



Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

2026 Accurate Picture Initiative:
Statewide Satisfaction Survey Report
May 2026
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Abstract

This project analyzes behavioral health satisfaction survey data collected from Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHPs), and private providers in the networks of the CMHSPs and PIHPs across Michigan. CMH organizations are local public agencies responsible for delivering mental health and substance use services within specific counties, while PIHPs are regional entities that manage Medicaid behavioral health services and funding, often overseeing multiple CMH organizations or coordinating care across a service region. The primary purpose of this project is to standardize survey results drawn from multiple instruments into a consistent analytical framework so that findings can be compared meaningfully across providers. Because CMH organizations and PIHPs use different survey tools, scoring systems, question wording, and reporting formats, direct comparison is difficult without a common structure.

To address this issue, survey responses were reorganized into six standardized categories: Overall Satisfaction/Improvement, Accessibility/Responsiveness, Supportiveness, Dignity, Respect, Cultural Competency, Person-Centered Planning, and Being Heard & Confidentiality. Questions from different instruments were assigned to these categories based on substantive content rather than original numbering or survey source. Positive response values were then converted into comparable percentages and aggregated within each category.

The findings indicate that Supportiveness, Dignity, Respect and Overall Satisfaction/Improvement tended to score relatively high across organizations, suggesting generally positive perceptions of service quality and benefit. Cultural Competency also showed consistently strong performance across many providers. In contrast, Person-Centered Planning, Accessibility/Responsiveness, and Being Heard & Confidentiality showed greater variability, indicating uneven performance across organizations and survey types. Overall, this project demonstrates the value of standardizing behavioral health satisfaction data to improve cross-agency comparison, strengthen transparency, and support data-informed evaluation and policy decision-making.

Background

Behavioral health systems rely heavily on client, family, and stakeholder feedback to assess service quality, identify strengths, and reveal areas needing improvement. Satisfaction surveys are one of the most common tools used to capture these perspectives. However, these instruments vary considerably across CMHSPs, PIHPs, and private providers in the CMHSP and PIHP networks in question wording, response options, scoring methods, and domain structure. As a result, even when different organizations attempt to measure similar concepts, such as satisfaction, access, or cultural respect, their results are not automatically comparable.

In Michigan, CMHSPs, PIHPs, and private providers in the CMHSP and PIHP networks administer multiple survey tools, including the Mental Health Statistics Improvement Program (MHSIP) Adult Survey, the Youth Satisfaction Survey (YSS), and other organization-specific tools. These instruments often measure overlapping concepts, but they do so in different ways. One survey may assess confidentiality through a single question, while another may combine several items related to rights, information sharing, and privacy. Likewise, one instrument may report percentage agreement, while another reports Likert-scale averages that must be converted before comparison is possible.

Without standardization, this variation limits the usefulness of survey data for statewide comparison, cross-provider benchmarking, and system-level evaluation. This project addresses that challenge by creating a unified category framework and applying a consistent scoring method to survey data from multiple organizations. In doing so, it improves comparability and makes the data more useful for administrative review, policy discussion, and quality improvement planning.

Methods

This project analyzed behavioral health satisfaction survey data from respondents across 25 CMHSPs, PIHPs, and private providers in the CMHSP and PIHP networks in Michigan using FY25 survey reports and internal datasets. The dataset included Barry County Community Mental Health, Bay-Arenac Behavioral Health Authority, Centra Wellness Network, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties, Copper Country Community Mental Health, Gratiot Integrated Health Network, Hiawatha Behavioral Health, Huron Behavioral Health, Lakeshore Behavioral Services Program, Lakeshore Regional Entity, LifeWays Community Mental Health, Macomb County Community Mental Health, Mid-State Health Network, Montcalm Care Network, Newaygo County Mental Health, Northern Lakes Community Mental Health, Oakland Family Services, Ottawa County Community Mental Health, Region 10 Prepaid Inpatient Health Plan, Right Door Organization, Saginaw County Community Mental Health Authority, Services to Enhance Potential, St. Clair County Community Mental Health Authority,

The Guidance Center, Tuscola Behavioral Health Systems, and Washtenaw County Community Mental Health. Data was compiled between March 31 and April 23 during the FY25 reporting period.

