SUPPLEMENTAL MATERIAL

Supplemental Methods

Study Population and Design

The SPRINT was a multicenter, open-label, parallel-arm, randomized clinical trial conducted between November 2010 and March 2013 at 102 clinical sites (organized into five clinical center networks) in the United States and Puerto Rico.[53, 54] The SPRINT randomized 9,361 hypertensive participants aged ≥50 years to either standard (treatment to systolic blood pressure <140 mmHg) or intensive (treatment to systolic blood pressure <120 mmHg) blood pressure management.[53, 54] The study protocol was approved by the local Institutional Review Boards at the respective trial sites. Written informed consent was obtained from all participants. The study complied with principles detailed in the Declaration of Helsinki. The detailed inclusion and exclusion criteria of the SPRINT have been previously described.[53, 54] Participants enrolled in the SPRINT trial were ≥50 years of age, with no history of diabetes, stroke, and with systolic blood pressure of 130-180 mmHg and increased risk of cardiovascular events. The higher risk of increased cardiovascular events was defined as having at least one of the following criteria: age ≥75 years, Framingham risk score of ≥15%, clinical or subclinical cardiovascular disease, or chronic kidney disease. Subclinical cardiovascular disease was defined as having an ankle-brachial index ≤0.90, left ventricular hypertrophy by electrocardiography or other cardiac imaging in the two years prior to enrollment, or coronary artery calcium score of ≥400 Agatston units. Clinical cardiovascular disease was defined as having a history of myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, carotid endarterectomy, carotid stenting, peripheral arterial disease with revascularization, acute coronary syndrome with

or without electrocardiographic changes, abdominal aortic aneurysm ≥5 cm, or 50% diameter stenosis of a coronary, carotid, or lower extremity artery.

This study included self-identified non-Hispanic Black participants and non-Hispanic White participants from the SPRINT who were free of diabetes at baseline. We excluded individuals with fasting blood glucose ≥126 mg/dL (≥6.99 mmol/L) at baseline and those with missing blood glucose at baseline. Genetic ancestry data were collected in a subset of self-identified non-Hispanic Black SPRINT participants who consented to molecular genetic analyses.[55, 56] In our analysis of genetic ancestry proportion with incident diabetes mellitus, we included self-identified non-Hispanic Black SPRINT participants with genetic European ancestry proportion data available and who were free of diabetes at baseline (N=2,466).

Measures

The sociodemographic data, including self-reported race/ethnicity, were collected by trained study personnel at both randomization and subsequent study visits. The laboratory parameters were collected at baseline, year 2, year 4, and the closeout visit. The blood glucose was estimated by using the hexokinase method on a Roche analyzer in stored samples at the central laboratory. Only fasting blood glucose results were deemed acceptable for the ascertainment of the study outcome. A detailed medical history, including the diagnosis of diabetes and the use of glucose-lowering medications, was collected annually during the study period. The baseline estimated glomerular filtration rate (eGFR) was computed using the modification of diet in renal disease 4-component equation.

Genotyping and Ancestry Proportion Estimation

Genotyping was performed on genetic samples obtained from consenting participants. The investigators utilized 106 biallelic ancestry informative markers (AIMs) to compute the European ancestry proportion (**Supplementary Table I**).[24, 56, 57] The genotypic data for these AIMs were obtained from 44 HapMap Yoruba individuals (Yoruba in Ibadan, Nigeria), with 39 European American controls serving as a reference.[56, 57] The AIMs represent the continental ancestry, and the AIMs for Yoruba individuals are specific for Western and Central Africa, and are deemed to be representative of the ancestry for most of the Black American population.[57] The previously validated methodology of genetic ancestry estimation utilizing the maximum likelihood approach using frequentist estimation of individual ancestry proportion (FRAPPE) was used for estimating the European and African ancestry proportion.[24, 56-60] The principal component analysis plot of the AIMs with the European and African populations in the 1000 Genomes project assessed using PLINK 2.0 and plotted using R 4.1.0 (R Core Team, Vienna) is demonstrated in **Supplementary Figure I.**

Outcomes

The outcome of interest in this study was the development of incident diabetes mellitus. As previously described,[61] this was defined as fasting blood glucose ≥126 mg/dL (≥6.99 mmol/L), self-reported diabetes mellitus, or the new use of glucose-lowering medications at the annual examinations. As previously described, if the participant's blood sample was labeled as non-fasting, the fasting blood glucose was deemed as missing for this analysis.[61]

Statistical Analyses

The baseline characteristics were compared using descriptive statistics. Continuous variables were summarized using medians and interquartile ranges and then compared using the Wilcoxon rank-sum test or Jonckheere-Terpstra test. Categorical variables were summarized as counts and frequencies and compared using the Chi-Square test or Cochran-Armitage test. In the secondary analysis across race, the cumulative incidence rate (per 1000-person years) of diabetes mellitus among non-Hispanic Black participants and non-Hispanic White participants was computed using Poisson regression. The log-rank test and multivariable-adjusted Cox proportional hazard models were used to estimate the risk of incident diabetes mellitus stratified by the racial groups. The proportional hazard assumption was assessed using Schoenfeld residuals. The follow-up duration was censored after participants reached the study outcome, died, were deemed to have been lost to follow-up or at study closeout. Chi-square values from multivariable-adjusted Cox models with and without the respective covariates were used to rank the relative strength of association of the various clinical and social factors with incident diabetes mellitus. They were then compared using the likelihood ratio test, as previously described.[62, 63] Based on previously reported sex-related differences in the race-stratified incident and prevalent diabetes mellitus, we assessed the interaction between sex and race (non-Hispanic White or non-Hispanic Black participants) on incident diabetes mellitus using multiplicative interaction term (race*sex).[5, 13]

Black participants free of diabetes at baseline, who consented for genetic analyses, had their DNA analyzed, and had their ancestry proportions available (N=2,466) were stratified into tertiles of European ancestry. We assessed the multivariable-adjusted relationship between genetic European ancestry proportion and metabolic syndrome components (body mass index

[BMI], triglyceride levels, HDL-C levels, fasting blood glucose, and systolic/diastolic blood pressure) among non-Hispanic Black individuals. We used BMI because waist-hip ratio measurements, which are traditionally used to assess metabolic syndrome, were not available in the study population. We assessed the non-linearity of association as previously described, using the testnl command in STATA.[64] We used restricted cubic splines to depict the non-linear relationship.[64]

