**Supplementary Material**

Supplement to: La Grotta R., et al. Feasibility of a diabetes prevention program at nationwide level in general practice: a pilot study in Italy.

**Supplementary Table 1. Examples of physical activity prescriptions tailored according to category of risk. Source references for evidence-based prescriptions are provided.**

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| --- | --- | --- | --- | --- |
| **Category of risk (PAR-Q)** | **Prescription** | **Resistance Training** | **Example** | **Reference** |
| **Low Risk (** **Younger individuals, asymptomatic, meeting no more than one risk factor threshold)** | Recommend moderate-intensity aerobic activities | 150 minutes per week.Suggest incorporating two or more days a week focusing on major muscle groups using body weight exercises or weights | Encourage activities such as brisk walking, cycling, swimming, or dancing for 30 minutes on most days of the week | 1,2 |
| **Moderate Risk (Older individuals over 45 years old with two or more risk factors)** | Advocate a combination of moderate to vigorous aerobic exercises | Emphasize incorporating resistance exercises targeting major muscle groups using weights or resistance bands at least two days a week | Recommend alternating between jogging or cycling for 25-30 minutes on most days along with high-intensity interval training (HIIT) twice a week | 3,4 |
| **High Risk (Individuals with known cardiovascular or pulmonary diseases)** | Advocate supervised exercise programs focusing on low to moderate intensity, gradually progressing over time. | Highlight the importance of focusing on cardiac rehabilitation exercises under professional guidance to ensure safety and proper monitoring | Initiate with supervised low-impact exercises like water aerobics or stationary cycling for 20-30 minutes, three times a week, gradually increasing duration and intensity under supervision | 5,6 |

References:

1. Haskell, W. L., et al. (2007). Physical activity and public health: updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. Medicine and Science in Sports and Exercise, 39(8), 1423-1434. DOI: 10.1249/mss.0b013e3180616b27.
2. Garber, C. E., et al. (2011). Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults: guidance for prescribing exercise. Medicine and Science in Sports and Exercise, 43(7), 1334-1359. DOI: 10.1249/MSS.0b013e318213fefb.
3. Weston, K. S., et al. (2014). High-intensity interval training in patients with lifestyle-induced cardiometabolic disease: a systematic review and meta-analysis. British Journal of Sports Medicine, 48(16), 1227-1234. DOI: 10.1136/bjsports-2013-092576.
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5. Taylor, R. S., et al. (2014). Exercise-based rehabilitation for heart failure. Cochrane Database of Systematic Reviews, 4(4), CD003331. DOI: 10.1002/14651858.CD003331.pub4.
6. Fletcher, G. F., et al. (2013). Exercise standards for testing and training: a scientific statement from the American Heart Association. Circulation, 128(8), 873-934. DOI: 10.1161/CIR.0b013e31829b5b44.

**Supplementary Figure S1. Screenshots from the web-based app used by the general practitioners showing the used version of the Findrisc and PAR-Q questionnaires.**

