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Quality Improvement

Autonomous nurse practitioners in Florida frequently practice outside their legal scope of primary care: a cross-sectional study

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Abstract

Introduction: Nurse practitioner (NP) organizations have advocated for expanding the NP scope of practice as a means of meeting the increasing demand for primary care services. Florida enacted the NP unsupervised practice of medicine (UPM) as part of House Bill 607 in July 2020, with the stipulation that autonomous NPs practice within primary care. The objective of this study was to determine the extent to which autonomous NPs in Florida have limited their scope of practice to primary care.
Methods: We obtained a database of the population of autonomous NPs in Florida on 27 August 2024 from the Florida Department of Health, which contained a total of 11 925 NPs. Between November 2024 and February 2025, we randomly sampled 464 autonomous NPs across the state of Florida, ultimately reaching 328 autonomous NP practices.
Results: Of the 328 autonomous NP practices reached, 128 NPs were working in primary care, and 6 NPs were working in non-clinical roles. The remaining 194 autonomous NPs were working clinically in non-primary care settings, with the top five most common being (i) cosmetic and non-standard medical/surgical practices such as antiaging, IV hydration, vitamin infusions, hormonal therapy, and supplements ($n = 53$), (ii) psychiatry/addiction medicine ($n = 53$), (iii) emergency/urgent care ($n = 20$), (iv) inpatient medicine ($n = 13$), and (v) cardiology ($n = 9$).
Conclusions: Our study provides strong evidence that many autonomous NPs in Florida have established specialty practices and other services not within the legal scope of practice of Florida law. Stricter enforcement of NP practice within the scope of training and legislation is needed.
Keywords: primary care; independent practice; nurse practitioners; full practice authority; unsupervised practice of medicine

Introduction

Many Americans face barriers to accessing high-quality, affordable primary care, including a lack of appointment availability and geographic distance [1, 2]. Nurse practitioner (NP) organizations, as well as some public health officials and researchers, have advocated for expanding the NP scope of practice as a means of meeting the increasing demand for primary care services in the USA [3–5]. As of February 2025, 27 states, in addition to the District of Columbia, had passed legislation allowing NPs unsupervised practice of medicine (UPM), which nursing organizations typically refer to as "full practice authority." Florida enacted UPM as part of House Bill 607 in July 2020 with the stipulation that autonomous NPs practice within primary care.

The Centers for Medicare and Medicaid Services defines primary care as "health services that cover a range of prevention, wellness, and treatment for common illnesses." [6] Traditionally, medical specialties designated as primary care include family medicine, internal medicine, obstetrics/gynecology, pediatrics, and combinations thereof [7, 8]. These definitions align with Florida Statute 464.0123, which states that autonomous nurse practitioners may practice in general internal medicine, family medicine, pediatrics, and midwifery [9]. While there is tremendous variation in specific responsibilities across states and practices, family nurse practitioners (FNPs) are intended to "provide care for common acute and chronic illnesses in primary care as well as preventive care to individuals and families across the life span" [10] and refer patients to specialty care providers when necessary [11]. Adult-gerontology nurse practitioners [10], pediatric nurse practitioners (PNPs) [12], and nurse midwives [13] serve a similar role in contributing the principal source of care for specific patient populations (either age- or pregnancy-related).

According to data from the 2020 National Nurse Practitioner Sample Survey, 88.9% of NPs were certified in an area of primary care [14], suggesting good alignment between the training of NPs and the intended area of UPM in Florida. However, previous scholarship has described complexities regarding the NP certification process as well as the presence of NPs working in settings outside their training and scope of practice [15–18]. Specifically, literature has found that a large percentage of NPs certified in primary care are not practicing in primary care [19]. In addition, recent research from the Health Resources and Services Administration suggests that only 81 548 of 331 513 NPs (24.6%) active NPs are working in primary care [20], and

Key Messages

- Florida law requires autonomous nurse practitioners to practice in primary care
- More than half of Florida's autonomous nurse practitioners specialize
- Many Florida NPs choose cosmetic or non-standard medical/surgical services
- Overall, our study suggests substantial misalignment with statutory requirements
- Stronger regulatory oversight may be required to ensure adherence to Florida law

scholars have found that declines in NPs practicing primary care are on a similar trajectory as physicians [21]. As a result, ambiguity remains regarding whether NPs with primary care certification have remained within their legal scope of autonomous practice in Florida.

The objective of this study is to estimate the proportion of autonomous NPs in Florida working within their legal and intended scope of practice. In so doing, we aim to understand the impact of House Bill 607 on Florida's primary care workforce. We hypothesize that many autonomous NPs are working outside their legal scope of practice in primary care.

