Practicing at the Edge

Adolescent TMS and the Path to Scale

A quick tour through where the field stands, what it takes to grow it, and what stands in the way

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Why Adolescent TMS, Why Now

Mar 2024	Mar 2025	Aug 2025	Nov 2025
NeuroStar	Magstim	MagVenture	BrainsWay (Deep TMS)

Four TMS devices now hold FDA clearance for adolescent MDD (ages 15–21)

The academic medicine advantage — and its responsibility

Being embedded in research, industry, and clinical trials gives academic medical centers earlier access to innovations like SAINT — and a credible path toward building the nation's first adolescent-focused TMS clinic. But greater access to innovation comes with greater responsibility: new doesn't automatically mean better. Every advance still has to earn its place through evidence, not novelty.

Staying engaged with emerging science allows us to continually ask whether there is something newer, better, or more effective that could improve outcomes—or even save lives.

Avoid the status quo!

The Scale Problem

*Efficacy isn't the bottleneck — **access** is, and it's very acute right where you practice*

1 in 5

adolescents nationally will have a major depressive episode before adulthood

68

North Carolina counties have no child or adolescent psychiatrist

6 vs 25

child/adolescent psychiatrists per 100,000 youth, rural vs. urban NC counties

An encouraging opening: BCBS of North Carolina

Already expanded its TMS policy to cover adolescents 15 and older — a new policy for insurer covering more than 2.2 million people in the state. Commercial coverage is already moving

The “You Meet Criteria, But…” Problem

Even when the science says yes, coverage can be slow to follow

Patient A

Treatment-resistant depression. Meets clinical criteria. Covered by BCBS SC.

→ Can access treatment

Patient B

Same presentation. Same criteria met. Covered by TRICARE or Medicaid.

→ Cannot access treatment

Clinically identical. Access to care is not — and the caveats keep stacking: coverage for adolescents, medication-trial counts, prior-auth rules all vary by plan.

That knowledge can't live only in our clinic — referring pediatricians and therapists need the same picture, and direct lines to Medical/Operational Directors keep referrals from getting lost.

Adolescent Care Is Different

Scaling this treatment means scaling a different care-delivery model, not just a device

1 **The family system, not just the patient**

Adults are treated as individuals; adolescents bring the whole family into the room.
Consent looks different.

2 **Different Logistics**

Scheduling/treating around school

Transportation needs

3 **Educating the school system**

School therapists and staff need to understand TMS before they can refer appropriately.

4 **A collaborative approach**

TMS is one piece — C/A psychiatrist, adolescent medicine, therapy, and pediatric specialists complete the picture.

Scaling Responsibly

A treatment existing does not create population-level impact on its own

What it takes

- Payer strategy - Actively working coverage relationships rather than waiting for policy to catch up to evidence
- Community partnerships – relationships with schools, pediatricians, C/A Psychiatrists, other referring providers
- Standardized referral pathways- a consistent, repeatable process
- Marketing & education, inside and outside the organization

What's in the way

- Evidence-practice gap (youth-specific protocols still maturing)
- Consent complexity (adolescent assent + guardian consent)
- Coverage/Reimbursement inconsistency across payers
- No established workforce training pipeline

Models for Expanding Access

1 Workforce training

Build certification pathways so general/child & adolescent psychiatry practices — not just specialty TMS centers — can deliver treatment.

TMS training in residency

2 Primary care & school pathways

Embed TMS referral triggers into pediatric primary care and school-based mental health screening.

3 Satellite & mobile units

Extend delivery into rural and underserved areas that can't support a full standalone clinic.

4 Telepsychiatry-linked care

Handle intake, monitoring, and follow-up remotely to reduce the burden of in-person visits.

Questions to Consider

- How do we responsibly offer a promising treatment while the evidence base is still developing?
- How do we confront/eliminate the barriers that exist to accessing novel treatments?

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