SUPPLEMENTAL TABLE 1: Medications

The medications in this study were extracted by the California Department of Health Care Services (DHCS) Medi-Cal pharmacy data based on general therapeutic category (GTC) and selective therapeutic category (STC). The following is a list of medications included in this study:

Antipsychotic medications (GTC 80 "psychotherapeutic drugs")		
Antipsychotic medication class	**Selective therapeutic category name (code)**	**Specific medication**
First-generation antipsychotics	Dopamine antagonists, butyrophenones (9153)	Droperidol Haloperidol; haloperidol decanoate; haloperidol lactate
	Dopamine antagonists,thioxanthenes (9154)	Chlorprothixene Thiothixene; thiothixene HCL
	Dopamine antagonists, diphenylbutypiperidines (9156)	Pimozide
	Dopamine antagonist, dihydroindolones (9157)	Molindone HCL
	Dopamine & serotonin antagonists (9159)	Loxapine HCL, loxapine succinate
Second-generation antipsychotics	Atypical, dopamine & serotonin antagonist (9158)	Asenapine maleate Clozapine Iloperidone Lurasidone HCL Olanzapine; olanzapine pamoate Paliperidone; paliperidone palmitate Quetiapine fumarate Risperidone, risperidone microspheres Ziprasidone HCL, ziprasidone mesylate
	Atypical, D2 partial agonist/5HT mixed (9851)	Aripiprazole
Anti-diabetic medications (GTC 71 "antihyperglycemics")		
Selective therapeutic category name (code)		**Specific medication**
Insulins (0177)		Insulin (all forms)
Antihyperglycemic, insulin-release stimulant type (0178)		Acetohexamide Chlorpropamide Glimepiride Glipizide Glyburide; glyburide micronized Nateglinide Repaglinide Tolazamide Tolbutamide
Antihyperglycemic, biguanide type (0179)		Metformin HCL
Antihyperglycemic, alpha-glucosidase inhibitor (N-S) (7768)		Acarbose Miglitol
Antihyperglycemic, insulin-response enhancer (N-S) (7769)		Pioglitazone HCL Rosiglitazone maleate Troglitazone

SUPPLEMENTAL TABLE 2: Estimating DM in the screened and overall samples

Estimates of the prevalence of diabetes presented in this manuscript are based on screened participants. As reported, overall and standardized prevalence was 32.0% and 27.3%, respectively. These results are likely biased high, because providers preferentially screen patients who are at elevated risk of diabetes. To reduce selection effects, we repeated this analysis using inverse weighting of the screened sample, to make it representative of the demographic and risk factor distribution of the parent sample of people with severe mental illness taking antipsychotic medications.(9) The resulting estimate was 27.8% (95%CI 27.0-28.6%). Finally, we re-estimated diabetes prevalence among all participants from the parent sample, including the unscreened, to establish a lower bound for the SMI population. Resulting lower bound estimates of overall and standardized diabetes prevalence rates were 10.9% and 9.6% respectively.

Since this manuscript focuses on racial/ethnic minorities, we wanted to make sure that there were not differences in screening based on race/ethnicity that could explain the differences in diabetes prevalence among these minority populations. In the parent study, almost 70% of the population was unscreened for diabetes, with some variability in diabetes based upon race/ethnicity (29.3-31.4%), but these differences were only statistically significant when comparing Hispanics to whites (APR=1.12, 95%CI=1.01-1.24, p=.03).(9) Below are the differences in prevalence of diabetes among racial/ethnic minorities using inverse probability weighting.

Prevalence of diabetes among racial/ethnic minorities (inverse probability weighting)

Race	Proportion	95% CI
Asian	.278	.256-.302
Black	.301	.282-.320
Hispanic	.284	.266-.302
Other	.309	.284-.335
White	.255	.242-.268