Methods

This is a cross-sectional study of autonomous NPs' specialties, including primary care, in Florida. We followed STROBE reporting guidelines. We obtained a database of the population of autonomous NPs in Florida on 27 August 2024 from the Florida Department of Health, which contained a total of 11 925 NPs practicing without physician supervision. Between November 2024 and February 2025, we randomly sampled 464 autonomous NPs across the state of Florida and obtained contact information for their primary practices through internet searches. A maximum of three attempts to contact each practice were made, and contact was made with a total of 328 autonomous NP practices. The final sample size was based on a prestudy power calculation. Fig. 1 shows the development of the study sample.

Practices were asked what services they provide, including specifically whether they offer primary care services. Due to the overlap between dermatology practices and medspas providing only cosmetic care (not skin cancer screenings, evaluation of rashes, or other standard dermatology care), practices that were initially coded as either dermatology or medspa underwent a second round review of websites, with a second phone call to clarify whether non-cosmetic services were offered if this information was unavailable on the website. An independent research assistant conducted verification of 10% of the coded data.

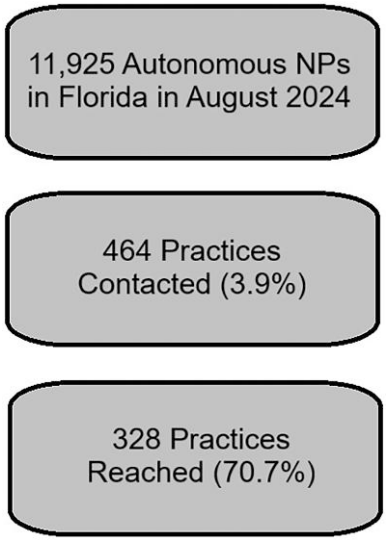

Figure 1 Development of study sample. NP, nurse practitioner.

Results

Of the 328 autonomous NP practices reached, 128 NPs were working in primary care, and 6 NPs were working in non-clinical roles, including academic positions. The remaining 194 autonomous NPs were working clinically in non-primary care settings, with the top five most common being (i) cosmetic and non-standard medical/surgical practices such as antiaging, IV hydration, vitamin infusions, hormonal therapy, and supplements ($n = 53$), (ii) psychiatry/addiction medicine ($n = 53$), (iii) emergency/urgent care ($n = 20$), (iv) inpatient medicine ($n = 13$), and (v) cardiology ($n = 9$). Table 1 shows the practice settings for the entire sample of autonomous NPs. Our estimated proportion of the autonomous NP population in Florida practicing outside their legal scope in Florida is 59.1% with 95% confidence interval [53.6, 64.4].

Of the 328 offices reached, 18 represented NPs who had moved their primary practice setting from out-of-state to Florida after the enactment of UPM. Among these NPs, only 3/18 (16.7%) had moved to Florida to practice primary care.

Conclusions

Challenges to increasing the primary care workforce include lower compensation compared to specialties, unrealistic workloads and expectations, and high rates of burnout [22]. These challenges exist for all healthcare professionals and likely contribute to increasing rates of specialization among non-physician clinicians [17, 23]. While it is understandable and unsurprising that NPs, like other healthcare professionals, prioritize compensation and lifestyle in their practice choices, our data counter existing narratives that NPs choose practice settings and specialties in a different way than other clinicians.

The NP role was created in 1965 to help physicians provide primary care and extend health care access to patients in underserved areas. Studies have shown that in both primary and acute care settings, physician supervision and involvement in care have been associated with higher-quality healthcare outcomes for patients [24, 25]. Ideally, physicians are available in-person to evaluate primary care patients at the time of visit; however, telemedicine consultation and alternating visits between physicians and NPs or physician assistants have also been shown to be effective [24, 26, 27]. While some NP advocates have argued that requiring physician supervision is a disincentive to choosing primary care, our data show that in the absence of supervision, the majority of NPs chose specialty practices as well.

Table 1 Specialties for autonomous nurse practitioners in Florida.

Specialty	Number (% of total)
Within scope of autonomous practice	
Primary care	128 (39.0)
Non-clinical (research, teaching, administration)	6 (1.8)
Outside scope of autonomous practice	
Cosmetic only or not standard medical/surgical practice	53 (16.2)
Medical specialties	
Psychiatry/addiction medicine	53 (16.2)
Emergency medicine/urgent care	20 (6.1)
Inpatient (hospitalist team, critical care)	13 (4.0)
Cardiology	9 (2.7)
Anesthesia and pain medicine	7 (2.1)
Neurology	6 (1.8)
Rehabilitation, skilled nursing, and wound care	5 (1.5)
Infectious disease	5 (1.5)
Hematology/oncology	3 (0.9)
Hospice and palliative care	2 (0.6)
Corrections	2 (0.6)
Accident and injury/workers" compensation	2 (0.6)
Rheumatology	1 (0.3)
Gastroenterology	1 (0.3)
Surgical specialties	
General surgery	3 (0.9)
Orthopedic surgery	2 (0.6)
Dermatology	2 (0.6)
Plastic surgery	1 (0.3)
Vascular surgery	1 (0.3)
Otolaryngology	1 (0.3)
Neurosurgery	1 (0.3)
Interventional radiology	1 (0.3)

