, loved home health, and then when I moved here in '95, I knew I wanted to be closer to home so I applied to the health department and I ended up in maternity. And I've been in maternity the whole time either as a staff nurse, as a supervisor, and then with the program that I am now. So the whole time I've been with the health department since '95 it's been with maternal health never left.

DO 2:20

Wow, that's very, that must be very interesting to be able to say and just like, staying in the same area. I mean, maybe seeing changes within that, I guess, broader area, as time has gone on.

JJ 2:32

Yeah, I've see a lot of changes. I think what I've liked the most is, since I've been there so long, I've seen like three generations go through and it's so cool. With my mom's back in '95, their kids are having kids now and they're like, you gotta go see Miss Joyce, she's gonna tell you how it is and she's not gonna let you get away. Don't let you miss an appointment, she gonna come and come sit and come to your house, which I will do. I call them drive-bys but they told me not to say drive-bys, I need to say pop-ins. Right, okay, whatever. But I think that that's the most important thing, is that rapport with the patients. But I have seen changes with the maternal health program itself when it comes to being more in tune to the mother's entire being, not just the pregnancy part, because that's just a little part of life. That's not your whole life. Because when you're pregnant, you have other things going on, that you have to deal with. So just to see that is awesome.

DO 3:43

Yeah, taking into account, like socioeconomic factors and all the things like that, and also, like, I think a lot of, I guess, present day talks about like your providers having cultural competence and kind of taking in those things.

JJ 4:00

Yes, I think that uh (if I talk too much, let me know).`

DO 4:04

Not possible (laughs).

JJ 4:08

When I first realized that the providers weren't quite where we were, was when we had a doctor, tell the patient "You need to go home and be on complete bed rest." And I'm like, that's what she needed you know, she was having premature labor pains. But, so I pulled them over to the side and I said, "Sir, this lady has five kids. Three toddlers (and she was a single mom) there's no way that she can go home and be on complete bed rest." And for complete bed rest you can only get up to shower and use the bathroom. And I said "She's not going to be able to do that." It's not because she doesn't want to, she absolutely cannot be on complete bed rest at home with five

kids and she's a single mom. And you can't make her feel guilty for not following your orders. And he was like, "What?" I was like, yeah, so we got to come up with something else. You know so even if you do want her to be on bed rest you can't make her feel guilty because she can't. Cuz she's gonna pick her kids that are there; do what she can for them first.

DO 5:17

100% and was this one of the stories like early in your career?

JJ 5:24

This is early. Yeah, this is early.

DO 5:27

And like, I guess continuing off of like early in your career, what made you want to go, I guess into the healthcare field? I know you're from Alabama, originally?

JJ 5:35

Well, Virginia. I'm originally from Virginia. And then I got married and moved to Alabama and then left and came here what was the question I forgot? (laughs)

DO 5:45

What made you want to go into the healthcare field specifically as an RN?

JJ 5:49

Um, wow. Well, actually, I wanted to be a veterinarian. Seeing how much time and schooling I was like nevermind, then I switched to nursing. But I've always been the one in the family -- if you get a cut, I'm gonna fix it, you know. And my parents kind of fostered that by giving me a microscope. And that was a big mistake, because I wanted to prick you and get blood and look at it, you know, stuff like that -- snatch hair out your head. But I was always a nurturer. And I had a friend of mine, we went to high school together. He had gone to Hampton University. I went with him one weekend to view the campus and I said, This is it. And they had a nursing program. And that was it. But I think just being a nurturer. And I figured nursing was a good way to do it and I chose correctly.

DO 6:43

And look where it's taken you now. So much has happened (laughs). And do you know of any other specific stories like the ones you mentioned, that highlight challenges faced by mothers of maybe low SES [socio-economic status] or Black maternal mothers, mothers of high-risk pregnancies and things like that?

JJ 7:02

I think the most issues that I have, is... [I'm] trying to be politically correct here.. providers not listening to the moms. If the mother will say something simple, like, you know, I'm having these headaches. And then the provider says, oh, just drink water instead of, okay. Are we stressing? Are you on blood pressure medication? Are you taking your blood pressure medications. You know, just not listening -- because a lot of times a mom is not able to really say exactly what's wrong, they might just say, I'm having headaches, or I feel funny, and they can't describe it. And understanding the providers have certain times and stuff that they have to do. But to delve just a little bit more into what the mom is saying, and to really ask more questions, to really, at least validate their feelings, validate what they're saying, I hear you and go from there, instead of you know, zipping over it and going into something else.

DO 8:11

Yeah, I think I think as a provider, that would definitely be something that would be significant to have. And also, it makes me think about like, I guess the concept of provider that kind of is an overarching is a term that applies to so many people. And just like, each individual's interaction with the patient, I guess, is important in that way.

JJ 8:34

Absolutely, because everybody wants to be heard. You may not understand everything, but at least I know that if you hear me, then that we can work we can work together.

DO 8:48

Yeah, and so as an African American woman, someone who has seen the inside of the healthcare system, have you encountered any specific systematic or just general personal biases? (Racism, prejudice, discrimination). Or, have you faced any specific opposition while you've had to deal with these kinds of things?

JJ 9:09

As a nurse or as just ab Black woman period?

DO 9:12

Well, both I guess. We can talk about both separately, whichever is comfortable.

