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Article

An exploratory study on client service experience for health protection of medicaid case managers in Korea

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Abstract: The purpose of this study is to explore the client service experience of medicaid case managers in Korea and prepare health protection measures. The research method was in-depth interviews, and data was collected twice in total from 04 September to 06 September, 2023. The study participants were five medicaid care managers belonging to cities, counties, and districts across the country. As a result of this study, participants experienced problem behaviors such as unreasonable demands, verbal abuse and assault, a threatening environment, a passive attitude toward expressing emotions, and a defensive attitude when performing work. In addition, the participants appeared to be unaware of the organization's management policy, the absence of a healing program for health disorders, and the follow-up management system to resolve client problem behavior. In conclusion, the organization must establish a safety and health management policy, establish a grievance handling committee, conduct safety and health education, investigate job stress and prepare countermeasures, prepare follow-up measures to protect health, and prepare a job stress relief program.

Keywords: medicaid case managers; client; service experience; health; protection

1. Introduction

Korea's social security system consists of social insurance, public assistance, and social services. Among these, public assistance is when the government provides necessary protection to those who are unable to maintain their livelihood or have difficulty making a living and guarantees their minimum standard of living. Public assistance consists of income security and medical security. The medical security system is called Medicaid, and people with no or low income receive medical benefits, and these people are called medical benefit recipients(Health Insurance Review and Assessment Service, 2024). A person who works to ensure medical coverage for beneficiaries of medical benefits in the Medicaid system is called a Medicaid case manager(Ministry of Health and Welfare, 2023). The qualifications for a medicaid case manager are medical personnel under medical law and a person with at least 2 years of work experience at a medical institution prescribed by the Act (Medical Law, 2023).

The main tasks of medicaid case managers are education and counseling for clients to improve their health management abilities, guidance on the medical benefit system, consultation on the use of medical institutions, monitoring of recipients' compliance with doctors' medical and health guidance, and pharmacists' medication guidance; Guidance on treatment methods and linkage between recipients, insurance facilities, and health and welfare resources are provided (Medicaid Act, 2023). As of

2021, the total number of medicaid case managers deployed in Korea is 618 in cities, county, and district offices in 228 autonomous districts, and this number is increasing every year (Ministry of Health and Welfare, 2020). Those eligible to receive medicaid care is those who do not have the ability to maintain a living or have difficulty making a living, and their qualifications are determined by the Medicaid Act (2023).

Medicaid care managers provide client service for medicaid care recipients. In the process of working with clients, expressing emotions such as tone of voice, facial expressions, and gestures is a part of the job, and requires business and organizational reasons to control one's emotions and express specific emotions that are different from what one feels. It is required, and this is called 'emotional labor' (Hochschild, 1983).

Due to this emotional labor, workers complained of mental symptoms such as depression and insomnia, and physical symptoms including digestive disorders and musculoskeletal symptoms. In particular, the incidence of work-related diseases such as cardiovascular disease and back pain was high (Lee et al., 2015). In particular, it is suggested that workers who directly visit homes to provide services to clients should be provided with a manual for responding to malicious and violent complaints, the right to stop work, psychological counseling, and legal support, and that there is an urgent need to disseminate emotional labor standard manuals for each industry (Kong et al., 2022).

The U.S. Occupational Safety and Health Administration (OSHA) stipulated in Article 5 (a) (1) of the Occupational Safety and Health Act of 1970(OSHA, 2023).

It is stated that "employers must provide employees with employment and places of employment that are free from known hazards that cause or are likely to cause death or serious physical harm." Accordingly, organizations have a legal obligation to provide workers with a workplace that is recognized as hazardous and free from conditions or activities that pose a risk. In Korea, the Occupational Safety and Health Act was implemented in October 2018, which requires employers to take action to prevent health problems in client service workers from verbal abuse by clients (Occupational Safety and Health Act, 2023). In addition, in accordance with Article 37 (Standards for Recognition of Occupational Accidents) of the Industrial Accident Compensation Insurance Act, diseases caused by mental stress at work due to workplace harassment, verbal abuse by clients, etc. in accordance with Article 76-2 of the Labor Standards Act are considered occupational diseases (Industrial Accident Compensation Insurance Act, 2023). Since then, research has been conducted to protect the health of client service workers in various occupational fields. Therefore, when medicaid care managers provide necessary services to clients, there is a need to conduct in-depth research on the problematic behavior experiences of clients experienced by workers.

