·标准与共识·

中国头痛门诊和头痛中心建设专家共识

中国医师协会神经内科医师分会 中国研究型医院学会头痛与感觉障碍专业委员会
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【摘要】 我国因地域广阔、人口众多,医疗资源、水平和服务质量的区域性差异,头痛诊疗尚未实现规范化和系统化。中国医师协会神经内科医师分会和中国研究型医院学会头痛与感觉障碍专业委员会的头痛学科领域专家,按照国家卫生健康委员会提出的以单病种诊疗能力为核心的医疗服务体系建设要求,共同发起并制订本共识。共识由编写委员会专家通过多轮意见征集与修改完善而成。本共识对头痛门诊和头痛中心在建设中的单元定位、人员资质和配置、硬件和能力建设、工作要求和运行质量评价等方面制定了相应的建设标准,希望在全国范围内按诊疗能力建立国家和区域中心及头痛门诊,以规范化头痛的全程管理。

【关键词】 头痛; 疾病管理; 指南; 全程管理; 头痛中心和头痛门诊
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Expert consensus on the construction of headache clinics and headache centers in China

Chinese Medical Doctor Association Neurologist Branch & Headache and Sensory Disorders Professional Committee of Chinese Research Hospital Association
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Headache, as a common clinical symptom, is one of the main reasons for visits to neurology clinics. Due to its high prevalence, high disability rate, and increased disease burden, it has become an important global public health issue[1,2]. Although countries around the world have invested substantial resources in headache prevention and control, differences in economic development, population quality, and attention to medical and health care have limited the standardization of headache diagnosis and treatment.

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Some regions in developed countries and most developing countries still face problems such as low consultation rate, low diagnostic accuracy, insufficient preventive treatment, and overuse of analgesic drugs[3].

In China, with its vast territory and large population, there are significant regional differences in medical resources, service levels, and quality, and the imbalance in standardized diagnosis and treatment of headache is prominent, leading to a heavy disease burden[4, 5]. Therefore, establishing a unified standardized process for headache diagnosis and treatment, standardized management systems, and comprehensive management procedures nationwide, constructing headache clinics and headache centers with certain organizational structures, and improving the overall level of headache diagnosis and treatment in China are urgent goals and tasks[6]. In recent years, the National Health Commission has continuously promoted the construction of a medical service system centered on the diagnosis and treatment capabilities of single diseases. Hospitals with top-tier diagnosis and treatment capabilities are selected as national or regional centers based on disease types, breaking administrative level restrictions, gradually downplaying traditional hospital grades (such as Grade A tertiary and Grade A secondary hospitals), and emphasizing clinical actual needs and diagnosis and treatment levels as the basis for resource allocation [7, 8]. In this context, the Neurology Branch of the Chinese Medical Doctor Association and the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association have promoted the construction of a headache prevention and control base and system nationwide in accordance with the diagnosis and treatment rules of headache diseases, the distribution characteristics of medical resources in China, and the principle of hierarchical diagnosis and treatment for specific diseases[9], which has initially taken shape[10]. Standardized headache diagnosis and treatment units are important components of the headache prevention and control system[9, 11, 12] and specific implementation units for standardized whole-course management of headache[13]. All headache diagnosis and treatment units are subspecialties of neurology in hospitals at all levels, not independent medical institutions. According to the level of diagnosis and treatment, hardware and software configuration, and professional capabilities, headache diagnosis and treatment units are divided into headache clinics and headache centers; the latter are further classified into headache centers and advanced headache centers based on their business scope, academic level, and capabilities and proportions in diagnosing and treating complex and intractable diseases. Different diagnosis and treatment units undertake different responsibilities and tasks. To better interpret the connotative construction of the headache prevention and control system, guide the construction of headache diagnosis and treatment units inside and outside the system nationwide, experts from the Neurology Branch of the Chinese Medical Doctor Association and the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association have initiated and formulated this consensus. It aims to provide guiding opinions and suggestions for the construction of hierarchical headache diagnosis and treatment units, clarify the work details in aspects such as unit construction conditions, business scope, quality control management, and continuing education, so as to realize the standardized and homogeneous diagnosis and treatment of headache in China at an early date.