JJ 9:19

Well, as a Black woman in the real world, yes. (I really gotta be politically correct). Okay, um, as a Black woman, yes, there are certain things that I could do, that my white counterparts, that they can do, that I can't [Aside, to a white individual in the room]. Um, for example, something simple like going into a store. You know, I gotta make sure my stuff is in my purse, I gotta keep my hands out my pocket. If I have on a hoodie, I gotta take it off, or I'm gonna be followed around the store. And then when you go, and then to do it toward medicine, most of the time I have on jeans and a T-shirt. So when I go into a doctor's office, they immediately think of stupid, just because I'm Black. I don't know what I'm talking about. And I'm kinda loud, and a little assertive. So immediately, I get labeled as an angry Black woman. And they don't want to listen to what I say, then I just get louder.

DO 10:26

And those are important things for that role [not being discriminatory].

JJ 10:31

Yeah, it, but you know, it's come.... it's come a long way. Because with me, when like, (I go back to talk about my mom, my mom was in the hospital) and the way I dress you know, they automatically think I don't know what I'm doing (blah blah) I never tell anybody what I do [that she is a registered nurse]... So when they were like, disrespect my mom, because she's older, you know, they don't listen to her, they "poopoo" her and they keep going, and I gotta rein you in... So, I'm an advocate for anybody that I love when it comes to medicine, because they don't get listened to. You know, I'm here to do that. But when I go in, I never tell them what I do until you say something or be disrespectful, and then I have to come out with, that's when all my medical jargon comes in. They ask me, what do you do, I work at the health department. Because I'm Black, they automatically assume I do the floors or something. And I'm gonna let you assume that every single time until you say something that's crazy, or you get disrespectful, then I have to come out.

DO 11:33

And it's interesting that you talk about that. I feel like that's an idea spoken about. That it's not necessarily your idea [job] to correct someone until it becomes an issue, your [job] to guide them towards the right assumption towards you.

JJ 11:45

Exactly, I'm gonna see how far you're gonna go. I'm gonna see how far are you gonna go..

DO 11:52

And also, I guess going back a little bit, just want to make sure to get a clear timeline. So you said you went to Hampton University, and then you went to move to Alabama? And then would you have specific dates or years of I guess, just Duke?

JJ 12:06

I was in Alabama. I graduated in '87. I started working in '88 in Alabama, and then I left there in '95. So yeah, I was like, maybe nine years in Alabama, and then I moved here, been here [North Carolina] for the entire time. So that's what 29 years?

DO 12:29

When you first came to Duke was it a position you applied for? Did someone specific reach out to you?

JJ 12:34

No, I chose the health department, I work for the health department, I'm just embedded in Duke. No, when I came to Alabama, when I came from Alabama here, I wanted to be close to Virginia, to where my mom was. And I was reading in Ebony Essence in Fortune 500?.. Where, North Carolina, specifically RDU, was good for education and for Black women to be according to employment, and I said that's where I want to go. I applied for the health department. I flew up for the day, did my interview, went back home the same day. You know, I called out sick, did my interview and came back and I was so sure I had the job, I went back home and started packing. So by the time they called me and said I officially had the job I gave my two-week notice because I was already packed, just prayed nobody came to my house to see the stuff was disappearing. So um, that's how I got here with maternal health. I think at the same time I applied because they didn't want me to keep coming back and forth. So I applied for every position that they had: OB, school health, jail health, and something else, and I chose maternal health. I'm glad I did.

DO 14:03

Is there a specific reason why you chose or did you always, was there was something more that you were leaning towards?

JJ 14:08

I didn't know a thing about babies nothing, which I told them, I'm a fast learner. But I had done home health before and I didn't want to do that. School Health that was like, what, nine months out of the year and the pay....So like, maternity is Monday through Friday, no weekends, no holidays. That's what drew me in. But then I fell in love with it. Because I did not like maternity in school. Now, I like public health and school, now look at me, maternal health and public health.

DO 14:43

Wow, that's funny.

JJ 14:45

Life has a sense of humor.

DO 14:46

It does. And also, I guess, going into the program or its preferred name, Baby Love to now CMHRP program... How did you specifically become part of this initiative? What led you specifically to becoming part of it? What motivated you to work with individuals in that demographic?

JJ 15:05

With the Baby Love program? I like the autonomy. In the clinic, you know, you're under somebody, they're watching you all the time. With this program, you get your case-load, you know what you're supposed to do with them, and you do it. It is up to you to do the job. If you make a mistake, and you did it, if you did an excellent job, it was you It wasn't like I was dependent on somebody else to get my job done. And I think most of us, it was the autonomy. Tell me what to do, I go do it, and I'm good. So that was the main part. And then when I started having such long, lasting rapport with my patients going on for years, even after, that just sucked me anymore. So I'm still there, I still have patients who will call patients, they've gone through

the program, and they will call them their friend or their sister who's pregnant. [They'll] say, you got to ask them for Miss Joyce, because she does this and she's gonna be on you, don't get mad if she show up at your house. So I think that's what really struck me. I came apart of people's families.

DO 16:12

Also was it kind of like primary care oriented? Were you able to see these people for a long time afterwards, after they've kind of given birth?

JJ 16:19

No, we only care for them for two months. We cared for them into after their six-week checkup, or eight weeks, whichever came first. But if they need extra help, we would refer them to other companies or other agencies to carry on after that. But we would make sure that they had that six months, six weeks appointment, and make sure that they had their birth control if they wanted it, and that their baby is in pediatric care and go from there. Then, we let them go. But we just don't drop them after they had the baby, which a lot of them are concerned about.

DO 16:54

That's really nice and additionally, so this program started after you kind of already integrated into the Duke Health System, where you asked specifically to join this program? Or was it something that you were interested in specifically that you kind of push yourself towards?