Poisson regression was used to estimate the incidence rate (per 1000-person years) of diabetes mellitus across the genetic European ancestry tertiles among non-Hispanic Black individuals. Restricted cubic splines were used to evaluate the continuous relationship of European ancestry proportion and incidence of diabetes mellitus. The risk of incident diabetes mellitus among non-Hispanic Black individuals was estimated across the tertiles of European ancestry proportion using the log-rank test and multivariable-adjusted Cox regression models. The risk of incident diabetes was also assessed for every 5% increment in European ancestry proportion. All of the abovementioned models were adjusted for age, sex, BMI, baseline blood glucose, treatment arm, clinical or subclinical cardiovascular disease, serum creatinine, aspirin use, statin use, urine albumin-creatinine ratio, HDL-C, triglyceride levels, low-density lipoprotein cholesterol (LDL-C), total cholesterol, randomization site, health insurance status, employment status, and education status. The interaction between European ancestry and treatment arm (intensive versus standard) on incident diabetes mellitus was estimated using a multiplicative-interaction term (tertile*treatment arm). We also assessed the interaction between European ancestry and sex on incident diabetes mellitus (tertile*sex). The ranking of the relative

strength of association of the various clinical and social factors with incident diabetes mellitus within non-Hispanic Black individuals was also performed.

We performed sensitivity analyses to estimate the risk of incident diabetes mellitus stratified by racial groups and across European ancestry proportion tertiles among Black individuals by taking death as a competing event.[65] We also performed post-hoc sensitivity analyses by using age as the time-scale in Cox regression models instead of the follow-up period.

All statistical analyses were completed using SAS 9.4 (Cary, NC) and STATA SE 16.0 (College Station, TX) in December 2020. A two-sided type I error of 0.05 was used to ascertain statistical significance. The primary analysis of the study was the risk of incident diabetes mellitus across ancestry proportion tertiles, and the remaining are secondary analyses. Hence, the type I error has not been adjusted for multiple comparisons.

Supplementary Table I. Reference SNP Numbers for the Ancestry Informative Markers

Ancestry Informative Markers: Reference SNP Numbers
rs1240709
rs1739897
rs630101
rs2339475
rs975612
rs935925
rs4596126
rs1039524
rs3846193
rs758973
rs1525760
rs930072
rs3317
rs185493
rs3024354
rs3734693
rs1029122
rs1480642
rs736946
rs362949
rs6928254
rs793979
rs742813
rs2965404
rs2740574
rs285
rs7845391
rs913258
rs2301550
rs803733
rs7349
rs992528
rs905552
rs7957445
rs4759816
rs895898
rs913607
rs179562
rs981270

rs2862
rs1374092
rs1557519
rs7201030
rs2891
rs8082034
rs1941141
rs4436849
rs2900918
rs4884
rs6034866
rs6062548
rs2064056
rs4821667
rs455726
rs680273
rs2814778
rs6003
rs2065160
rs2752
rs3287
rs3340
rs2763
rs2161
rs3176921
rs1042602
rs1800498
rs1800404
rs4646
rs2228478
rs2816
rs344454
rs554362
rs580897
rs735480
rs932327
rs1006689
rs1041931
rs1184089
rs1259448
rs1431479

rs2407582
rs2416791
rs2426515
rs3745099
rs4811651
rs5752014
rs6007220
rs6491743
rs6510761
rs7084970
rs7689126
rs7689609
rs7908735
rs7978988
rs8106013
rs9510171
rs9525462
rs9542741
rs9626698
rs9977149
rs10884277
rs11064432
rs11112724
rs11698339
rs13148562
rs17614025

Supplementary Table II. Baseline Characteristics of Study Population: Stratified by Race.

Characteristics	Non-Hispanic Blacks (N=2,673)	Non-Hispanic Whites (N=5,256)	P-value
Age	63 (57-71)	70 (64-77)	<.001
Age ≥ 75 years	435 (16.3)	1,927 (36.7)	<.001
Age ≥ 65 years	1,105 (41.4)	3,733 (71.0)	<.001
Female	1,212 (45.3)	1,514 (28.8)	<.001
Cardiovascular Disease	438 (16.4)	1175 (22.4)	<.001
Clinical	293 (10.9)	1073 (20.4)	<.001
Subclinical	192 (7.18)	199 (3.79)	<.001
Framingham 10-year CHD Risk Score	18.9 (13.1-27.8)	24.4 (17.3-33.89)	0.42
Framingham 10-year CHD risk ≥15%	1,774 (66.4)	4,322 (82.2)	<.001
Body Mass Index (kg/m^2)	29.9 (26.6-34.3)	28.5 (25.6-32.2)	<.001
Systolic Blood Pressure (mmHg)	139 (129-150)	138 (129-149)	0.42
Diastolic Blood Pressure (mmHg)	81 (73-90)	77 (69-84)	<.001
Fasting Plasma Glucose (mg/dL)	95 (88-103)	98 (91-105)	<.001
Total Cholesterol (mg/dL)	193 (169-220)	182 (157-211)	<.001
LDL Cholesterol (mg/dL)	117 (94-140)	105 (84-129)	<.001
HDL Cholesterol (mg/dL)	53 (45-63)	50 (42-60)	<.001
Triglycerides (mg/dL)	91 (68-126)	110 (80-155)	<.001
Serum Creatinine (mg/dL)	1.06 (0.89-1.28)	1.01 (0.87-1.20)	<.001
Urine Albumin to Creatinine Ratio (mg/gm)	9.1 (5.1-21.8)	9.7 (5.9-21.5)	<.001
Estimated GFR ($mL/min/1.73m^2$)	76.4 (61.6-90.8)	67.7 (55.8-79.6)	<.001
CKD (eGFR <60 $mL/min/1.73m^2$)	613 (22.9)	1742 (33.1)	<.001
CKD Stage IIIa (eGFR 45-59 $mL/min/1.73m^2$)	389 (14.6)	1175 (22.4)	<.001
CKD Stage IIIb (eGFR 30-59 $mL/min/1.73m^2$)	167 (6.3)	494 (9.4)	
CKD Stage IV (eGFR 15-29 $mL/min/1.73m^2$)	58 (2.2)	74 (1.4)	

