Appendix Table 1

	Statements by Cluster (n=95)	Bridging Value	Average Importance Rating	Average Feasibility Rating	Priority Quadrant
1. Community and partner engagement (n=11)		**0.18**	**4.08**	**3.76**	
23	Be available to tribes when studies are done in their communities.	0.16	4.26	3.83	I
50	Conduct more community-engaged research addressing social context of diabetes prevention	0.01	4.17	3.82	I
61	Engage community stakeholders and residents using a community-engaged research process to identify critical areas to focus on	0.04	4.18	3.90	I
60	Engage members of communities with high disease burden in the design and implementation of prevention and treatment solutions	0.02	4.28	3.73	I
37	Include the patient population so they are equal partners in research, clinical care, outreach and long term care	0.14	4.00	3.77	I
8	Incorporate pre-existing community programs that have had success in the prevention and treatment of diabetes	0.30	4.38	4.04	I
38	Partner with the community to raise awareness of both the health implications of diabetes and the simplicity of treatment.	0.11	4.00	3.91	I
25	Work with local communities and tribes to understand and restore/develop local and indigenous food systems that are responsive to climate change	0.06	3.94	2.86	II
1	Be incorporated into community health centers	0.30	3.90	3.88	IV
28	Engage youth -- some proven prevention and intervention strategies need repackaging for the varied contexts and experiences of today's young people	0.48	3.83	3.86	IV
13	Focus on understanding social determinants of health through the lens of structural violence, i.e., systems underlying patterns of health equity	0.39	3.89	3.72	IV
2. Enrichment and capacity building (n=12)		**0.67**	**3.87**	**3.80**	
48	Engage clinics and the social service sector	0.35	4.06	3.86	I
18	Develop provider and researcher capacity for conducting community-engaged research and addressing social determinants	0.38	4.00	3.65	I
34	Disseminate research findings to make leaders and members of society more aware of the societal costs of poor health access	0.73	4.06	3.86	I
81	Ensure clear action steps to allow individuals and communities to benefit from research	0.65	3.94	3.68	I
4	Recruit and retain diverse physicians and researchers with experience working with communities impacted by diabetes	0.73	4.38	3.60	II
40	Engage and involve young people (e.g., high school and undergraduate students) in early exposure to public health and prevention science to increase and ensure the future diversity of researchers	1.00	3.72	3.48	III
78	Support pre-doctoral and post-doctoral training of researchers in systems science	0.95	3.33	3.62	III

58	Capture and report real-world experiences	0.76	3.71	3.71	IV
22	Develop more creative methods of dissemination of research results to non-research audiences	0.69	3.85	4.25	IV
83	Identify barriers to communicating effectively and openly with the health care team	0.72	3.67	3.90	IV
33	Increase academic-community partnerships	0.17	3.88	4.09	IV
42	Provide training, career development, and mentoring opportunities for young and mid-career scholars to engage and develop collaborations with communities in diverse geographic settings	0.91	3.83	3.86	IV
3. Interventions for specific populations (n=8)		**0.20**	**4.08**	**3.74**	
3	Understand and implement strategies that are adapted to or tailored for communities that experience health disparities	0.11	4.57	3.84	I
95	Understand the diversity of individuals at risk for diabetes and their experiences and perspectives	0.33	4.10	4.14	I
91	Build capacity and increase resources within communities of color	0.15	4.29	3.38	II
90	Create programs tailored to individual tribal communities	0.12	4.17	3.64	II
94	Focus on reservation communities to build strategies that are sustainable and accessible in those settings	0.22	4.00	3.50	II
26	Focus on rural populations to build strategies that are sustainable and accessible in those settings	0.17	4.00	3.59	II
35	Focus on identifying capacity building models to support community-based outreach and delivery programs for high risk populations	0.31	3.61	3.64	III
84	Focus on the communities in greatest need	0.16	3.89	4.23	IV
4. Context specific intervention (n=7)		**0.29**	**3.96**	**3.78**	
11	Address diabetes prevention among young adults who are disproportionately at risk	0.29	4.00	3.88	I
44	Assess whether commonly accepted treatments are having a positive effect on underrepresented populations	0.37	3.94	3.82	I
85	Develop interventions and implementation strategies with vulnerable populations in mind	0.32	4.22	4.15	I
67	Address co-morbidity with behavioral and mental health, especially in the context of low resources and limited access to care	0.31	4.12	3.33	II
76	Focus more on the unique social determinants in diverse communities	0.37	4.22	3.48	II
68	Focus on youth who are diagnosed at young ages to understand the impact of diabetes diagnosis on quality of life, overall health and	0.22	3.71	3.81	IV
54	Use burden data to target specific populations and geographic areas	0.17	3.53	4.00	IV
5. Dissemination and implementation principles (n=9)		**0.24**	**3.96**	**3.79**	
2	Adopt a multi-disciplinary approach	0.4	4.52	4.24	I
51	Focus on dissemination and implementation of culturally tailored diabetes prevention programs	0.29	4.17	4.14	I
17	Focus on providing preventative health care	0.48	4.25	3.75	I