JJ 17:09

Our program started out as eight of us and it started out as all social workers. And I don't know whose bright idea was, but it was great. They wanted nurses, they wanted to try to see how nurses would do in the program. So they decided to do two nurses, and I got one of the spots, then I have another co-worker, she's over at Duke as well. And Duke specifically asked for nurses to be in the program embedded in Duke because that program now has gone from the social, psychosocial issues to the medical part. So having nurses there at the high-risk clinic is a lot because a lot of times we will see the patients more than the clinic people will because we've seen them throughout the whole thing, making home visits. So we can go, for example, if I go out to drop off some Pampers. And I'm looking at mom and her ankles are hanging over his shoes. And she's talking about I got a headache. I'm on the phone, I'm calling the triage nurse. And a lot of times if it wasn't for us, they would wait until that six-weeks appointment or they would end up in the emergency room. So that part is great. Kind of, we all work together to make uh, to get to the process.

DO 18:26

It's a very good structure, I guess to have nurses embedded because nurses what very hard as we all know,

JJ 18:31

I absolutely love that they wanted nurses, like that's me. And I absolutely love it. They treat us as family and a lot of people don't know that we are our health department employees. Because it's like home. They have events, like birthdays, and they include us so we forget we're the health department (laughs).

DO 18:57

And do you know any specific ways -- and I know it's kind of a difficult question because it sounds number-oriented, but not necessarily -- that the program has positively impacted people of low-income or informed them about maternal health? Could you just describe like the program in general, like what exactly you do for these girls?

JJ 19:19

The program initially started because of the infant mortality and maternal maternity death rates was so high. And due to their studies, they found that a lot of it was because of late entry into prenatal care. So they were trying to figure out a way now how do we do this? The state said we got to go ahead and we got to lower these rates. So they came up with this program of Baby Love which was specifically for Medicaid patients and low-income patients and they come into the system, we would meet up with the, we would do the basics, connect them to the community resource that they need.. Like a lot of them didn't have Medicaid and they were waiting to get Medicaid to start prenatal care -- which is not the case, you could start your prenatal care and then we could get you sign up for Medicare, and Medicaid will go back and pick up [schedule] your first appointment . So we had to get rid of that "He said, she said" stuff in the neighborhood. You know, apartment A talks to apartment B and C and then all this wrong information is out there. So once we started doing that, and then they started talking amongst themselves, it got way better.

So I think the main thing was getting them into the prenatal care and not waiting until they're 20 weeks and 30 weeks to come in. And we would make sure they got connected with WIC [North Carolina Women, Infants, and Children program] so they could eat more food for them, and food supplement. Then later on, the WIC department decided they're gonna add fresh fruits and

vegetables, because eating healthy is expensive. So they added that to help out and then once the baby's born, we got the formula for the babies. We have a wonderful community resource called "Welcome Baby" where they can go get discounted car seats, and pack and plays. And these are brand new stuff. This is not hand-me-downs. This is still in the plastic. So we make referrals for the Medicaid patients to do that. Because car seats are expensive. Oh my gosh, I saw one in Walmart the other day. I'm like, this is a Bently car, this car seat. And so that really helps. It reduces the stress. It helps the moms like you know, I'm like I can do this. And then "Welcome Baby" is still there for diapers, they have diapers up to like size five. So diapers, strollers, clothes, like some of our moms are going to work they don't have the clothes. We call "Welcome Baby", we have this mom, we can go pick up the clothes for them. So pretty much whatever they need, we try. We also have, for those who have food insecurities, Tasha picks up, I forgot the name of the church, they give us food every two weeks. We have a food pantry in our office and a food pantry at the health department. So we are able to help with that too. So pretty much whatever they need, if we can't do it, we find somebody who does.

DO 22:20

I see, and for the food pantry, is it just food or like formula or is it food for the mother as well?

JJ 22:24

It's food for the mothers as well. A lot of parent non-perishables (the cans, the pasta, the peanut butter, crackers, juice)... Now we do have some companies who will drop off, who would give us samples of Enfamil or Similac and we have that in the office as well. And then we also have the great doctors over there and employees, like when they have their babies, they donate their formula or donate their Pampers once the child gets out of the "ones." They give them all to us so it's a never-ending cycle.

DO 23:06

Wow, that's a very multifaceted approach. Like, you guys help with food, you guys have, even just doing house calls or going to their house directly, it's very personalized.

JJ 23:15

We do transportation, we don't do transportation, but we refer them to their Medicaid transportation, because that's a big deal with the patients too is transportation. So once you tell them about that, and nine times out of 10, they go ahead and sign up and make their appointments and it be no problem. So once we give them the tools, they do what they need to do.

DO 23:39

I see, and continuing off of that. Could you like speak to your current role as a registered nurse and pregnancy care manager for high-risk pregnancies? What does your day-to-day look like? Or specific, specific things you might do in the average day, like what you like to do what you don't like to do, whatever you would like.