Aspirin Use	1,099 (41.2)	3,087 (58.8)	<.001
Statin Use	894 (33.7)	2,587 (49.6)	<.001
Antihypertensive Medications	2 (1-3)	2 (1-2)	<.001
Smoking Status			
Never	1159 (43.4)	2199 (41.8)	<.001
Former	895 (33.5)	2601 (49.5)	
Current	615 (23.0)	451 (8.6)	
Education			
Less than High School	932 (34.8)	943 (17.9)	<.001
High School or GED	269 (10.1)	373 (7.1)	
Business or Vocational Training	635 (23.8)	1,096 (20.9)	
Some College or Associate Degree	453 (17.0)	1,211 (23.0)	
College Graduate	306 (11.5)	1,232 (23.4)	
Doctoral or Masters Degree	79 (3.0)	401 (7.6)	
Employment			
Full Time	563 (21.8)	1,090 (21.1)	<.001
Part Time	230 (8.9)	386 (7.5)	
Retired	1,355 (52.4)	3,468 (67.0)	
Looking for Employment	125 (4.8)	57 (1.1)	
Unemployed	313 (12.1)	173 (3.3)	
Lack of Health Insurance	491 (18.4)	297 (5.7)	<.001

Categorical variables are represented as counts with proportions, and continuous variables are represented as medians with interquartile ranges. **Abbreviations:** GFR: Glomerular Filtration Rate; CKD: Chronic Kidney Disease; HDL: High-Density Lipoprotein; LDL: Low-Density Lipoprotein; CHD: Coronary Heart Disease.

Supplementary Table III. Hazard Ratio for Risk of Incident Diabetes Between Racial Groups in the Multivariable-Adjusted Model

Variables Included in Model	Hazard Ratio (95% Confidence Interval)
Race (Black)	1.43 (1.14-1.80)
Total Cholesterol	1.50 (0.20-3.00)
Clinical/Subclinical CVD	1.30 (1.04-1.60)
Smoking	
Never	Ref.
Former	1.20 (1.01-1.43)
Current	1.30 (1.01-1.68)
Triglycerides	1.28 (0.85-1.94)
Treatment Arm	1.21 (0.98-1.43)
Aspirin Use	1.13 (0.94-1.35)
Statin Use	1.10 (0.91-1.32)
Employment	
Full Time	Ref.
Part-Time	1.07 (0.78-1.47)
Retired	0.95 (0.76-1.18)
Looking for Employment	0.92 (0.55-1.53)
Unemployed	0.91 (0.65-1.27)
Health Insurance	0.86 (0.65-1.12)
BMI	1.05 (1.03-1.06)
Age	1.04 (1.02-1.05)
Blood Glucose	1.01 (0.95-1.07)
Urine Albumin-Creatinine Ratio	1.00 (0.97-1.05)
Randomization Site	1.00 (0.98-1.01)
LDL-C	0.93 (0.27-3.18)
Sex	0.82 (0.66-1.02)
Education Status	
Doctoral/Masters Degree	Ref.
College Graduate	0.84 (0.56-1.27)
Some College/Associate Degree	0.98 (0.66-1.47)
Business/Vocational Training	0.86 (0.57-1.28)
High School/GED	0.83 (0.52-1.32)
<High School	0.84 (0.60-1.30)
S. Creatinine	0.80 (0.60-1.02)
HDL-C	0.42 (0.20-0.88)

Abbreviations: BMI: Body mass index; GFR: Glomerular Filtration Rate; CKD: Chronic Kidney Disease; HDL: High-Density Lipoprotein; LDL: Low-Density Lipoprotein; CVD: Cardiovascular Disease.

Supplementary Table IV. Multivariable-Adjusted Competing Risk Analysis for Incident Diabetes

Multivariable-Adjusted Competing Risk Analysis for Incident Diabetes	
	Hazard Ratio (95% CI)
Comparison Between Non-Hispanic Black and Non-Hispanic White Individuals	
Non-Hispanic White Participants	Ref.
Non-Hispanic Blacks Participants	1.50 (1.23-1.84)
Comparison Within Non-Hispanic Black Individuals	
European Ancestry Proportion Tertile	
Tertile 1	Ref.
Tertile 2	0.69 (0.49-0.96)
Tertile 3	0.67 (0.49-0.93)
Risk for Every 5% Increase in European Ancestry Proportion	0.74 (0.56-0.97)
The models were adjusted for age, sex, BMI, baseline blood glucose, treatment arm, clinical or subclinical cardiovascular disease, serum creatinine, aspirin use, statin use, urine albumin-creatinine ratio, high-density lipoprotein-cholesterol, triglyceride levels, low-density lipoprotein cholesterol, total cholesterol, randomization site, health insurance status, employment status, and education status	

Abbreviation: CI: Confidence Interval.

Supplementary Table V. Multivariable-Adjusted Cox Regression for Incident Diabetes Taking Age on Time-Scale

Multivariable-Adjusted Cox Regression for Incident Diabetes Taking Age on Time-Scale	
	Hazard Ratio (95% CI)
Comparison Between Non-Hispanic Black and Non-Hispanic White Individuals	
Non-Hispanic White Participants	Ref.
Non-Hispanic Blacks Participants	2.65 (2.19-3.21)
Comparison Within Non-Hispanic Black Individuals	
European Ancestry Proportion Tertile	
Tertile 1	Ref.
Tertile 2	0.76 (0.55-1.06)
Tertile 3	0.65 (0.47-0.89)
Risk for Every 5% Increase in European Ancestry Proportion	0.70 (0.56-0.88)
Competing Risk Analysis	
Comparison Between Non-Hispanic Black and Non-Hispanic White Individuals	
Non-Hispanic White Participants	Ref.
Non-Hispanic Blacks Participants	2.47 (95% CI: 2.01-3.03)
Comparison Within Non-Hispanic Black Individuals	
European Ancestry Proportion Tertile	
Tertile 1	Ref.
Tertile 2	0.78 (0.55-1.10)

Tertile 3	0.66 (0.47-0.94)
Risk for Every 5% Increase in European Ancestry Proportion	0.70 (0.56-0.88)
The models were adjusted for sex, BMI, baseline blood glucose, treatment arm, clinical or subclinical cardiovascular disease, serum creatinine, aspirin use, statin use, urine albumin-creatinine ratio, high-density lipoprotein-cholesterol, triglyceride levels, low-density lipoprotein cholesterol, total cholesterol, randomization site, health insurance status, employment status, and education status.	

