Advance Care Planning: Overview and Resources for Healthcare Professionals, Patients, and Families

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Article

Abstract

Many people in the United States suffer from one or more major chronic diseases. With the rise of individuals living with chronic and serious illnesses, effective advance care planning (ACP) is essential to ensure all patients receive care that is congruent with their preferences. Advance care planning (ACP) is a proactive, patient-centered process in which individuals delineate their preferences about medical care before losing their decision-making capacity. This process is ongoing and should be re-visited regularly to ensure it remains relevant and reflective of an individual's current wishes. In this article, we provide an overview of ACP, components of ACP, benefits and barriers of ACP, resources available for nurses/healthcare professionals, patients, and families. We also discuss the role of nurses in facilitating ACP, and additional policy considerations.

Key Words: Advance care planning, advance directives, healthcare proxy, surrogate decision-maker, goal-concordant care, wishes, resources, POLST, MOLST, healthcare policy

Approximately 129 million people in the United States (U.S.) are suffering from at least one major chronic disease, and 42% of the population have two or more chronic diseases (Benavidez et al., 2024). With the aging of the population and the rise of individuals living with chronic and serious illnesses, there is a critical need for effective advance care planning (ACP) to ensure all patients receive goal-concordant care that aligns with their values and preferences. Advance care planning is an ongoing process where individuals discuss and communicate their values, goals, and preferences for current and future healthcare with family members and healthcare providers before losing their decision-making capacity (Rietjens et al., 2017; Sudore et al., 2017).

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The main goal of ACP is to ensure that individuals receive goal-concordant end-of-life care (Morrison et al., 2021). ACP is considered one aspect of palliative care that increases the likelihood of ensuring that individual wishes are known and followed (Bond et al., 2021). Individuals, their families, and decision makers are encouraged to start ACP conversations early in the disease process, before the disease has progressed and before situations become more critical or chaotic (Brull, 2019).

ACP is particularly important for individuals with advanced age, chronic illness, serious illnesses, or life-threatening conditions. Many advanced serious illnesses, such as dementia and metastatic cancer, can impair cognitive function and potentially shorten the window during which a patient is able to express their healthcare preferences. That burden would then be placed on the family or a designated decision maker. Making difficult decisions in emergency situations or when symptoms have progressed to a later stage is always more difficult than in a controlled situation when interventions, wishes, and goals can be discussed openly, and the patient is not in physical or emotional distress related to the disease.

The trend of professionals taking a reactive versus proactive approach can also result in a delay of initiating these conversations (Zhu et al., 2025). A proactive approach involves initiating goals-of-care conversations early, before an acute medical crisis, and allows patients to reflect on what matters most to them. It also allows time for them to communicate their wishes to loved ones to ensure their preferences are respected. A recent paradigm shift recommends that ACP should focus on individual's current health-care scenario, rather than completing documents that depend on hypothesizing about potential future situations (Graham et al., 2022; Jacobsen et al., 2022; Morrison et al., 2021; O'Rourke et al., 2023). Recent evidence has suggested reconceptualizing ACP as a holistic process over the life course, consisting of both in-the-moment decision making and advanced decisions at every life stage (Hickman et al., 2022). Individual health status, goals, preferences, and values may change over time as the trajectory of serious illness progresses or as conditions and life situation change (Izumi et al., 2017). Therefore, ACP should be an ongoing process that involves regular discussions, reassessment of treatment goals and care preferences, and shared decision-making among individuals, families, and healthcare providers.

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Components of Advance Care Planning

In this article, we provide a description of the different components of ACP, benefits and barriers of ACP, and resources available for nurses/healthcare professionals, patients, and families. We also discuss the role of nurses in facilitating ACP, and additional policy considerations. To begin, there are generally three steps involved in completing an ACP, a) ACP discussions, b) assigning a healthcare proxy/surrogate decision maker, and c) completing written advance directives.