Ⅰ. Methods for the development of the consensus

(Ⅰ)Scope and purpose

To assist and promote the construction of headache clinics and headache centers in China, the Neurology Branch of the Chinese Medical Doctor Association, together with the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association, initiated, discussed, and formulated this expert consensus. This consensus covers specific content involved in the construction of headache clinics and headache centers, including positioning, physician qualifications, personnel allocation, hardware construction, capacity building, work requirements, and operational quality evaluation. The purpose of publishing this expert consensus is to provide a basis, framework, and guidelines for the development of specialized departments.

(Ⅱ)Expert group for consensus development

The expert group members of this consensus consist of experts from the Department of Neurology, Chinese PLA General Hospital, as well as neurology and related discipline experts from across the country. It includes senior scholars in the field of headache, neurology department managers from hospitals at all levels, statistical experts, and review experts for headache clinics and headache centers in the "Construction of China's Headache Prevention and Control Bases and Systems" project. A total of 89 experts are involved, including clinical medicine experts, methodological experts, and evidence-based medicine experts.

(Ⅲ)Discussion and drafting of the consensus

In accordance with the principle that "when evidence is controversial, uncertain, or lacks high-quality evidence, which is insufficient to form guidelines but clinical issues urgently need to be addressed, expert consensus documents should be adopted"[14]. The expert group systematically reviewed domestic and foreign literature on headache management methods, conducted preliminary drafting, discussions, and expert group meetings. Combining with China's actual medical situation, headache management experience, and practical operation experience, questionnaire surveys were conducted using the Delphi method, and final recommendations were formed.

(Ⅳ)Release, dissemination, and update of the consensus

After the formation of the expert consensus, it was finalized and released following multiple rounds of expert demonstration meetings. The consensus will be disseminated and promoted mainly through the following ways: (1) Publication in relevant academic journals; (2) Presentation at academic conferences; (3) Application through China's headache prevention and control system. After its release, this expert consensus will be updated based on practical application and the emergence of relevant research evidence to better guide practice and form standards.

Ⅱ. Specific content of headache clinic in the consensus

(Ⅰ)Positioning

Headache clinics are established to address the difficulty of cross-regional medical treatment for headache patients in the region and realize medical treatment nearby. They can provide professional diagnosis, treatment, and whole-course management for various headache patients in the region, including long-term follow-up, data storage and update, and face-to-face health education[15]. Clinical services include standardized diagnosis and treatment of primary headaches, routine examination, diagnosis and treatment of secondary headaches, as well as identification and referral of complex and intractable cases[9].

(Ⅱ) Physician qualifications and personnel allocation

Neurologists with professional training qualifications in headache diagnosis and treatment are required. The personnel allocation may include general practitioners and pain medicine physicians, with no fewer than 3 personnel to promote the rapid launch of the clinic.

(Ⅲ)Hardware construction

1. The medical institution shall have the qualifications of Grade A secondary or higher general hospitals or specialized hospitals.

2. The clinic shall have a fixed space and provide fixed dedicated consultation time for headache (at least 3 times a week). It shall be equipped with necessary physical examination tools and equipment for headache diagnosis and treatment, as well as health education materials and headache diaries[16].

3. In terms of equipment configuration: The laboratory shall be equipped with instruments for blood routine, blood biochemistry, coagulation function, immunology, blood gas analysis, as well as cerebrospinal fluid routine, biochemistry, immunology, and pathology examinations; in terms of imaging, it shall be equipped with CT, MRI, electroencephalogram, electrocardiograph, vascular ultrasound, and other equipment[17, 18], and may provide 24-hour ambulatory electrocardiography (Holter).