Abbreviation: CI: Confidence Interval.

Supplementary Table VI. Baseline Characteristics: Stratified by Inclusion in Current Analysis.

Characteristics	Black Participants with Ancestry Proportion Data Available (N=2,466)	Remaining SPRINT Participants (N=6,895)	P-value
Age	63 (57-71)	69 (62-77)	<.001
Age ≥ 75 years	403 (16.3)	2,233 (32.4)	<.001
Age ≥ 65 years	1,026 (41.6)	4,530 (65.7)	<.001
Female	1,124 (45.6)	2,208 (32.0)	<.001
Cardiovascular Disease	409 (16.6)	1468 (21.3)	<.001
Clinical	272 (11.0)	1290 (18.7)	<.001
Subclinical	181 (7.3)	312 (4.5)	<.001
Framingham 10-year CHD Risk Score	18.9 (13.1-27.8)	23.6 (16.3-33.0)	<0.001
Framingham 10-year CHD risk ≥15%	1,630 (66.1)	5,472 (79.4)	<.001
Body Mass Index (kg/m^2)	30.0 (26.5-34.3)	28.7 (25.8-32.4)	<.001
Systolic Blood Pressure (mmHg)	139 (129-149)	138 (130-149)	0.74
Diastolic Blood Pressure (mmHg)	81 (73-90)	77 (69-85)	<.001
Fasting Plasma Glucose (mg/dL)	95 (88-102)	98 (91-106)	<.001
Total Cholesterol (mg/dL)	194 (169-220)	184 (158-213)	<.001
LDL Cholesterol (mg/dL)	118 (95-140)	107 (85-130)	<.001
HDL Cholesterol (mg/dL)	53 (45-63)	49 (42-59)	<.001
Triglycerides (mg/dL)	92 (68-126)	112 (81-159)	<.001
Serum Creatinine (mg/dL)	1.06 (0.88-1.28)	0.99 (0.85-1.18)	<.001
Urine Albumin to Creatinine Ratio (mg/gm)	9.2 (5.1-22.6)	9.7 (5.8-21.1)	<.001
Estimated GFR ($mL/min/1.73m^2$)	76.2 (61.3-90.8)	69.9 (57.3-82.3)	<.001
CKD (eGFR <60 $mL/min/1.73m^2$)	581 (23.6)	2065 (30.0)	<.001
CKD Stage IIIa (eGFR 45-59 $mL/min/1.73m^2$)	365 (14.8)	1,394 (20.2)	<.001
CKD Stage IIIb (eGFR 30-59	161 (6.5)	575 (8.3)	

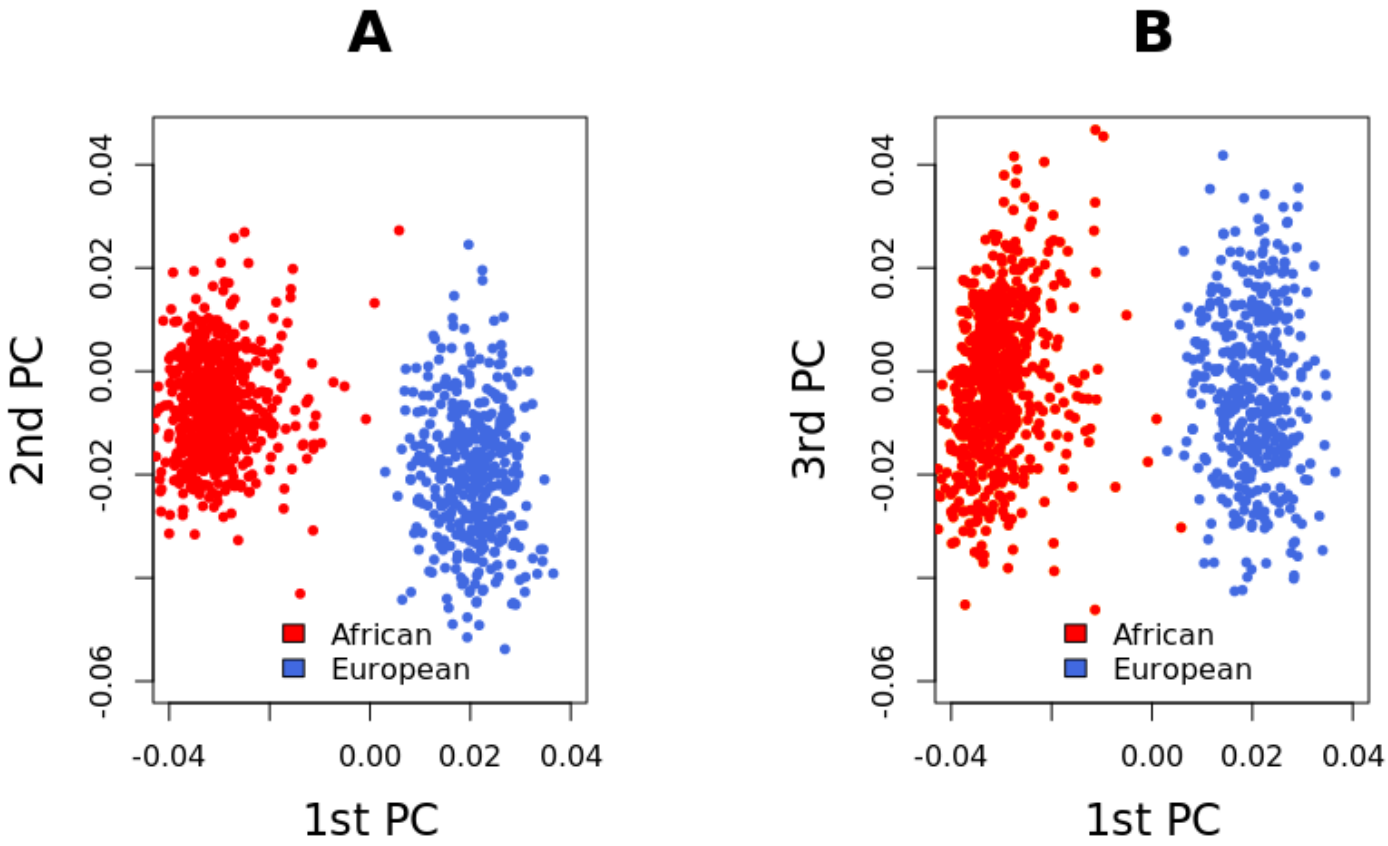
mL/min/1.73m^2)			
CKD Stage IV (eGFR 15-29 mL/min/1.73m^2)	56 (2.3)	136 (2.0)	
Aspirin Use	1,019 (41.4)	3,737 (54.4)	<.001
Statin Use	827 (33.7)	3,227 (47.2)	<.001
Antihypertensive Medications	2 (1-3)	2 (1-2)	<.001
Smoking Status			
Never	1,072 (43.5)	3,050 (44.2)	<.001
Former	823 (33.4)	3,150 (45.7)	
Current	568 (23.0)	672 (9.8)	
Education			
Less than High School	866 (35.1)	1,448 (21.0)	<.001
High School or GED	250 (10.1)	505 (7.3)	
Business or Vocational Training	583 (23.6)	1,356 (19.7)	
Some College or Associate Degree	415 (21.0)	1,557 (22.6)	
College Graduate	279 (11.3)	1,491 (21.6)	
Doctoral or Masters Degree	73 (3.0)	538 (7.8)	
Employment			
Full Time	518 (21.7)	1,475 (22.1)	<.001
Part Time	217 (9.1)	512 (7.7)	
Retired	1,252 (52.5)	4,319 (64.6)	
Looking for Employment	118 (5.0)	85 (1.3)	
Unemployed	280 (11.7)	298 (4.5)	
Lack of Health Insurance	442 (17.9)	531 (7.7)	<.001