Conversations can be initiated by a patient, provider, social worker, or any other member of the interdisciplinary team

Advance Care Planning Discussions

The advance care planning discussion usually involves a process of talking about or sharing one's values, goals, wishes and preferences concerning the care desired at the end of life or potential future medical care decisions (Morrison et al., 2021). Conversations can be initiated by a patient, provider, social worker, or any other member of the interdisciplinary team (IDT). Primary care providers as well as specialists can place palliative care referrals to initiate these conversations with patients and families. However, palliative and hospice care team members have specialized training and skills about how to initiate and facilitate these difficult and often emotional conversations. These providers are typically available for consultation/assistance in navigating these challenging situations.

Assigning a Healthcare Proxy

Assigning a healthcare proxy or a surrogate decision-maker is a process where patients choose and prepare a specific trusted person to make medical decision on their behalf in situations where they lose their decision-making capacity or are unable to express their preferences for end-of-life care (Morrison et al., 2021). The main purpose is to ensure that patients have shared their values and preferences with their healthcare proxy so they can make end of life decisions that align with their goals. This will also tremendously reduce distress and burden for the designated healthcare proxy if/when asked to make complex end of life decisions during the final days of a patient's life.

Advance Directives

Advance directives (ADs) are the written documents that capture patients' wishes and desires about the treatment or care they want to receive at the end of life. Documenting these wishes ensures that their wishes are followed as closely as possible when future medical decisions need to be made (Morrison et al., 2021). ADs become a legal description of individual preferences, delineating specific healthcare options that may be accepted or rejected, in the event of a major illness (House et al., 2025). They also provide legal documentation of the designated individual or individuals who may act on behalf of patients in the event they are unable to communicate their wishes (House et al., 2025). Advance directives serve as a valuable record/document that assists surrogate decision-makers and healthcare providers to honor patient wishes and provide goal-concordant care in evolving and complex medical situations (House et al., 2025).

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Other Advance Care Documents

POLST. Other options to document personal wishes for medical care during serious illnesses may be applicable depending on the state of residence. Many states have adopted a variation of an advance directive called a POLST (Provider Orders for Life Sustaining Treatment). Another name that may be used in some states is a Physician Orders for Scope of Treatment (POST), MOLST (Medical Order for Life-Sustaining Treatment) or MOST (Medical Order for Scope of Treatment). In this article, we will use the term POLST to represent these documents. This type of document is not an advance directive per se, but rather a portable medical order that can complement advance care documents.

POLSTs are portable, modifiable, and specifically relate to the current clinical state of the person with a serious medical illness (National POLST, 2022). A POLST document allows patients to express their preference for very specific types of medical interventions in the case of a serious illness. Examples include cardiopulmonary resuscitation (CPR), full treatment, intensive care unit interventions, hospital transfers, intravenous fluids, intubation, comfort care, use of oxygen, antibiotics, and medically administered fluids and nutrition. In each section "other instructions" may be added to individualize treatment preferences. For example, the use of mechanical ventilation may be limited to no longer than a specific length of time and details about tracheostomies or feeding tubes may be specified. Because POLST forms only require a healthcare provider's signature instead of an attorney, they are easier to complete. The type of provider who can complete the form varies from state to state. In many states, a POLST can be signed by a physician, nurse practitioner, or physician assistant. These documents should be frequently reviewed and revised as necessary when there is a significant change in condition or a hospitalization.