JJ 23:57

Average, my average day starts the day before. I will look at my caseload and see who's coming in for the appointment the next day. And I have this little template that I fill out with the name, how pregnant they are, are they having a boy or girl, what we need to talk about. So when I get there, the next morning, I can hit the ground running. I come in and log in and then I will go and ask one of the employees to give me the schedule for the day, just in case I had a patient on my caseload that had a sick visit I didn't know about the night before. And I go over that. And when the patient comes in, I tried to sneak in either before the provider or after provider because I don't want to interrupt their timeline. And I will discuss with the patient what I need to discuss ask them if they have any questions... And if there's something that I saw right then and there I do it; if not, I just call them later. But when they come in, someone always lets me know that the patient is there and then I scurry around to the room or meet him in the lobby and we'll talk about what we need to talk about, and, and I will come back and do the documenting. That's the part I don't like is the charting. I can see and talk to the patient all day, then I gotta come back and chart. I don't like that part at all. But I know it's necessary and I do it. So I might have anywhere from one patient a day to eight patients a day. And even though I might not have but one patient, the providers will still call us and say this patient is homeless, this patient has domestic violence. So, it's not just our caseload. If patients come in who on Medicaid but not on our program, we can still help them. We don't carry them on our load unless it's something you know, really bad. [But] we will still see them and talk to them. We just don't, we don't turn them away. Just because they're not on our caseload.

DO 25:52

Yeah, that makes sense. So it's very, very high intake, or I guess, high effect, maybe I should say. And do you have any specific anecdotes, instances where you might have like, stepped up? I know, you talked earlier about like, kind of dealing with people having negative attitudes towards you. But do you remember any stories where you had to step up for someone besides the ones previously mentioned? Or where you had to contribute to more equitable health outcomes in a tangible way?

JJ 26:24

Um, I think the most fun story I had to deal with was we had a mom who came in, she was showing her breath. But she wouldn't, she didn't want to tell her provider because she was trying to get a letter, so she could go back to work. Literally, she couldn't walk five feet, and she was just breathing so hard. And so when I left out the room, I went straight to the provider and told her "She's having problems breathing. She's not gonna tell you." So when she went in, she said, "Okay, looks like you're breathing kind of funny..." (She didn't tell on me). "Really, really kind of funny; let's walk in the hallway. And we're gonna have the pulse ox on your finger, and we're gonna see how --" Anyway, the child's oxygen was low, sent her to the hospital and come to find out she had a pulmonary embolism. So I will snitch on you for your better health. And I tell my patient, I will snitch if it's medical, anything like that. Because if you're not okay, your baby's not gonna be okay. Of course, she fussed at me but now we still good friends. She got over it. Because this is not, it's not about you now, its about you and the baby. So yeah, I will, I will speak up when it comes to something that they're not wanting -- and not understand that she had to work. But if your dead, you know, your job is going to have your position posted before five o'clock.

DO 27:56

(Laughs). Yeah, and can you think of any other stories? I know that might be kind of difficult to think.

JJ 28:01

Let's see. Let's see. Let's see... Now, because we.. I guess it's kind of hard to think of stuff because, and I was told this before, the stuff that we do to us is so normal that we don't see it is going above and beyond.

DO 28:20

And maybe calling it stories is not the best thing. It's like real life for somebody and it's yeah, but I understand. And do you, I guess besides like, you know, having to be sneaky, do you use any other methods when encountering issues with patients, maybe with better [worse] odds with the healthcare system due to their race, minority status, socio-economic status, or other things?

JJ 28:50

My nickname at work for my patients is either mama or auntie, because I go in like your mom or auntie, I'm old enough to be your mom and your auntie. So like I always tell the med students

and nursing students, be yourself because your clients need the authentic you. Don't do a lot of verbiage, it's like this is what you should do or need to do. If you decide not to do it, let me inform you of what can and cannot or will or will not happen. So I'm pretty much upfront. And I use a lot of humor with my teaching. I don't go in and say [indistinct]... I don't do that. But I use humor, and when the patient comes in and they've missed three or four appointments I'm like what is your problem? I came to work looking for you. I didn't eat breakfast. I didn't have my coffee because you had an eight o'clock appointment. I was here for you and I do that little rambley thing. So they're like okay, she don't shut up. So I take on the mama role or the aunty role with them. So they take in what I say, but they know I'm serious, but I coded it in humor. So that really helps. Because some of them, you know, if you come off rough and straight-faced and stern, they've already tuned you out. And you could tell when a patient has tuned you out. So now I go in, and act up. You know, if they say, for example, they've been smoking 20 cigarettes a day, they dropped down to 10, I tried to do my best Running Man situation, because you know, I'm happy you gone from 20 to 10. And that's the big thing you know, and I just lay on the compliments, you know, stopping smoking is hard. You know, so for you to do that. and then you got to take care of your kids and your husband's over here saying, I want dinner cooked... And so that's awesome. So yeah, I cut up with that. Can't do the Running Man though, but I try. So a lot of it is humor. A lot of it is humor, the way I do stuff. Now, my coworker, Tasha, she's more politically correct than I am. She's like, therefore, what could you have...? [Interruption]. So I cover it in humor, but Tasha, she's very politically correct. She has other registers. And there's also a social worker there. So there's three of us there every day. Um, she's more politically correct. And, you know, she's more so than me. But my patients need me and her patients need her. Because I probably couldn't say some of the things I say to my patients in the same way to her patients. You know, my patients straight off the cuff. And I love it. I love it. I love it.

DO 31:36

Yeah 100%. And I think that definitely makes sense. I think a lot of times humor's something you have to be very careful with but I think if you use it, well, it could be actually very useful.

JJ 31:47

Mhm, exactly, exactly. Mhm, absolutely.

DO 31:52

Is there anything else you wanted to add to that?

JJ 31:55

Nope.

DO 31:56`

Okay, so if I remember correctly, you had some time working in the prison?

JJ 32:04

Oh, yeah. That was, ooh, wow. Yeah, that was a while ago, that was so different.