Categorical variables are represented as counts with proportions, and continuous variables are represented as medians with interquartile ranges. **Abbreviations:** GFR: Glomerular Filtration Rate; CKD: Chronic Kidney Disease; HDL: High-Density Lipoprotein; LDL: Low-Density Lipoprotein; CVD: Cardiovascular Disease.

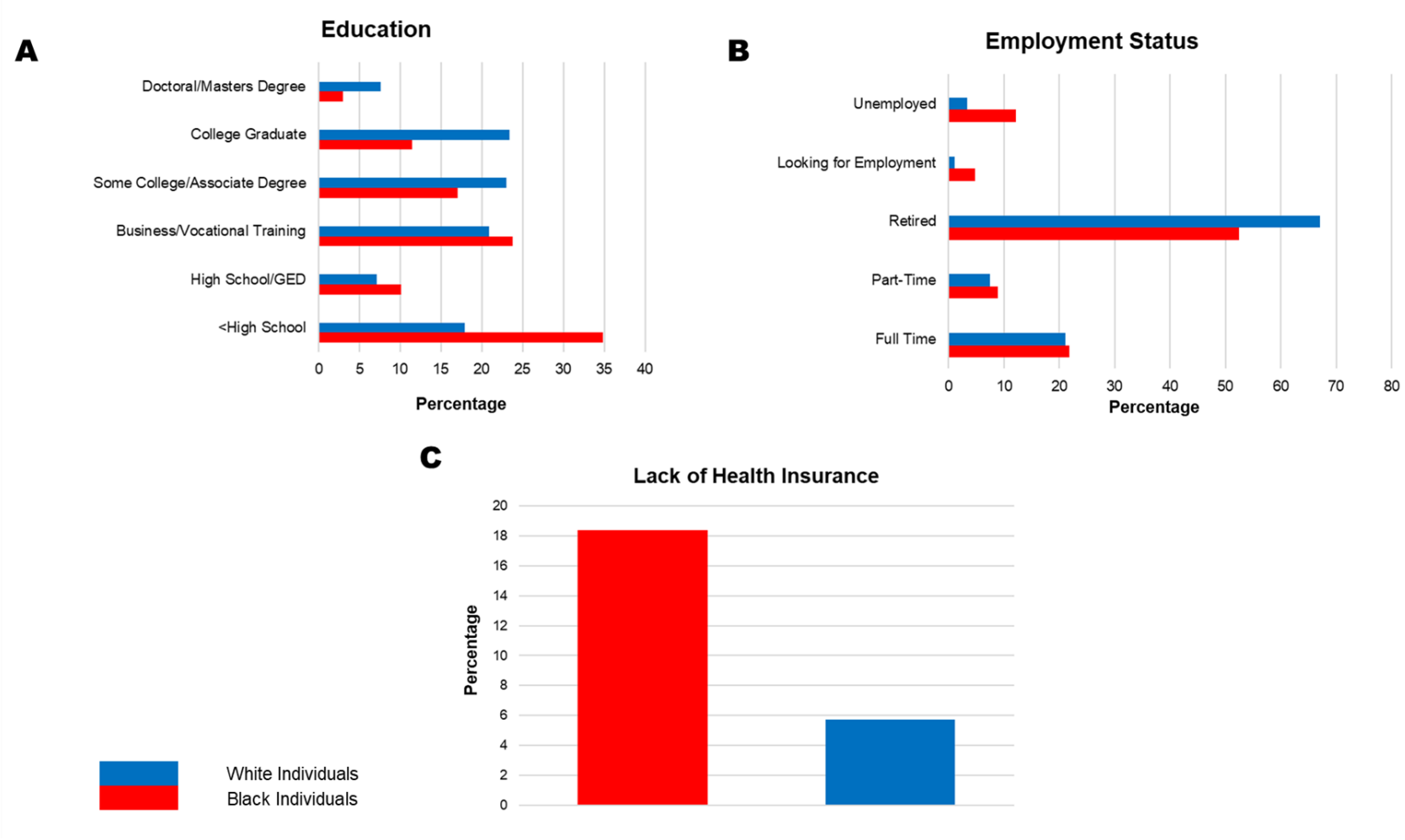
Supplementary Table VII. Hazard Ratio for Risk of Incident Diabetes Across European Ancestry Tertiles in the Multivariable-Adjusted Model