Five Wishes. Another option, similar but more comprehensive than standard advance directive documents, is the *Five Wishes* program (Five Wishes, 2025). This program is recognized nationally except for the states of Texas, Kansas, New Hampshire, and Ohio where an additional notarized form must be filed to ensure its validity. *Five Wishes* is unique in that it addresses not only medical treatment, but also emotional, legal, spiritual, and other personal treatment. It is a comprehensive workbook that, when completed, becomes an actual legal document. *Five Wishes* includes identifying healthcare surrogates, selections among various medication treatments, provides scenarios that assist people to determine their own wishes given a certain situation, and offers areas for additional written individualized documentation. Comfort care is also a major focus. Comfort care decisions involve determinations around which types of pharmacological and non-pharmacological interventions that a person will accept (or not). Other aspects unique to *Five Wishes* include wishes for the presence of clergy or other spiritual advisors, the use of music, family presence, and more. Unlike POLST, Five Wishes documentation requires a witness signature but does not require the signature of a medical provider.

In summary, goals of care conversations and completing advance care planning can be accomplished by any member of the healthcare team including registered nurses, nurse practitioners or other advanced practice providers, physicians, or social workers. Starting advance care planning conversations early and revisiting them often is essential. It is important to ensure that healthcare providers are familiar with their own state regulations to ensure the correct documents are completed accurately.

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Benefits and Barriers to ACP

The Institute of Medicine's (IOM)*Dying in America* (2025) report emphasized the need for new models of care that promote ACP conversations. Despite the recommendation and potential positive benefits, ACP execution is low in the general population. A recent systematic review of literature that examined 150 studies for ACP completion rates found that 36.7% of participants had completed ADs and only 29.3% had living wills (Yadav et al., 2017). The proportion of those engaging in ACP is even lower in older adults in general at 2.8% to 26% (Bischoff et al., 2013). Lack of ACP can lead to reduced autonomy and increased healthcare costs during end-of-life (Michael et al., 2014). Without ACP, patients may receive aggressive, high-intensity care that may not be concordant with their goals and preferences (Johnson et al., 2016).

Despite the recommendation and potential positive benefits, ACP execution is low in the general population.

With the aging of the population an increased number of older adults are living longer with one or more chronic diseases (and the associated physical and psychological symptom burden and functional decline). Given this, ACP discussion and completion become increasingly important (Watson et al., 2025). Recent literature has documented benefits to ACP, and a number of barriers that prevent greater participation in this process.

Benefits of ACP

Despite the evolving paradigm shift and reconceptualization of ACP to focus on a patient's current health-care scenario, a recent scoping review found that all ACP intervention outcomes were positive. Outcomes included increased satisfaction of care among patients and surrogates, and decreased distress among surrogates and clinicians (McMahan et al., 2021). Other potential benefits of ACP have included increased sense of control, feeling respected and heard, an improved quality of end-of-life (EOL) care, improved EOL communication, enhanced satisfaction with care, fewer hospitalizations, increased use of palliative care, reduced stress, anxiety, depression, burden, and grief among family members, and lower healthcare costs (Bond et al., 2018; Brinkman-Stoppelenburg et al., 2018; Houben et al., 2018; Jimenez et al., 2018; 2019; Johnson et al., 2016; Zwakman et al., 2018). ACP conversations help individuals exercise autonomy and make informed decisions about their care (IOM, 2015). They have also been found to reduce moral distress among healthcare professionals because of greater awareness about what matters most to their patients (McMahan et al., 2021).

Barriers to Participation in ACP

Patient/family related barriers noted in the literature included lack of knowledge about ACP, fear of negative impact on relationship with providers, uncertainty about healthcare preferences, lack of ability to initiate ACP, consideration of ACP as an emotional/sensitive topic, perception of being too young to complete ACP, lack of clarity about who is responsible for initiating ACP conversations, lack of time for appointments, concerns about family dynamics, and ACP not being a priority (Bernard et al., 2020; Moore et al., 2022; Poveda-Moral et al., 2021). Provider related barriers included lack of knowledge, education, understanding, and skills for ACP; fear, hesitation, discomfort, or resistance to starting conversations about ACP; difficulties with follow-up; a lack of time for discussions; and differences in ACP policies across various geographic regions (Blackwood et al., 2019; Kim & Flieger, 2023; Poveda-Moral et al., 2021).