DO 32:11

Is there anything you want to talk about with that?

JJ 32:15

And it's so funny. You asked because I specifically remember we had a pregnant mom; they took her out of the prison. This is what in Raleigh; they took her out of the prison to have her baby. And literally within hours of deliverance, she was back. She got maybe an hour spent with her child. And she didn't have any family to take the baby. So the baby went into foster care. And it was just so sad all she came back with just pictures. And that's it. We had to do the massaging of the fundus. So they literally, she spit the baby out and they shipped her back to the prison. No time to bond with the baby, nothing. And that ripped my heart out just as bad as it ripped her heart out because she had no family who would take the baby. So that was it for her, until I guess the baby got to be 18 and looked her up. Because from what I understand the baby was put in foster care and then adopted so she never got a chance to.. because she was in there for a long time. I'm talking the female prison in Raleigh, it wasn't jail, this was prison so they were going to be in there for a while. So that is just I guess, the inhumane part. And at that time, they were still shackling them to the bed.

DO 33:51

During childbirth? Wow.

JJ 33:53

Where is she going? So now, I don't remember how many years but Amy came back and was so excited was telling us about the rules that changed, the laws that changed. Now they do not have to be shackled to the bed. And I'm like, it took a bill and a law to do that? But it was, that was

great. That was really great. You're already in pain, you're already scared to death. And your leg is handcuffed to the rail, or your arm is handcuffed to the rail. No. What if we don't want to labor on our back what if we want to be on all fours, we want to be on our side, roll around on the ball. So I think that's one of the greatest things, I think, is not being shackled to the bed during labor, because I know I was all over the place when I was in labor, so...

DO 34:46

That sounds like a very powerful story.

JJ 34:48

I can't imagine being shackled to the bed during labor.

DO 34:54

Especially because there's so many other risks and fears depending on your race or whatever that come with being in labor anyways.

JJ 35:01

Because I know when they come into the prison when they bring the ones from the jail over to the health department for.. and even at Duke for care, you know you already you automatically got on bright orange, you're shackled. It depends on what you did if you have one or two people with you, and they got guns, so as soon as you hit the door everybody's watching. So we would come up with ways to bring them through the back. And that's for safety as well. Because we don't know if Uncle Ray is there to break them out or not. You know, so we don't tell the inmates when they have their next appointment. Because of that, you know, Uncle Ray might be there waiting. But um, that when it comes to pregnancy in prisons is better. Not great, but it's better, so...

DO 35:48

And could you, I guess timeline-wise like, [say] when specifically you worked for the prison.,the name of the prison and how you kind of got there.

JJ 35:57

It was... Raleigh Correctional Center for Women. It's in Raleigh off of Rock Quarry Road? And it was a part-time job -- that was way back in probably 2000, 2001. So it was just something for

extra income when I first got here. And yeah, that was, I tell everybody: nursing in the prison is something that someone, should do everybody should do, for at least six months, because it's a whole new world.

DO 36:34

Can you describe like, I guess the average day?

JJ 36:36

Oh yeah, you go in no phones, no keys, no nothing. You go in, every door you go through is locked. The inmates are not allowed to get within so many feet of you. Like I have pins in my hair, you get written up for if q bobby pin falls out because it's a weapon. It can be used as a weapon. But inmates, you know, the thermometers used to have the plastic covering, when we took their temperature, we had to throw them away because they could sharpen them and use it as weapons. Or they could use it, cut the ends off and use it to snort the drugs that somebody brought in for them. Alcohol pads, we couldn't, they couldn't do their own alcohol, because they would suck the alcohol out of the alcohol bands... It was just so many rules that you had to remember so you wouldn't get written up. And I'm like every day I'm like, okay gotta make sure these suckers stay in because you don't want to get written up for a bobby pin. But it was just so much you had to remember you had to keep the needles in your pocket. You know, and that's one of the reasons they weren't allowed to get so close to us at one time. So, yeah, that was a lot of rules. I think I lasted six months.

DO 37:50

Wow. And did you teach a lot of maternal health patients?

JJ 37:55

In the prison? No, just that one. I just remember that one. And, um, and that was only when I was working in the hospital part because the prison had a clinic and the inpatient and I only saw her is inpatient because we had to cap the pads and did perineal care. So the maternity part, because I didn't do day shift, I did not see them. But there was plenty out there. They were pregnant. Well, I just got to meet that one who delivered on my night shift. Yeah, it's fun. It was quite interesting. Most of my patients in the prison were elderly and HIV.

DO 38:36

No, definitely not many people can say they've worked in a prison. Six months, a long time.

JJ 38:40

Yeah, six months was a long time. And it was very eye-opening. It was very eye-opening so that was great.

DO 38:47

So this, this was when you first came to this area? Was this before the Baby Love program? Or this was during?

JJ 38:54

I think it was during? I think it was during because I just did that like on every other weekend. Saturday and Sunday, or was it Friday and Saturday? Yep, mhm.

DO 39:06

So I wanted to allow you, if you wanted to describe any participation in organizations dedicated to the causes you believe in or anything that you personally are involved in. I know you've definitely talked about a few...