Variables Included in Model	Hazard Ratio (95% Confidence Interval)
European Ancestry Tertile	
Tertile 1	Ref.
Tertile 2	0.64 (0.45-0.90)
Tertile 3	0.61 (0.44-0.89)
Education Status	
Doctoral/Masters Degree	Ref.
College Graduate	2.17 (0.49-5.00)
Some College/Associate Degree	2.84 (0.67-5.00)
Business/Vocational Training	2.59 (0.61-5.00)
High School/GED	2.26 (0.51-5.00)
<High School	2.64 (0.63-5.00)
LDL-C	1.96 (0.41-5.00)
Triglycerides	1.62 (0.94-2.78)
Clinical/Subclinical CVD	1.32 (0.90-1.93)
Smoking	
Never	Ref.
Former	1.15 (0.83-1.61)
Current	1.06 (0.72-1.56)
Aspirin Use	1.13 (0.83-1.52)
Blood Glucose	1.06 (1.05-1.07)
BMI	1.04 (1.02-1.07)
Age	1.02 (1.01-1.03)
Statin Use	1.01 (0.74-1.38)
Employment	
Full Time	Ref.
Part-Time	0.99 (0.56-1.74)
Retired	1.02 (0.68-1.53)
Looking for Employment	0.99 (0.48-2.06)
Unemployed	1.18 (0.72-1.95)
Sex	0.82 (0.57-1.18)
Urine Albumin-Creatinine Ratio	1.00 (0.97-1.01)
Randomization Site	1.00 (0.98-1.01)
Total Cholesterol	0.99 (0.98-1.01)
Treatment Arm	0.92 (0.69-1.22)
HDL-C	0.86 (0.31-2.39)
Health Insurance	0.80 (0.53-1.20)
S. Creatinine	0.60 (0.36-1.03)

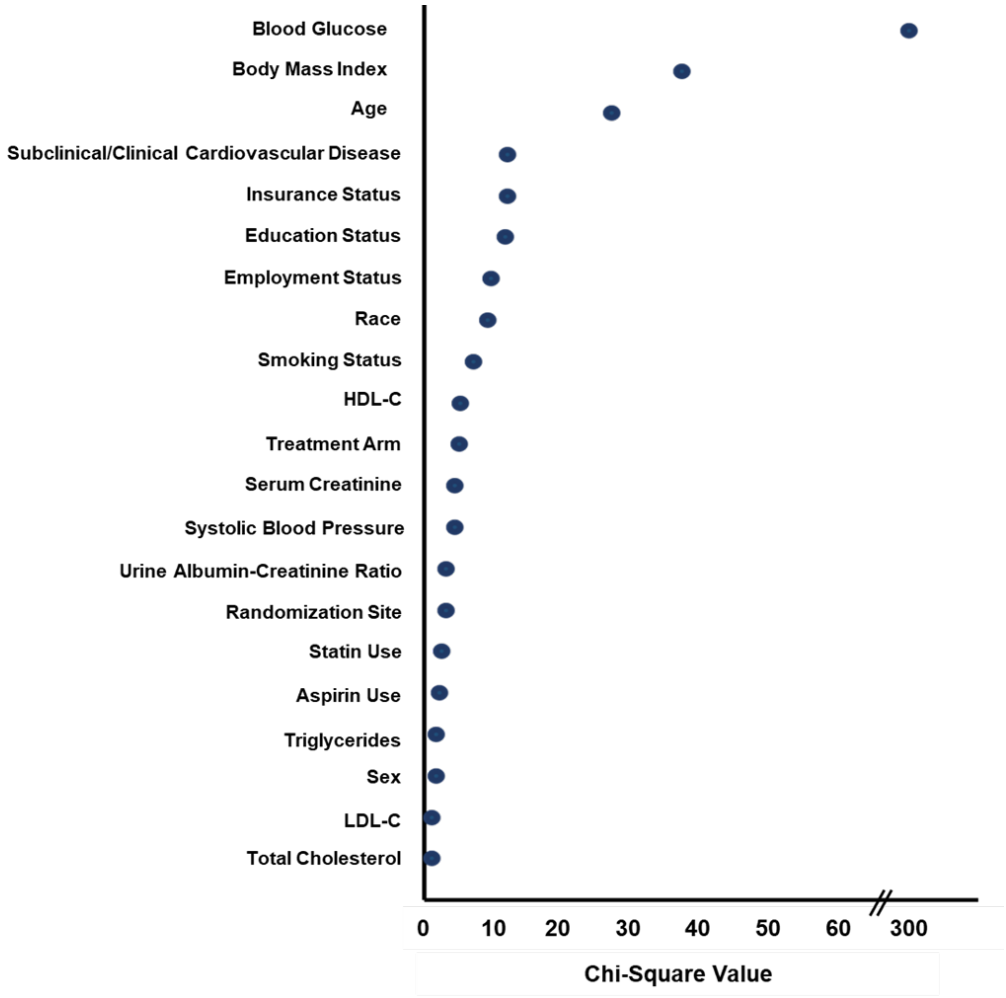
Abbreviations: BMI: Body mass index; GFR: Glomerular Filtration Rate; CKD: Chronic Kidney Disease; HDL: High-Density Lipoprotein; LDL: Low-Density Lipoprotein; CVD: Cardiovascular Disease.