Survey items were reorganized into six standardized domains based on conceptual alignment, with original wording retained for transparency. All question-level results were converted into a common percentage format. Positive response rates were calculated using one of three methods: combining Agree and Strongly Agree responses, using the percentage of Yes responses for binary items, or converting mean Likert scores to percentages using the formula $(\text{Mean} \div 5) \times 100$. After conversion, category-level scores were calculated by averaging all question-level percentages assigned to the same domain. This method was applied consistently across organizations and survey instruments, even when the number of items within a category varied. Across all organizations, domain-level averages were calculated by averaging question-level percentages within each category and ranged from 83.53% to 87.97%. Cultural Competency (87.97%) was highest, followed by Overall Satisfaction/Improvement (87.48), Person-Centered Planning (87.15%), Being Heard & Confidentiality (86.02%), and Supportiveness, Dignity, Respect (86.0%), while Accessibility/Responsiveness (83.53%) was the lowest-performing domain.

To illustrate this process, a representative example of this analysis is provided as item A in the Appendix.

The final dataset was structured in Excel format, with each row containing organization name, survey type, standardized category, aggregate positive percentage, question numbers, and full question text. The method prioritizes conceptual consistency over identical survey design while preserving traceability back to the original survey items.

Findings & Analysis

Table 1: Statewide Behavioral Health Satisfaction Summary by Domain

Satisfaction Domain	Positive Average (%)
Overall Satisfaction / Improvement	87.48%
Accessibility and Responsiveness	83.53%
Supportiveness, Respect, Dignity	85.35%
Cultural Competency	87.97%
Person-Centered Planning	87.15%
Being Heard & Confidentiality	86.02%

The analysis reveals clear and measurable patterns across CMH organizations and PIHPs, with performance varying by domain and survey instrument. This approach enables direct comparison across providers using different survey tools while still capturing similar service concepts.

Across the dataset, Overall Satisfaction/Improvement and Supportiveness, Dignity, Respect consistently demonstrated the strongest performance. Most results in these categories fell within the high 80% to mid-90% range, with several reaching 95% or higher. Even lower values generally remained in the mid-70% range, indicating that overall satisfaction and communication were strong across nearly all providers. These consistently high scores suggest that respondents broadly reported positive service experiences, felt supported by staff, and believed services were beneficial.

Cultural Competency also showed strong performance overall, most commonly ranging from the mid-80% to high-90% range, with some results approaching 100%. However, compared to satisfaction and communication, this category showed slightly more variation, with some scores dropping into the low 70% range, indicating less consistency across providers.

Greater variability was observed in Accessibility/Responsiveness and Person-Centered Planning. Expedience scores ranged from approximately the mid-70% range to the upper-90% range, reflecting differences in access to care, scheduling, and service availability. Person-Centered Planning showed a similarly broad range, from the low-to-mid 70% range up to nearly 100%, indicating that client involvement in treatment decisions and goal setting is not implemented consistently across organizations. These differences likely reflect variation in staffing, service capacity, and organizational practices.

Being Heard & Confidentiality showed the greatest inconsistency in both measurement and results. Scores ranged from approximately the low-60% to high-90% range, but in many cases this domain was measured using only a single question or was not included at all. This makes comparisons less reliable and suggests that variation reflects both actual performance differences and inconsistencies in survey design.

Overall, the findings demonstrate that standardization is effective for identifying broad trends across organizations, particularly in highlighting consistently strong domains such as satisfaction and communication. However, interpretation must still consider variation in score ranges and differences in how domains are measured.

Conclusion

This project demonstrates that standardizing behavioral health survey data improves the ability to compare outcomes across CMH organizations and PIHPs. By aligning diverse survey instruments into consistent domains, the analysis provides a clearer and more structured view of service quality across Michigan providers.

The results indicate that overall satisfaction, communication, and cultural competency were generally strong across providers, while access-related domains, person-centered planning, and confidentiality-related measures showed greater variation. These patterns highlight areas where organizations may benefit from targeted improvement and where statewide standardization could strengthen interpretation.

More broadly, this project offers a replicable method for organizing and analyzing survey data across nonuniform instruments. This makes the results useful not only for describing current performance, but also for supporting future benchmarking, quality improvement, and policy development within Michigan's behavioral health system.

The Center for Healthcare Integration and Innovation (CHI2) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.