This study attempted to explore client problem behaviors experienced by medicaid care managers during the client service process and identify necessary measures when problem behaviors occur. Based on the research, this study was conducted to respond more quickly to health problems that may arise in the workplace in the future and to prepare measures to protect workers' health due to emotional labor.

The specific research purpose is as follows.

- First, subjects explore their experiences of problem behavior from clients.

- Second, we explore the experiences of subjects receiving health disorder prevention and education from institutions.
- Third, explore the status and systems within the organization to resolve
- client problem behavior.
- Fourth, explore the systems necessary to manage client problem behavior

2. Research methods

2.1. Data collection methods

This study is a qualitative research that conducts in-depth interviews to explore the experiences of clients problem behaviors faced by medicaid case managers and to seek follow-up measures to address these issues. Phenomenological qualitative research is a qualitative research method aimed at revealing the essential meaning structures of human experiences (Choi, 2024; Jung and Kim, 2014; Van Manen, 1990). It focuses on how individuals interpret the meanings of their experiences (Han, 2011) and has the advantage of allowing for the interpretation and reconstruction of data with an emphasis on vocabulary or observation (Lee, 2014).

Participants for the in-depth interviews for data collection (medicaid case managers) were recommended through associations and related organizations, and a voluntary convenience sampling method was used to establish the selection criteria for research participants. The reason for setting these selection criteria was to gather more in-depth and comprehensive data regarding the nature of work, the current status of the system, the circumstances of problem-causing clients, and health issues. The selection criteria were: first, participants must have at least 10 years of work experience as medicaid case managers, and second, a diverse distribution of selected participants based on their work regions was ensured. Among those who expressed their willingness to participate and met the selection criteria, a total of five individuals who completed written consent were selected.

Interviews are widely conducted using small focus groups consisting of 4–6 people, as smaller group sizes make it easier for participants to attend and feel more comfortable (Krueger and Casey, 2009). Additionally, the researcher can obtain high-quality information through in-depth interviews, allowing for comparative analysis. Based on this, this study selected a total of 5 participants for the interviews and classified them into 2 groups for the interview process.

Before starting the in-depth interviews, the research participants were clearly informed about the background, purpose of the study and compensated with a small honorarium, as well as the interview methods. Additionally, to help participants relax and encourage more honest and in-depth conversations, a Warming Up and Ice Breaking activity was conducted, as shown in **Table 1**. Additionally, participants were informed that all responses during the interview process would be recorded, and that all data would be anonymized. Following this, consent for the interview was obtained in compliance with research ethics, which included information about participants' personal data and confidentiality, before beginning the recording.

The interviews were conducted using the Zoom video conferencing system from 04 September to 06 September 2023, over a total of two sessions, each lasting

approximately 1 h and 30 min. Two researchers participated as moderators, ensuring that participants could freely and honestly share their experiences in response to the interview questions. Finally, after the in-depth interviews were completed, a small honorarium of 100,000 won (KRW) was given to each research participant.

Table 1. Process of Warming Up and Ice Breaking before in-depth interviews.

1. Explanation of the purpose and topic of the in-depth interviews
2. Introduction of the moderator (researcher)
3. Explanation of the interview process and response guidelines ・ Duration: Within 1 to 2 h ・ Encourage participants to express their opinions and thoughts comfortably ・ Clarify that there is no need to feel burdened when sharing their opinions ・ Request honest sharing of opinions, as there are no right or wrong answers ・ Ensure that everyone has the opportunity to share their views and listen to others' opinions ・ Explain that the moderator (researcher) may intervene if the discussion strays off-topic or becomes unstructured ・ Request confidentiality regarding the information and content obtained during the session
4. Introduction of participants ・ Place of residence and work area (e.g., Incheon, Jeonbuk, Daegu, etc.) ・ Age group (e.g., 20s, 30s, 40s, etc.) ・ Length of experience in the field ・ Simple introduction of their profession (their work) and a description of the services they provide to clients

2.2. Characteristics of interview participants

The five medicaid case managers who participated in the in-depth interviews were all women due to the nature of their work. The characteristics of the interview participants are summarized in **Table 2** below. Among them, one participant was in her 40s and four were in their 50s, with relevant work experience ranging from 10 to 19 years, indicating a long career in the field. All participants held nursing licenses and had prior clinical experience as nurses before transitioning to their current roles as medicaid case managers.

The participants worked in various regions, including Incheon, Jeonbuk, Daegu, and Gyeongnam, reflecting a diverse distribution between metropolitan and non-metropolitan areas. Their typical workday started at 9 AM and ended at 6 PM, although overtime was common. All participants were employed in public service positions affiliated with their local city, county, or district offices.

