Advance care planning (ACP) has gained momentum as a vital component of quality healthcare decision making for all individuals, and for optimizing palliative and end-of-life care for those with advanced illness. However, the ultimate and potential impact of ACP services will be dependent on the answers to several key questions. How will ACP services be appropriately embedded into the routines of care delivery models over the lifetime of an individual? Can there be consensus on the outcomes that should be achieved when building ACP services? Will the role of the ACP facilitator be embraced as an integral component of an ACP team that delivers competent and reliable planning assistance? How will these individuals be trained and reimbursed for their services? What commitment will be required of organizational and community leaders in developing an ACP system that is sustainable and enduring? Will improved strategies be developed that provide flexibility in documenting individual preferences for treatment decisions and effective strategies for storage and retrieval be created? This session will explore these questions and provide the presenter’s reflection on her 14-year history assisting organizations throughout the world in implementing improved ACP programs and practices.