ACP conversations help individuals exercise autonomy and make informed decisions about their care

Provider uncertainty about prognosis or what constitutes a terminal diagnosis can also impact the ACP discussions. Im et al. (2023) noted that physicians found it difficult to diagnose terminal illnesses promptly due to uncertainty about how the disease would progress (34.1%) and unclear diagnostic criteria (30.1%). Evidence has also suggested there is a lack of standard guidelines and documentation systems for how to facilitate and document ACP discussions (Izumi, 2017). As a result, conversations about end-of-life care often do not happen until very late, and patients and their families arrive at difficult decision-making points unprepared by any prior conversations (Izumi, 2017).

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Barriers related to ACP conversation and documentation highlight the importance of raising knowledge and awareness of ACP among patients, families, and healthcare providers in general. Below we present ACP resources available for each of these groups assist them to navigate the complexities of the ACP process and facilitate timely ACP discussion and documentation.

Advanced Care Planning Resources

Resources for Healthcare Professionals

Many national organizations provide training and education for healthcare professionals to advance knowledge about facilitating ACP discussions. Listed below are descriptions for several frequently and most used ACP resources/programs with links and additional helpful resources listed in the comprehensive Table following this discussion.

Serious Illness Care Program (SICP). The SICP serves as a framework for healthcare professionals/clinicians to explore, fully understand, and honor what matters most to their patients (Ariadne Labs, n.d.). The program has resulted in increased earlier and better serious illness conversation leading to reduced stress, anxiety, and depression among patients; improved patient and clinician experiences; and reduced medical costs.

Respecting Choices. The Respecting Choices (n.d.) program offers guidance and support to implement effective systems for advance care planning and person-centered decision making. The main goal is to integrate and disseminate evidence-based best practices that ensure individuals' preferences and decisions for healthcare are known and honored through shared decision-making. This program has developed conversations to meet the care planning needs of individuals in all walks of life, including healthy adults, a patient navigating a complex serious illness, or individuals approaching the end of their lives.

Center to Advance Palliative Care (CAPC). Center to Advance Palliative Care ([CAPC], n.d.) offers events, ideas, and various resources to improve care for people with a serious illness. In particular, the center features online courses and toolkits for communication skills and care planning, including information on billing and coding for ACP services. For healthcare providers and organizations, CAPC offers information for hospitals such as a state-by-state serious illness scorecard, quality outcomes for healthcare organizations, building and strengthening a palliative care program, workforce training, and policy recommendations that address access, quality, and training about palliative care.

The End-of-Life Nursing Education Consortium (ELNEC). ELNEC (American Association of Colleges of Nursing, n.d.) is an educational program for nursing faculty, continuing education providers, staff development educators, and nurses in various specialties (e.g., pediatrics, oncology) to provide training in palliative care. The purpose is to improve palliative care by training educators to teach the essential information to other healthcare providers. The ELNEC curriculum consists of six modules about various components of palliative care: Nursing Care at the EOL; Pain Management; Symptom Management; Communication; Loss, Grief, and Bereavement and Preparation for and Care at the Time of Death. ELNEC could be a helpful resource to integrate more palliative care content in nursing curricula to equip nurses to raise knowledge and awareness about ACP.

The Hospice and Palliative Nursing Association (HPNA). The purpose of the HPNA is to advance nursing expertise in palliative and hospice care. HPNA provides numerous resources including orientation guides, study guides for certification exams, scopes and competencies, position statements, managing grief, and more. Specific to ACP, they have provided a brief overview and have shared several online resources on ACP (Hospice and Palliative Nurses Association, n.d.).

Resources for Patients/Families

There are well-established programs to educate and promote ACP engagement among patients and family members/care partners. These programs have demonstrated improved rates of ACP conversations with loved ones/healthcare professionals about care preferences and completion of advance directives. Below are examples of several ACP programs for patient and family members/care partners. Additional resources, including links to websites, are located in the Table at the end of this discussion.

