

The Heart Success Center

AdventHealth Cardiovascular Institute



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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número siguiente 407-303-3025.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki anba an 407-303-3025.



Where Heart Failure Becomes Heart Success

For patients diagnosed with heart failure, the Heart Success Center at AdventHealth Heart of Florida delivers coordinated, evidence-based, effective care that ensures a safe transition from hospital to community.

The Heart Success Center's goal is to keep people in their communities and out of the hospital. To achieve this, our multidisciplinary team utilizes evidence-based practices intended to keep patients healthy longer. Working with the patient's primary care physician or cardiologist, our services are provided as a supplement to the patient's care plan.

Multidisciplinary Team

The medical director of the clinic, a cardiologist specializing in heart failure, leads our multidisciplinary team and manages patient care with the assistance of advanced practice registered nurses (APRNs). They work in conjunction with a pharmacist, dietitian, social worker, and transitional care registered nurses — all in one location.

Additionally, the team collaborates with the AdventHealth Transplant Institute to provide heart transplant services.

- **APRN:** Patient care will be managed by an APRN, who has advanced training in cardiology and heart failure.
- **Pharmacist:** Our cardiology-trained clinical pharmacist will help patients manage their disease through education and medication management.



- **Registered licensed dietitian:** The dietitian provides nutritional services, including dietary education for disease management, personalized meal plans and feedback to help patients succeed.
- **Social worker:** A social worker is available to assist qualified patients with coordination of care and navigating any obstacles they encounter within the health care system. They also coordinate post-clinic care, including home health care, meal options, financial assistance, access to health care services, transportation, and social and family support.
- **Transitional-care registered nurses:** These nurses assist in the transition from hospital to home through inpatient education, coordinating care and calling patients at home to answer questions and offer support.

To learn more or to schedule an appointment, call 863-422-5331.