4. In terms of basic treatment and management: It shall be equipped with basic acute and preventive migraine medications[19] and specific acute migraine medications[20]; standardized prescription

management shall be implemented.

(Ⅳ)Clinical capabilities and team management

1. The team shall be a multidisciplinary team (MDT) centered on neurology, integrating neurosurgery, pain medicine, traditional Chinese medicine, rehabilitation medicine, psychiatry, radiology, and ultrasound departments. Regular training shall be provided to specialized physicians, who are required to participate in continuing education programs related to headache at least once a year[21].

2. Business scope includes: (1) Standardized diagnosis and treatment, adhere to headache diagnosis and treatment guidelines and clinical pathways[19, 20] to ensure the standardization of diagnosis and treatment. (2) Treatment technologies, standardize medication use for acute phase treatment in accordance with acute phase treatment guidelines[20], avoid overuse of medications, identify and refer complex and intractable cases; standardize preventive treatment and medication use in accordance with guidelines, conduct regular follow-up, provide headache consultation and health education; guide patients to record headache diaries and collect medical data; support supporting treatment technologies such as cognitive behavioral therapy (CBT)[22], physical therapy, and TCM acupuncture therapy[23]. (3) Whole-cycle patient management, implement health education[24], record diagnosis and treatment data, update data, conduct regular follow-up on patients' conditions and medication use, assess the recording of patients' headache diaries, and evaluate disease burden using scales[25]; use standardized follow-up manuals covering diagnosis, treatment plans, and follow-up schedules.

(Ⅴ)Work requirements

Optimize diagnosis and treatment processes to improve diagnostic accuracy and treatment efficiency. Actively participate in continuing education for medical staff, manage data, conduct follow-up visits, and engage in scientific research. Carry out health education for patients in the region (e.g., free clinic during Migraine Awareness Month) at least once a year. Cooperate with regional headache centers to establish a clinical data set of local patients[2] and accept quality control from regional advanced headache centers.

(Ⅵ) Operational quality evaluation

Establish a quality control assessment system and quality control indicators, and implement construction in accordance with these indicators[26].

1. Hospital admission capacity: Monthly number of headache outpatients (headache consultation volume), proportion of migraine patients among total headache outpatients during the same period (migraine consultation rate).

2. Assessment indicators for standardized diagnosis and treatment: Rate of standardized medical records for migraine outpatients, correct diagnosis rate of headache patients, recording rate of acute medication use, application rate of specific acute medications, prescription rate of addictive medications (e. g., opioids, barbiturates), application rate of preventive medications for migraine outpatients, notification rate of medication withdrawal for patients with medication overuse headache, screening rate for comorbid anxiety and depression, screening rate for comorbid sleep disorders, disability assessment rate.

3. Evaluation indicators for whole-process patient management: Follow-up rate, headache diary recording rate, frequency of patient education.

4. Professionalism of the team: Proportion of physician participating in professional training.

5. Annual inspection of data management and quality control.

Ⅲ. Specific content of headache centers in the consensus

(Ⅰ)Positioning

Headache centers are specialized headache diagnosis and treatment units that set up a certain number of beds in the ward on the basis of established headache clinics, admitting complex and intractable headache patients. Institutions establishing headache centers shall represent the regional level of diagnosis and treatment for headache disorders, possess rich experience in headache management, and be affiliated with hospitals equipped with comprehensive clinical resources for the diagnosis and treatment of all types of headache. They are responsible for undertaking clinical, teaching, research, and quality

control tasks related to headache in the region, promoting standardized diagnosis and treatment of headache locally, and taking the lead in or participating in academic research of a certain level.

Based on factors such as clinical diagnosis and treatment capabilities, professional level, personnel allocation, and academic influence, headache centers are classified into two levels: Headache Centers and Advanced Headache Centers, each with distinct responsibilities and authorities.