Five Wishes. *Five Wishes* (n.d.) offers advance directive planning resources for organizations and patients and families in a variety of easily understood formats. Podcasts, videos, booklets, and paper and pencil documents are available depending on individual and group needs. Sample documents may be viewed on-line and are customized for the legal requirements in each state.

Prepare for your Care. Prepare for your Care is an ACP program whose mission is to help people have a voice in their own medical care. The program includes resources to prepare for your own care, to help other people, and instructions about how to use the program within larger organizations or quality projects (PREPARE, n.d.). The PREPARE program includes video stories and easy to read advance directives that help patient and families to prepare for medical decision making. Information is available free on their website.

Begin the Conversation. Begin the Conversation (n.d.) is dedicated to helping people talk about their own end-of-life care and healthcare wishes. The difficulty of “facing the elephant in the room” is acknowledged. Begin the Conversation focuses on the following steps in the process: educate, prepare, communicate, document, act, and empower. Important information is covered, such as the fact that although 80% of people wish to die at home, only 75% actually achieve that goal. Patient and provider resources are available along with testimonies from people who have used the site.

The Conversation Project. The Institute for Healthcare Improvement offers several resources for patients, families, and providers about ACP. The Conversation Project (n.d.) was developed to assist people with talking about end-of-life care. It includes written guides to start the conversation and choose a healthcare proxy, and also how to become a proxy, how to talk with the healthcare team, and more. There are additional state-specific resources available.

My Directives. The focus of My Directives (n.d.) is making end-of-life planning simple and honoring medical wishes. Document storage can be cloud-based to allow access to the tools needed for patients to make their wishes known and for providers to access them as needed to avoid unnecessary or unwanted procedures. Resources for ACP can be found on their website.

Table. ***ACP Resources for Healthcare Professionals, Patients, and Families***

ACP Resource	Brief Description	Website
For Healthcare Professionals		
Center to Advance Palliative Care (CAPC) (n.d.)	Online courses and toolkits on communication skills and care planning	https://www.capc.org
The End-of-Life Nursing Education Consortium (ELNEC) (AACN, n.d.)	Educational program to provide training in palliative care	https://www.aacnnursing.org/elnec
The Hospice and Palliative Nurses Association (HPNA) (n.d.)	Definition and online resources on ACP	https://www.advancingexpertcare.org/practice-research/resource-pages/advance-care-planning/
Serious Illness Care Program (SICP) (Ariadne Labs, n.d.)	Framework for providers to explore and honor what matters most to patients	https://www.ariadnelabs.org/serious-illness-care/
Respecting Choices (n.d.)	Guidance and support in implementation of effective systems for ACP and shared decision making	https://respectingchoices.org/
Vital Talk	Offers courses and other resources to train healthcare providers to have effective meaningful conversations with patients/families with serious illness	https://vitaltalk.org