Table 2. Characteristics of interview participants.

Participants	Sex	Age	Relevant experience	Work location
A	Female	50s	15y	Jeonbuk
B	Female	50s	12y	Incheon
C	Female	40s	10y	Daegu
D	Female	50s	18y	Gyeongnam
E	Female	50s	19y	Jeonbuk

2.3. Interview survey content

The content of the survey conducted through interviews is summarized in **Table 3**. First, it covered the problem behavior experiences encountered by medicaid case

managers when interacting with clients; second, it explored their experiences receiving training and education on health hazard prevention from their affiliated organizations; third, it assessed the current status and systems in place for addressing clients' problem behaviors; fourth, it gathered opinions on the necessary systems for managing clients' problem behaviors; and fifth, it identified follow-up measures needed to resolve these behaviors.

Table 3. Structure of the questions.

Main and Sub questions
1. Have you experienced any conflicts when visiting clients as a medicaid case manager? 1-1. What were the causes and reasons for the conflicts that arose?
2. Please share an example of a conflict you experienced and how you felt at that time.
3. Did you express your feelings during the conflict? 3-1. If you did not express your feelings, what was the reason?
4. During your tenure, have you received any training on health hazard prevention (such as violence prevention and management, mental health promotion)? 4-1. If you have received training, what topics did it cover?
5. Does your organization have any healing programs or support systems for counseling related to health hazards? 5-1. If so, what programs and systems are in place, and have you utilized them?
6. Is there a management policy in place within your organization to protect the health of medicaid case managers (yourself) in the event of clients' problem behaviors?
7. Is there a department within the organization responsible for managing clients' problem behaviors? 7-1. If so, which department manages this and how?
8. Based on your experience, what systems do you believe are necessary within your organization for managing clients' problem behaviors?
9. In your opinion, what essential elements should be included in a health protection manual for medicaid case managers regarding preventive measures for worker health, such as "management policy," "grievance committee," and "declaration of rights"?
10. What content and methods do you think would be effective for campaigns and promotions aimed at preventing and managing clients' problem behaviors, such as posting related phrases, audio guidance, or attaching stickers (e.g., Ministry of Employment and Labor prevention stickers for verbal and physical abuse)?
11. If a medicaid case manager experiences verbal abuse or violence from a client, how should break times for health hazard prevention be determined, and what actions do you think the organization should take?
12. Regarding the response procedures for clients' verbal abuse or violence, what do you think is the most appropriate measure to protect medicaid case managers?
13. If it becomes necessary to file a complaint regarding clients' problem behaviors, what systems and support do you believe should be in place?

2.4. Data analysis

For data analysis, the recordings collected from the in-depth interviews were transcribed into written form, and participants were anonymized. After identifying the meaningful content, a constant comparison method was used to classify and categorize the concepts, assigning names to each category. To achieve this, two researchers thoroughly read the content multiple times. The flow of the topics discussed in the interviews is illustrated in the diagram below (**Figure 1**).

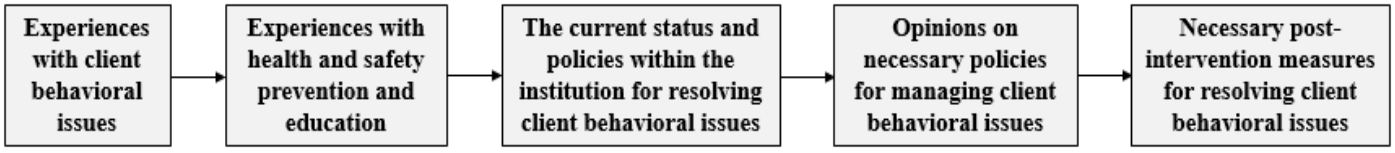

Figure 1. Flow of in-depth interview topics.

This study applied a phenomenological analysis method to illuminate the experiences and meanings of research participants within qualitative research. Specifically, to focus on understanding the meanings of participants' lived experiences, the four-step procedure of Giorgi's phenomenological analysis (Giorgi, 1985; Giorgi, 1997) was followed. First, the transcribed content was repeatedly read with the overall context in mind. Second, the content was divided into meaning units. Third, these units were transformed into the most appropriate academic expressions. Finally, the transformed meanings were integrated into a psychological structure, described in both situational and general terms.

3. Results

The analysis of the data collected through the interviews revealed the core components and opinions experienced by participants for each of the final themes, as shown in **Table 4**. The subcomponents included in the core components consist of the resulting factors and meanings associated with those components.