JJ 39:21

What, like the Black Maternal Health Equity Initiative? That awesome program where the med students get paired to pregnant moms, and they get to follow them and offer support and they also have resources themselves. And that's to help give the patients extra support, give them somebody to bounce ideas off of, and the students encourage them to advocate for themselves and to speak up for themselves. And then at the end of the pregnancy, they have a little gift bag and they form very good rapport as well. They come with them to their appointments and make sure that the patient understands everything the doctor says and that they're okay with it. So, that program is good. I think this is my second year working with them? Second or third of working with them. So that's the biggest one right there that we've got a chance to work with. And I see them on a regular basis, coming and going with the patients. And we check in with them to see if they need any resources or everything's okay. And if they have a question about the patient, they'll call us, they have our work and personal number. So, they'll call us if they don't know what to tell the patient. So it's not like we push them out there by themselves, they still have us to come back to good to ask questions, you know. So far, they've done quite well. There've not been any issues at all. So the patients love it.

DO 40:55

They do?

JJ 40:56

They do. They like, they think they're special! When they get assigned somebody else to watch over them and meet them at their appointment. It's like, they feel special... If they're too shy to speak up, they will ask them to bring it up or so, that really helps. Really helps.

DO 41:12

And you've been doing that for about the past two years?

JJ 41:15

Yeah, that yeah, that Black maternal health equity initiative's probably been about two years.

DO 41:21

And what specifically made you want to get involved in that program at the start?

JJ 41:27

Dr. Wheeler! So Ron Wheeler brought it up, she came to us one day, and she was talking about, I had this idea, because I want the med students to really understand what's going on in the families, not just to see what's there, but need to see what's in the background, and what makes them act like this, and what makes them make this choice. And, um, and it's working, really because, you know, the students are like, I never knew that. And, you know, they will say things differently, or word things differently or approach it another way. So that's great.

DO 42:02

And how specifically, do you think it's helped people? Do you think it helps them in general just feeling more comfortable, less stressed, more supported, or..

JJ 42:12

The patients or the provider?

DO 42:13

The patients.

JJ

The patients, are more um, they feel more supported. I think that's a big one, they feel more supported. They're not doing it by themselves, even if they're single moms, they have somebody, they have me, and a lot of times, I'm with them as well. And then the medical student is with them too. So they're seeing somebody like every other week. And they're usually talking to somebody every week. So they get a chance to not have any questions left unanswered because we're checking in so much, because we just call them like -- I haven't talked to you in a while. How's it going? Did you make your appointment? And why not? You know?

DO 42:50

I'm sure it feels to you, especially if it's, maybe patients that don't have a support system that feels like an even bigger, like another level to them.

JJ 43:01

Right, absolutely. Just to know somebody cares, somebody's listening. Big surprise yeah?

DO 43:10

And is there any other organization specifically you'd like to talk about? I know you had a podcast briefly (laughs).

JJ 43:19

Yeah, that was a friend of mine, who's very much into -- now I don't know all alphabets behind her name, but she's really big into mental health. And specifically, the mental health of Black women. And she asked me to do that podcast, (I thought it was dead and buried). And it was very good. The question that she asked, she gave a lot of scenarios and asked, you know, what would I do? And how would I have handled that? And I was like, this is needed. I mean It's just like, everything is coming around now to mental health and maternity it's all entwined. And now people are like, oh, this is great. This is connected to this and, and mental health, maternal health, pregnancy, stress is all coming in together now. And it's like, people are just realizing that. And we've been screaming this all along. But now, but as long as you hear now that you're hearing it

and understand and let's move on, and make these things, make these things better. So that's great.

DO 44:21

Yeah, it's definitely something and I feel like in the last couple years, it's very well talked about, but it's interesting to kind of see. It's like both, it's being talked about more. and also I still feel like for Black women, the fear is still there...

JJ 44:39

Especially when it comes to mental health. I know I have. And just being, um, self-disclosure, I have a lot of patients who come in who are dealing with depression and postpartum depression, and they're coming in and they're like, I don't know if I want to take that medicine and, my mama said and my big momma said.. You know, and I'm like, okay, I have depression. I'm on medication. (Tada), you know, I'm out here functioning. And if I didn't tell you, you wouldn't know. You know, then I tell them, you know, you got to take your medicine every day.. You know about the depression and falling into the pit when you're depressed. And every time you go deeper into that pit, it's harder to climb back out. So the medications will keep you above, not to do this dippy thing if you miss [indistinct] But when people know, when you share a part of yourself with them, they're like, well, if she can do it, I could do it too. And the providers are, when it comes to counseling, they are now opening up more and say yes, yeah, my husband went to counseling, you know, I need to go to counseling before I hit him with the frying pan. You know, they're like, oh, my gosh, the doctor goes to counseling, you know, and it's not, it's no longer a big deal. But we've come a long way. Because, you know, we were told, "go pray about it." What do you have to be depressed about, you got food on the table, a roof over your head, that's not helping. It just makes you internalize and they want to know why you acting up, or you gain 152 pounds because you eat bananas and bonbons all day. So it's getting better. We still have a lot to talk and, uh, you know, when it comes to mental health, I think the churches need to come to be a little bit more active in the mental health because I've heard you know, preachers talk about pray more, and, and pray that demon away. Okay, can we?.. That's fine and good. But can we add some counseling and maybe live drugs in there? To keep it level? Because we want these people to function in society! You know, because it's easier to be... (pause) it's easier to be not okay. It's hard work to keep yourself together. And sometimes you need help. So because when I was 16, 17, I didn't know what it was. I just knew I didn't want to do anything, I didn't want to eat, all I did was slee, I didn't want to eat. And only thing I heard was, what you got to be depressed about? Then I'm mad, then I keep it to myself. But as I got older, my mom finally understood and was very good at picking up when I was slipping. You know, she was like "What's wrong with you? What's going on?" So, that's great.