Oncology Nursing Society (ONS)	Clinical practice resources, videos, and educational articles on ACP in oncology	https://www.ons.org/publications-research/voice/news-views/04-2023/advance-care-planning
Center for Medicare and Medicaid (CMS) (2025)	Information for providers about ICD codes and other billing guidelines to use for ACP discussion	https://www.cms.gov/files/document/mln-advanced-care-planning.pdf
ASCO post on ACP Advocacy (Doyle, 2023)	Summary on the last decade of research findings on ACP benefits for cancer	https://ascopost.com/issues/december-25-2023/the-power-of-patient-advocacy-10-year-study-reveals-increased-survival-rates-with-enhanced-advance-care-planning/
For Patients & Families		
Five Wishes (2025)	Advance directive planning resources for organizations and patients and families in easily understood formats	https://www.fivewishes.org/
Prepare for Your Care (PREPARE, n.d.)	Online interactive ACP program that helps patients prepare for their care	https://prepareforyourcare.org/
Begin the Conversation (n.d.)	Has resources dedicated to helping people to talk about their own end-of-life care and healthcare wishes	https://www.beginttheconversation.org/
The Conversation Project (n.d.)	Resources to help people share their wishes for end-of-life care. Has written guides for areas such as starting the conversation, choosing a healthcare proxy, talking with the healthcare team	https://theconversationproject.org/
My Directives (n.d.)	Resources focused on making end-of-life planning simple and honoring wishes	https://www.mydirectives.com/
Death Over Dinner (Round Glass, 2025)	Offers options for people ready to engage in difficult conversations with friends and family and for healthcare professionals	https://deathoverdinner.org/
Honoring Choices (n.d.)	Helps create a plan that aligns with individuals' preferences and goals for their care with their tools and support	https://www.honoringchoices.org/
ACP Decisions (n.d.)	Offers evidence-based videos in a variety of languages on ACP topics by physicians and health-care experts	https://www.acpdecisions.org/
Caring Conversations Materials (Center for Practical Bioethics, 2018)	Guide individuals and families through the ACP process. Includes forms for documenting who can speak for you and what treatment preferences you may have	https://www.practicalbioethics.org/featured-resources/caring-conversations/
National Alliance for Care at home (n.d.)	Free resources to educate and empower patients and caregivers to make decisions about serious illness and end-of-life care	https://www.caringinfo.org/
Medicare Advance Care Planning (n.d.)	ACP information including financial guidance about Medicare Part B coverage, deductibles and co-insurance coverage	https://www.medicare.gov/coverage/advance-care-planning
Family Caregiver Alliance (n.d.)	Information on end-of-life care specifically for caregivers of persons with advanced illnesses like Alzheimer's Disease/Dementia	https://www.caregiver.org/news/15-advance-care-planning-resources-for-national-healthcare-decisions-day/
US Department of Veterans Affairs (n.d.)	Resources about ACP and making decisions about health care priorities	https://www.va.gov/geriatrics/pages/advance_care_planning_topics.asp
Advance Care Planning (National Institute on Aging, (n.d.a; n.d.b.; 2023)	Multiple resources to learn more about ACP including common myths, tips for patients and families, advance directives, choosing a health care proxy, preparing a living will, ACP worksheets, and checklist for getting your affairs in order etc. NIA also has guides and tip sheets on various aspects of ACP (see links on the next column)	https://order.nia.nih.gov/publication/advance-care-planning-a-conversation-guide

Hello Game (Common Practice, n.d.)	Gaming activities to start to talk about difficult topics such as death and dying. Games are available as kits with materials depending on the number of participants.	https://commonpractice.com/products/hello-game

Nurse Role in ACP Discussions and Documentation

Nurses are ubiquitous healthcare providers of care across all settings. They are very well positioned to improve knowledge, awareness, processes, and documentation about ACP and can play an instrumental role in promoting discussion and completion of the ACP process and documents (Izumi, 2017). Several national nursing organizations emphasize the role nurses can play to facilitate ACP. For example, the American Nurses Association ([ANA], 2025) Code of Ethics Provision 1.4 'the right to self-determination' emphasizes the role of nurses in promoting ACP conversations and assisting patients and families in reflecting on end-of-life decisions. Similarly, the Oncology Nursing Society (ONS) emphasizes that nurses are perfectly positioned to educate patients about ACP and implement the plans throughout their care (Greer, 2023).

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Patients have reported that they feel comfortable with nurse-led discussions about health-related values and consider them helpful (Epstein et al., 2019). Additionally, in its value statement on ACP, the HPNA (2025) recognizes and values ACP as an essential part of nursing care and believes that nurses are well-positioned to initiate, facilitate, and support ACP with patients and their families across all practice settings, helping them make informed decisions that reflect and align with their values, preferences, and goals. HPNA encourages palliative and hospice nurses to lead educational efforts to raise awareness about the importance of ACP to colleagues, patients, families, and the larger community (HPNA, 2025). Hospice and palliative care nurses have additional expertise to help individuals and families who are managing serious illnesses to engage in ACP discussions and documentation.