(Ⅱ) Physician qualifications and personnel allocation

The requirements for physician qualifications are the same as those for headache clinics. In terms of personnel allocation, academic leaders specialized in headache are required. Advanced Headache Centers shall establish a well-structured professional team for headache diagnosis and treatment.

(Ⅲ) Hardware construction

1. Medical institution qualifications: Grade A tertiary general hospitals or specialized hospitals.

2. Clinic and ward configuration: The clinic configuration shall be equivalent to or higher than that of headache clinics (e.g., data collection personnel, clinical research coordinators). The ward shall be equipped with no fewer than 5 fixed dedicated beds for headache.

3. Inspection configuration: Equivalent to or higher than that of headache clinics. Equipped with 3T or higher MR for the brain, as well as CTA, DSA, transesophageal echocardiography, contrast-enhanced transthoracic echocardiography, transcranial Doppler bubble test, electroencephalogram, and other equipment for further diagnosis and treatment of headache or clinical research.

4. Treatment foundation: Equipped with specific medications for headache diagnosis and treatment. Capable of performing therapeutic technologies such as nerve block[27], botulinum toxin type A injection[28], and non-invasive neuromodulation[29]. Advanced Headache Centers may provide epidural blood patch treatment[30].

(Ⅳ) Capacity building

1. Team management: The headache team includes academic leaders and team members. The academic leader shall be a chief physician or associate chief physician with rich clinical experience and research capabilities. Advanced Headache Centers shall have influence in the field of headache within the region. Core team members shall have received specialized training in headache diagnosis and treatment organized by provincial or higher academic institutions, and the team structure shall be reasonable. The multidisciplinary team shall integrate, but not be limited to, departments such as neurosurgery, radiology, imaging, ultrasound, pain medicine, traditional Chinese medicine, rehabilitation medicine, cardiology, and psychiatry.

2. Business scope: (1) Standardized diagnosis and treatment: Conduct standardized diagnosis and treatment for all types of headache. (2) Treatment technologies: Including standardized diagnosis and treatment (pharmacological and non-pharmacological) of primary headaches; diagnosis and treatment of secondary headaches; identification and referral of complex and intractable headaches. Advanced Headache Centers shall be capable of providing diagnosis and treatment for all types of headache, teleconsultation, and managing complex and intractable headache cases. (3) Whole-cycle patient management: Including data management, whole-process follow-up, and referral of primary headache patients. Advanced Headache Centers shall be responsible for standardized diagnosis and treatment data management, follow-up, and rational triage of all headache patients, as well as health education for patients in the region. (4) Specialized continuing education in the region: Including continuing education for regional headache specialists to update their theoretical knowledge system; Advanced Headache Centers shall carry out training programs for headache specialists to cultivate professional talents. (5) Quality control: Advanced Headache Centers shall participate in and manage the construction of regional quality control networks and quality control work.

(Ⅴ) Work requirements

1. Precision diagnosis and treatment: Advanced centers shall have the capability to implement precision diagnosis and treatment, optimize diagnosis and treatment processes, and establish application demonstration units.

2. Application of AI-assisted systems: Popularize and apply AI-based data collection and auxiliary diagnosis systems (e. g., Clinical Decision Support System[31]).

3. Public education and promotion: Regularly carry out continuing education for specialized headache physicians and science popularization for patients within the region, at least once a year.

4. Quality control: Undergo regular quality control inspections and comply with quality control requirements, at least once a year.

5. Functions of advanced centers: Shall organize the formulation and update of diagnosis and treatment guidelines for various common types of headache and popularize such guidelines; organize national and international headache-related scientific research.

6. Experimental research: Encourage qualified headache centers to establish headache laboratories and conduct basic animal research.

(Ⅵ) Operational quality evaluation

Establish a quality control assessment system and quality control indicators, and implement construction in accordance with these indicators[26].

The outpatient operational quality evaluation is the same as mentioned above.