Table 4. Subcomponents included in the core components.

Theme/Category	Sub categories	Semantic unit
1. Occurrence of client behavioral issues	Demanding excessive work	Excessive work demands Demands unrelated to work Unreasonable assertions
	Verbal abuse and physical assault	Profanity, Threats Verbal violence, Violent behavior
	Threatening environment	Physical injury caused by pets
	Passive attitude toward emotional expression	Endurance of unreasonable insults Unnecessary apologies Wounded self-esteem
	Defensive posture during work performance	Defensive posture, personal counseling records
2. Received health and safety prevention education from the institution	Health hazard prevention education	Training on the prevention of the four types of violence (sexual harassment, sexual violence, prostitution, domestic violence) Job-related safety training Distribution of safety-related guidelines and manuals Pprogram-based daily video training (verbal abuse and physical assault)
	Health hazard support system	Health hazard healing programs Mindfulness programs Exclusion from healing program participants
	Absence of a support system for counseling	Discussion with superiors
3. Current status and policies within the institution for resolving client behavioral issues	System for managing clients' problem behaviors	Use of emergency contact devices (smart watches) Phone voice guidance Organizational indifference and avoidance Absence of practical management and protective measures
	Absence of a department for managing clients' problem behaviors	Utilization of the audit team Need for self-initiated actions
	Uncertainty regarding the presence or absence of a management policy for health protection	Uncertainty regarding the operation of the grievance committee Uncertainty about the presence of a declaration of rights Absence of a management policy for health protection Uncertainty regarding the presence or absence of a management policy for health protection

Table 4. (*Continued*).

Theme/Category	Sub categories	Semantic unit
4. Expectations regarding policies for managing client behavioral issues	Strengthening safety regulations and guidelines for visit activities	Mandatory regulation for visiting in pairs Permission for recording and provision of necessary supplies Issuance of dedicated work phones for visits
	Need for management of clients' problem behaviors and a dedicated department	Need for a dedicated department to address problem behaviors, need for a coordinated response system
	Need for a health protection manual	Management policy for health protection Operation of a grievance committee Declaration of rights Enhanced participation in health hazard healing programs
	Need for campaigns and promotions	Phone voice guidance (scripts) Promotion for the prevention of clients' problem behaviors Prior notifications regarding consideration for others using social media
5. Necessary post-intervention measures for resolving client behavioral issues	Need for follow-up measures to resolve issues	Need for rest facilities and spaces Separation measures for specific clients Provision of appropriate break times as a health protection measure Sending warning messages to clients exhibiting problem behaviors
	Need for a system that allows for legal action	Support for legal consultations for legal actions A system that allows for legal action, Support for attorney appointment costs

3.1. Occurrence of client behavioral issues

3.1.1. Demanding excessive work

The research participants reported experiencing demands from clients that extended beyond their professional responsibilities, including clients' unreasonable assertions and the challenges associated with addressing these issues. Despite receiving ongoing support from the local governments where the clients reside, situations arose where clients made excessive financial demands. When these issues remained unresolved from the clients' perspectives, the research participants expressed psychological distress, fearing the repetition of such situations, and indicated a reluctance to visit those clients.

> *"My work doesn't cover this, and I don't have the authority to handle it. It's not within my scope to exercise discretion, yet they demand it excessively. I really don't want to revisit because of that. There are tasks related to medical benefits, but clients seem to think that everything related to medical issues is something we handle, which adds to the difficulty."* (Participant A)
>
> *"They complain that they do not have money to buy osteoporosis medicine or health foods through home shopping. Additionally, they ask for assistance, saying they cannot afford to go to the hospital. However, they were already receiving significant health coverage benefits. As in other regions, we cannot provide assistance with non-covered services or out-of-pocket costs."* (Participant B)

3.1.2. Verbal abuse and physical assault

When complaints arise, participants have experienced verbal abuse, threats, and instances of verbal violence from clients, and in severe cases, even violent behavior. Specifically, when unfavorable situations occur for visiting clients, such as limitations on benefits, medicaid case managers have reported hearing verbal abuse. Additionally,

there have been cases where clients, although not actually suicidal, have made threatening remarks to medicaid case managers, stating they would commit suicide if their benefit support was not increased.