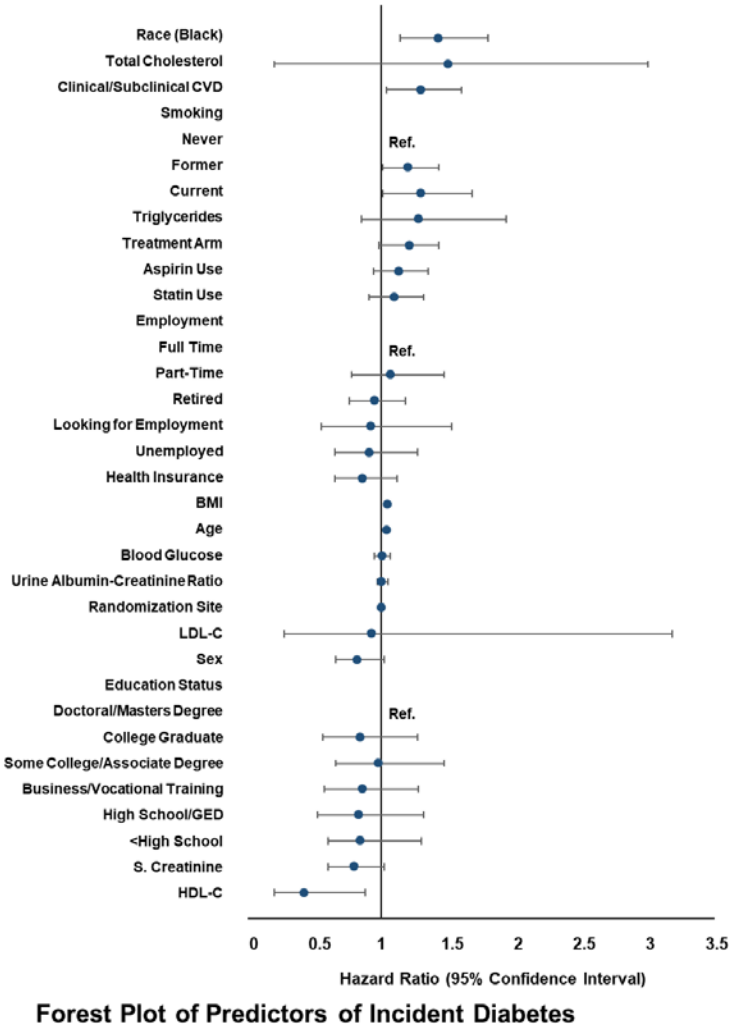
Supplementary Figure I. Principal Component Analysis of Biallelic Ancestry Informative Markers in The 1000 Genomes Project



Supplementary Figure II. Social Determinants of Health in White and Black Individuals
P for education status<0.001. P for employment status<0.001. P for health insurance status<0.001.

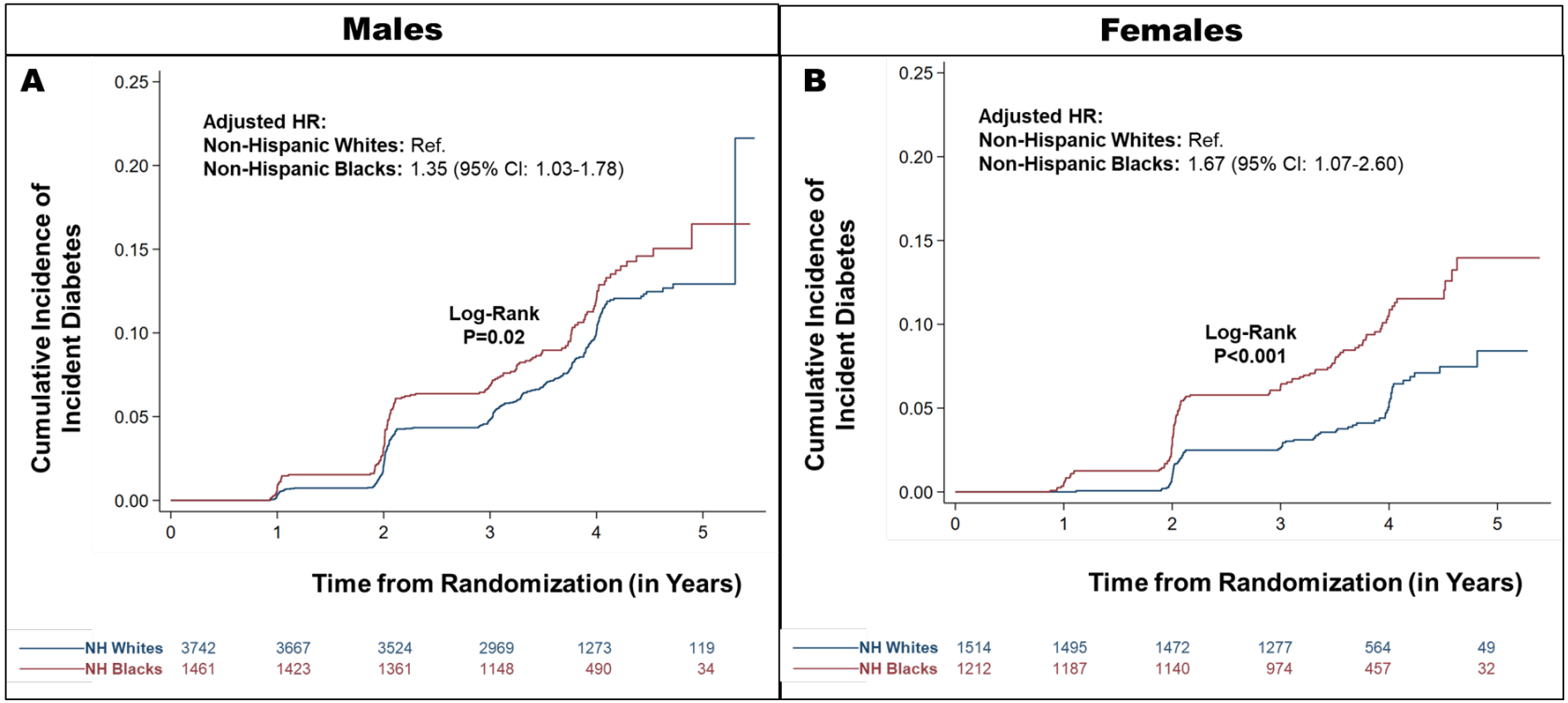


Supplementary Figure III. Relative Strength of Association Between Incident Diabetes and Clinical and Demographic Factors Among White and Black Individuals (Combined). This figure depicts the relative strength of association of the respective covariates, which are ranked according to the Chi-square values from the multivariable-adjusted Cox model. The Chi-square values are corrected for the degree of freedom to allow comparison on the same scale.