Quality control indicators after setting up beds include: (1) Hospital admission capacity: The proportion of dedicated headache beds in the total number of beds in the neurology department (admission capacity); annual number of hospitalized headache patients. (2) Standardized diagnosis and treatment status: Rate of standardized medical records for hospitalized migraine patients, correct diagnosis rate of hospitalized headache patients, recording rate of acute medication use, application rate of specific acute medications, application rate of preventive medications, notification rate of medication withdrawal for patients with medication overuse headache, rate of non-oral medication treatment provided in the hospital, screening rate for comorbid anxiety and depression, screening rate for comorbid sleep disorders, disability assessment rate. (3) Whole-process patient management: Follow-up rate, headache diary recording rate, number of patient education sessions conducted annually. (4) Professionalism of the team: Proportion of personnel participating in professional training. (5) Data management and quality control: Application of clinical decision support system; participation of Advanced Headache Centers in regional quality control and management. (6) Continuing education: Conduct of continuing education by Advanced Headache Centers.

The number of headache patients in China is enormous. To achieve standardized whole-course management of headache, it is imperative to construct a national systematic prevention and control system and implement hierarchical diagnosis and treatment based on diagnostic and treatment capabilities and resource integration. Experts in the field of headache from the Neurology Branch of the Chinese Medical Doctor Association and the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association have been promoting the construction of a national headache prevention and control base and system. Headache clinics and headache centers are specialized and independent diagnosis and treatment units for headache management, capable of fulfilling various tasks related to the whole-process management of headache disorders. Institutionalized construction and quality control are the foundations for ensuring standardized diagnosis and treatment. Based on their respective experience in chronic headache management in affiliated hospitals, combined with domestic and foreign literature, experts nationwide have formulated this consensus after repeated discussions and practice, aiming to provide guidance and suggestions for the construction of headache clinics and headache centers. In the later stage, it will be continuously updated based on feedback from the actual construction process for reference by physicians at all levels.

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Conflicts of Interest All authors declare no conflicts of interest.

头痛作为临床常见症状,是神经内科门诊的主要就诊原因之一。因其患病率高、致残率高及增加疾病负担而成为全球公共卫生的重要问题[1,2]。虽然各国在头痛防控方面都投入了大量资源,但经济水平、人口素质及医疗卫生重视程度等方面的差异限制了头痛诊治规范化水平。发达国家部分地区及大多数发展中国家仍面临就诊率低、诊断准确率低、预防治疗不足及止痛药物过度使用等问题[3]。

我国地域广阔、人口众多,医疗资源、水平和服务质量存在显著区域差异,头痛规范化诊治不平衡问题突出,导致疾病负担沉重[4,5]。因此,在全国范围内建立统一的头痛诊疗标准化流程、规范管理制度和综合管理流程,建设一定建制的头痛门诊和头痛中心,提高我国整体的头痛诊疗水平,是亟待完成的目标和任务[6]。近年来,国家卫生健康委员会持续推动以单病种诊疗能力为核心的医疗服务体系建设,按病种遴选具备顶尖诊疗能力的医院作为国家级或区域级中心,打破行政级别限制,逐步淡化传统的医院等级(如三甲、二甲),强调以临床实际需求和诊疗水平作为资源配置的依据[7,8]。据此,中国医师协会神经内科医师分会和中国研究型医院学会头痛与感觉障碍专业委员会,根据头痛疾病的诊疗规律和我国医疗资源分布特点,遵循专病分级诊疗的原则[9],在全国范围内推动头痛防控基地和体系建设[10],且已初具规模。头痛规范化诊疗单元是头痛防控体系的重要组成部分[9,11,12],是头痛规范化全程管理的具体实施单位[13]。所有头痛诊疗单元都是各级医院神经内科下属的头痛亚专科,非独立诊疗机构。根据诊疗水平、软硬件配置及专业能力,头痛诊疗单元分为头痛门诊和头痛中心,后者又根据其开展的业务范围、学术水平、复杂疑难疾病诊治能力和比例等进一步分为头痛中心和高级头痛中心。不同诊疗单元承担的职责和任务不同。为了更好地诠释头痛防控体系的内涵建设,指导全国范围内体系内外的头痛诊疗单元做好建设工作,中国医师协会神经内科医师分会和中国研究型医院学会头痛与感觉障碍专业委员会的专家发起并制定本共识,旨在对建设分级头痛诊疗单元给予指导性意见和建议,明确在单元建设条件、业务范围、质控管理和继续教育等方面的工作细节,以期早日实现头痛在我国的规范化、同质化诊治。