> *"There were instances of swearing... Even if they weren't actually hitting me, there were actions like throwing books, which made me quite scared to go to that house."* (Participant A)
>
> *"The last thing they say is, 'I have no money, nothing to do, I might as well die.' They say they will commit suicide... When I asked what they spent the money on, they mentioned buying 1 million won worth of medication from home shopping and giving money for local events, which depleted their already limited living expenses."* (Participant B)
>
> *"We must investigate our customers' benefit restrictions and determine whether they are actually eligible for medical benefits. Then, after researching, customers say they don't want to pay Avoids investigation. As a result, we end up experiencing verbal abuse from customers.* (Participant E)

3.1.3. Threatening environment

Among the participants, there were medicaid case managers who experienced physical injuries due to pets while visiting homes. Most of the time, they visited without any prior information about this, and in rural areas, pets are often left loose, which could understandably catch the participants off guard.

> *"While I was visiting, a dog ran out of the house, and I was so startled that I turned around without thinking. However, there was a ditch about 2 meters deep right behind me. I've fallen in before."* (Participant D)

3.1.4. Passive attitude toward emotional expression

When the issue of clients' problem behaviors was brought up to the public officials in the responsible department, the officials prioritized resolving the complaints themselves. As a result, the audit office did not address the clients' problem behaviors from the perspective of the medicaid case managers. Consequently, when complaints arose from clients, participants had no choice but to adopt a passive attitude toward expressing their emotions. Due to the lack of active resolution from both clients and their affiliated organizations regarding these issues, medicaid case managers found themselves needing to endure unreasonable insults. Moreover, even when the issues arose from clients' excessive demands, the managers were sometimes encouraged to apologize to prevent the situation from escalating, which led to unnecessary apologies. This impacted the participants' self-esteem and caused them mental distress.

> *"No matter how well we do, if one complaint arises, those around us or the decision-makers will view us with suspicion. They start to think, 'There must be some problem with you."* (Participant D)
>
> *"In reality, it wasn't my job. I knew exactly who was responsible at the community center and what documents were needed. But at that moment, I couldn't express that it was an unreasonable demand..."* (Participant A)
>
> *"The audit office and such don't like situations escalating, so they often pushed us to just apologize and end it. So it felt bad; I was the one who should be receiving apologies... Being urged to apologize by them is frustrating, but since*

I'm in a position where I get paid, I often ended up apologizing, which hurt my pride." (Participant E)

3.1.5. Defensive posture during work performance

Due to the work environment described above, participants had no choice but to perform their duties defensively. To protect themselves, they found their own wise methods through years of experience, such as keeping personal counseling records.

"Since I provide restricted services, the frequency and intensity of complaints tend to be higher. As a result, I work very defensively to avoid complaints. Given my long tenure, I meticulously document everything to protect myself. That's how I handle it." (Participant D)

3.2. Received health and safety prevention education from the institution

3.2.1. Health hazard prevention education

All participants received annual training on the four types of violence (sexual harassment, sexual violence, prostitution, and domestic violence) and job-related safety education. Some participants also received health hazard prevention training through refresher courses, and there were participants in regions that exposed them to program-based daily video training on verbal and physical abuse. Job-related safety education was provided either by trainers who came directly to educate the medicaid case managers or through safety guidelines and handbooks that they had read. While some participants received training on how to protect themselves in physically dangerous situations, others reported that they had not received any practical training that could be applied in their work as medicaid case managers.

"Isn't there mandatory training on the four types of violence in public offices? We participate because we are the target audience. Regarding my job, we have safety training every year, and we are required to establish safety measures according to guidelines. We do receive safety training, but it doesn't cover practical content or real-case scenarios. It's more about reading through the training materials." (Participant D)

"We have an administrative program that we log into every morning. There are video trainings that show how to respond step by step when a client verbally abuses or physically assaults you." (Participant C)

"When exposed to dangerous situations, we even receive self-defense training... (omitted) Various trainers come, and we have a diverse range of training every year." (Participant B)

3.2.2. Health hazard support system

All figures Regarding the health hazard support system, all participants reported that their organizations offered healing programs and mindfulness programs. Additionally, medicaid case managers at the national level conduct healing programs. However, due to busy workloads and frequent overtime, no participants had utilized these programs, as they required setting aside personal time to participate. Some participants also mentioned that, as public employees rather than civil servants, they had been excluded from eligibility for the healing programs.

"I know that there are programs for mental health and other similar initiatives. And it is announced in the notifications. However, if I want to attend, I have to

contact them and carve out my own time. Given all these various tasks, I recognize that such programs exist, but I haven't actually used them." (Participant E)

3.2.3. Absence of a support system for counseling

All participants noted that there were no support systems for counseling within their organizations, and no one had experienced this issue. In other words, discussions with superiors and the audit team were the only processes for addressing conflicts and resolving issues related to client problem behaviors.