DO 47:24

I mean, I think this is probably definitely another thing that like, I guess being someone in this field for so long, you've seen so many changes over time. Both good and bad..

JJ 47:33

Good, bad, and everything, yep.

DO 47:36

And is there anything else specifically you talked about on the podcast? Or maybe you don't want to talk about that?

JJ 47:42

I'm trying to think about -- because all I remember is she had scenarios. And now she talked about menopause a lot. And so I don't get to talk about that at work a lot now, except for when I'm flashing. But um, it's just mostly with the menopause stuff. So and women, if you look at TV, they're more talking about menopause now. I have never seen so many commercials about hot flashes in my life than within the last six months. So that's being more --because from what I understand talking about menopause was [in the past] "a no, no," it was like, clutching my pearls type stuff. So now that's coming out. And, and that's great. And it should. This menopause stuff is no joke. No sir. This is real.

DO 48:32

And on like the issue with the topic, I mean, of like, Black maternal health. Is there anything else you want to add to that or anything? Any of your, I guess, opinions, you could say or things to add?

JJ 48:45

No, I think I pretty much hit it all that I'm just so glad that um, this subject as a topic is out in the open and that people are realizing that yeah, there is an issue here. And we have to do better. And encouraging the patients themselves to speak up for themselves. If, if Dr. A is not listening, then you tell Dr. B, and C until you're heard, until you're heard.

DO 49:14

And I guess we kind of touched on that. But are there any other deeper insights that you've come about or realized while working in your field over the years or any specific stories that come to mind with that?

JJ 49:32

Now I remember a story and Amy might have told you... I think it was Amy. When we were stationed at Lincoln Community Health Center-- that's where the maternity clinic was before it moved into that big beautiful building on Main Street --we had an African mom came in. And for some reason, Lincoln Community Health Center used to be a hospital for Blacks. And, People still come to Lincoln thinking it's the hospital when it's just a clinic. Well she came in, in labor, and they delivered the baby in the room. But what was so great, Amy was saying, was the grandmother was there and she started singing some ritualistic song. And Amy was saying how it just calmed the room down and everything flowed. There was no screaming, no yelling, everything was just because Big Mama was there. And she's sang the entire time. I was like, and I missed it!? I was out seeing somebody else. And I missed it! But Amy was talking about how wonderful it was. Everybody was just great. So I think that's the best experience when it comes to maternity -- how pregnancy is a family thing. It's not just the mom, it's the father, the baby, the kids, grandma, grandpa, the whole village. Because like I said, it does take a village to raise a child. So I missed that. That was absolutely awesome. But the way you would hear her talk about it is like, wow, that was awesome.

DO 51:17

And I guess, yeah, your time at Lincoln Health centers.. Anything you'd want to add with that? Or any stories? Lke how maybe your schedule was different then or..?

JJ 51:27

When I was at Lincoln, um, the majority of the time at Lincoln, I was a staff nurse. And it was just busy. And being at Lincoln was like being at family too, because I liked being at Lincoln, at the time because it was one-stop shopping, meaning you had the OB clinic there, you had to wait next door, you had pediatrics over here, you had the lab over here, you had the dentists over here, so you just come to link and get everybody hooked up. So that part was really good about Lincoln. And now that we have the health department, they do now have.. WIC is there as well. And Dental is there. So that's really helped. But yeah, at the time, Lincoln was a one-stop shop. And that was great.

DO 52:18

And also, I guess, throughout, could you describe overall how your role has changed through, I guess, pre to [before] the Duke Health System? Because I know you've been in like several spaces, including like Lincoln Health Center. Are there any like differences you've seen or any insights you have to give in that way?

JJ 52:38

Any differences? No, I don't see any differences. What I do like about going from Lincoln to the health department is everything is still locally centered so that everything's on a bus route. And that's going back to transportation. That nothing is put like way out on 55 or 501, or, um North Durham, everything is downtown where transportation is easier. And the buses are still free. So I think that's one of the best things that I can remember. But it was still business as usual, from Lincoln, to the Health Department. Yeah.

DO 53:33

And going back to the Baby Love program. How has that changed over time? I guess besides the name change, like going to more of like a state-level.

JJ 53:45

Okay. That has changed a lot. When Baby Love was in effect any and everybody could be a patient of ours, as long as they're on Medicaid. So long as you're on Medicaid, come on in, we got you. Now, the independent insurance companies, Healthy Blue, Carolina ACCESS, United Health... I'm missing two, there's two more.. They will send us a list of who they want on the caseload. So we just can't pick you up just because you're Medicaid. Now the insurance companies are saying: I want Theresa to be on your program. I want such and such and we have to pick them up, which is, no big deal. So I think that's the biggest change. We no longer just pick you up just because you have Medicaid. They have to tell us who they want. But another way we can get referrals is the providers can say: Jackie's having issues with the Father of the baby hitting her. And so that's one of the reasons that we can pick them up because it'd be considered a provider request. So we can pick them up then as well. And it kind of almost evens out. Because usually at some point in time, during the pregnancy, they become what we call a priority. And the insurance company says, oh, yeah, by the way, pick her up, too. So by the time we have picked up on issues, then, the insurance company can pick up on it after we've already picked her up, because we saw something that they didn't in the beginning. So that's the biggest thing. It went from nobody being excluded to now the insurance companies tell us who they want to be on the program.