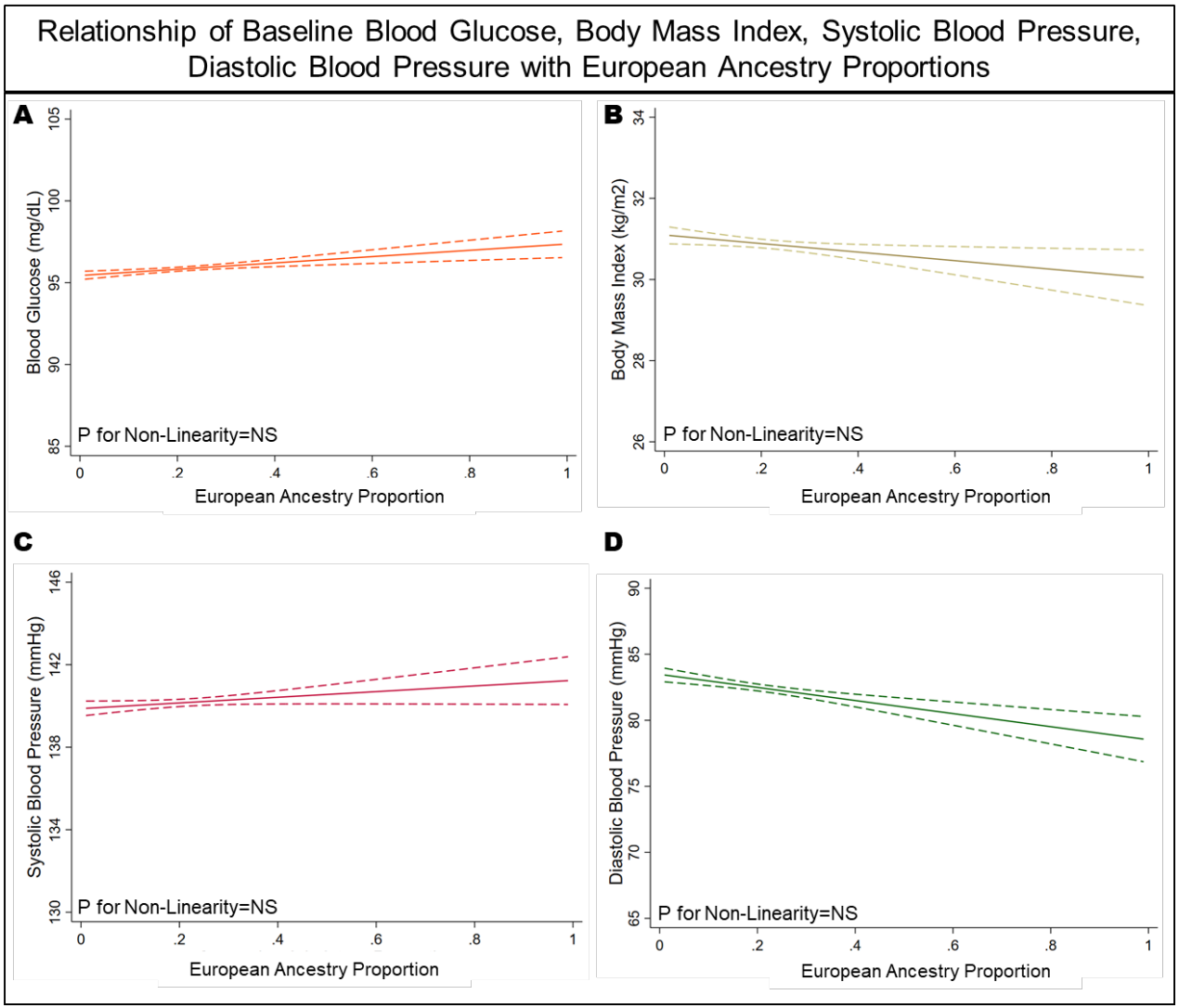


Supplementary Figure IV. Forest Plot of Predictors of Incident Diabetes Among White and Black Individuals.

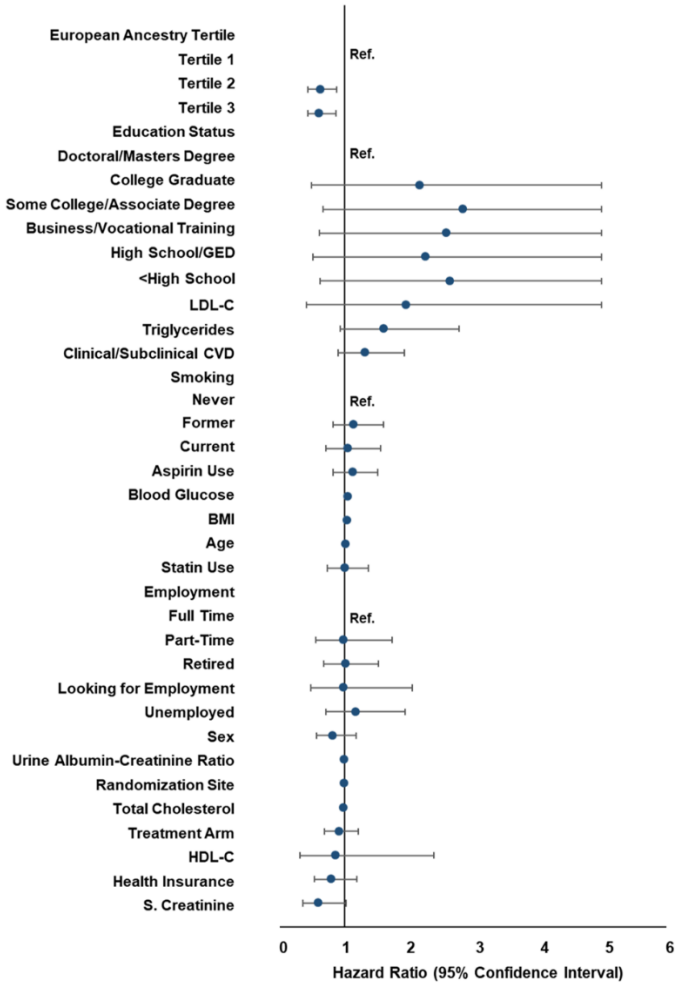
This figure depicts the parameter estimates of the individual variables included in the multivariable-adjusted Cox regression model.



Supplementary Figure V. Risk of Incident Diabetes Mellitus: Stratified by Race and Sex



Supplementary Figure VI. Relationship of Baseline Blood Glucose, Body Mass Index, Systolic Blood Pressure, Diastolic Blood Pressure with European Ancestry Proportion



Supplementary Figure VII. Forest Plot of Predictors of Incident Diabetes Among Black Individuals.

This figure depicts the parameter estimates of the individual variables included in the multivariable-adjusted Cox regression model.