Many ACP discussions begin at home, in long term care facilities, and other outpatient settings where there are home health, palliative, or hospice care nurses. These nurses are able to monitor functional or cognitive decline, disease progression, or other changes that warrant the ACP conversation to be initiated or revisited. Examples of when nurses can intervene to initiate or revisit an ACP conversation may be at the time of diagnosis of a progressive or chronic disease, after a hospitalization, during an acute disease exacerbation or progression, or if a patient verbalizes a desire or has questions about ACP.

Many ACP discussions begin at home, in long term care facilities, and other outpatient settings where there are home health, palliative, or hospice care nurses.

One method that is helpful to begin and facilitate these delicate conversations is the SPIKES protocol (Baile et al., 2000). This six-step process involves: Setting up the interview; assessing the patient's Perception; obtaining the patient's Invitation; giving Knowledge and information to the patient; addressing the patient's Emotions with empathetic responses; and finally Strategy/summary (Baile et al., 2000). In conversation, nurses can inquire patients wish to be hospitalized or return to the hospital, or if they wish to be on a ventilator. These informal questions can open the door to a more advanced ACP conversation. Another successful strategy to raise awareness of ACP in the community is for nurses to partner with community leaders to train them as palliative care lay advisors. Such partnership has demonstrated success in engaging rural minoritized adults with cancer in ACP conversations (Larson, 2023).

Policy Considerations

One important strategy to facilitate discussion and completion of ACP earlier in the disease trajectory among patients with serious illness is to pass legislation to cover the costs of palliative care for patients and to incentivize providers for initiating ACP conversation and documentation. The Center for Medicare and Medicaid Services ([CMS], 2025) allows billing for ACP when only ACP is discussed, and the discussion is greater than 16 minutes. However, there remains a need for more insurers to provide reimbursement for ACP discussions with patients and families.

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With the aging population and an increasing number of individuals living with serious illness in the United States, the demand for quality palliative care is constantly on the rise. To meet this increasing demand, it is imperative for policymakers to build and sustain palliative and hospice interprofessional collaborative or interdisciplinary teams (which include physicians, advanced practice nurses/registered nurses, social workers, and chaplains). Such teams can enhance engagement about palliative care and ACP with patients and caregivers to meet their healthcare goals, and ensure their preferences are honored and they receive goal-concordant care (Lake, 2020).

In addition, effective policy efforts are needed to develop educational content and training programs for healthcare professionals to better equip them with the necessary knowledge and skill sets to work with patients in facilitating ACP (Jimenez et al., 2018; 2019). Evidence has suggested that there is an overall lack of palliative care integration in undergraduate and graduate nursing curricula (Ferrell et al., 2018). Therefore, to raise knowledge and awareness of ACP, additional content about palliative care should be integrated in undergraduate and graduate nursing curricula. Postgraduate formal training and certification in palliative care and ACP, such as the End-of-Life Nursing Education Consortium modules (ELNEC, 2023) should be encouraged.

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Conclusion

With the growing number of individuals who live with chronic and serious illnesses, ACP is essential to ensure that patients receive care aligned with their values and preferences. The ACP process empowers individuals to make informed decisions, reduces the burden on families, and improves the quality of end-of-life care. Despite its benefits, ACP remains underutilized due to barriers such as lack of awareness, discomfort with end-of-life discussions, and inconsistent provider training. Nurses, especially those in palliative and hospice care, are well-positioned to lead these conversations and advocate for patient-centered care. To improve ACP uptake, system-level changes are needed, including policy support for provider reimbursement, better education for healthcare professionals, and integration of ACP into routine care. Normalizing ACP as an ongoing, proactive process can ensure that more individuals receive goal-concordant care throughout their healthcare journeys.

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