3.3. Current status and policies within the institution for resolving client behavioral issues

3.3.1. System for managing clients' problem behaviors

In the organizations, there were management systems for medicaid case managers that included the use of emergency contact devices (smartwatches) and phone voice notifications to manage client problem behaviors. The emergency contact device, in particular, helped prevent the exposure of the medicaid case manager's personal phone number and was used for contacting clients during home visits or in emergency situations related to client problem behaviors. However, participants stated that they were only allowed to use this device for 30 min during their work hours, making it practically ineffective. Additionally, while some regions had implemented the phone voice notification system, others had not.

"We were provided with a way to contact each other through the emergency contact system, using smartwatches in case of such situations, but in reality, we can only use the smartwatch for 30 minutes. That's simply not enough time. It seems to lack effectiveness." (Participant A)

"The voice notification system was introduced this year. Typically, when we deal with card companies or similar entities, there are requests to protect client service workers. Our main office staff have continually asked for this, but it didn't happen until this year after the mayor changed last year." (Participant B)

Furthermore, due to the lack of systems for participants to discuss and resolve client problem behaviors, they experienced indifference and avoidance from their organizations, even when mentioning these issues to the responsible public officials. Essentially, without effective management and protective measures, they would often take personal leave to rest before resuming work.

"So, while they may hold positions of authority, they often want to avoid facing such situations, leading to their escape or indifference. We've been in the same position for 19 years, while the supervisors and department heads change every 6 months to a year. Among them, there are good supervisors, but there are definitely some who just sit back and ignore the work while simply approving decisions." (Participant E)

3.3.2. Absence of a department for managing clients' problem behaviors

In the organization, there was no department to manage client problem behaviors, so participants had to contact the audit team to discuss problem resolution or take measures for themselves. One participant mentioned that when they reached out to the

audit team for problem-solving, the staff focused on resolving issues from the client's perspective and did not provide solutions for the medicaid case managers, which caused psychological stress.

> *"They don't provide protection and instead keep speaking from the perspective of the complainant. I didn't respond with insults; I just pressed the recording button while they were shouting. The recording captures the voice, and they said I didn't give prior notice in my voice. I find that unreasonable…"* (Participant B)

3.3.3. Uncertainty regarding the presence or absence of a management policy for health protection

Participants reported that there were no management policies or guidelines for health protection for medicaid case managers within the organization, or they had never experienced such policies. In other words, they were unaware of the existence of management policies for health protection, rights guarantees, or the operation of a grievance committee because they had never utilized or seen related information. One participant mentioned that while there was a grievance committee in their organization, a friend's experience with it ended poorly, leading to a negative perception of its effectiveness.

> *"When we raised an issue with the grievance committee, we couldn't expect it to be resolved in our favor or that they would support us. The people who had previously raised issues didn't see favorable outcomes. So, we don't have high expectations. I often think of it as just a gesture."* (Participant E)

3.4. Current status and policies within the institution for resolving client behavioral issues

3.4.1. Strengthening safety regulations and guidelines for visit activities

Based on the cases of client problem behavior, participants emphasized the necessity of requiring a two-person team for home visits by medicaid case managers for their safety. Currently, in areas where a two-person team is feasible, visits are conducted with public service personnel; however, in less accessible regions, medicaid case managers often have to visit alone, highlighting the need to reinforce this regulation. They also suggested establishing safety guidelines that allow for recording conversations with clients, with necessary equipment provided and dedicated work phones for visits.

> *"Recently, they've started providing recording devices for use at the client service center, which can be used for recording conversations. I think it's more important that we get protective equipment that can safeguard us."* (Participant B)

3.4.2. Need for management of clients' problem behaviors and a dedicated department

Participants expressed the need for a dedicated department to handle and manage clients who exhibit severe problem behavior. Furthermore, they highlighted the importance of a collaborative response system between medicaid case managers and department heads to effectively resolve these issues.

"I believe a dedicated channel for dealing with malicious complaints is absolutely necessary. It's too much for one individual to quietly resolve these issues without escalating them, as the emotional toll is significant. If there were a channel where we could attach verification documents for complaints, we could receive guidance or suggestions for handling such situations. We are just regular public service workers without any rank, yet we have a high workload and frequent emotional labor interactions. It would be beneficial if team leaders and department heads could collaborate in these situations." (Participant A)

3.4.3. Need for a health protection manual

Participants indicated the need for a health protection manual for medicaid case managers, particularly to ensure that those excluded from participating in healing programs due to their status as non-regular public employees could access health impairment prevention programs. They stressed the need for specific content related to health protection measures, including management policies, the operation of grievance committees, and rights guarantees.