DO 55:47

And so specifically, just like to clarify, the program started as a Duke-run program, and then... [Joyce shakes her head] It didn't start as runned..? You just had like a Duke specific...`

JJ 55:58

Yeah. We have several clinics throughout Durham. And three of us are at Duke. We have one who covers Harrison Smith, UNC, Weaver Street, Panther Creek... So we're all over the place. But Duke specifically asked for us to be embedded. Duke is the only one who has their own embedded pregnancy care managers. The others are stationed at the health department. That's their base, and they run in, you know, back and forth to different clinics, but we're there. Now one of the other nurses, she does have Duke Family Medicine, which is down the street, from where we are. So yeah, Duke specifically said we want the nurses here. It seems like the mothers are more high-risk and having more issues, when it comes to medical, medical stuff. They're having more complications, you know, diabetes, hypertension, mental health, there's a lot going on.

DO 57:02

And then, um, feel free to skip this question. But as a Black woman who has you know, I guess been in that position, is there any specific personal story you'd like to talk about with the issue of like pregnancy or maternal health, Black maternal health?

JJ 57:21

One more time.

DO 57:25

Sorry, yes. As a Black woman, and I believe you have children... one child. Is there any specific personal stuff you would like to talk about in that respect about your process?

JJ 57:38

My process and pregnancy was different because I, my OB doctor was a Black female. My father-in-law was Black surgeon. So it was all-inclusive, (power to the people). So it wasn't-- what I see here was not what I saw in Alabama when it came to my maternity part. And it was it was great. It was it was beautiful. I couldn't ask for a better pregnancy. She was there, she told me like it was, she listened. And then when I got into hospital, she was there from the time I got there till I left. It was it was a great experience. I can't -- there was absolutely nothing about my

pregnancy I would change. And normally when you go through labor and delivery you always remember your OB nurse, that's your labor delivery nurse. Her name was Kathy and I never forget Kathy Doris too... And I remember Kathy um, she was wonderful. even went to the point where, at the time, I didn't know it was called transition when I was getting ready to push. And I labored totally naked. Nothing. My mother was mortified. And I mean, my mother was a Southern Belle, you know, you don't talk about periods and menopause and you don't poop, you know? All that stuff. Um, I stood up in the middle of the bed, I took off the bands. I said, I'm going home. I let y'all know what I had when I get home. Kathy said "Joyce if you lay down I'm going to check you one more time. If you're not ready to push if you're not 10 centimeters, I'm gonna let you go home." Okay, I believed the girl. I just laid down, she looked, she put her hand up there and said push. She knew how to handle me because I was leaving. Because the pain was -- I didn't know enough. But I think if I had to have a baby now I wouldn't because I know too much. I know too much. I know too much... But my pregnancy was great. I would have done it three, four more times if I could have, but, it was wonderful.

DO 1:00:16

And based on your experience, like, do you have anything specific you feel would, I guess not necessarily help other Black mothers have youe exact experience, but just have a better experience? Do you think it's something similar with just having more Black health professionals there or..?

JJ 1:00:32

There are definitely Black providers, Doulas. Because it seems like we will be more comfortable if we see somebody who looks like us. You always hope that they understand. and they know how to talk to you, they know how to give you the respect that you want, or that you need. That definitely helps.

DO 1:01:04

And are there any specific ideas you have within the Duke or just the broader Southern -- I don't know, Northeastern, Southeastern system of health that you think should be implemented specifically? Whether that is like maternal health or other areas?

JJ 1:01:36

Anything new?... (pause). Not that I could think of at the moment, because we're doing more to listen to the patient, we're adding extra support, connecting them with community resources, follow-up phone calls. We're involving the family because like I said, Mom is not the only one

pregnant, everybody's involved. At the moment, I think that we;re going down that path and picking up all the options and actions that we need to do.

DO 1:02:18

Do you think -- would you wish that like a similar program as to the one that you're in (CMHRP) is like more broadly implemented? Do you think that would be helpful?

JJ 1:02:27

Right now, North Carolina, they have CMHRP workers in all counties. The only difference is Durham County has way more resources, than in all the other counties. You know, like, Person County, does not have a lot of resources. And the way the ones way out in the country don't have a lot of resources that we do here... Durham is very lucky, very blessed to have so much resources here for our moms so much support for their moms. But yeah, we're all over North Carolina. But not everybody is embedded like we are. And that makes it easier to stay in contact with patients.

DO 1:03:26

And so in closing, is there anything else you want to talk more on specifically that we touched on?

JJ 1:03:34

[Pauses]. No.

DO 1:03:36

Well, lastly, I guess an important question is, Would you call yourself an activist or an agent of change?

JJ 1:03:46

I think so. Only because I'm very big on getting my patients to advocate for themselves, to speak up for themselves. And if they don't, I will deal with the fallout later. Because, you know, sometimes they don't want us to tell on them. But when it comes to your health, or being unwell I'm telling. So yeah, I think so. The patients look forward to seeing me when they come to the clinic. And that's what I want. I want them to expect me to be there. When they come to the clinic, I'm there too. And I stalk outside their rooms until I can slip in. If it's just to say hi, how

you doing anything changed since I saw you last week. And who is this, you know, just make them laugh make them smile. I'm big on giving hugs and stuff you know, I will grab you in a minute you know. And usually... and I always do that because a lot of times that's the only hug or friendly word that they get all day. Because they only get it from Miss Joyce.

DO 1:04:55

Definitely, a patient advocate and agent of change and activist, all of the above at least I would say (laughs).

JJ 1:05:01

(Laughs). Auntie, yes.

DO 1:05:05

Thank you so much for your time. These were very amazing stories and everything to hear; I really appreciate it

JJ 1:05:13

Thank you, I appreciate it.