一、共识制定方法

(一)共识涵盖范围和目的

为帮助和促进我国头痛门诊和头痛中心建设,中国医师协会神经内科医师分会联合中国研究型医院学会头痛与感觉障碍专业委员会发起、讨论并制订本专家共识。内容涵盖了头痛门诊和头痛中心建设中涉及的定位、医师资质、人员配备、硬件建设、能力建设、工作要求、运行质量评价等具体内容。专家共识发布的目的旨在专科建设过程中有据可依、有纲可查、有纪可循。

(二)共识制定专家组

本专家共识的专家组成员以中国人民解放军总医院神经内科医学部及来自全国各地的神经内科及相关学科专家组成,囊括了头痛专业的资深学者,不同级别医院神经内科专科管理者、统计学专家、《中国头痛防控基地和体系建设》项目中头痛门诊和头痛中心评审专家等,包括临床医学专家、方法学专家、循证医学专家等共89名。

(三)共识的讨论与撰写

根据“当证据存在争议、不确定或缺乏高质量证据,尚不足以形成指南且临床问题又亟待解决,宜采用专家共识类文件”的原则[14]。专家组系统回顾了国内外关于头痛管理方法的文献,通过专家草拟、讨论、专家小组会讨论,结合我国实际的医疗现状、头痛管理和实际运行经验,采用德尔菲法进行问卷调查,最终形成推荐意见。

(四)共识的发布、传播与更新

专家共识形成后,经多轮专家论证会,最终确定并发布。共识将主要通过以下方式传播与推广:(1)在相关学术期刊发表;(2)在学术会议宣讲;(3)通过中国头痛防控体系应用。本专家共识发布后,将根据实际应用及相关研究证据的出炉完成更新,以更好地指导实践并形成规范。

二、共识中头痛门诊的具体内容

(一)定位

开设头痛门诊是为解决区域内头痛患者跨区域就诊困难,实现就近诊疗。头痛门诊可以为区域内各类头痛患者提供专业诊疗和全程管理,为头痛患者提供长期随访、数据存储和更新、面对面宣教等全程管理[15]。临床开展业务包括原发性头痛的规范化诊断与治疗、继发性头痛的常规检查与诊治,以及疑难复杂病例的识别和转诊[9]。

(二)医师资质和人员配置

具备经过头痛诊疗专业化培训资质的神经内

科专科医师。人员配置可纳入全科和疼痛科医师，不少于3人，以推动门诊尽快开展。

(三)硬件建设

1.医疗机构应：具备二级及以上综合性或专科医院资质。

2.诊室配置：应有固定空间，提供固定的头痛专病诊疗时间，至少3次/周。配备头痛诊疗必备的体格检查工具和设备。提供宣教资料、头痛日记[16]等。

3.设备配置方面：实验室应具备血常规、血生化、凝血、免疫、血气等，脑脊液常规、生化、免疫及病理等检查的仪器设备；影像方面，应配备CT、MR、脑电图、心电图仪、血管超声等设备[17, 18]，可提供24 h动态心电图设备(Holter)。