"When we experience stress from dealing with complaints, there are healing programs, but none are available for non-regular public employees. It would be great if such programs were accessible..." (Participant C)

3.4.4. Need for campaigns and promotions

To proactively prevent and manage client problem behavior, participants noted the need for office phone voice announcements currently in use in some regions to be implemented everywhere, along with additional promotional efforts to prevent such behaviors. They also emphasized the importance of realistic promotional efforts that translate into client behavior, in addition to preemptive guidance on mutual consideration through social media.

"It would be nice if, when the county office receives calls, they include a message like 'This is your family.' That would be a good start..." (Participant B)

3.5. Necessary post-intervention measures for resolving client behavioral issues

3.5.1. Need for follow-up measures to resolve issues

Participants emphasized the need for rest facilities and spaces for medicaid case managers to protect their health as a follow-up measure to client problem behavior. They expressed a desire for appropriate break times and separation measures from problematic clients. Additionally, since many clients are often unaware of their behavior and repeatedly cause issues, they suggested that their organization should send warning messages to these clients as a follow-up action.

"We don't have a health room or even a place like a nursing break room for breastfeeding, so there's nowhere to rest. (Omitted) So, when I hear verbal abuse or insults, it seems impossible for my supervisor to say, 'You're having a tough day, go take a 30-minute break.' If there were some space to rest, it would help to sit down and take a break." (Participant B)

"I would appreciate it if there could at least be a written warning stating that due to certain behaviors, you need to be cautious in the future, and send that to the client." (Participant C)

3.5.2. Need for a system that allows for legal action

In situations where legal action, such as filing a complaint, is necessary due to client problem behavior, participants indicated the need for legal counseling support from their organization to facilitate such actions. They also called for assistance with attorney fees. Above all, they stressed the importance of ensuring that these supports are not at the discretion of local governments but are equitably available across all regions.

"Public officials only receive partial support for legal fees related to complaints, and I wonder if we could receive similar support." (Participant B)

"If local governments were to support attorney fees for complaints, some municipalities would be protected while others might lack the funds or support. I believe everyone should receive equal protection when such incidents occur." (Participant A)

4. Discussion

This study conducted a phenomenological approach to explore client problem behaviors experienced in the process of responding to clients to protect the health of medicaid care managers.

The components derived are 'experience of problematic behavior', 'experience of receiving education on preventing health disorders', 'current status and system within the institution for client's problematic behavior', 'opinion on the institution's system', and it was a 'follow-up action to resolve client problem behavior.'

As a result of the study, client problem behaviors experienced by medicaid care managers were found to be unreasonable demands, verbal abuse, assault, threatening environment, passive attitude toward expressing emotions, and defensive attitude when performing work. Among the problem behaviors, unreasonable demands were found to include unreasonable tasks, unreasonable claims, and demands other than work, which are inferred to be caused by the characteristics of the client. Therefore, it is believed that forming a trust relationship between the case manager and the subject is important. According to the results of a case management study in the United States, It was found that for successful case management, the case manager and the subject must first build a trusting relationship and carefully observe changes in their way of thinking and plans (Knox et al., 2022).

Client characteristics can be known in detail as a result of an in-depth study (Park and Kim, 2008) on the case management process of medicaid care managers. Most case management clients are elderly and in desperate situations such as low educational level, economic difficulties, and complex diseases, so they have many negative views, such as distrust, about society. In addition, although they do not know exactly about medical laws or related systems, they are dependent on society, and due to the nature of their residence, they live crowded with people in similar situations, so incorrect information can easily spread. Because they communicate quickly with each other, they try to receive various social services that others receive in an overlapping

and competitive manner, which turns out to be making unreasonable demands. The client's verbal abuse and assault included swearing, threats, verbal intimidation, and violent behavior.

As of 2022, there were 1,517,000 people receiving Medicaid benefits in Korea, of which 625,000 people were over 65 years old, or 41.2%(National Health Insurance Service, 2024). Korea's elderly population aged 65 or older was 18.4% of the total population in 2023, and is expected to reach 20.6% in 25, entering a super-aging society. The relative poverty rate of Korean seniors is the highest among OECD countries. The relative poverty rate was 4.4% in Norway, 22.6% in Australia, 21.6% in the United States, and 40.4% in Korea. Additionally, the elderly responded that they were the group most subject to human rights violations and discrimination. Additionally, people perceived themselves as being discriminated against as they got older (Statistics Korea, 2024).