52	Make sure data is reported by subgroups so comparisons can be made across research projects	0.16	3.94	4.00	I
30	Address meaningful access to diabetes education, nutritionists, etc. (i.e. more than just a referral once at diagnosis from a physician)	0.45	4.06	3.55	II
65	Identify successful collective impact models that increase access to evidence-based programs	0.15	3.65	3.43	III
80	Identity models that can be scaled and funded to increase access to evidence-based diabetes prevention and self-management programs	0.1	3.82	3.62	III
86	Leverage common systems (i.e. feedback structure or social network structures) to better inform the design and adaptation of interventions for scale	0.04	3.72	3.43	III
5	Approach intervention planning using a feedback perspective	0.12	3.55	3.96	IV
6. Non-traditional settings and strategies (n=11)		**0.22**	**3.62**	**3.62**	
20	Test different models to effectively integrate lay/traditional health workers in clinical settings that can provide self-management support	0.43	3.39	3.52	III
53	Examine strategies to support patients between clinic appointments to achieve treatment goals, i.e. Patient navigators, community-health workers	0.19	4.00	4.05	I
63	Develop novel strategies to promote nutritious dietary patterns, which will help to prevent/manage overweight and obesity	0.07	3.67	3.19	III
64	Evaluate opt-out approaches including in education and medical care of prediabetes	0.3	3.06	3.10	III
93	Study (and alter) environmental and social structures in the workplace in order to encourage healthy behavior by individuals	0.26	3.72	3.19	III
41	Study strategies to improve patients' ability to make the best possible health and healthcare decisions with the options that are currently available to them	0.14	3.53	3.62	III
71	Develop family-focused health and prevention strategies that can be realistically applied and accomplished	0.45	3.76	3.67	IV
45	Examine the impact of extending home visitation programs and adding diabetes prevention curriculum	0.31	3.41	3.86	IV
89	Rigorously examine the effect of online-based diabetes prevention and diabetes management interventions among racial/ethnic minorities and low-income individuals	0.14	3.65	3.73	IV
36	Test adaptations of effective interventions for greater adoption in real-world contexts	0.05	3.89	3.81	IV
87	Understand what barriers and challenges exist for patient compliance to treatment and follow-up	0.13	3.74	4.05	IV
7. Cost and health economics (n=6)		**0.44**	**3.86**	**3.65**	
9	Study and measure the costs required to continue an effective intervention for longer than 24 months duration	0.31	4.00	3.48	II
57	Emphasize dissemination and implementation of evidence-based treatments and programs.	0.37	4.18	4.18	I