The majority of NPs who moved to Florida after UPM was enacted also began specialty practices, most commonly in cosmetic or non-standard medical/surgical practice antiaging (medspas, IV hydration, vitamin infusions, hormonal therapy, and supplements) and psychiatry/addiction medicine. We cannot determine how this pattern differs from what would have been seen in the absence of UPM. However, the data raise concerns that UPM may have drawn NPs from out of state in order to practice autonomously in lucrative specialties rather than expand the primary care workforce. Given that expansion of the primary care workforce has been a key aspect of NP legislative advocacy for expanded scope of practice and the primary objective for legislators granting UPM, our study suggests that more transparency is needed regarding the actual practice choices of NPs.

While specialization among all healthcare professionals is on the rise, it is important to note that, unlike physicians and physician assistants, nurse practitioners are only certified to work with a specific patient population and setting. For example, a psychiatric mental health nurse practitioner is certified to work with patients seeking mental health services, and a family nurse practitioner is certified to work in family practice/primary care. There is significant misalignment between NP certifications and practice settings, meaning that NPs are frequently working in settings for which they do not have formal training [17]. In one study, for example, the majority of NPs working with critical care pediatric patients were not required to have acute care certifications [28]. Our study provides strong support that NPs are frequently working in settings outside their scope of practice and outside of Florida's legal statute for autonomous practice. For example, we found that certified registered nurse anesthetists, who do not have primary care within their scope of practice, were nonetheless granted autonomous licensure by the Florida Board of Nursing under the primary care designation after UPM in Florida was enacted. While it may be the case that autonomous NPs collaborate or receive some supervision in practice, their designation as autonomous is a question of legal status through the Florida Board of Nursing, not one of the diversity of supervision models in practice [29, 30]. Thus, our work is indicative of autonomy inconsistent with legal statute in Florida.

To compound the issue of misalignment between NP training in primary care and practice in specialty or subspecialty settings, few laws are in place that require nurses to disclose to patients whether or not they have training in the area in which they are providing patient care, nor should patients be expected to ask. Furthermore, particularly in the hospital setting, patients are unlikely to have the option to choose which clinician cares for them. Until 2023, no state required an emergency department to have a physician present in the building, and only two states have enacted such requirements as of 2025 [31]. Thus, there is a need for greater transparency to patients and their families regarding the training and scope of practice for NPs involved in their care, especially if they are practicing autonomously without physician oversight.

An important limitation of this study is that many NPs practiced in more than one specialty. To address this conservatively, we coded all NPs practicing at least some primary care as primary care clinicians, even if they were also working at a medspa or an urgent care, for example. As such, our study may underestimate the number of autonomous NPs working outside their legal scope. A second limitation of this study is that we were not able to reach all offices, and we cannot say with certainty that the offices that were reachable are representative of all offices. Furthermore, not all websites contained detailed information about the practice or practice setting. However, given the extent of practice outside of primary care, we are confident that we have identified a widespread concern. Third, this study was conducted in Florida, and the findings may not be generalizable to other states. Next, the definition of primary care differs by source. While we selected widely used definitions from national sources, it is worth noting that the Florida Board of Nursing's definition of primary care includes the following phrasing: "diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions," which could be applied to any medical specialty or subspecialty. Notably, the Board of Nursing had previously acknowledged specifically that NPs practicing in specialty areas, such as psychiatric mental health NPs, were not within the scope of primary care, then subsequently deleted that acknowledgment [32]. We do not believe that services such as interventional radiology, vascular surgery, and medspa or hormonal treatment, among others, fit

standard definitions of primary care or are the intended purpose of Florida House Bill 607. As such, we relied on traditional definitions. Finally, because our study took place at a single time point, we cannot determine whether the enactment of UPM contributed to NPs moving from primary care to higher-paying specialties, or whether they were practicing in specialty fields even prior to UPM.

Our study provides strong evidence that many autonomous NPs in Florida have established specialty practices and other services that are not within the intended legal scope of practice of Florida Statutes 464.0123 [9]. Stricter regulation and enforcement of NP practice within the scope of training and legislation are needed. Future research should examine the impact of this finding both on changes to primary care access and on patient care outcomes.

Conflicts of interest

All authors are financially uncompensated members of multiple patient advocacy and physician organizations, including specialty societies, Physicians for Patient Protection, and American Medical Association. None of these organizations had a role in study design or the development of this manuscript, and the views here do not necessarily reflect the views of any organization.

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Data availability

No privately generated or acquired data were used as part of this work; all data are publicly available.

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