Appendix

A. Standardized Category Framework

Category	Description	Example Question Focus
Overall Satisfaction/Improvement	Measures overall experience and perceived benefit of services	Satisfaction, recommendation, perceived improvement
Accessibility/Responsiveness	Assesses access to care and timeliness of services	Scheduling, response times, availability of services
Supportiveness, Dignity, Respect	Evaluates how well staff communicate and provide information	Clarity, respect, shared information, understanding
Cultural Competency	Measures sensitivity to cultural, ethnic, and personal backgrounds	Respect for identity, inclusivity, cultural awareness
Person-Centered Planning	Assesses involvement in treatment decisions and goal setting	Client choice, participation, autonomy
Being Heard & Confidentiality	Evaluates privacy and protection of personal information	Confidentiality, control over information sharing

B. Example of Standardized Survey Mapping and Category Aggregation (Organization A)

Organization	Survey Type	Category	Positive Avg %	Question Numbers	Questions
Organization A	MHSIP	Overall Satisfaction/Improvement	82.60%	Q1–Q3	Q1. I like the services I received here. Q2. If I had other choices, I would still get services from this agency. Q3. I would recommend this agency to a friend or family member.
Organization A	MHSIP	Accessibility/Responsiveness	76.10%	Q4–Q7	Q4. The location of services was convenient (parking, public transportation, distance, etc.). Q5. Staff were willing to see me as often as I felt it was necessary. Q6. Staff returned my call within 24 hours. Q7. Services were available at

					times that were good for me.
Organization A	MHSIP	Supportiveness, Dignity, Respect	82.30%	Q5–Q7	Q5. Staff were willing to see me as often as I felt it was necessary. Q6. Staff returned my call within 24 hours. Q7. Services were available at times that were good for me.
Organization A	MHSIP	Cultural Competency	85.40%	Q18	Q18. Staff were sensitive to my cultural background (race, religion, language, etc.).
Organization A	MHSIP	Person-Centered Planning	77.60%	Q17	Q17. I, not staff, decided my treatment goals.
Organization A	MHSIP	Being Heard & Confidentiality	87.90%	Q13, Q16	Q13. I was given information about my rights. Q16. Staff respected my wishes about who is and who is not to be given information about my treatment.
Organization A	YSS	Overall Satisfaction/Improvement	88.30%	Q1	Q1. Overall, I am satisfied with the services my child received.
Organization A	YSS	Accessibility/Responsiveness	89.70%	Q8–Q9	Q8. The location of services was convenient for us. Q9. Services were available at times that were convenient for us.
Organization A	YSS	Supportiveness, Dignity, Respect	89.60%	Q2–Q6	Q2. I helped to choose my child’s services. Q3. I helped to choose my child’s treatment goals. Q4. The people helping my child stuck with us no matter what. Q5. I felt my child had someone to talk to when she/he was troubled. Q6. I participated in my child’s treatment.
Organization A	YSS	Cultural Competency	71.20%	Q15	Q15. Staff were sensitive to my cultural/ethnic background.

					Q13. Staff respected my family's religious/spiritual beliefs.
Organization A	YSS	Person-Centered Planning	92.10%	Q3	Q3. I helped to choose my child's treatment goals.

C. Data Structure Template Example

Organization	Survey Type	Category	Positive Avg %	Question Numbers	Questions
CMHSP, PIHP, or provider in network	MHSIP	Overall Satisfaction/Improvement	90%	Q1–Q3	Full question text

D. Standardization Method Notes

"Positive Avg %" is calculated using:

- Agree + Strongly Agree
- Yes responses (binary)
- $\text{Mean} \div 5 \times 100$ (Likert conversion)

Survey questions are mapped into standardized domains based on conceptual content rather than original numbering or survey instrument. Each domain score is calculated by averaging all question-level percentages assigned to that category, even when the number of items varies across surveys.

Domain-level ranges are calculated by identifying the minimum and maximum category scores observed across all organizations within each standardized domain. Overall domain averages are calculated by averaging category-level scores across all organizations.

Categories may include overlapping items across survey types when questions measure similar concepts. Missing data is recorded only when a domain is not measured by a given survey instrument.

E. Key Limitations

Variation in survey design across CMHs and PIHPs means that not all domains are equally represented. Some organizations do not include direct measures of Being Heard & Confidentiality, and differences in wording and structure may still affect comparability despite standardization.

Additionally, some domains are based on a limited number of questions, and in some cases a single item, which may reduce the reliability and stability of those category scores compared to

multi-item domains. Differences in response scales and survey design may also introduce minor inconsistencies even after conversion to percentages.

Because category scores are calculated as simple averages, all questions within a domain are weighted equally, which may not reflect differences in importance across items. Variation in sample size across organizations may also influence results, as organizations with fewer respondents may show greater variability in scores.

Finally, while standardization improves comparability, it does not fully eliminate differences in how concepts are measured across survey instruments, meaning that results should be interpreted as approximations of domain performance rather than exact equivalents.

R. Survey Instruments

- Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey:
<https://www.samhsa.gov/sites/default/files/mhbg-mhsip-consumer-survey.pdf>
- Youth Services Survey for Families (YSS-F):
<https://www.samhsa.gov/sites/default/files/mhbg-youth-services-families-survey.pdf>