

Abstract

This analysis evaluates the integrity of Florida’s Autonomous APRN licensure system after the implementation of **HB 607**. Utilizing publicly available data from **15,355 Autonomous APRN licensees**, PCG examined clinical hour reasonability, practice specialty, disciplinary history, and geographic distribution across rural and nonrural counties. In total, **1,731 Autonomous APRNs** were identified as **noncompliant** within one or more of the examined groups. These findings indicate inconsistent license verification, demonstrating the **need for a structured audit system, improved data reporting, and stricter application evaluation**.

Introduction

FLORIDA AUTONOMOUS APRN POLICY
In March 2020, Florida’s HB 607 authorized APRNs with the following qualifications to provide primary care without physician supervision to address workforce shortages: (1) either a **Masters of Science in Nursing (MSN)** or **Doctorate of Nursing Practice (DNP)**, (2) a **Florida APRN license**, (3) **completion of 3,000 MD/DO-supervised clinical hours**, and (4) **have no disciplinary action on record within the past 5 years** (Florida Statutes, 2025). In 2021, Rule 64B9-4.021 formally defined autonomous practice scope to be **limited to primary care**, described as including disease prevention, diagnosis, treatment, and discharge (Florida Statutes, 2025). **Renewal** of Autonomous practice status occurs **every two years** on the same schedule as a nurse’s APRN license and requires the completion of an additional **10 hours of continuous education (CE)** on top of the standard CE required for APRN licensure.

Methodology

DATA ANALYSIS

Using the Florida Department of Health’s (DOH) Division of MQA APRN licensure data, compliance with Autonomous APRN standards was evaluated across three domains: (1) disciplinary history, (2) practice specialty, and (3) supervised clinical hour analysis across in-state and out-of-state Autonomous APRNs.

MEASURES & PROCEDURES

(1) Compliance with **disciplinary standards** was assessed for in-state (rural & nonrural) and out-of-state Autonomous APRNs using public records from 2020-2025. Any practitioner with confirmed disciplinary action in the prior five years was classified as noncompliant. (2) Compliance with Florida’s autonomous nursing restrictions to primary care practice was collected using a custom web-scraper of Florida DOH profiles, classifying nurses into one of the following categories: **Primary Care License, Primary & Specialty Care License, Specialty License, No License, or Inconclusive**. Specialty License and No License nurses were flagged as noncompliant. Unspecified licenses were deemed as Inconclusive. (3) Compliance with the 3,000 supervised clinical hours was evaluated by calculating the elapsed time from **first APRN licensure date** to the **data download date**. Nurses that completed this requirement in 1.6 years or less were classified as noncompliant.

Compliance Evaluation of Autonomous Advanced Practice Registered Nurse Licensure Requirements in Florida

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Results

Compiled Autonomous APRN Results After Specialty and Clinical Hour Analysis

	Specialty Analysis Autonomous APRNs practicing with _____					Clinical Hours Analysis Reported 3000 hours in _____				
	Primary care License	Primary care + Specialty	Specialty License	No License	Inconclusive	1 yr.	1.2 yrs.	1.4 yrs.	1.6 yrs.	>1.6 yrs.
Rural 563	364	143	48	1	7	1	3	3	4	559
Nonrural 12,615	7,796	3,595	1,113	5	106	64	123	170	241	12,374
Out of State 2,103	1,579	252	261	4	7	41	54	64	82	2,021

Compliant Nurses

Potentially Non-compliant Nurses

Inconclusive Nurses

FIGURE 1. Table displaying the complete breakdown of compliant and noncomplaint Autonomous APRNs in Florida according to the analysis conducted. No noncomplaint Autonomous APRNs were discovered from the disciplinary action and are therefore, not included in the table.

Autonomous APRNs Completing 3,000 Clinical Hours by Timeframe

Florida’s Autonomous APRN License Type

FIGURE 2. This figure illustrates the number of Autonomous APRNs who completed 3,000 clinical hours in less time than the predetermined estimates set by the four work schedule models. Duplicate entries appearing across the progressively longer timeframes are shown in dark teal for nonrural nurses, dark blue for rural nurses, and dark purple for out-of-state nurses.

FIGURE 3. The figure above displays the distribution of the types of licenses among in-state (rural & nonrural) and out-of-state nurses. Overall, approximately 10% of all active Autonomous APRNs in Florida were found practicing in non-primary care specialties.

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SUMMARY

In summary, **1,731 nurses** (excluding duplicates) were discovered to be **potentially noncompliant with 0 nurses** having **disciplinary action** within the last 5 years. Furthermore, **1,432 nurses** were identified as **not practicing in primary care**, and **327** received their license in **under 1.6 years**. Additionally, the distribution of nurses equated to **45 rural nurses and 57 nonrural nurses per 100,000 residents**, respectively.

Discussion

IMPLICATIONS

Advanced nursing education is not as standardized as MD/DO programs. Many MSN and DNP programs offer **accelerated online options**, which may reduce hands-on training. Limited hands-on experience in core clinical domains may reduce the foundational skills expected of all healthcare practitioners and increase variability in readiness for autonomous practice. Additionally, initial licensure approval relies primarily on **self-attestation**, the 3,000 clinical hours are **not re-verified** at biennial renewal, and random audits **lack transparent details**.

RECOMMENDATIONS

To preserve Florida’s Autonomous APRN model without sacrificing patient safety, the Florida BON must strengthen its verification and audit process. Based off policy analyses on other restricted practice states, the following recommendations can be made: the Florida BON should adopt California’s **stepwise audit trail to create records of each review** and Texas and Virginia’s **independent verification** of supervised clinical hours via employment records, work schedules, or billing and claims data. Requiring all **original Autonomous APRN applications be retained** for subsequent audits and reviewing patient encounter logs in escalated and/or complex cases could further **detect noncompliance more reliably**.

LIMITATIONS

Our analysis was constrained by the Florida Department of Health APRN Licensure dataset’s **limited specificity and disclosure**. Key fields were missing, such as **academic credentials and date of first Autonomous licensure**. The lack of an original Autonomous APRN licensing date further limited our clinical hours analysis to **1.6 years prior to 10/02/2025**, and limited our **disciplinary action analysis to 2020-2025**.

Conclusion

Our analysis found **1731 noncompliant nurses**, indicating gaps in adherence to the Autonomous qualification standards. Strengthening the auditing process by replacing random audits with a **structured process, more consistent reviews, and clearer guidelines**, has the potential to reduce variability in compliance. Future studies might examine the impact of targeted education on **compliance rates**, investigate patterns of **education program type** and correlation to **documentation patterns**, and determine whether electronic prompts or workflow redesigns enhance adherence.

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