47	Calculate the return on investment for health equity interventions	0.48	3.82	3.24	III
15	Conduct more cost-effectiveness studies of implementing lay/traditional health workers for diabetes management in clinical settings	0.43	3.79	3.64	III
55	Explore reimbursement for diabetes self-management education delivered by trained community health workers	0.59	3.88	3.68	IV
39	Focus on developing robust longitudinal data sources (including clinical, administrative, social and economic data) to better understand the impacts of interventions in under resourced settings	0.45	3.50	3.67	IV
8. Innovative methods and metrics (n=9)		**0.27**	**3.71**	**3.93**	
7	Design studies to include implementation outcomes	0.28	4.00	4.36	I
12	Include outcome measures around disparities	0.46	4.05	4.60	I
56	Conduct longitudinal studies that examine the impact of adolescent and young adult prediabetes education and prevention on the development of diabetes and age of diagnosis	0.45	3.76	3.38	III
59	Consider studies that examine the impact of cash incentives for physical activity and healthy eating among Medicaid patients at risk for diabetes	0.21	2.76	3.48	III
27	Design and test multilevel strategies	0.00	3.89	3.91	IV
21	Develop new metrics for progress in diabetes research that focus on indicators outside of the health sector	0.39	3.74	3.77	IV
29	Focus less on randomized controlled trials and include more quasi-experimental and observational studies situated in real-world clinics and communities	0.26	3.83	4.04	IV
82	Tap into new and innovative designs, such as human centered designs and rapid cycle evaluation designs.	0.11	3.65	3.81	IV
88	Utilize patient reported outcomes	0.23	3.74	4.05	IV
9. Policy approaches (n=11)		**0.36**	**4.03**	**3.10**	
31	Disseminate research findings to influence health policy	0.42	4.42	4.13	I
75	Find a way to reduce costs, especially for medication	0.44	4.00	2.60	II
74	Focus on societal/policy changes that can impact diabetes risk	0.28	4.22	3.19	II
72	Fund more research that budgets for implementation that is in line with real-world costs for future implementation	0.49	4.17	3.36	II
77	Have direct implications on practice, research, and policy	0.21	4.17	3.43	II
66	Inform an overhaul of the United States healthcare system to provide affordable, transparent, trustworthy, and high quality access to all	0.32	4.24	2.05	II
43	Map the policy context that perpetuate disparities and incorporate into planning for interventions	0.36	3.94	3.52	II
19	Change national food policies and services (e.g., SNAP, Supplemental Nutrition Assistance Program) to promote healthy eating	0.17	3.79	2.21	III
14	Develop policies that will support affordable healthy living strategies for the poor and working population	0.49	3.78	2.96	III

10	Focus on how to provide free and reduced prevention and treatment efforts by way of covered benefits for Medicare and Medicaid beneficiaries.	0.48	3.71	2.96	III
6	Contain explicit policy variables	0.28	3.90	3.72	IV
10. Next-generation interventions (n=11)		**0.19**	**3.94**	**3.42**	
16	on attributes, and induce behavioral changes for targeted sub-populations	0.14	3.44	3.73	IV
24	Study the effectiveness of simple, inexpensive, scalable interventions to influence health behaviors, particularly among medically underserved or low socioeconomic status populations	0.07	4.22	3.63	II
32	Identify affordable healthy living strategies for the poor and working population (i.e. people with time and money constraints such as working multiple jobs or working with significant caregiving responsibilities)	0.11	4.11	3.29	II
46	Employ methods that distinguish disparities driven by low socioeconomic status and poor access from those that may arise through implicit/explicit/systemic racism	0.26	3.82	3.05	III
49	Take into account co-morbidity and overall care of individuals with multiple, complex diagnoses and conditions.	0.13	3.94	4.00	I
62	Address root causes at patient and provider levels	0.06	4.06	2.71	II
69	Explicitly consider the role of historical trauma associate with colonialism and structural racism	0.35	3.76	3.20	III
70	Understand better the pathways by which socioeconomic status disparities drive diabetes (e.g., access to healthcare, environmental exposure, etc.)	0.43	4.06	3.50	II
73	Incorporate the broader contributors to unhealthy behaviors and lifestyles and work to address these in unison with clinical approaches	0.04	4.06	3.62	II
79	Find ways to address the social determinants of diabetes and related health disparities	0.14	4.24	3.43	II
92	Investigate sociological perspectives that could be highlighted or changed to affect perceptions of risk behaviors and inevitability/fatalism of getting diabetes	0.38	3.65	3.43	III