4.基础治疗和管理方面：配备基本的急性期和预防性治疗偏头痛药物[19]及偏头痛急性期特异药物[20]；规范处方管理。

(四)临床能力及团队管理

1.团队管理：应为多学科协作团队，以神经内科为核心，整合神经外科、疼痛科、中医科、康复科、心理科、放射影像科和超声科等。对专科医师定期培训，要求定期参加头痛继续教育项目(至少1次/年)[21]。

2.业务范畴包括：(1)标准化诊疗，遵循头痛诊疗指南和临床路径[19,20]，确保诊疗规范性。(2)治疗技术，急性期治疗根据急性期治疗指南规范用药[20]、避免药物过度使用，鉴别并转诊疑难病例。预防性治疗根据指南规范预防、规范用药、定期随访，提供头痛咨询及健康教育；指导患者记录头痛日记，收集医疗资料；配套治疗技术，如精神心理治疗(CBT)[22]、物理治疗、中医针灸治疗等[23]技术。(3)患者全周期管理，实施健康宣教[24]、诊疗数据记录、数据更新，定期随访病情与用药情况，评估患者头痛日记的记录情况，应用量表评估疾病负担[25]；使用规范化随访手册，涵盖诊断、治疗方案及随访计划。

(五)工作要求

优化诊疗流程，提高诊疗正确率和诊疗效率。积极参加医务人员继续教育、管理数据、随诊，参与科学研究。开展区域内患者的健康宣教(如偏头痛关爱月义诊)，至少1次/年。配合区域内头痛中心，建立本地患者的临床资料数据集[2]，接受区域高级头痛中心质控。

(六)运行质量评价

建立质量控制考核制度、质量控制指标，按照该指标要求实施建设[26]。

1.医院接诊能力：门诊每月头痛患者的接诊量(头痛接诊量)，偏头痛占同期头痛患者接诊量的比例(偏头痛接诊率)。

2.标准化诊疗状况考核指标：偏头痛患者门诊规范病案率，头痛患者正确诊断率，急性期药物使用情况记录率，急性期特异性药物的应用率，含成瘾性药物(阿片、巴比妥等)的处方率，偏头痛门诊患者预防性药物的应用率、合并药物过度使用性头痛患者药物戒断告知率、共病焦虑抑郁筛查率，共病睡眠障碍筛查率，失能评估率。

3.患者全流程管理评价指标：随访率，头痛日记记录率，患者教育开展频率。

4.团队专业程度：参与专业培训的医师比例。

5.数据管理和质量控制年度核查。

三、共识中头痛中心的具体内容

(一)定位

头痛中心是在开设头痛门诊的基础上在病房开设一定数量床位，收治疑难复杂头痛患者的头痛诊疗单元。开设头痛中心单位应代表区域内头痛疾病诊疗水平，具有较丰富的头痛诊治经验，所在医院应具有面向头痛全病种诊疗的临床配置，负责承担区域内头痛的临床、教学、科研及质控任务，在区域内推动头痛规范化诊治并牵头或参与一定水平的学术研究。

按照临床诊治能力、业务水平、人员配备和学术影响力等因素，分为头痛中心和高级头痛中心两个层级，各分权责。

(二)医师资质和人员配置

医师资质要求同头痛门诊，人员配置上需要具有头痛专病学术带头人。高级中心需要建立结构合理的头痛诊疗专业化的团队。

(三)硬件建设

1. 医疗机构资质：应为三级综合医院或专科医院。

2. 诊室和病房配置：诊室配置等同或高于头痛门诊诊室配置(如数据采集、临床试验专员)。病房应配备≥5张固定数量的头痛专病床位。

3. 检查配置：等同或高于头痛门诊检查配置。配备3 T及以上可行头颅MR及CTA、DSA、经食管心脏彩超、右心声学造影或经颅多普勒发泡实验、脑电图等设备，用于头痛的进一步诊治或开展临床研究。