The results of a study of 248 case managers, including medicaid care managers (Choi et al., 2021), showed that medicaid case managers frequently experience verbal abuse, abusive language, and sexual harassment from clients, and also have high levels of conflict with superiors. In addition, medicaid case managers were found to be passive in expressing emotions and display a defensive attitude when performing work. As a result of previous research (Choi et al., 2021), most of these people were public servants, and there was a poor working environment, a rigid organizational culture, a hierarchical order between civil servants and civil servants, social customs that forced sacrifices as public sector workers, and wage discrimination based on employment status. As a result, the case managers experienced a high level of emotional dissonance and damage, which seemed to affect not only the individual's emotional problems but also their families. It is inferred that these working environments resulted in a passive and defensive attitude. The level of communication skills of medicaid care managers was found to have an effect on job stress. Previous research has shown that the higher the level of communication, the lower the stress of job, and it is suggested that communication education and training should be provided to improve their communication skills (Lim, 2019). In a study on job stress among medicaid care managers, when job stress was converted to 100, the average score was 51.7, which was found to be in the top 50%. Among the sub-domains of job stress, relationship satisfaction and job instability were included in the top 25%, showing very high stress (Choi et al., 2008). In addition, in a study targeting 461 medicaid care managers, the results of a survey on the obstacles felt during case management work are as follows (Go et al., 2016). The biggest obstacles at work were low wages compared to the importance of the work, inadequate performance indicators, lack of community connection, and instability of employment. Accordingly, previous research suggested that it is urgent to improve the employment pattern and wage system of medicaid care managers (Hwang and Lee, 2023).

Research participants complained that the organization had no management policy, consultation system, or grievance committee as part of the organization's system to protect workers' health. In Korea, the Serious Accident Punishment Act was enacted in 2022 (Ministry of Government Legislation, 2023). The content states that business owners or management managers must follow all provisions to prevent safety and health hazards or risks to workers in the institution. The most important thing is

to establish a safety and health management policy, specify it to workers and clients, and establish a safety and health system for workers. It is expected that the systems within the above organizations will be overhauled with strong legal support over time.

A study on Australian case managers concluded that having workplace supervisors supervise and monitor case managers' workload is effective in reducing their stress(King, 2009).

The basic measures to protect the health of medicaid care managers derived from the research results are as follows. First, the organization must establish and promulgate an operating policy that states that the life and safety of medicaid case managers are the top management value and establish a grievance handling committee to protect health. Second, the organization identifies medicaid care managers' emotional labor and job stress levels, as well as physical and mental health problems that arise due to client service work. Third, organizations must provide worker safety and health education. Safety and health education includes preventive measures before visiting clients, response to client problem behavior during the visit, follow-up management measures after the visit, and emotional labor and job stress education. Fourth, the organization prepares health protection follow-up measures for medicaid care managers. Follow-up measures include protective isolation of client service workers, temporary suspension of work, granting transition and autonomy, granting and extending break time, and support for complaints, accusations, and claims for damages. Fifth, the organization supports emotional labor and job stress relief programs for medicaid care managers. The organization supports programs such as counseling programs, mindfulness programs, relaxation and imagery therapy, and healing programs when they request counseling.

5. Conclusion

This study was conducted to find development plans to protect workers' health by comprehensively exploring the meaning of medicaid care managers' experiences and status of client problem behavior that occurs during client service work. As a result of the study, medicaid care managers were exposed to unreasonable demands from clients, verbal language and assault, sexual harassment, and a threatening environment, and were experiencing stress due to their passive and defensive attitudes.

The conclusion of the study is as follows. First, it is necessary to have an institutional management policy and safety and health system to protect the health of medicaid care managers. Second, organizations must provide essential safety and health education in the working environment. Third, organizations must establish systems and support systems to manage the emotional labor that occurs during client service. Fourth, organizations must establish a system for follow-up management to protect worker health. Sixth, institutions should reduce the workload of Medicaid care managers and implement job stress relief programs.

This study applies qualitative research methods and is based on in-depth interviews conducted with 5 participants, so there are limitations to generalizing the findings. Considering this, future research should not only utilize qualitative methods but also incorporate various quantitative methodologies to explore diverse approaches and advancements in health protection for Medicaid case managers.

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