4. 治疗基础：具备特异性头痛诊疗药物。可开

展神经阻滞[27]、A 型肉毒素注射[28]、无创神经调控等治疗技术[29]。高级中心可开展硬膜外血贴治疗[30]。

(四)能力建设

1. 团队管理:头痛团队包括学科带头人和团队成员。学科带头人应为主任医师或副主任医师,具有丰富临床经验及科研能力。高级中心在区域内的头痛专业领域中具有影响力。团队骨干需经过省级或以上学术机构开展的头痛专业诊疗培训,团队人员结构合理。多学科协作团队应联合但不限于神经外科、放射科、影像科、超声科、疼痛科、中医科、康复科、心内科、心理科等专科。

2. 业务范畴:(1)标准化诊疗,即对各种类型的头痛开展标准化诊疗。(2)治疗技术,包括原发性头痛的规范化诊断和治疗(药物和非药物);继发性头痛的诊断和治疗;复杂疑难头痛的转诊识别。高级中心应能提供各种类型头痛的诊疗,远程会诊,接诊复杂疑难头痛患者的诊疗。(3)患者全周期管理,包括原发性头痛的数据管理、全流程随访和转诊。高级中心应承担各种头痛患者的规范化诊治数据管理、随访及合理分流。区域内患者的健康宣教。(4)区域内的专科继续教育,包括区域内头痛专科医师继续教育、更新理论知识体系;高级中心应开展头痛专科医师培训项目,培养专科医师。(5)质量控制,高级中心应参与和管理区域内质量控制网络建设和质量控制。

(五)工作要求

1. 精准诊疗:高级中心应具备实施精准诊疗,优化诊治流程,设立应用示范单位的能力。

2. 人工智能辅助系统应用:推广应用人工智能数据采集和辅助诊断系统(如临床决策支持系统[31])。

3. 宣教工作:定期开展区域内头痛专科医师继续教育及患者科普宣传,至少 1 次/年。

4. 质控:接受定期的质量控制检查,并符合质量控制的要求,至少 1 次/年。

5. 高级中心职能:应组织制定并更新各种常见头痛的诊疗指南并推广,组织全国性、国际性的头痛相关科学研究。

6. 实验研究:鼓励有条件的头痛中心建设头痛实验室,开展动物基础研究。

(六)运行质量评价

建立质量控制考核制度及质量控制指标,按照该指标要求实施建设[26]。

门诊运行质量评价同前述。

开设床位后的质量控制指标,包括(1)医院接诊能力:头痛专病单元开设床位占神经内科开设床位数的比例(接诊能力);头痛住院患者年接诊量。(2)标准化诊疗状况:偏头痛患者住院规范病案率,头痛住院患者正确诊断率,急性期药物使用情况记录率,急性期特异性药物的应用率,预防性药物的应用率,合并药物过度使用性头痛患者药物戒断告知率,院内开展的非口服药物治疗率,共病焦虑抑郁筛查率,共病睡眠障碍筛查率,失能评估率。(3)患者全流程管理:随访率,头痛日记记录率,每年开展患者教育次数。(4)团队专业程度:参与专业培训的比例。(5)数据管理与质量控制:临床决策支持系统应用,高级中心参与区域内质控和管理情况。(6)继续教育:高级中心开展继续教育情况。

综上所述,我国头痛患者数量庞大,为实现规范化头痛全程管理,构建全国的系统性防控体系、根据诊疗能力和整合资源分级诊疗势在必行。中国医师协会神经内科医师分会和中国研究型医院学会头痛与感觉障碍专业委员会头痛领域专家在全国范围内推进头痛防控基地和体系建设工作。头痛门诊和头痛中心是管理头痛专病的独立诊疗单元,可以实现头痛疾患全流程管理的多种任务。制度化建设和质量控制是保证规范化诊疗的基础。本共识由全国的头痛专家根据各自所在医院的头痛慢病管理经验,结合国内外文献,经反复讨论和实践后得以成文,旨在对头痛门诊和头痛中心建设给予指导和建议。后期也会根据实际建设过程中的反馈不断更新供各级医师参考。

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